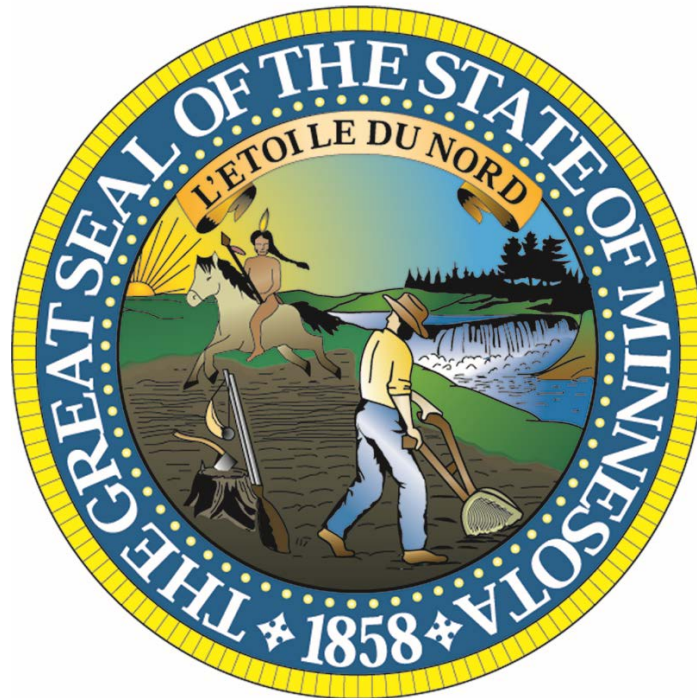


Putting the Promise of *Olmstead* into Practice: Minnesota's Olmstead Plan



February 2017 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	<ol style="list-style-type: none">1. Go to: Mn.gov/Olmstead2. 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

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Minnesota Olmstead Subcabinet

February 28, 2017

To the People of Minnesota,

On behalf of the Olmstead Subcabinet, I am pleased to present this February 2017 Revision of Minnesota's Olmstead Plan. This Plan continues our commitment to building a future where people with disabilities experience lives of inclusion and integration into the community.

This Plan takes into account feedback from people with disabilities and others about what is working and what needs improvement after the first full year of seeing the State's Olmstead Plan in action. It also gave people from State agencies the opportunity to fine tune the goals based on lessons learned.

This Plan is about choice, not about closure. The ultimate success of this Plan will be measured by an increase in the number of people with disabilities who have the opportunity to live close to friends and family, work in competitive, integrated employment, be educated in integrated school settings, and fully participate in community life – all based on their abilities and preferences.

The Olmstead Plan is a roadmap that lays out the broad measurable goals necessary to accomplish the vision of a more inclusive community. For those who want to see more detail, we publish workplans with specific actions that State agencies will take to make progress towards the goals. We also publish regular progress reports on both the workplans and the goals. These documents, as well as historical Olmstead documents and Subcabinet meeting materials, are available on the Olmstead website, www.Mn.gov/Olmstead.

Thank you to the people with disabilities that helped us to develop and revise the Plan. Thank you to the staff of our State agencies who have worked to create ambitious, but realistic goals and are now working to make real progress towards those goals. Thank you to the thousands of people around the State who are working 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 enacted by Congress 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 ADA, 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
- 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

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”), http://www.ada.gov/olmstead/q&a_olmstead.htm, last visited December 16, 2016.

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.R. §35.130(d).

⁶ 28 C.F.R. pt. 35, App. A (2010)(addressing §35.130).

⁷ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

⁸ *Olmstead*, 527 U.S. at 607.

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

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

⁹ 28 C.F.R. §35.130(b)(7).

¹⁰ *Olmstead*, 527 U.S. at 603.

¹¹ 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, <http://www.justice.gov/crt/opa/pr/speeches/2012/crt-speech-120621.html>, last visited December 16, 2016.

¹² For a list of recent DOJ enforcement actions, review US DOJ, “Olmstead: Community Integration for Everyone,” http://www.ada.gov/olmstead/olmstead_enforcement.htm, last visited December 16, 2016.

¹³ In particular, drafting teams consulted Question and Answer #12, *What is an Olmstead Plan?*, DOJ Statement, pg. 4.

¹⁴ Executive Orders 13-01 and 15-03, available on the Olmstead website, Mn.gov/Olmstead.

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

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 in 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 a number of State agencies as well as representatives from pertinent State entities. The Subcabinet includes the following:

- 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
- Office of the Ombudsman for Mental Health and Developmental Disabilities
- Governor’s Council on Developmental Disabilities

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

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 and 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 2015 study on homelessness in Minnesota, 60% of adults experiencing homelessness reported a serious mental illness, 51% reported a chronic physical health condition, 30% 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 21% reported a substance abuse disorder. 80% of 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 68 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.

Plan development and public comments

The Olmstead Plan is a vital roadmap that will help the Subcabinet and State agencies realize the vision of people with disabilities living, learning, working and enjoying life in the most integrated settings. The dynamic nature of the Plan means that the Olmstead Subcabinet and State agencies are regularly examining the Plan goals and strategies to ensure they are the most effective means to achieve meaningful change. Public comment played an important role in the development of the Olmstead Plan and continues to inform and shape amendments to the Plan.

There have been three major phases in the development of the current Olmstead Plan:

- The development of the August 2015 Olmstead Plan
- The June 2016 Plan amendment to incorporate additional goals and strategies
- The annual Plan review and amendment process, which resulted in this revised February 2017 Plan

The August 2015 Plan

The Olmstead Subcabinet and State agencies solicited extensive public comment on the development of the August 2015 Olmstead Plan. Between June 2013 and June 2015, over 400 public comments were received by the Olmstead Implementation Office. In addition the Olmstead Subcabinet conducted a number of listening sessions and the Olmstead Implementation Office conducted informational sessions that accepted public comments on the Plan.

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 The majority of the comments related to the 11 theme areas below.

²⁰ Wilder Research, "2015 Minnesota Homeless Study Fact Sheet," 2015, 3. <http://mnhomeless.org/pdfs/2015-homeless-study-initial-findings-fact-sheet.pdf>, last accessed January 5, 2017.

²¹ CDC, "Autism Spectrum Disorders: Data & Statistics." <http://www.cdc.gov/ncbddd/autism/data.html>, last accessed January 5, 2017.

²² These themes were derived from the April 24, 2015 to June 19, 2015 Plan comment period. For a more detailed discussion of the public comments received in the development of the August 2015 plan and how these themes were incorporated into the Olmstead Plan, please see the August 2015 or June 1, 2016 Plans, available on the Olmstead website, Mn.gov/Olmstead.

Theme Definitions

- 1) **Options and Choices** – 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.
- 2) **Financial Resources** – 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.
- 3) **Quality Assurance/Accountability** – 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.
- 4) **Access** – 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.
- 5) **Risk** – 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.
- 6) **Person-Centered** – People felt strongly that individuals should be able to make informed decisions in all areas of their lives.
- 7) **Barriers/Disincentives** – People shared that there are many policies that prevent individuals, families and businesses from achieving the Olmstead vision.
- 8) **Engagement** – People said that individuals with disabilities should be meaningfully involved in the direction of those policies and other things that impact their lives.
- 9) **Data** – People are dissatisfied with many of the data sources being used. They expressed that data need to be robust and understandable. Many people felt that as a State we collect a great deal of data about our citizens.
- 10) **Training and Technical Assistance** – People said that training and technical assistance is needed for everyone.
- 11) **Accessible Communications** – People were dissatisfied with the level of accessibility in State communications. Providing accessible communications will lead to transparency and awareness.

The public comments helped to determine the scope of the Plan, the topics it contains, and what outcomes the Plan should achieve. The August 2015 Plan focused 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. On September 29, 2015, the Court approved the State’s August 2015 Olmstead Plan.

The Olmstead Plan was structured to contain measurable goals and broad strategies to achieve them. The detailed actions to implement the strategies are contained in separate workplans created by the responsible agencies. The Subcabinet and State agencies review progress on the workplans on a periodic basis. More information on the workplans is available in the Plan Management and Oversight section.

June 2016 Plan Amendment

Two topic areas remained under development when the Court approved the August 2015 Olmstead Plan— Assistive Technology and Preventing Abuse and Neglect. The Olmstead Subcabinet and State agencies, with assistance from the Court, developed proposed goals and strategies in those topic areas in the first half of 2016. After soliciting public comments on the proposed goal areas, the Subcabinet approved the new goals and strategies. The June 2016 Plan amendment incorporated those new goals and strategies and was approved by the Court on June 21, 2016.

Plan amendment process and February 2017 Plan

The dynamic nature of the Plan means that it is important for the Subcabinet and State agencies to review and update the Plan regularly in light of progress made and lessons learned. The first year of Plan implementation resulted in new levels of coordination and collaboration among the State agencies as they worked to develop processes and mechanisms to make progress towards achieving Plan goals. The annual Plan amendment process is an opportunity to utilize both State agency experience over the past year as well as ongoing public comment to craft an updated Plan.

In the latter part of 2016, the Olmstead Subcabinet undertook the first annual Plan review and amendment process. An initial opportunity for public comments was provided from October 25 to November 14, 2016. This comment period focused on the 39 measurable goals in the Plan and sought to identify both barriers that hinder progress and opportunities to improve progress. Comments were accepted in a variety of formats, including at three public listening sessions. After the initial public comment period, the State agencies developed and the Subcabinet provisionally approved amendments to 15 of the measurable goals.

A second opportunity for public comment was provided from December 20, 2016 to January 19, 2017 regarding the proposed amendments to the measurable goals. The Subcabinet reviewed the public comments, the measurable goal amendments, and updates to the supporting Plan text at the January 30, 2017 Subcabinet meeting.

A final opportunity for public comments was provided from January 31, 2017 to February 7, 2017. During the three public comment periods, comments were received from 60 individuals or agencies. The 60 comments included approximately 180 recommendations or feedback on all fourteen topic areas. The topic areas that received the most attention were person-centered planning, transition services, housing, and employment.

Almost half of the 180 recommendations focused on direct service workforce issues either in general or as they related to person-centered planning, transition services, housing, and employment. These comments raised concern that without improvements to these workforce issues, improvement in the topic areas was unlikely.

After consideration of the public comments, the Olmstead Subcabinet reviewed and approved this February 2017 Plan on February 22, 2017.

Where to learn more?

The Olmstead website at Mn.gov/Olmstead, contains:

- Information and documents related to the history of the Minnesota Olmstead Plan, including Executive Orders;
- Previous versions of the Olmstead Plan, including historical supporting documentation;
- Periodic reports reflecting current and ongoing progress on measurable goals; and
- Information and materials related to Olmstead Subcabinet meetings.

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MEASURABLE GOALS

Topic Areas and Measurable Goals

The Minnesota Olmstead 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 Preventing 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 defined number of years.
- **Specific and reasonable timeframes:** Each measurable goal has specific and reasonable timeframes for which State agencies will be held accountable.
- **Funding:** Measurable goals 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.
- **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 develop workplans that 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.

Previous versions of the Olmstead Plan included a “What we have achieved” section in each topic area. These versions of the Plan, including historical supporting documentation are available on the Olmstead website.

Measurable Goals at a Glance

The table below provides a summary of the measurable goals contained in the Plan that indicate targeted outcomes within a defined number of years. More information about the specific goals is included in the topic area sections of the Plan. Agency acronyms are listed at the end of the table.

Topic	Goals	Agency
Person-Centered Planning	<p>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.</p> <p>Annual Goals for the percent of plans that meet required protocols:</p> <ul style="list-style-type: none"> • 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. 	<p>DHS, DEED, MDE, ADM</p>
	<p>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.</p> <p>(A) Annual Goals for the percent reporting they have input into major life decisions:</p> <ul style="list-style-type: none"> • By 2015, the percent will increase to $\geq 45\%$ • By 2016, the percent will increase to $\geq 50\%$ • By 2017, the percent will increase to $\geq 55\%$ <p>(B) Annual Goals for the percent reporting they have input in everyday decisions:</p> <ul style="list-style-type: none"> • By 2015, the percent will increase to $\geq 84\%$ • By 2016, the percent will increase to $\geq 85\%$ • By 2017, the percent will increase to $\geq 85\%$ <p>(C) Annual Goals the percent reporting they are always in charge of their services and supports:</p> <ul style="list-style-type: none"> • By 2015, the percent will increase to $\geq 70\%$ • By 2016, the percent will increase to $\geq 75\%$ • By 2017, the percent will increase to $\geq 80\%$ 	

Topic	Goals	Agency	
Transition Services	<p>Goal One: By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings will be 7,138.</p> <p>Annual Goals for the number of people moving from (A) ICFs/DD; (B) nursing facilities; and (C) other segregated settings</p> <ul style="list-style-type: none"> • 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	
	<p>Goal Two: By June 30, 2019, the percent of people under mental health commitment at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting will be reduced to 30% (based on daily average).</p> <p>Annual Goals to reduce the percent of people at AMRTC awaiting discharge:</p> <ul style="list-style-type: none"> • 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% 		
	<p>Goal Three: By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital to a more integrated setting will increase to 10 individuals per month.</p> <p>Annual Goals to increase average monthly number of individuals leaving MSH:</p> <ul style="list-style-type: none"> • By December 31, 2016 the number will increase to ≥ 7 • By December 31, 2017 the number will increase to ≥ 8 • By December 31, 2018 the number will increase to ≥ 9 • By December 31, 2019 the number will increase to ≥ 10 		
	<p>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.</p> <p>Annual Goals to increase the percent of plans that adhere to transition protocols:</p> <ul style="list-style-type: none"> • 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	<p>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).</p> <p>Annual Goals to increase the number living in the most integrated housing:</p> <ul style="list-style-type: none"> • 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	<p>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.</p> <p>Annual Goals to increase the number in competitive integrated employment:</p> <ul style="list-style-type: none"> • 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
<p>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.</p> <p>Annual Goals to increase the number in competitive integrated employment</p> <ul style="list-style-type: none"> • 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 		
<p>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.</p> <p>Annual Goals for the number of students in competitive integrated employment:</p> <ul style="list-style-type: none"> • 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
Employment	<p>Goal Four: By December 31, 2019, the number of Peer Support Specialists who are employed by mental health service providers will increase by 82.</p> <p>Annual Goals to increase the number of employed peer support specialists:</p> <ul style="list-style-type: none"> • By December 31, 2017, the number will increase by 14 • By December 30, 2018, the number will increase by 30 • By December 30, 2019, the number will increase by 38 	DHS
	Lifelong Learning & Education	<p>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).</p> <p>Annual Goals for the number of students in the most integrated settings:</p> <ul style="list-style-type: none"> • 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
<p>Goal Two: By June 30, 2020 the number of students with disabilities who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase by 425 (39%) (from 2,174 to 2,599).</p> <p>Annual Goals to increase the number of students entering an integrated postsecondary education setting are:</p> <ul style="list-style-type: none"> • By June 30, 2017 the number will increase by 100 over baseline • By June 30, 2018 the number will increase by 225 over baseline • By June 30, 2019 the number will increase by 325 over baseline • By June 30, 2020 the number will increase by 425 over baseline 		
<p>Goal Three: By June 30, 2020, 80% of students in 31 target school districts will meet required protocols for effective consideration of assistive technology (AT) in the student’s individualized education program (IEP). Protocols will be based upon the “Special factors” requirement as described in Individuals with Disabilities Education Act (IDEA) of 2004.</p> <p>Annual Goal</p> <ul style="list-style-type: none"> • By December 31, 2016, pilot teams will establish a baseline and annual goals of students for whom there is effective consideration of AT. 		MDE

Topic	Goals	Agency
Waiting List	<p>Goal One: By October 1, 2016, the Community Access for Disability Inclusion (CADI) waiver waiting list will be eliminated.</p>	DHS
	<p>Goal Two: By December 1, 2015, the Developmental Disabilities (DD) waiver waiting list will move at a reasonable pace.</p>	
	<p>(A) For persons exiting institutional settings</p> <ul style="list-style-type: none"> • 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. 	
	<p>(B) For persons with an immediate need</p> <ul style="list-style-type: none"> • 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). 	
	<p>(C) For persons with a defined need</p> <ul style="list-style-type: none"> • 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. 	
	<p>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).</p>	
<p>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.</p>		
<p>Goal Five: By June 30, 2020, the DD waiver waiting list will be eliminated, within available funding limits, for persons with a defined need.</p>		

Topic	Goals	Agency
Transportation	<p>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 October 31, 2021 improvements will be made to 30 miles of sidewalks.</p> <p>(A) Curb Ramps</p> <ul style="list-style-type: none"> By December 31, 2020, accessibility improvements will be made to 4,200 curb ramps. <p>(B) Accessible Pedestrian Signals</p> <ul style="list-style-type: none"> By December 31, 2020, accessibility improvements will be made to an additional 250 APS installations. <p>Annual Goals to increase the number of APS installations by 50 per year</p> <p>(C) Sidewalk Improvements</p> <ul style="list-style-type: none"> By October 31, 2021, improvements will be made to 30 miles of sidewalks. <p>Annual Goals to improve 6 miles of sidewalks per year.</p>	MnDOT, Metropolitan Council
	<p>Goal Two: By 2025, the annual number of service hours will increase to 1.71 million in Greater Minnesota (approximately 50% increase).</p> <p>Annual Goals to increase the annual number of service hours by 57,000 hours per year.</p>	
	<p>Goal Three: By 2025, expand transit coverage so that 90% of the public transportation service areas in Minnesota will meet minimum service guidelines for access.</p>	
	<p>Goal Four: By 2025, transit systems' on time performance will be 90% or greater statewide.</p>	
	Healthcare & Healthy Living	

Topic	Goals	Agency
Healthcare & Healthy Living	<p>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.</p> <p>(A) Annual Goals to increase the number of children accessing dental care:</p> <ul style="list-style-type: none"> • 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 <p>(B) Annual Goals to increase the number of adults accessing dental care:</p> <ul style="list-style-type: none"> • 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. 	DHS, MDH
	Positive Supports	<p>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.</p> <p>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.</p> <p>Annual Goals to reduce number of people experiencing a restrictive procedure:</p> <ul style="list-style-type: none"> • 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
<p>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.</p> <p>Annual Goals to reduce the number of reports of restrictive procedures:</p> <ul style="list-style-type: none"> • 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

Topic	Goals	Agency
Positive Supports	<p>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: (A) ≤ 93 reports; and (B) ≤ 7 individuals.</p> <p>Annual Goals to reduce the use of mechanical restraints:</p> <ul style="list-style-type: none"> • 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 	DHS, MDE, MDH, DOC
	<p>Goal Four: By June 30, 2020, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 318 students or decrease to 1.98% of the total number of students receiving special education services.</p> <p>Annual Goals to reduce the number experiencing restrictive procedures at school:</p> <ul style="list-style-type: none"> • By June 30, 2017, the number will be reduced by 80 or .02% of total students • By June 30, 2018, the number will be reduced by 80 or .02% of total students • By June 30, 2019, the number will be reduced by 79 or .02% of total students • By June 30, 2020, the number will be reduced by 79 or .02% of total students 	
	<p>Goal Five: By June 30, 2020, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 2,251 or by 0.8 incidents of restrictive procedures per student who experienced the use of restrictive procedures in the school setting.</p> <p>Annual Goals to reduce number of incidents of restrictive procedures in school:</p> <ul style="list-style-type: none"> • By June 30, 2017, the number of incidents will be reduced by 563 or 0.2 per student • By June 30, 2018, the number of incidents will be reduced by 563 or 0.2 per student • By June 30, 2019, the number of incidents will be reduced by 563 or 0.2 per student • By June 30, 2020, the number of incidents will be reduced by 562 or 0.2 per student 	

Topic	Goals	Agency
Crisis Services	<p>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.</p> <p>Annual Goals to increase the percent of children who remain in their community after a crisis:</p> <ul style="list-style-type: none"> • 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
	<p>Goal Two: By June 30, 2019, 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 64% or more.</p> <p>Annual Goals to increase the percent of adults who remain in their community after a crisis:</p> <ul style="list-style-type: none"> • By June 30, 2017, the percent will increase to 60% • By June 30, 2018, the percent will increase to 62% • By June 30, 2019, the percent will increase to 64% 	
	<p>Goal Three: By June 30, 2017, the number of people who discontinue waiver services after a crisis will decrease to 45 or fewer. (Leaving the waiver after a crisis indicates that they left community services, and are likely in a more segregated setting.)</p> <p>Annual Goals to decrease the number who discontinue waiver services after a crisis:</p> <ul style="list-style-type: none"> • 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 	
	<p>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.</p> <p>(A) Annual Goals to increase percent of people who are housed five months after discharge from the hospital:</p> <ul style="list-style-type: none"> • By June 30, 2017, the percent of people will increase to 83% • By June 30, 2018, the percent of people will increase to 84% <p>(B) Annual Goals to increase the percent of people receiving services within 30 days after being discharged from the hospital:</p> <ul style="list-style-type: none"> • By June 30, 2017, the percent of people will increase to 90% • By June 30, 2018, the percent of people will increase to 91% 	

Topic	Goals	Agency
Crisis Services	<p>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.</p> <p>Annual Goals to decrease the average length of a crisis episode:</p> <ul style="list-style-type: none"> • By June 30, 2017, decrease to 79 days. • By June 30, 2018, decrease to 77 days. • By June 30, 2019, decrease to 75 days. • By June 30, 2019, develop and establish a baseline and measurable goals that reflect the broader community crisis services. 	DHS, MDE
Community Engagement	<p>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.</p> <p>(A) Annual Goals to increase the number of self-advocates:</p> <ul style="list-style-type: none"> • 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 <p>(B) Annual Goals to increase the number involved in public planning projects:</p> <ul style="list-style-type: none"> • 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	Goals	Agency
Preventing Abuse & Neglect	<p>Goal One: By September 30, 2016, the Olmstead Subcabinet will approve a comprehensive abuse and neglect prevention plan, designed to educate people with disabilities and their families and guardians, all mandated reporters, and the general public on how to identify, report and prevent abuse of people with disabilities, and which includes at least the following elements:</p> <ul style="list-style-type: none"> • Information and training on the use of the Minnesota Adult Abuse Reporting Center (MAARC) • Recommendations regarding a “Stop Abuse” campaign • Recommendations regarding the feasibility for creating a system for reporting abuse of children • Analysis of data to develop materials for public awareness and targeted prevention activities • Timetable for implementation of each element of the abuse prevention plan • Recommendations for developing common definitions and metrics related to maltreatment <p>Annual goals will be established based on the timetable set forth in the abuse prevention plan.</p>	MDH, DHS, MDE, OMHDD
	<p>Goal Two: By January 31, 2020, the number of emergency room (ER) visits and hospitalizations of vulnerable individuals due to abuse and neglect will decrease by 50% compared to baseline.</p> <p>Annual Goals to reduce the number of ER visits and hospitalizations due to abuse:</p> <ul style="list-style-type: none"> • By January 31, 2017, a baseline and annual goals will be established. • By January 31, 2018, the number will decrease by 10% • By January 31, 2019, the number will decrease by 30% • By January 31, 2020, the number will decrease by 50% 	MDH
	<p>Goal Three: By December 31, 2021, the number of vulnerable adults who experience more than one episode of the same type of abuse or neglect within six months will be reduced by 20% compared to the baseline.</p> <p>Annual Goals to reduce the number of people experiencing more than one episode of abuse</p> <ul style="list-style-type: none"> • By December 31, 2017, a baseline will be established. • By December 31, 2018, the number of people will be reduced by 5% • By December 31, 2019, the number of people will be reduced by 10% • By December 31, 2020, the number of people will be reduced by 15% • By December 31, 2021, the number of people will be reduced by 20% 	DHS

Topic	Goals	Agency
Preventing Abuse & Neglect	<p>Goal Four: By July 31, 2020, the number of identified schools that have had three or more investigations of alleged maltreatment of a student with a disability within the three preceding years will decrease by 50% compared to baseline. The number of students with a disability who are identified as alleged victims of maltreatment within those schools will also decrease by 50% by July 31, 2020.</p> <ul style="list-style-type: none"> By July 31, 2017, a baseline and annual goals will be established. 	MDE
Assistive Technology	<ul style="list-style-type: none"> Lifelong Learning and Education Measurable Goal 3 relates to Assistive Technology. 	

Agency Acronyms

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

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 respectful of his or her important relationships and goals.
- The context of a person's unique life circumstances includes: culture, ethnicity, language, religion, gender and sexual orientation. All aspects of the person's individuality, when expressed, are acknowledged, 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.

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 2014, 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.

- (A) By 2017, increase the percent of people with intellectual and developmental disabilities (I/DD) who report they have input into major life decisions²³ 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 $\geq 45\%$
- By 2016, the percent will increase to $\geq 50\%$
- By 2017, the percent will increase to $\geq 55\%$

- (B) By 2017, increase the percent of people with intellectual and developmental disabilities who make or have input in everyday decisions²⁴ 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 $\geq 84\%$
- By 2016, the percent will increase to $\geq 85\%$
- By 2017, the percent will increase to $\geq 85\%$

- (C) By 2017, increase the percent of people with disabilities other than I/DD who are always in charge of their services and supports²⁵ 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 $\geq 70\%$
- By 2016, the percent will increase to $\geq 75\%$
- By 2017, the percent will increase to $\geq 80\%$

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

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.

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.

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 (NCI) 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.
- An important aspect for many people with disabilities is support through the use of assistive technologies. As part of the [Person-Centered, Informed Choice and Transition Protocol](#), individuals are assessed to determine the need for materials, equipment, or assistive technology and, if an individual plan includes assistive technology, that technology will be acquired and tested in the environment where it will be used.

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.
- Develop materials and training to guide professionals who inform people with disabilities about their rights and their individual abuse prevention plans to increase understanding of rights and the effectiveness of planning. [Note: professionals include providers (who are responsible for abuse prevention plans), case managers, qualified professionals overseeing Personal Care Attendant services, etc.]

Evaluate the Effectiveness of Person-Centered Planning Principles and Techniques

- Use the NCI survey to measure progress until the Quality of Life survey is available. See the [Plan Management and Oversight](#) section of the Plan for more information on the Quality of Life Survey.
- Use the established protocols to 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.
- Through the MnCHOICES assessment tool, assess whether assistive technology will be considered as part of an individual's support plan, and at reassessments, monitor access to and effective use of technology.
- DHS will work with System of Technology to Achieve Results (STAR) Program and the State Quality Council and its regional councils on strategies to increase awareness of, and monitor effective use of assistive technology as a means to increase quality of life and outcomes for people with disabilities.

Incorporate Assistive Technology Assessment into Person-Centered Planning Processes

- Person-centered planning processes will be enhanced through a common process across DHS, MDE, DEED and ADM. This process will increase awareness of Assistive Technology, related services, resources and funding sources.

Expand, Diversify and Improve Minnesota's Direct Service Workforce

DHS and DEED will:

- Convene a cross-agency workgroup, including people with disabilities, the Office of Higher Education, and colleges and universities in the Minnesota State system. The workgroup will focus on developing strategies and workplan activities to recruit, train and retain direct support workers to meet Minnesota's direct service workforce needs.
- Promote the development of recruitment and training programs that lead to meaningful career pathways for the direct service workforce.
- Continue to work with key stakeholders (including people with disabilities who utilize services and their families, service providers, and advocates) to set priorities and report on actions taken on recommendations from the July 26, 2016 Workforce Summit.²⁶

Responsible Agencies

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

²⁶ "Direct Care/Support Workforce Summit – Summary Report and Next Steps", November 18, 2016, found at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7271A-ENG> .

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.”

DeJo 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.

Measurable goals

Goal One: By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings²⁷ will be 7,138.

Annual Goals for the number of people moving from: **(A)** ICFs/DD; **(B)** nursing facilities; and **(C)** other segregated housing to more integrated settings are set forth in the following table.

	2014 Baseline	June 30, 2015	June 30, 2016	June 30, 2017	June 30, 2018	June 30, 2019	June 30, 2020	Cumulative Total
(A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72*	84	84	84	72	72	72	468
(B) Nursing Facilities (NF) under age 65 in NF > 90 days	707*	740	740	740	750	750	750	4,470
(C) 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

²⁷This 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 An interim baseline will be established in early 2017. A standardized informed choice process is being implemented. When data from this process is deemed reliable and valid, baseline and goals will be re-evaluated and revised as appropriate.

Goal Two: By June 30, 2019, the percent of people under mental health commitment at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting²⁹ will be reduced to 30% (based on daily average).

Baseline: In State Fiscal Year 2015, the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting was 36% on a daily average.

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

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

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

Baseline: In Calendar Year 2014, the average monthly number of individuals leaving Minnesota Security Hospital (MSH) to a more integrated setting was 4.6 individuals per month.

Annual Goals to increase the average monthly number of individuals leaving Minnesota Security Hospital to a more segregated setting:

- By December 31, 2016 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 7
- By December 31, 2017 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 8
- By December 31, 2018 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 9
- By December 31, 2019 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 10

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.

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%.
- 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.
- Individuals at AMRTC fall into one of two categories: 1) individuals under mental health commitment; and 2) individuals under criminal court Rule 20 competency restoration commitment who are there for competency restoration. For individuals under mental health commitment, discharge planning and discharge are under the authority of the AMRTC and the lead agency. For individuals under criminal court Rule 20 competency restoration commitment, discharge planning and discharge are under the authority of the criminal court. For the AMRTC goal, progress will be measured only for those individuals under mental health commitment.
- Individuals leaving MSH may move to a more integrated setting, transfer to a treatment facility or transfer to a correctional setting. For the MSH goal, progress will be measured only for those individuals leaving to more integrated settings.
- It is projected that the census of ICF/DD will decrease over time, therefore the number of people who leave an ICF/DD over time will also decrease.
- A standardized informed choice process is in place to determine how many individuals in segregated settings would choose or not oppose moving to a more integrated setting. A baseline will be established in early 2017 and the goals will be re-evaluated and revised as appropriate.
- The "[Person-Centered, Informed Choice and Transition Protocol](#)" was adopted in February 2016 and is being implemented. A baseline indicating the degree to which the protocols are followed will be established in early 2017 and the goals will be re-evaluated and revised as appropriate.
- 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

- The “[Person-Centered, Informed Choice and Transition Protocol](#)” was adopted in February 2016 and is being 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 goal one will be reassessed.

Implement New Transition Protocols

- A “[Person-Centered, Informed Choice and Transition Protocol](#)” is being used with individuals moving to integrated settings from segregated settings to ensure that planning includes what is important to the individual as well as for the individual. The protocol aligns 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.
- 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 technical assistance and education about assistive technology to lead agencies and providers and provide examples of innovative uses of assistive technology to support people in making successful transitions to the most integrated settings.
- 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 this 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 address any concerns or objections raised by the individual or another relevant decision-maker.”³⁰

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.

³⁰ “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 5, pg. 2.

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.³¹ 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.³²

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 State fiscal year 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.

³¹ Based on "[A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report](#)" and information from ICFs/DD and Nursing Facilities.

³² 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

- Continue to implement housing policy changes adopted during the 2015 legislative session. These policy changes 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 <i>Olmstead</i> 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 address 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 2014, published in 2016)³³:

- The employment rate of working-age people (ages 21 to 64) with disabilities in Minnesota was 44.0%. For the general population it was 84.3%.
- The percentage of working-age people with disabilities who were unemployed and actively looking for work was 8.3%. For people without a disability who were actively looking for work it was 21.2%.
- The percentage of working-age people with disabilities working full-time/full-year was 24.3% with average annual earnings of \$42,400. For working-age people without disabilities, 62.2% were working full-time/full-year with average annual earnings of \$48,400.

³³ 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.

Based on statistics reported by DEED from October 2015- September 2016:

- Vocational Rehabilitation Services (VRS) provided services to 17,674 persons under Title I of the Rehabilitation Act, all of whom were individuals with a significant disability.
- State Services for the Blind (SSB) provided vocational rehabilitation services to 1,027 persons who are blind, visually impaired, and DeafBlind.
- 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 12% received State Vocational Rehabilitation Services.
- For comparison, 20% 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.

Measurable goals

Goal One: By September 30, 2019 the number of new individuals³⁴ 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

³⁴ "New" individuals mean individuals who were closed successfully from the Vocational Rehabilitation 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.

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, the number of individuals in competitive integrated employment will increase by 1,500 individuals³⁵
- 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.

³⁵ 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.

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 fiscal years 2015 and 2016 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.

Goal Four: By December 31, 2019, the number of Peer Support Specialists who are employed by mental health service providers will increase by 82.

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

Annual Goals to increase the number of employed peer support specialists:

- By December 31, 2017, the number of employed peer support specialists will increase by 14
- By December 30, 2018, the number of employed peer support specialists will increase by 30
- By December 30, 2019, the number of employed peer support specialists will increase by 38

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.
- DHS has developed an interim data system to measure an increase in competitive integrated employment. See the [Plan Management and Oversight](#) section for more information on cross-agency coordination of data strategies.
- 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 the [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

- As of 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.
- Increase awareness of and education about ways that Assistive Technology products, services and resources can support competitive integrated employment outcomes. This includes working with the Diversity and Inclusion Council³⁶ as they address disparities for people with disabilities.
- Increase employment opportunities for certified peer specialists by mental health service providers.

³⁶ Governor Dayton's Executive Order [15-02](#) established the Diversity and Inclusion Council to improve diversity in recruiting, retaining, and promoting state employees, in state contracting, and civic engagement in Minnesota.

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 waived 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
- Department of Administration

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 2004³⁷ 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 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.

³⁷ IDEA is a federal law that governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

Measurable goals

Goal One: By December 1, 2019 the number of students with disabilities³⁸, receiving instruction in the most integrated setting³⁹, 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 June 30, 2020 the number of students with disabilities who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase by 425 (39%) (from 2,174 to 2,599).

Baseline: Using the 2014 Minnesota's Statewide Longitudinal Education Data System (SLEDS), of the 6,749 students with disabilities who graduated statewide in 2014, a total of 2,174 (32.2%) attended an integrated postsecondary institution from August 2014 to July 2015.

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

- By June 30, 2017 there will be an increase of 100 (34%) over baseline to 2,274
- By June 30, 2018 there will be an increase of 225 (36%) over baseline to 2,399
- By June 30, 2019 there will be an increase of 325 (37%) over baseline to 2,499
- By June 30, 2020 there will be an increase of 425 (39%) over baseline to 2,599

Goal Three: By June 30, 2020, 80% of students in 31 target school districts will meet required protocols for effective consideration of assistive technology (AT) in the student's individualized education program (IEP). Protocols will be based upon the "Special factors" requirement as described in Individuals with Disabilities Education Act (IDEA) of 2004.

Annual Goals

- By December 31, 2016, pilot teams will establish a baseline and annual goals of the number of students for whom there is effective consideration of AT.

³⁸ "Students with disabilities" are defined as students with an Individualized Education Program age 6 to 21 years.

³⁹ "Most integrated setting" refers to receiving instruction in regular classes alongside peers without disabilities, for 80% or more of the school day.

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

- In 2016, progress on this goal was measured using the annual Post School Outcome Survey, which uses a limited sample of students who voluntarily participate.
- A broader data system, the Minnesota's Statewide Longitudinal Education Data System (SLEDS), is now available. This data system will more accurately measure statewide progress on the goal.
- SLEDS data is available annually and includes the number of special education students who graduated the prior school year and enrolled in a postsecondary institution within one year of graduation. In addition, summary data provides student's racial/ethnic group and the primary type of disability.

Goal Three

- As part of the "Special Factors" requirement in the federal Individuals with Disabilities Education Act of 2004, IEP teams must "consider whether the child requires assistive technology devices and services." (34 C.F.R. §300.324(a)(2)(v)).
- There are four potential outcomes to consideration of assistive technology to support achievement of IEP goals. These are:
 - The student is making adequate educational progress without the use of AT. No further action is needed.
 - The student is making adequate educational progress with the use of AT. The use of AT should be documented in the IEP and continued in use.
 - The student may or may not be using AT, but is not making adequate educational progress. The IEP team should explore other AT strategies that can be of benefit.
 - No one on the IEP team knows enough to determine if AT can be of benefit. The IEP team needs to add membership with information and knowledge of AT.
- Many school districts' IEP forms only document whether AT has been considered and whether it is necessary. This is not enough information to determine if the consideration was effective.

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. During the 2016-2017 school year there are 576 or 28% of Minnesota schools implementing PBIS, impacting an estimated 288,477 students. (33% of all students)

Continue Strategies to Effectively Support Students with Low-Incidence Disabilities

- 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 Identified 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.

Goal Three

Expand Effectiveness of Assistive Technology Teams Project

- Continue to host AT Teams Projects, designed to support school district AT Teams in providing services that are in alignment with legal standard and best practices in AT. Target districts for this goal will be AT Teams Project participants. There are currently 31 school districts actively participating in the AT Teams Project, with new teams being added for state fiscal year 2017.
- Develop protocols for consideration of AT that includes documentation to record the four potential outcomes and to demonstrate that AT consideration was effective.

- Each target district will gather baseline data on the outcome of consideration of AT for the students on whose IEP team they serve. A matrix of potential determinations will be provided to each team member, which will then be provided to MDE as part of the team's agreement for participation in the AT Teams Project.
- It is a best practice to document the decision making process used to consider the student's need for assistive technology. For example a statement regarding the discussion of assistive technology needs may be documented in the minutes of the IEP meeting and may be included in other components of the IEP.

Responsible Agencies

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

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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.

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.

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

- 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.

(B) 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.

(C) 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 date 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 CADI waiver waiting list was eliminated in October 2016. DHS will continue to monitor access to CADI waiver services.
- The reasonable pace standards outlined in goal two were implemented on December 1, 2015, and planned new data systems and training was provided on the new urgency categories and standards to lead agencies. Annual data will be available by May 2017, 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.
- 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 and the legislature as required.
- Due process protections available to people with disabilities will be modified as necessary, to reflect new waiting list protocols.
- DHS will complete an analysis of baseline data on urgency of need and reasonable pace. The analysis will consider the needs of persons waiting, potential options to meet their needs, and the evaluation of existing programs to determine if there are changes which would enable programs to be more effective.

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.

Responsible Agency

- Department of Human Services

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.”	<i>Dalaine Remes</i> (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.

Measurable goals

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

(A) Curb Ramps

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

- By December 31, 2020 accessibility improvements will be made to 4,200 curb ramps⁴⁰ bringing the percentage of compliant ramps to approximately 38%.

⁴⁰ ADA Title II Requirements for curb ramps at www.fhwa.dot.gov/civilrights/programs/doj_fhwa_ta_glossary.cfm

(B) Accessible Pedestrian Signals

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

- By December 31, 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

(C) Sidewalks

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

- By October 31, 2021 improvements will be made to an additional 30 miles of sidewalks

Annual Goals to improve sidewalks:

- By October 31, 2017 improvements will be made to an additional 6 miles of sidewalks
- By October 31, 2018, improvements will be made to an additional 6 miles of sidewalks
- By October 31, 2019, improvements will be made to an additional 6 miles of sidewalks
- By October 31, 2020, improvements will be made to an additional 6 miles of sidewalks
- By October 31, 2021, improvements will be made to an additional 6 miles of sidewalks

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

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

Annual Goals to increase the annual number of service hours by 57,000 per year:

- By December 31, 2017, the annual number of service hours will increase to 1,257,000
- By December 31, 2018, the annual number of service hours will increase to 1,314,000
- By December 31, 2019, the annual number of service hours will increase to 1,371,000
- By December 31, 2020, the annual number of service hours will increase to 1,428,000
- By December 31, 2021, the annual number of service hours will increase to 1,485,000
- By December 31, 2022, the annual number of service hours will increase to 1,542,000
- By December 31, 2023, the annual number of service hours will increase to 1,599,000
- By December 31, 2024, the annual number of service hours will increase to 1,656,000
- By December 31, 2025, the annual number of service hours will increase to 1,713,000

Goal Three: By 2025, 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](#)."⁴¹

Baseline: A baseline for access will be established by April 30, 2017.

Goal Four: By 2025, transit systems' on time performance will be 90% or greater statewide.

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

Baseline for on time performance in 2014 was:

- Transit Link – 97% within a half hour
- Metro Mobility – 96.3% within a half hour timeframe
- Metro Transit – 86% within one minute early – four minutes late
- Greater Minnesota – 76% within a 45 minute timeframe

Ten year goals to improve on time performance:

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

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.

⁴¹ Greater Minnesota Transit Investment Plan is available at www.dot.state.mn.us/transitinvestment.

Goal Two

- Service hours are a more effective metric for measuring the availability of transit service in Greater Minnesota than ridership. The MnDOT Office of Transit currently tracks and reports on the number of service hours by system in the Annual Transit Report. Beginning with the 2001 Greater Minnesota Transit Plan, the number of service hours of transit have been used in describing the future level of service to address the transit need/demand. This metric is also one of the factors mentioned in recent research that impacts the transit travel demand (ridership).
- The annual goals are incrementally ramped up each year by 57,000. Of the total 57,000 additional hours each year, 28,500 will be added to urban systems and 28,500 to small urban and rural transit systems combined. The 57,000 additional hours will provide service needed to increase ridership to meet the 90 percent of demand target by 2025.
- In addition to data on service hours, MnDOT reporting will also include data on passenger trips.
- MnDOT is monitoring emerging issues in alternatives to public transportation and the impact that such alternatives may have on public transportation.

Goal Three

- The goal is linked to the system expansion goal which 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 goal ensures that system expansion has appropriate geographic balance and service variety to provide for a variety of trip needs.
- 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 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.

Goal Four

- The five year goals for on-time performance are consistent with the Metropolitan Council's long standing goal of 95%. The 95% goal is the performance goal used in Metropolitan Council's service contracts which is reported to the Federal Transit Administration.

Strategies

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 \(STIP\)](#).⁴²
- MnDOT will continue to work with our local partners through our project development process to encourage additional accessibility improvements whenever possible.

⁴² More information on STIP can be found at www.dot.state.mn.us/planning/program/stip.html.

Increase Involvement in Transportation Planning by People with Disabilities

- MnSHIP was updated in 2017 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.

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

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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.”⁴³

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.”⁴⁴ 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.⁴⁵

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.

⁴³ American Heritage Medical Dictionary, “Healthcare.” Boston: Houghton Mifflin Harcourt Publishing, 2008, 236.

⁴⁴ 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>.

⁴⁵ 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/hpdata2010_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.

Measurable goals

Goal One: By December 31, 2018, the number/percent of individuals with disabilities and/or serious mental illness accessing appropriate preventive care⁴⁶ 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).

Baseline: In 2013, the number of women receiving cervical cancer screenings was 21,393 and the number of individuals accessing follow up care for cardiovascular conditions was 1,589.⁴⁷

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.

(A) Children accessing dental care

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

⁴⁶ Appropriate care will be measured by current clinical standards.

⁴⁷ Baselines for these goals are from the 2013 "Olmstead Plan: [Baseline Data for Current Care](#)" Report.

(B) Adults accessing dental care

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).
- 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

- Monitor the implementation of the increase in dental payment rates in January 2016 and thereafter. 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 the "[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

- Monitor the implementation of behavioral health homes that began 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.⁴⁸ 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. As of August 31, 2015, with the adoption of the Positive Supports Rule, those same requirements 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 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.

⁴⁸ 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.

- 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.

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. These situations include 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 9544⁴⁹, with limited exceptions to protect the person from imminent risk of serious injury. Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and safety clips for safe vehicle transport. By December 31, 2019 the emergency use of mechanical restraints will be reduced to: (A) ≤ 93 reports; and (B) ≤ 7 individuals.

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

Annual Goals to reduce the use of mechanical restraints:

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

Goal Four: By June 30, 2020, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 318 students or decrease to 1.98% of the total number of students receiving special education services.

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

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

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

⁴⁹ Minnesota Security Hospital (MSH) is governed by the Positive Supports Rule when serving people with a developmental disability.

- By June 30, 2018 the number of students experiencing emergency use of restrictive procedures will be reduced by 80 students or .02% of the total number of students receiving special education services.
- By June 30, 2019 the number of students experiencing emergency use of restrictive procedures will be reduced by 79 students or .02% of the total number of students receiving special education services.
- By June 30, 2020 the number of students experiencing emergency use of restrictive procedures will be reduced by 79 students or .02% of the total number of students receiving special education services.

Goal Five: By June 30, 2020, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 2,251 or by 0.8 incidents of restrictive procedures per student who experienced the use of restrictive procedures in the school setting.

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

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

- By June 30, 2017, the number of incidents of emergency use of restrictive procedures will be reduced by 563 incidents, or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.
- By June 30, 2018, the number of incidents of emergency use of restrictive procedures will be reduced by 563 incidents or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.
- By June 30, 2019, the number of incidents of emergency use of restrictive procedures will be reduced by 563 incidents or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.
- By June 30, 2020, the number of incidents of emergency use of restrictive procedures will be reduced by 562 incidents or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.

Rationale

Goals One - Three

- Progress towards these goals will be measured through incident tracking from Behavioral Intervention Reporting Forms (BIRFs). 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.
- 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.)
- These 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.
- The new positive supports rule (Minn. Rule, part 6544) that went into effect in August 2015 for providers with 245A licenses who serve people with developmental disabilities also report through the BIRF system. This may require a reassessment of the baseline and goals.
- DHS believes the targets to be realistic based upon the experience from other states and Minnesota's success following positive supports training.

Goals Four - Five

- Progress towards these goals will be measured through incident tracking from annual restrictive procedure summary reports.
- 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 1 of each year.
- The number of students receiving special education services varies each year. Reporting by number of incidents alone does not accurately reflect performance. A secondary measure of a percentage reduction is included to allow for fluctuations in the total number of students.

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

- The number of students experiencing restrictive procedures varies each year. Reporting by number of incidents alone does not accurately reflect performance. A secondary measure of a rate per student is being added to allow for fluctuations in the total number of students experiencing restrictive procedures.
- MDE and school districts provided training to staff to assure common definitions were used to make reporting more consistent. During this training it became evident that there were different definitions of reporting across school districts and across the State. In order to better measure progress, a new baseline has been established using the common definitions for reporting during the 2015-2016 school year. Annual targets are being adjusted accordingly.
- There is funding to support actions related to the current goals.

Strategies

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

- Continue to implement the Positive Supports Rule (Minnesota Rules Chapter 9544) which became 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. During the 2016 - 2017 school year there are 576 or 28% of Minnesota schools implementing PBIS, impacting an estimated 288,477 students. (33% of total students)
- Continue to 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 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; (2) assess the number of individuals experiencing restrictive procedures and the number of incidents or applications of restrictive procedures; and (3) to identify situations to be targeted for technical assistance.
- 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.

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.

- Continue to implement MDE’s Statewide Plan to Reduce the Use of Restrictive Procedures and Eliminate the Use of Prone Restraint. (Statewide Plan) If the legislature acts to eliminate the use of seclusion in schools, MDE will adjust goals four and five as needed to reflect the changes.
- MDE will document progress in Statewide Plan implementation and summarize restrictive procedure data in the annual legislative report submitted February 1 of each year. MDE will track individual uses of seclusion on students receiving special education services by requiring districts to submit individual incident reports of each use of seclusion. These reports will assist MDE and the Restrictive Procedures Work Group in identifying areas of concern and developing strategies for eliminating the use of seclusion.
- Restrictive procedures may only be used in the school setting in an emergency, by licensed professionals, who have received training which includes positive behavioral interventions, de-escalation, alternatives to restrictive procedures, and impacts of physical holding and seclusion.
- MDE will provide evidence-based strategies to use with students with disabilities who have significant needs that result in self-injurious or physically aggressive behaviors.

Reduce the Use of Seclusion in Educational Settings

- Engage the Restrictive Procedures Work Group⁵² 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.

Vision 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.

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, 2019, 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 64% or more.

Baseline: From January to June 2016, of the 5,206 episodes, for persons over 18 years, the person remained in their community 3,008 times or 57.8% of the time.

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

- By June 30, 2017, the percent who remain in their community after a crisis will increase to 60%
- By June 30, 2018, the percent who remain in their community after a crisis will increase to 62%
- By June 30, 2019, the percent who remain in their community after a crisis will increase to 64%

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

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

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

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

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.

There are two measures for this goal:

(A) Stable Housing

Baseline: From July 2014 – June 2015, 81.9% of people discharged from the hospital due to a crisis were housed five months after the date of discharge compared to 80.9% in the previous year.

Annual Goals to increase the percent of people who are housed five months after discharge from the hospital.

- By June 30, 2017, the percent of people who are housed five months after discharge from the hospital will increase to 83%.
- By June 30, 2018, the percent of people who are housed five months after discharge from the hospital will increase to 84%.

(B) Community Services

Baseline: From July 2014 – June 2015, 89.2% people received follow-up services within 30-days after discharge from the hospital compared to 88.6% in the previous year.

Annual Goal to increase the percent of people who receive appropriate community services within 30-days after discharge from the hospital.

- By June 30, 2017, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 90%.
- By June 30, 2018, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 91%.

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.

Baseline: Between September 1, 2015 and January 31, 2016, the average length of a crisis episode was 81.3 days.

Annual Goals to decrease the average length of a crisis episode:

- By June 30, 2017, decrease the average length of a crisis episode to **79** days.
- By June 30, 2018, decrease the average length of a crisis episode to **77** days.
- By June 30, 2019, decrease the average length of a crisis episode to **75** days.
- By June 30, 2019, develop and establish a baseline and measurable goals that reflect the broader community crisis services.

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.
- 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.

Goals One - Three

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”.
- Effective January 1, 2016, adult mental health crisis providers were required to report the location of residence after a crisis event into the Mental Health Information System (MHIS). Prior to January 1, 2016, mental health providers only reported if the individual was admitted to an inpatient psychiatric unit.
- 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.

Goal Four

- This goal uses two separate measures. The first measure represents the percent of people on Medical Assistance (MA) who received community services within thirty days after discharge from a hospital due to a crisis. The second measure includes the percent of people that were housed, not housed, or in a treatment facility, five months after their discharge date.
- The number of people served in crisis services carries yearly. Using a percentage measure allows for fluctuations in the total number of individuals receiving services in a year.

Goal Five

- The baseline and the 2017, 2018 and 2019 goals for the average length of a crisis episode is a proxy measure for access to crisis services. By June 30, 2019, a new baseline and measurable goals will be established, based on the crisis services system experience.

Strategies

Evaluate Effectiveness of Crisis Services

- Examine the utilization of crisis services to determine:
 - the number of individuals who use crisis services
 - the number of individuals demitted from where they live or work after a crisis episode
 - timeliness of crisis interventions
 - length of time crisis services are used, and
 - barriers to stable services, and permanent 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 an individual remains in a residential crisis setting when stable, and reasons for delay in returning 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 this level of service is 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)

- Implement the December 2015 recommendations from the Community-Based Services Steering Committee (DHS and stakeholder committee focused on safety net service infrastructure) to address 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.
 - Collaborate with counties to develop a plan to increase in-home respite.
 - Develop 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.
- Continue to implement Behavioral Health Homes which began 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.”	<i>Patricia Ann Wallace (2013)</i>
	“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.”	<i>Laura Birnbaum (2013)</i>
	“Not enough mental health providers are employing certified peer specialists.”	<i>NAMI Minnesota (2013)</i>

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.

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: (A) self-advocates; and (B) individuals involved in publicly funded projects.)

Baseline: As of June 30, 2014, the number of individuals engaged as self-advocates, in leadership roles (such as Governor appointed councils) or in publicly funded projects is 1,242.

(A) Self-Advocates

By June 30, 2019 the number of self-advocates or people with disabilities involved in leadership opportunities (such as governor-appointed boards and councils) will increase to 1,575.

Baseline: There are 1,200 active self-advocates involved in the Self Advocates Minnesota (SAM) network statewide and participating in Tuesday's at the Capitol⁵³

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.

(B) Involvement in Publicly Funded Projects

By June 30, 2019, the number of people with disabilities involved in planning publicly funded projects (such as stadium plans, sidewalk improvements, public infrastructure, etc.) at the Subcabinet agency level will increase to 417.

Baseline: There were 42 individuals with disabilities involved in planning 6 publicly funded projects (such as stadium plans, sidewalk improvements, public infrastructure, etc.).

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.

⁵³ Self- Advocates Minnesota is a statewide network of regional self-advocacy groups coordinated through Advocating Change Together. Tuesdays 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.

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.
- 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.
- 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.

Strategies

Increase the Number of Leadership Opportunities for People with Disabilities

- Gather additional data and reassess goal periodically, 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 Making⁵⁴ and the Olmstead Academy⁵⁵.
- 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 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.

⁵⁴ 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.

⁵⁵ 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.

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Preventing Abuse and Neglect

What this topic means

Research shows that vulnerable adults and children (including individuals with disabilities) are at a higher risk for maltreatment (abuse and neglect⁵⁶) than the population as a whole, and that allegations of maltreatment in this population are under reported. The Olmstead Plan website will include trend data on the occurrence of abuse and neglect and violent crimes.

This topic is about the prevention of abuse and neglect of people with disabilities in all settings, increasing the likelihood that potential abuse and neglect is reported, and taking care that these efforts do not inadvertently create barriers to reporting. Tracking and analysis of data will inform decision makers about setting priorities for public education campaigns. These campaigns will identify areas where prevention strategies can be applied that improve the safety and quality of life for people with disabilities wherever they may choose to live, learn, work and enjoy life.

Vision statement

The State of Minnesota declares as a top concern, the safety and quality of life of people with disabilities. It is the goal of the State that people with disabilities are free from abuse and neglect.

In this effort the State will utilize three strategies: prevention, reduction, and remediation.

- Prevention by education and public information to improve the awareness of the occurrence of abuse and neglect, and how to report it;
- Reduction of maltreatment by carefully monitoring trends of abuse and neglect and targeting abusers for prosecution and providing caregivers with effective education; and
- Remediation by addressing patterns and issues of occurrence both at the system level and the individual level.

Measurable goals

Goal One: By September 30, 2016, the Olmstead Subcabinet will approve a comprehensive abuse and neglect prevention plan, designed to educate people with disabilities and their families and guardians, all mandated reporters, and the general public on how to identify, report and prevent abuse of people with disabilities, and which includes at least the following elements:

- A comprehensive information and training program on the use of the Minnesota Adult Abuse Reporting Center (MAARC).
- Recommendations regarding the feasibility and estimated cost of a major “Stop Abuse” campaign, including an element for teaching people with disabilities their rights and how to identify if they are being abused.
- Recommendations regarding the feasibility and cost of creating a system for reporting abuse of children which is similar to MAARC.

⁵⁶ As defined in Minnesota Statutes 626.556 and 626.557. Examples of abuse may include: physical, verbal, emotional or sexual abuse or financial exploitation. Examples of neglect include: failure to provide with necessary food, shelter, supervision, health, medical or other care required for the individual’s physical or mental health.

- Utilizing existing data collected by MDE, DHS, and MDH on maltreatment, complete an analysis by type, type of disability and other demographic factors such as age and gender on at least an annual basis. Based upon this analysis, agencies will develop informational materials for public awareness campaigns and mitigation strategies targeting prevention activities.
- A timetable for the implementation of each element of the abuse prevention plan.
- Recommendations for the development of common definitions and metrics related to maltreatment across state agencies and other mandated reporters.

Annual goals will be established based on the timetable set forth in the abuse prevention plan.

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

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

- By January 31, 2017, a baseline and annual goals will be established. At that time, and on an annual basis, the goals will be reviewed and revised as needed based on the most current data.
- By January 31, 2018, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 10% compared to baseline
- By January 31, 2019, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 30% compared to baseline
- By January 31, 2020, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 50% compared to baseline

Goal Three: By December 31, 2021, the number of vulnerable adults who experience more than one episode of the same type of abuse or neglect within six months will be reduced by 20% compared to the baseline.

Annual Goals to reduce the number of people who experience more than one episode of the same type of abuse or neglect:

- By December 31, 2017, a baseline will be established. At that time, and on an annual basis, the goals will be reviewed and revised as needed based on the most current data.
- By December 31, 2018, the number of people who experience more than one episode will be reduced by 5% compared to baseline
- By December 31, 2019, the number of people who experience more than one episode will be reduced by 10% compared to baseline
- By December 31, 2020, the number of people who experience more than one episode will be reduced by 15% compared to baseline
- By December 31, 2021, the number of people who experience more than one episode will be reduced by 20% compared to baseline

Goal Four: By July 31, 2020, the number of identified schools that have had three or more investigations of alleged maltreatment of a student with a disability within the three preceding years will decrease by 50% compared to baseline. The number of students with a disability who are identified as alleged victims of maltreatment within those schools will also decrease by 50% by July 31, 2020.

- By July 31, 2017, a baseline and annual goals will be established.

Rationale

- It is well-known that people with disabilities are subject to abuse and neglect at rates much greater than the population as a whole. It is also well-known that incidents of abuse and neglect are under-reported by the population as a whole, but particularly among people with disabilities. The advent of the MAARC system presents an opportunity for the State of Minnesota to not only have a centralized reporting protocol for all incidents of abuse and neglect in adults, but will provide the opportunity to analyze data from the reporting system that will allow for targeting information and remediation activities to the areas where they can have the biggest impact. The development of a comprehensive abuse prevention plan at this time will ensure that the state identifies opportunities for using this new resource in multiple ways to promote prevention of abuse and neglect and includes the best opportunities in future budgets and work plans.
- A key factor in reducing the level of abuse and neglect is to increase the ability of people with disabilities and their families to know their rights and to identify and report incidents of suspected abuse and neglect. A campaign targeted at informing the general public can be a major boost to turning around the current under-reporting of these incidents.
- The MAARC system provides a “one number” capability for anyone, including mandated reporters and the general public, to report suspected abuse or neglect and removes the confusing complexity of the multiple reporting point system that previously existed. It is reasonable to actively consider whether a similar centralized system for reporting suspected abuse or neglect for children under 18 can similarly improve the complicated child protection system.
- The Minnesota Hospital Association (MHA) currently tracks reasons for ER visits and hospitalizations by International Classification of Diseases (ICD) codes. These ICD codes indicate incidents of abuse and neglect that resulted in an ER visit or hospitalization. Due to the fact the data captures information on any individuals who receive services at a hospital, pre-baseline work will be conducted to identify which individuals are vulnerable individuals. This would include individuals who receive services licensed by either MDH or DHS.
- Five years of MHA data (2010-2014) will be analyzed to determine the number of vulnerable individuals who receive services licensed by either MDH or DHS and have been treated at a hospital due to abuse or neglect. This data will then be analyzed to determine any existing patterns and geographic areas which reflect a higher incidences of abuse or neglect. Due to the fact that this data has not been analyzed for this purpose in the past, MDH anticipates needing adequate time to establish an accurate baseline.
- The baseline data for the measure in Goal Three will be gathered through the MAARC system. This will include the number of vulnerable adults who are the subject of a report of suspected maltreatment who are the subject of another report for the same type of maltreatment within a six month time period. This measure only includes reports where the allegation is determined to be substantiated or inconclusive following investigation. Additional data collected on the vulnerable

adult by the MAARC includes age, race, ethnicity, gender, disability/impairment, and licensed services received.

- The MAARC system launched on July 1, 2015 and baseline data for Goal Three is not available.
 - Validation testing of the data system will be completed by December 31, 2016.
 - Baseline data for repeat maltreatment reports will be reliable and collected for the 6 month time frame, January 1 – June 30, 2017, for the baseline.
 - Repeat reports will be compared to the first set of initial reports to determine the number of vulnerable adults who experience repeat maltreatment of the same type.
 - Data and reports will be validated and a baseline will be established by December 31, 2017.
- Prior to the launch of the MAARC, the statewide percentage of vulnerable adults who experience repeat maltreatment of the same type was at 5%, County level repeat maltreatment ranged between 2- 20%. It is important to establish a baseline for this measure for all lead investigative agencies responsible for reports of suspected maltreatment due to the new way of capturing reports in a centralized manner.
- Baseline data for Goal Four is not currently available on the MDE maltreatment program database.
 - Database development and validation testing will be completed by June 15, 2017.
 - Baseline data will be collected by July 31, 2017 and will identify schools that have had three or more investigations of alleged maltreatment of a student with a disability within the three preceding schools year (FY2015 - FY 2017). Identified schools will be reevaluated following the implementation of multiple preventative services, including Positive Behavioral Intervention and Support (PBIS) training.
- In an effort to avoid misperceived “targeting” of schools, to maintain objectivity, and to ensure school compliance with mandated reporting requirements without consequence, MDE felt three investigations during a three year time period was a reasonable indicator of schools that may need preventative services and assistance to help eliminate potential situations of abuse and neglect.
- Identified schools will be offered PBIS training and support. Schools that implement PBIS with fidelity and sustainability have teaching and learning environments that are less reactive, aversive, dangerous and exclusionary. They are more engaging, responsive, productive and preventative of situations that may otherwise result in negative outcomes, including the abuse and neglect of students. It is expected that the training and support offered by PBIS, in addition to increased training and awareness of child maltreatment issues and mandated reporting requirements, will reduce the need for multiple investigations of alleged maltreatment of students with disabilities in identified schools and provide staff with the technical skills and support to address challenging behaviors.

Strategies

Goal One

Develop Educational Campaign for Mandated Reporters and Professional Caregivers

- Conduct an education campaign targeted to providers who serve individuals with disabilities. Since research shows that many vulnerable individuals have not been educated on how to recognize maltreatment, the campaign will focus on how to recognize abuse and neglect. In order to prevent future abuse and neglect, the campaign will focus on how to prevent maltreatment. The campaign will also include an effort to reduce barriers in reporting suspected maltreatment.
- Outreach to mandated reporters will include targeted online and videoconference trainings and print materials.

Develop Public Awareness Campaign

- Provide information and education on the prevention and reporting of abuse and neglect to all Minnesota communities including individuals with disabilities, families, and guardians.
- Collaborate with State agencies and other stakeholders on public education campaigns.
- The public awareness campaign for the MN Adult Abuse Reporting Center (MAARC), beginning in summer of 2016, focused on education regarding vulnerable adult maltreatment which includes abuse, neglect and financial exploitation.
 - The campaign encouraged individuals to take action by calling the MAARC, when vulnerable adult maltreatment is suspected.
 - The educational content targeted to the general public was delivered through radio shorts, brief online videos and print materials. Social media was also used to drive people to the educational content.
 - The goal was to reach a broad statewide audience with key messages to encourage reporting.

Goal Two

Use Data to Identify Victims and Target Prevention

- Analyze MHA data on vulnerable individuals who have been the victim of abuse and neglect.
- Identify patterns and geographic areas for targeted prevention efforts.

Monitor and Improve Accountability of Providers

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

Refine Measurable Goals

- After the establishment of a baseline, the measurable goal will be reviewed on an annual basis to determine if the targets need to be revised.

Goal Three

Develop Remediation Strategies for Providers and Professional Caregivers

- Collect and review data on reports of repeat maltreatment of the same type, and additional data available from the MAARC.
 - Review data at individual-level to inform system level actions to remedy the effect of maltreatment.
 - Share remediation strategies effective at preventing repeat maltreatment.
 - Effective remediation may prevent repeat maltreatment.
 - Examples of individual remediation: adult protective services; recovery of assets; emergency assistance; victim services (sexual assault, domestic violence); medical evaluation and services; restraining order for removal of the perpetrator; prosecution of perpetrator; case management services; guardianship and conservatorship services; mental health treatment; representative payee services; home and community-based services
 - Examples of systems remediation: license holder responsible: licensing sanctions including fine, conditional license, corrective action order, etc.; individual responsible:

training, retraining, coaching, suspension or termination, referral to background studies for disqualification.

- Use data to identify patterns/ trends of abuse and neglect to inform communication alerts and remediation strategies.

Engage Quality Councils

- Provide the State Quality Council and Regional councils (as they are established) with statewide and regional data on maltreatment reporting. The Council will develop strategies to reduce the risk of abuse and to improve the quality of practice.

Refine Measurable Goals

- After the establishment of a baseline, the measurable goal will be reviewed on an annual basis to determine if the targets need to be revised.

Goal Four

Develop and Utilize School Tracking Database

- Utilize database to track and identify schools that have multiple investigations of alleged maltreatment of students with a disability.

Continue and Expand Training for School Personnel

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

Improve School Accountability for Training

- Collect annual verification from school districts indicating all school employees have been trained on mandated reporter duties and protections from retaliation when a report is made in good faith.

Responsible Agencies

- Department of Health
- Department of Human Services
- Department of Education
- Ombudsman for Mental Health and Developmental Disabilities

Assistive Technology

What this topic means

This topic is about people of all ages, all disabilities, and all settings having access to assistive and other technologies that will improve their quality of life and support them, especially in integrated settings.

The timely access to assistive and other technologies will result in progress on measurable goals found elsewhere in the Olmstead Plan. It is expected that the results can be measured in improved quality of life and increased movement from segregated settings to integrated settings.

It is also about building program capacity, leveraging resources and increasing the efficiency and effectiveness of assistive technology services through coordination and collaboration among state agencies.

Definition of assistive technology

Assistive technology is “any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. This definition does not include a medical device that is surgically implanted, or the replacement of such a device.”⁵⁷

Assistive technology service is any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. This includes:

- The evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in the individual’s customary environments;
- Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities;
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- Training or technical assistance for individuals with a disability or, if appropriate, that individual’s family; and
- Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of that individual.⁵⁸

Other Technologies will become more prevalent as Minnesota adopts 21st century technology to address the needs of Minnesotans with disabilities. Although the term *other technologies* has yet to be defined within the scope of this plan, it will likely reference such things as remote support services, telemedicine and telehealth systems.

Another influence in this topic area is the concept of universal design. Universal design is the design of products and environments for use by all people to the greatest extent possible without the need for adaptation or specialized design.

⁵⁷ 20 U.S.C. Chapter 33, Section 1401 (25)

⁵⁸ 20 U.S.C. Chapter 33, Section 1401 (26)

Collaboration with community partners – public and private – will be essential in order to innovate and integrate technologies and technology-enabled services that meet needs identified in person-centered plans.

Programs and services related to assistive technology

There are a number of agencies and programs providing information and services that make needed assistive and other technologies available to those they serve.

Department of Human Services

The majority of funding for assistive technology and modifications for people with disabilities is provided through Medical Assistance administered by the Department of Human Services (DHS). Nearly 160,000 Minnesotans with disabilities, older adults, and people with chronic health conditions receive assistive technologies, home modifications and durable medical equipment and supplies annually.

Technology for Home (TFH) offers at-home, in-person assistive technology (AT) consultation and technical assistance to help people with disabilities live more independently. Expert consultants, provided through the Technology for Home program:

- Consult with eligible people in their own homes, workplaces, or public locations,
- Connect people to resources that will help them live in their own homes,
- Conduct follow up to ensure effective training, set up and installation,
- Serve on the person's care team to develop and monitor a plan to assure that AT goals are met.

Since inception, the TFH program has assessed 851 individuals for AT, of which 398 were children and 453 were adults.

Individuals who are deaf or hard of hearing can access assistive technology such as the Telephone Equipment Distribution (TED) Program, which is administered through DHS.

Department of Education

- The Minnesota Department of Education (MDE) has published a Manual for Consideration of Assistive Technology (AT), which is available to Minnesotans as a download from the MDE website.
- MDE also sponsors an Assistive Technology Leadership Team, with cross-agency representation and representatives from each region of the state to develop resources and provide professional development statewide on topics related to AT.
- MDE hosts AT Teams Projects, designed to support school district AT Teams in providing services that are in alignment with legal standard and best practices in AT.
- MDE hosts an active list serve focusing on AT, with over 350 members.

Department of Employment and Economic Development, State Services for the Blind (SSB)

Assistive technology is available to individuals with disabilities accessing Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB). This includes evaluations, provision of necessary equipment and training to help ensure job and career success.

To ensure that transition aged customers are successful in their move from school to the adult world, the Workforce Development Unit at SSB has developed steps so that blind, visually impaired, and DeafBlind graduating high school students are prepared to engage in productive employment by:

- Completing a full technology assessment in the fall of their senior year to determine the necessary technology and training needed prior to entering further academic or vocational education

- Providing the identified technology and training during the course of the year so they are ready to enter a college or vocational institution fully able to use their technology
- Orient them to the campus website and the physical campus of their school

Department of Administration, STAR Program

The System of Technology to Achieve Results (STAR) Program is Minnesota's federally funded Assistive Technology Act program and serves Minnesotans of all ages and disabilities, including older adults with functional needs. STAR partners with other state agencies and community organizations to provide assistive technology demonstrations and device loans. There is no charge for these services.

Services provided by STAR include:

- **Device loans:** The four primary purposes for a short term (30 days or less) device loan are to:
 - Assist in decision making (device trial or evaluation)
 - Serve as a loaner during device repair or while waiting for funding
 - Provide an accommodation on a short term basis for a time-limited event/situation
 - Conduct training, self-education or other professional development activity

During State Fiscal Year 2015, STAR loaned 401 assistive technology devices to 360 Minnesotans for short-term use. Of the device loans made, 297 were to assist the individual in determining if the AT met their needs. Of that group, 97% made a decision on whether it met their needs.

- **Device Demonstration:** Demonstrations allow consumers to compare features and benefits of a specific device or device category. The purpose of a demonstration is to assist with decision making. A demonstration may lead to a formal evaluation or a request for a short-term loan to trial a device. During State Fiscal Year 2015, STAR demonstrated 118 assistive technology devices to 250 Minnesotans. Of the 118 demonstrations conducted, 93% made a decision on whether the AT met their needs.
- **Open-Ended Device Loans:** In certain limited circumstances, open-ended device loans are for Minnesotans who need assistive technology in education, employment, and certain community environments, such as hospice or assisted living. Open-ended loans allow a borrower to keep a device for as long as it is needed. For many borrowers this is the only resource they have available. During State Fiscal Year 2015, 171 Minnesotans received AT through this program.

Vision statement

People of all ages and all disability types will have assistive and other technologies necessary to support living, learning, working and enjoying life in the most integrated settings.

Measurable Goals and Strategies

The Assistive Technology topic area was added to the Olmstead Plan in June 2016. When the topic area was in development, stand-alone assistive technology measurable goals and strategies were considered. In light of the fundamental importance of assistive technology to a number of different topic areas in the Plan, it was decided that it would be more appropriate to add assistive technology goals and strategies throughout the Plan.

Measurable goals

Lifelong Learning and Education measurable Goal Three, relates to assistive technology.

Strategies

Strategies related to assistive technology are included in the following topic areas:

- Person-Centered Planning
- Transition Services
- Employment
- Lifelong Learning and Education

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 quality assurance processes.

The Executive Order further directed the Subcabinet to adopt procedures that would include clarifying and defining the role of the OIO. The Subcabinet adopted procedures in March 2015 and updated those procedures in January 2016 to establish 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 develop specific strategies and workplans. Each measurable goal is supported by several key strategies, which are articulated in the Plan. Key strategies are supported by workplans.

Workplans describe the action items that agencies will use to support the strategies and goals. For each strategy identified in the Plan, the workplans identify a series of key activities, expected outcomes, deadlines and the agency or agencies responsible for implementation. Workplans are the purview of the responsible State agencies. With the assistance of the OIO, the agencies develop the workplans to encompass anticipated action items over 1-2 years. Those workplans are submitted to, and approved by, the Olmstead Subcabinet and are 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. When new measurable goals or strategies are adopted by the Subcabinet, the agencies will develop accompanying workplans within a reasonable period of time and present them to the Subcabinet.

The OIO Director of Compliance maintains a schedule for reporting on the activities in the workplans. The frequency of reporting to OIO 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 is provided to the Subcabinet and available to the public on the Olmstead website. By regularly reviewing the progress of the workplans, both the Subcabinet and the public will be able to see that work is being done to support the achievement of the measurable goals in the Olmstead Plan.

Compliance evaluation, verification and oversight

The OIO 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, which will be made available on the Olmstead website. 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 OIO 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.

The OIO is in the process of undertaking the initial Quality of Life Survey. The OIO 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:

- Selecting 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.
- Securing funding for and completing the pilot survey designed to test the effectiveness of the selected survey tool.
- Submitting a "[Minnesota's Olmstead Plan Quality of Life Survey Pilot Study](#)" Report.
- Requesting and receiving funding for the full implementation of the Quality of Life baseline survey.
- Obtaining approval of the Quality of Life survey process by the Institutional Review Board.
- Issuing a Request for Proposal (RFP) for the next phase of the survey process in August 2016 and entered into a contract with the vendor selected to carry out the baseline survey in October 2016.

The initial Quality of Life Survey is expected to be completed in mid-2017 to establish a sample baseline. Subsequent surveys will be conducted two or three times during the following three years to measure changes from the baseline, subject to adequate funding.

A critical piece of establishing the baseline will be the identification of 8,000 potential survey participants to develop a valid sample of 2,000 respondents.

The results of each 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 OIO 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. The Executive Director will continue to work with State agencies to improve performance under the dispute resolution processes.

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 continue to implement the processes and 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.

In addition to its on-going oversight of workplans, the Subcabinet and State agencies will undertake an annual review process to evaluate whether the measurable goals should be amended for future years. The Subcabinet will seek public comment regarding the existing measurable goals. Based on that feedback and the experience of the agencies over the preceding year, State agencies will develop a set of proposed amendments to the measurable goals and present them to the Subcabinet for review and approval. Any amendments that are provisionally approved by the Subcabinet 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 contemplate actions over a number of years, the Subcabinet and State agencies will also undertake a strategic review of the Plan in 2018. The strategic review 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 subsequent periods. 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 OIO 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 OIO 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 OIO will develop a revised Communications Plan that will guide the direct communication messages and activities of the OIO, but will also establish guidelines for materials that are developed by State agencies.

The Subcabinet and OIO 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 OIO 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 OIO and to State agencies. OIO 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, the Subcabinet, OIO, and State agencies are working to develop a meaningful method of cross-agency collaboration around these strategies.

State agencies will create interim data systems to address identified gaps in a number of Plan topic areas. A workgroup will also study the long-term cross-agency data needs for implementation of the Olmstead Plan. The workgroup will develop an assessment report and recommendations to the Subcabinet regarding appropriate data systems and measurement of data through those systems. A subset of the workgroup is also creating a “use case” approach that would rely upon informed consent to facilitate data sharing between agencies. In this case, a “use case” refers to a methodology to clarify and organize data systems that will allow the sharing of certain protected data across agencies. The methodology is intended to improve people’s access to services and supports and to improve the ability of the agencies to measure progress on increasing people’s access to integrated settings.

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. Significant changes in the appropriations and regulatory processes at

either the State or Federal level may impact the ability of State agencies to achieve Plan goals within the time frames specified in the Plan.

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	<ol style="list-style-type: none">1. Go to: Mn.gov/Olmstead2. 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

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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 were implemented January 1, 2014.

Abuse and Neglect is defined in Minnesota Statutes 626.556 and 626.557. Examples of abuse may include: physical, verbal, emotional or sexual abuse or financial exploitation. Examples of neglect include: failure to provide with necessary food, shelter, supervision, health, medical or other care required for the individual’s physical or mental health.

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.

Assistive technology is “any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. This definition does not include a medical device that is surgically implanted, or the replacement of such a device.” [See 20 U.S.C. Chapter 33, Section 1401 (25)]

Assistive technology service is any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. This includes:

- The evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in the individual’s customary environments;
- Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities;
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- Training or technical assistance for individuals with a disability or, if appropriate, that individual’s family; and
- Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are

otherwise substantially involved in the major life functions of that individual. [See 20 U.S.C. Chapter 33, Section 1401 (26)]

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. [See 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. [See 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. [See 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. [See 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.

Mandated reporter: "Mandated reporter" means a professional or professional's delegate while engaged in: (1) social services; (2) law enforcement; (3) education; (4) the care of vulnerable adults; (5) any of the occupations referred to in section [214.01, subdivision 2](#) (health care licensing board); (6) an employee of a rehabilitation facility certified by the commissioner of jobs and training for vocational rehabilitation; (7) an employee or person providing services in a facility as defined in subdivision 6; or (8) a person that performs the duties of the medical examiner or coroner. [See Minnesota Statutes §626.5572]

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.

MnCHOICES: MnCHOICES is a person-centered assessment to help people with long-term or chronic-care needs make care decisions and select support and service options.

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.” [See US Department of Justice, “Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*”, http://www.ada.gov/olmstead/q&a_olmstead.pdf]

Person-centered: This concept is described in the Person-Centered Planning measurable goals section of the Plan.

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.

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.

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 sections 125A.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 18-62 to 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. [See US Department of Justice, “Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.” http://www.ada.gov/olmstead/q&a_olmstead.htm]

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. [See <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.

Vulnerable adult: (a) "Vulnerable adult" means any person 18 years of age or older who: (1) is a resident or inpatient of a facility; (2) receives services required to be licensed under chapter 245A, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4); (3) receives services from a home care provider required to be licensed under section [144A.46](#); or from a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under section [256B.0625, subdivision 19a, 256B.0651, 256B.0653, 256B.0654, 256B.0659, or 256B.85](#); or (4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment. (b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual. [See Minnesota Statutes §626.5572]

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 became effective on July 22, 2016. More information on WIOA can be found on the US Department of Labor website at: <http://www.doleta.gov/wioa/>

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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

AT – Assistive Technology

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

MAARC – Minnesota Adult Abuse Reporting Center

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