Minnesota Department of **Human Services**

August 10, 2015

The Honorable Donovan W. Frank
United States District Court
724 Federal Building
316 North Robert Street
St. Paul, MN 55101

Re: *Jensen, et al. v. Minnesota Department of Human Services, et al.*
Court File No.: 09-CV-01775 DWF/FLN
Revised Olmstead Plan

Dear Judge Frank,

I am pleased to present the revised Olmstead Plan, as ordered by the Court on May 6, 2015 (Dkt. 435) and on July 9, 2015 (Dkt. 472). This morning, the Olmstead Subcabinet Executive Committee adopted this Plan on behalf of the Subcabinet.

As you know, this revised Plan is the result of many hours of hard work on the part of Plaintiffs' class counsel, the Executive Director of the Governor's Council on Disabilities, the Ombudsman for Mental Health and Disabilities, Olmstead Subcabinet members, and agency staff. I am sure you are also aware that the Plan presented to you today would not have been possible without the time and effort of Magistrate Judge Thorson, and I would like the Court to know that the State is most grateful to her and her staff for facilitating development of the Plan.

You will see that this is a very different Plan from previous versions. This Plan focusses on setting measurable goals to achieve defined outcomes, rather than on government processes and actions alone. The Plan has eleven topic areas; each one contains one or more measurable goals over a three to five-year period, with annual targets. Two additional topic areas are currently under development and will be added in 2016. We have chosen three to five years as the immediate strategic planning period, but we intend the Olmstead Plan to continue well into the future, as a dynamic roadmap, determining its direction from information gained by experience implementing the Plan.

Each measurable goal is accompanied by broad strategies for how the goal will be achieved, as well as by a "rationale" section explaining the reasons for the goal. Funding is

either addressed in the rationale section, or will be addressed in the relevant work plans. The detailed implementation of the strategies will be addressed in work plans. These will be developed by each responsible agency or agencies working with the staff of the Olmstead Implementation Office, reviewed and approved by the Subcabinet and submitted to the court within 60 days, as the court has ordered. The work plans will contain specific actions, timelines for completion, and persons or entities responsible. We include an example of a work plan with the Plan submitted to you today.

Care was taken to ensure that the Plan submitted today accounted for all content contained in the original and previous versions of the Plan. To verify this, a comparison document was created showing all of the action items from the March 20, 2015 Plan and where each is accounted for in the current Plan. (Document attached).

We established the measurable goals using a set of criteria derived from the language in the *Jensen* Settlement Agreement, the Court's previous Orders, *Olmstead v. L.C.*, 527 U.S. 581 (1999), and the Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the ADA and *Olmstead v. L.C.* Taking all of these together, we established a checklist of criteria for the Plan and its content. Following is a summary of these criteria:

- Comprehensive: the Plan must include commitments for each group of people who are unnecessarily segregated;
- Baseline: each goal must have a baseline analysis from which progress can be measured;
- Measurable: the goal must achieve a defined outcome;
- Concrete, reliable, and realistic: the commitments must be specific, and capable of achievement in the specified time period;
- Strategic: the goals must be important to initiation, conduct, or completion of the Plan within the first three to five-year time period;
- Timeframes: there must be specific and reasonable timeframes established;
- Responsibility: the Plan must indicate which agency or agencies are responsible for achieving the goal;
- Resources/funding: the Plan must indicate the extent to which funding exists to support the relevant goal, including consideration of reallocating existing service dollars.

Additionally, I would like to highlight an area in which the revised Plan respectfully, proposes procedures that are also the subject of a previous Court Order. Regarding amendments to the Plan, the revised Plan establishes annual Subcabinet review of the measurable goals, with proposed amendments posted for public review and comment before the Subcabinet acts upon them.[1] Please note that the Court's Order of August 28, 2013 establishes procedures by which Plan modifications must be submitted to the Court Monitor, subject to review by the Court.[2]

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[1] "Updating and Extending the Olmstead Plan," p. 97.

[2] Order, Dkt. 224, August 28, 2013, p. 6.

We submit this Plan with the understanding that all parties—plaintiffs' class counsel, the Ombudsman, the Executive Director of the Governor's Council on Disabilities, and DHS—are in agreement, except for certain features of the Positive Supports and Waiting List portions of the Plan, where plaintiffs' class counsel is not in full agreement. Additionally, we have heard from and met with the Minnesota Disability Law Center on the provisions for Employment, Housing and Services, and the Waiting List. We have taken MDLC's comments into consideration in these provisions.

Finally, the revised Plan addresses communications and public relations.[3] The Olmstead Implementation Office (OIO) is responsible for managing communications and is responsible for responding to communications from the public. If the Court receives communications about the Olmstead Plan, the Court is invited to forward those communications to the OIO, which will work with agency staff to respond directly. Items may be forwarded by email to MNOlmsteadPlan@state.mn.us.

This is a promising time for people with disabilities in Minnesota, and for all citizens of the State, as greater inclusion and integration begin to enrich Minnesota's many communities in ways both seen and unseen. With the submission of this Plan we now turn to the difficult but exciting work of achieving our goals.

Sincerely,

Lucinda E. Jesson
Commissioner, Minnesota Department of Human Services

cc: Shamus O'Meara, Attorney for Plaintiffs
Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities
Colleen Wieck, Executive Director for the Governor's Council on Developmental Disabilities
Mary Tingerthal, Chair, Olmstead Subcabinet

[3] "Communications and public relations," p.98.

Appendix A: Recommended changes to the survey

Prescreening Questions

A prescreening process should be developed to collect demographic, disability, and housing information about the participant. These questions were consistently the most difficult for participants to answer, it is important to have accurate information about these items, and there are other sources from which this information can be gathered. The answers to these questions can be obtained from other sources, including agency records, providers, and the county from which the participant receives services. Table 8 includes the question we recommend collecting during prescreening and a potential data source.

TABLE 8: PRESCREENING QUESTIONS AND RECOMMENDED SOURCES

Question	Source
What is your race and / or ethnicity?	State Agency
What is your marital status?	State Agency
What is your legal status?	State Agency
Disabilities and Perceived Significance	State Agency
What type of home are you living in now?	Department of Human Services (unless the person lives with friends for family)
How many people live in this home right now?	Providers
How many direct care staff work at this home?	State Licensing Information
Have you ever lived in a regional treatment center, state hospital or state institution?	Department of Human Services

Content

Several survey questions need to be reviewed for content in order to reflect the experiences of the participants. The following tables include the question that needs to be addressed, the problem, and our recommendation for solving the problem.

In addition, the Olmstead Implementation Office should arrange the survey so that the sections of greatest interest for the Olmstead Plan are at the beginning of the survey. This will ensure that the most important sections have the highest response rate.

TABLE 9: COMMUNITY INTEGRATION AND ENGAGEMENT: TIME, MONEY & INTEGRATION – DURING THE DAY

Question	Problem	Recommendation
Do you work in any of the following settings? (work, school, and day activities)	Settings do not match participant's understanding of services.	Plain language definitions from state agencies.

TABLE 10: COMMUNITY INTEGRATION AND ENGAGEMENT: INTEGRATIVE ACTIVITIES SCALE

Question	Problem	Recommendation
About how many times did you do each of the following in the past four weeks?	Activities may not reflect the activities people engage in	Monitor responses and revise list after the baseline survey.
Do you normally have any interactions with community members during this kind of trip or outing?	Scale is difficult.	Change the scale to a 4-point scale (none, little, some, a lot). Work with the survey developer to validate the scale.

TABLE 11: DECISION CONTROL INVENTORY

Question	Problem	Recommendation
All questions	The scale is not relevant to people who live independently or with family.	Use the alternate scale for people without paid staff.
Interviewer: Check here if you wish to report perception of possibly unfair or excessive domination of this person's life by anyone.	This was not checked, even in situations with suspected abuse or neglect.	Move to the end of the survey and add language about reporting abuse and neglect.

TABLE 12: PERCEIVED QUALITIES OF LIFE

Question	Problem	Recommendation
How would you rate your quality of life related to getting out and getting around?	"Getting out and getting around" is vague.	Work with the survey developer to add language to clarify the question.

TABLE 13: ELEMENTS OF PERSON-CENTERED PLANNING

Question	Problem	Recommendation
My planning process is person-centered	Participants do not know what "person-centered" means	State agencies should provide a plain language definition of person-centered planning

Interviewer Training

The abbreviated training period did not allow enough time for thoroughly training interviewers on the survey content and context. While the interviewers had enough information to conduct the survey, future trainings should go into more depth about survey content, methods for recording responses, and how the results will be used. Many of the questions require additional training to ensure interviewers are able to support the participant in answering the questions. The following tables include the

question, the problem that arose during interviews, and our recommended strategy for addressing the problem.

TABLE 14: COMMUNITY INTEGRATION AND ENGAGEMENT: TIME, MONEY & INTEGRATION – DURING THE DAY

Question	Problem	Recommended Strategy
How many hours per week did you work, on average, in each kind of work setting?	Participants do not know how many hours a week they work.	Ask the participant to describe their work schedule. For example, ask when they start work and when they are done. Then ask if they work every day.
Estimate how much money per week you earn from each activity on average.	Participants do not know their earnings or know how much they are paid but are not paid weekly.	Ask about hourly wage or what they earned on their last paycheck. Calculate average weekly earnings based on wages. There should also be a strategy for recording wages for people who are paid in piecework.
For each of the places you worked, how integrated were you in that facility?	Scale is difficult.	Once the scale is explained, ask participants if they are only with people with disabilities or if they are with people without disabilities.
Estimate how many hours per week you spend, on average, in each educational setting.	Participants do not know how many hours a week they attend school.	Ask the participant to describe their schedule. For example, ask when they start school and when they are done. Then ask if they go to school every day.
For each of the school settings you mentioned, how integrated were you in that setting?	Scale is difficult.	Once the scale is explained, ask participants if they are only with people with disabilities or if they are with people without disabilities.
Estimate how many hours per week you spend, on average, at each setting.	Participants do not know how many hours a week they spend at each setting.	Ask the participant to describe their schedule. For example, ask when they start the program and when they are done. Then ask if they go every day.
For each of the programs or activities you mentioned, how integrated were you in that setting?	Scale is difficult.	Once the scale is explained, ask participants if they are only with people with disabilities or if they are with people without disabilities.

TABLE 15: COMMUNITY INTEGRATION AND ENGAGEMENT: INTEGRATIVE ACTIVITIES SCALE

Question	Problem	Recommended Strategy
About how many times did you do each of the following in the past four weeks?	Recall.	You may also ask the person how many times a week they do each activity and multiply by four.
What is the average group size in which you had each kind of experience?	Participants respond with a range.	Record the average.
Do you normally have any interactions with community members during this kind of trip or outing?	Scale is difficult.	Once the question is established, tailor the question for each activity. For example, "Do you talk to other shoppers or people who work at the store?" or "Do you talk to other people on the bus?"

TABLE 16: DECISION CONTROL INVENTORY

Question	Problem	Recommended Strategy
All questions	Participant does not have paid staff.	Use the alternate scale for people who live independently.
Support Agencies and Staff	Participant does not know which service agencies work with them.	Interviewers should have training about service agencies and providers.

TABLE 17: ELEMENTS OF PERSON-CENTERED PLANNING

Question	Problem	Recommended Strategy
All questions	The participant has multiple planning groups.	Ask them to respond about the planning group for the service agency they were selected through.
All questions	The participant is unsure about the role of planning groups.	Interviewers should have training about planning meetings in each agency.

TABLE 18: CLOSE RELATIONSHIPS INVENTORY

Question	Problem	Recommended Strategy
Can you tell me the names of the 5 people who know you best?	The focus person or their ally says the person has no friends.	Clarify this is not just friends, but close relationships. The person may talk about relatives, service providers, neighbors, or anyone they feel they have a relationship with.
Can you tell me the names of the 5 people who know you best?	The focus person thinks the questions will be too personal.	Explain the questions that will be asked. For example, I'm just going to ask you a little bit about how you know the person and often you see them. Tell the person they do not have to give you names if they do not want to.
What kind of a relationship do you have with that person? Are they a...	The focus person says the individual is a friend.	Ask, "how do you know this person?" and select the most appropriate category.
What is the person's gender?	The focus person indicates the individual's gender in the response.	Do not ask if gender was implied.
Is this relationship romantic?	The focus person indicates a non-romantic relationship with the response.	Do not ask if non-romantic was implied, such as a relative.
Is this person involved in planning meetings or Person Centered Planning?	The focus person does not know or is not sure.	Asked if the person helped plan their services.
About how long have you know this person?	The focus person says "all my life."	Record the focus person's age even if the relationship is with an older relative.
About how many times did you have any contact with this person in the past four weeks?	The focus person is unsure.	Ask clarifying questions such as "how many times a week do you see this person?" or "do you see them every day?"

Appendix B: Selecting a sample for the Olmstead Quality of Life baseline survey

The Olmstead Sub-Cabinet and Olmstead Implementation Office will have to consider a few factors in selecting a baseline sample size. The confidence level will tell you how sure you are that the number you found in your study applies to the broader population. The confidence interval (margin of error) is the range that the result falls within. The Survey System provides additional plain language definitions of confidence level and confidence intervals at http://www.surveysystem.com/sscalc.htm#one.

> If you selected the 95% confidence level plus or minus 5% confidence interval, you could say:
>
> On average, Minnesotans with disabilities rated their health as 4.2 on a 1 to 5 scale, where 1= very bad and 5= very good. I am 95% certain that the "true" rating for Minnesotans with disabilities is between 4.02 and 4.22.

Table 19 below shows the sample needed for a 5% confidence interval at various confidence levels. This stratified sampling strategy will allow you to demonstrate differences by setting. Most researchers use a 95% confidence level and try to get the confidence interval as small as possible. The sample size calculator used for Table 19 from Calculator.net is available at http://www.calculator.net/sample-size-calculator.html.

TABLE 19: CONFIDENCE LEVEL AND WITH A 5% MARGIN OF ERROR FOR A STRATIFIED SAMPLE

Setting	Total population	98% confidence level + / - 5% confidence interval	95% confidence level + / - 5% confidence interval	90% confidence level + / - 5% confidence interval
Center Based Employment	2,497	447	334	246
Children in segregated school settings 50% or more of the time	4,472	485	354	257
DT&H	10,135	516	371	266
Board and Lodging	3,070	462	342	251
Supervised Living Facilities	1,046	358	282	217
Boarding care	521	267	222	180
Nursing Homes and Assisted Living Facilities	24,407	543	385	273
Adult Foster Care	5,318	493	359	260

Setting	**Total population**	**98% confidence level + / - 5% confidence interval**	**95% confidence level + / - 5% confidence interval**	**90% confidence level + / - 5% confidence interval**
ICF / DD	1,697	412	314	235
Total	**53,163**	**3,983**	**2,963**	**2,185**

Appendix C: Pilot tools and materials that could be modified for the baseline survey

Participant consent form language

We're going to ask you about your services and your life. We'll use what we learn to try to make services better for you and for others.

The purpose of the work

To find out if the services and supports you're getting are good or bad or in between. We want to find out if there are ways we can make things better for you.

What we're going to ask you to do

To talk with us for about an hour. We will write down or record on the computer what we find out about your life and your services. This could happen again next year.

The risks to you

The only risks we can think of from this would be if it bothers you to talk about your services and your life. Almost no one has been bothered by this kind of talking in many years, and your privacy will be kept – that's the law.

The benefits to you

Thinking about quality in new ways may help you get better at asking for and shopping for the supports you really need for a good life.

The benefits to other people

What we learn from talking to you may help us learn how to give better services to everyone. We will write reports about what we learn. We might even write an article about the quality of services in Minnesota. (But no one's name will ever be used, and everything you tell us will stay private.) We will also use your answers to make the survey better for people who take it next year.

You can refuse, and that's no problem

There will be absolutely no problem to you or anyone else if you decide not to take part in this. Even if you agree to take the survey, you can stop at any time with no problem. You can even decide not to answer part of the survey. If there is a question you do not want to answer, you do not have to answer it.

We will protect your privacy

We will keep everything private and protect your privacy – unless you're in danger. We will not tell anyone in the agency, your providers, or family anything you tell us in private.

Contacts and Questions

If you have any questions, please contact Elizabeth Radel Freeman, Research and Evaluation Director, at:

The Improve Group:

700 Raymond Ave., Suite 140

St. Paul, MN 55114

Phone: (651) 315-8922.

Email: lizf@theimprovegroup.com

Tennessen Warning:

State and federal privacy laws protect my information. I know:

- Why I am being asked these questions;
- How my answers will be used;
- That I do not have to answer these questions. I can decide to stop at any time, no problem;
- I can take back this consent at any time. I can ask to have my responses erased by contacting Elizabeth Radel Freeman before December 1, 2014.
- My information will be combined with all the other answers to this survey, and this information may be shared with Minnesota state agencies to improve services for people with disabilities. The combined information will also be publicly available. My individual responses will be kept private.

Sign or check the space below if you agree to be a part of this study

The participant has chosen these individuals to help them with the survey:

Guardian consent form language

Background

Researchers from the Improve Group are conducting a survey of individuals with disabilities for the Olmstead Implementation Office. Your child or an individual you serve as a guardian for has been selected to participate in this study. The Olmstead Quality of Life Survey is designed to collect information from people with disabilities about their daily lives. The survey includes questions about where your child or ward lives, their activities, closest relationships, and who makes decisions in different areas of their life.

This study is designed to get a better idea of the quality of life of people with disabilities living in Minnesota. The results of this survey will be used to show how well Minnesota is doing in achieving its goal of making Minnesota a place where people with disabilities are living, learning, working, and enjoying life in the most integrated setting. This pilot study will also be used to make changes to future surveys.

Procedures

The interviewer will ask your child or ward for permission to participate in the study. If they agree to participate, the interviewer will ask your child or ward some questions about their regular activities and their quality of life. Your child or ward will be asked to answer the questions to the best of their ability. If your child or ward is able to participate in the survey but needs assistance, they may elect to have you or another person who knows them best help with some of the questions. The survey will take about 60 minutes.

Risk

There is minimal risk for participating in this study. Talking about their lives or services may upset some participants.

Benefits

Thinking about quality of life in new ways may help participants get better at asking for and shopping for the supports they need for a good life. The results of the study may be used to improve the quality of life for people with disabilities in Minnesota.

Confidentiality

Although your child or ward's name and contact information are on the survey, they will not be included in the database with their survey responses. Their responses will be combined with all of the other responses to the survey. All publicly available data will be reported at the state level. Individual

responses will not be made public. You may ask to have your child or ward's information removed from research records or returned.

Costs and Payment

There is no cost to you for participating in this study. You will not be paid for your participation in this study.

Voluntary Participation & Disclosure of Health and Private Information

You do not have to take part in this study or agree to release private information. Your decision to participate in the study and release private information is completely voluntary. Your decision not to participate, to withdraw, or to not release records will not affect your child or ward's treatment or benefits in any way.

By agreeing to participate and by signing this form, you are not giving up or waiving any of your legal rights or your child or ward's legal rights. However, you are agreeing to allow researchers to obtain private information about you for the reasons described above.

Abuse and Neglect

Interviewers are required to report suspected abuse or neglect to the appropriate agency.

Contacts and Questions

If you have any questions, please contact Elizabeth Radel Freeman, Research and Evaluation Director, at:

The Improve Group:

700 Raymond Ave., Suite 140

St. Paul, MN 55114

Phone: (651) 315-8922.

Email: lizf@theimprovegroup.com

Tennessen Warning:

State and federal privacy laws protect my information. I know:

- Why my child or ward is being asked to participate in this survey;
- How the responses will be used;

- That my child or ward is not required to take part in this survey. My child or ward may stop the survey at any time. If they stop the survey, the survey will be destroyed and the answers will not be used in the study.
- Participation is voluntary, and will not change the services received;
- My child or ward's information will be combined with all the other answers to this survey, and this information may be shared with Minnesota state agencies to improve services for people with disabilities. The combined information will also be publicly available. Individual responses will be kept private; and

I have reviewed the study information and agree to allow my child or ward to participate in the study if they choose.

Participant Name (please print)

Parent / Guardian Name (please print)

Parent / Guardian Signature

Date

Please return signed consent forms to:

The Improve Group

700 Raymond Ave., Suite 700

St. Paul, MN 55114

Accommodations

The survey will be conducted in English by interviewers. Participants will be given a copy of the survey at the time of the interview and will be encouraged to read along. If your child or ward requires accommodations to participate in the survey, please complete this section.

My child or ward requires the following accommodations:

Introductory script about the survey for participants

Hi, my name is [name] and I am here to ask you some questions for the Olmstead Quality of Life Survey. I work for the Improve Group, a research company in Saint Paul, and we are helping conduct the survey. This survey will let Minnesota know if the state is doing a good or bad job at making life better for people with disabilities.

We are going to ask you about your services and your life. We will use what we learn to try to make services better for you and for others. The survey will take about an hour, but we can take longer if you need to so that you can do it your favorite way.

We spoke earlier about doing the interview now, is this still a good time?

Introductory script about the survey for providers and families

I am visiting [name] and collecting information about his / her situation as part of the Olmstead Plan Quality of Life Survey. I have the permission of the [agency] to visit [name] and collect information by interviewing him / her if possible and the staff or others who know him / her best.

In *Olmstead v. L.C.,* (1999), the U.S. Supreme Court held that it is unlawful for governments to keep people with disabilities in segregated settings when they can be supported in the community. Many states, including Minnesota, have implemented an Olmstead Plan to document plans to provide services to individuals with disabilities in the most integrated setting appropriate for the individual. Minnesota is also required to develop and implement an Olmstead Plan as a part of a settlement agreement in a federal court case. This survey is required as a part of the plan.

Under State and Federal regulations for the protection of human subjects in research, this activity is not research, but rather ongoing quality assurance conducted by the funding agency. Nevertheless, any individual's wish to decline to participate will be respected by our staff.

The survey will let Minnesota know if the state is doing a good or bad job at making life better for people with disabilities. Areas of quality include: community integration and engagement, autonomy, quality of life, person-centered planning, and close relationships.

Any questions about the study can be directed to:

Elizabeth Radel Freeman
Research and Evaluation Director
The Improve Group
(651) 315-8922
lizf@theimprovegroup.com

And / or

Darlene Zangara
Executive Director
Olmstead Implementation Office
(651) 259-0505
Darlene.zangara@state.mn.us

Letter about the survey to participants that do not have a guardian

Hello,

I'm Elizabeth, and I work for the Improve Group. The Improve Group is working to survey people with disabilities for the Olmstead Plan. The survey is a part of Minnesota's plan to support all people to be living, learning, working, and enjoying life in the community. If you would like to learn more about the Olmstead Plan, please read the handout I put in this letter.

I'm asking you to take the Olmstead Quality of Life survey in November. We are asking to survey you because of the services you receive. We will be interviewing people all over the state to ask them about their services and their lives. We will use what we learn to try to make services better for you and for others. For each person, we want to be able to answer the question "Are you better off now than you were before?"

If you'd like to be interviewed for this project, we will schedule a time to come talk with you for about an hour. Everything you say during the interview will be kept private. If you do not want to be interviewed, that is just fine.

If you do want to participate, please fill out the form on the next page and send it to us.

Thank you for your time. If you have any questions, please contact me by email (lizf@theimprovegroup.com) or phone at (651) 315-8922.

Sincerely,

Elizabeth Radel Freeman
Research and Evaluation Director
The Improve Group

Please fill out this form and send it in the envelope we provided.

Choose one:
□ Yes, I would like to be interviewed for the Olmstead Quality of Life Survey
□ No, I would not like to be interviewed for the Olmstead Quality of Life Survey
□ I'm not sure

First Name:

Last Name:

Street Address:

City:

Zip code:

Phone number:

Email:

If you would like to participate, do you need any accommodations, like an interpreter or a copy of the survey in Braille?

□ Yes, I need:
□ No, I do not need accommodations
□ I'm not sure

Letter about the survey to guardians

Dear [Guardian name],

Someone you serve as a guardian for has been selected to participate in the Olmstead Quality of Life Survey. The survey is a part of Minnesota's plan to support all people to be living, learning, working, and enjoying life in the community (the Olmstead Plan). More information about the Olmstead Plan and Quality of Life survey is enclosed.

The Improve Group is an independent firm conducting the survey on behalf of the Department of Human Services and the Olmstead Implementation Office. [Editor's note: while this reflects the language used, it should have stated the survey was conducted on behalf of the Olmstead Sub-Cabinet]. We will be interviewing people all over the state to ask them about their services and their lives. We will use what they learn to prepare to survey thousands of people with disabilities in 2015 and beyond. Ultimately, they will use what they learn to try to make services better people with disabilities across the state.

The survey will be conducted in person and will be scheduled at a time and place for participants. The interview will take **about an hour,** and you may participate with your student if you'd like. Everything said during the interview will be kept private. If you do not want your child or ward to be included in the survey, that is just fine.

If you consent to have your child or ward to be interviewed for this project, send the completed guardian consent form to the Improve Group using the enclosed return envelope. Someone from the Improve Group will follow up with you to confirm your participation and schedule an interview.

Thank you for your time. If you have any questions about the project, please contact me by email (lizf@theimprovegroup.com) or phone at (651) 315-8922.

Sincerely,

Elizabeth Radel Freeman
Research and Evaluation Director
The Improve Group

Letter about the survey to providers

Dear [Provider name or contact]

The Minnesota Olmstead Plan is a Federal Court mandated plan to move Minnesota forward towards greater integration and inclusion for people with disabilities. The plan requires an annual Quality of Life survey of people with disabilities starting in 2015. The results of the survey will be used to measure changes in the lives of people with disabilities over time. More information about the Minnesota Olmstead Plan and Quality of Life survey is attached.

The Olmstead Implementation Office has hired the Improve Group, an independent research and evaluation firm, to conduct a pilot of the survey before it is administered statewide. Your organization has been selected as an interview site for the pilot.

The survey will take about 60 minutes of your participants' time and will be conducted at a time that minimizes the disruption of programs or service delivery. The results of the pilot survey will be used when planning the statewide Quality of Life Survey in 2015. The results will not be used to determine program eligibility or to evaluate the services your agency provides. Any public reports use data aggregated to the state level. Individuals and providers will not be identified.

A list of people who have been selected to participate in the survey is included in this packet. We are asking that you take a few minutes with each of these individuals to explain the survey and let them know that someone from the Improve Group will be contacting them to schedule an interview. If they are not interested, let them know that is just fine. If the participant has a legal guardian, we are also requesting your assistance with obtaining the guardian's consent to include the participant in the survey. Interviews will begin in early October.

Thank you in advance for your help with this important project. More information about the Olmstead Plan, the Quality of Life Survey, and provider roles are enclosed. A representative from the Improve Group will follow up with you in 3-5 days to answer any questions and to schedule interviews. If you have any concerns, please feel free to contact me at (651) 315-8922 or LizF@theimprovegroup.com.

Sincerely,

Elizabeth Radel Freeman
Research and Evaluation Director
The Improve Group

Olmstead Quality of Life Pilot Survey Interviewer Training Agenda

Interviewer Training

Day 1

Friday September 19, 2014

9 am – 1 pm

1. Welcome and Introductions (10 minutes)
2. Training Overview and Olmstead Pilot Survey Overview (10 minutes)
    a. Go over training plan
    b. Goals of Pilot Survey
        i. Test a survey tool with multiple groups of people
        ii. Work out the kinks of the project so some of these are figured out prior to 2015 administration
3. Improve Group Policies (30 minutes)
    a. Materials: Employee Handbook, October Calendar, New Hire Paperwork
    b. Confidentiality
    c. Communication
    d. Equipment
    e. Travel
    f. Paperwork
4. FAQs and responses (30 minutes)
    a. Materials: Olmstead Quick Guide
    b. What is Olmstead?
    http://www.mn.gov/mnddc/meto_settlement/shamusOmeara/olmstead.html
    c. Talking points
        i. Olmstead v. L.C.
        ii. Jensen and METO settlements
        iii. Olmstead Plan
        iv. Quality of Life Survey – pilot & baseline
    d. Materials: Olmstead FAQs, Interviewer FAQs
    e. Little steps, big dreams (2:42)
    http://www.mn.gov/mnddc/meto_settlement/selfAdvocates/big-dreams.html
    f. Person-centered planning (3:18):
    http://www.mn.gov/mnddc/meto_settlement/selfAdvocates/person-centered.html
    g. About the project
        i. Olmstead Sub-cabinet, Olmstead Implementation Office
        ii. Integration and opportunity
    h. About the consent process
        i. Empower people to participate
        ii. Protect participants
    i. About the survey
        1. Jim Conroy and Center for Outcome Analysis
        2. Studying the impact of moving from institutions to the community (1:50)
        http://www.mn.gov/mnddc/jim_conroy/jimConroy06.html
    j. What other questions do interviewers anticipate?

5. Working with providers, family, caretakers (20 minutes)
    a. **Materials: Provider introduction script**
    b. Before the interview
    c. On site
    d. Requesting accommodations
6. Common accommodations or communication tools (15 minutes)
    a. Interpreters
    b. Large print
    c. Augmentative and alternative communication
    d. Accessibility for mobility
7. Break
8. Reporting Abuse / Neglect (30 minutes)
    a. **Materials: Mandated Reporting Resource Guide, Abuse / Neglect Reporting Form, Vulnerable Adult Guide**
    b. Definitions
        i. Vulnerable adult:
            1. Lives in a facility that is licensed for adult care
            2. An adult who has a physical, mental, or emotional disability that keeps them from being able to meet their own needs for food, shelter, clothing, health care, supervision, or safety; and this disability prevents this person from self-protection from maltreatment.
            3. Or a person who has home care, a PCA, caregivers in the home, is staying somewhere they get care services or help
        ii. Abuse
            1. Physical, emotional
        iii. Neglect
            1. Not providing the resources the person needs to survive / thrive
        iv. Financial exploitation
    c. Legal requirements
        i. Mandated reporters legally have to make a report; we've decided to hold ourselves to that standard.
        ii. Report to common entry point (adult protection or child protection) within 24 hours
        iii. Written report within 72 hours
    d. Protecting yourself and the respondent
        i. If you or the person you are interviewing are not safe, call 911
    e. Procedures for documenting and reporting abuse
        i. Make sure the person is safe (not in immediate danger)
        ii. Fill out the abuse/neglect form
        iii. Call Liz or Becky after the interview
        iv. Call in the report, send in the written report
9. Pilot Review Questionnaire (45 minutes)
    a. **Materials: Pilot Review Questionnaire**
    b. Introduction and purpose
    c. Q by Q
    d. Recording responses

Interviewer Training
Day 2
Monday September 22, 2014
8 am – 12 pm

1. Check in about Day 1
    a. Any questions about Friday's training
    b. Scenarios for role play
    c. Calendars and logistics
2. Human Subjects Protections (30 minutes)
    a. Materials: Participant Consent Form, Guardian Consent Form
    b. Review of Human Subjects Training
        i. Questions interviews have after taking it
    c. Olmstead Specific steps (30 minutes)
        i. Consent process (obtaining and documenting)
            1. Consent / assent
            2. Adapting consent to meet participant's needs
        ii. Protecting personal information
        iii. Data security
3. Orientation to the survey tool (60 minutes)
    a. Materials: Quality of Life Survey
    b. Introduction to each section and purpose
    c. Q by Q
    d. Using scales
    e. Probing
    f. Recording responses
        i. Using computer
        ii. Using paper and pencil
4. Role Play (2 hours)
    a. Materials: Role Play Scenarios & Computers
5. Technology overview and troubleshooting (45 minutes)
    a. Materials: Laptops
    b. Survey software
    c. IG software
6. Questions?

Olmstead Quality of Life Pilot Survey Background Information

What is the Olmstead Plan?

The Olmstead Decision

In the 1999 civil rights case, Olmstead v. L.C., the U.S. Supreme Court held that it is unlawful for governments to keep people with disabilities in segregated settings when they can be supported in the community. This means that states must offer services in the most integrated setting, including providing community based services when possible. The Court also emphasized it is important for governments to develop and implement a plan to increase integration. This plan is referred to as an Olmstead Plan.

The Jensen Settlement

In 2009, a federal class action lawsuit was filed on behalf of individuals who had been secluded or restrained at the Minnesota Extended Treatment Options (METO) program. The resulting settlement agreement requires policy changes to significantly improve the care and treatment of individuals with developmental and other disabilities. One provision of the Jensen settlement agreement is that Minnesota will develop and implement an Olmstead Plan.

Minnesota's Olmstead Plan

Minnesota is required to develop and implement an Olmstead Plan as a part of the Jensen Settlement agreement. An Olmstead Plan is a way for government entities to document its plans to provide services to individuals with disabilities in the most integrated setting appropriate to the individual. In January 2013, Governor Mark Dayton signed an executive order establishing an Olmstead Sub-Cabinet to develop the Olmstead plan. The 2013 plan has been provisionally accepted, and the US District Judge overseeing the Jensen settlement agreement must approve all plan modifications.

The goal of Minnesota's Olmstead Plan is to make Minnesota a place where "people with disabilities are living, learning, working, and enjoying life in the most integrated setting."

What is the Quality of Life Survey?

Quality of Life Survey

The Quality of Life survey is one component of the Quality Assurance and Accountability section of the Olmstead Plan. The Plan requires Minnesota to conduct annual surveys of people with disabilities on quality including level of integration and autonomy over decision making. The survey will be used to measure changes in the lives of people with disabilities over time.

The Quality of Life survey will measure:

- 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; and
- Whether people with disabilities are working and living in the most integrated setting that they choose.

Several areas of the survey are required as a part of the Olmstead Plan and cannot be changed. This includes the target population, the primary sampling method, and the timeline. These aspects of the project are strictly defined, and the Quality of Life survey must be implemented according to these constraints.

The Quality of Life survey is only one way in which the experiences of people with disabilities will be gathered. The survey is not intended to be comprehensive, but rather a tool for providing oversight and accountability for the plan. Minnesota will use additional methods including collecting individual stories to enhance the survey data.

Quality Of Life Assessment Tool

The Olmstead Implementation Office contracted with the Center for Outcome Analysis to use a Quality Of Life (QOL) assessment tool that is specific to the Minnesota Olmstead Plan's requirements. The Center for Outcome Analysis has previously developed QOL scales that can be used across multiple disabilities, ages, and setting types. The contract includes survey development, administration instructions, documentation of validity and reliability studies, and the authorization to use the tool through December 2018.

Who will be surveyed?

A sample of people with disabilities will be invited to participate in the survey starting in August 2014. Individuals will be invited to participate in the survey by phone or mail, and will be asked to schedule an interview at a time and location that is convenient for them. Individuals who wish to participate but would prefer not to be interviewed may opt to take an online version of the survey. Potential participants will be selected to reflect diversity in disability type, culture, location within the state, and demographics. The primary disability types included in the sample are:

- People with physical disabilities
- People with developmental disabilities
- People with mental health needs / dual diagnosis
- People who are deaf or hard of hearing
- People who are blind or visually impaired
- People with traumatic brain injury

How many surveys will be conducted?

Approximately 200-250 surveys will be conducted during the pilot.

What settings are included?

The purpose of the pilot survey is to learn how best to administer the baseline survey, including identifying challenges that may arise from conducting the survey in a variety of settings. For that reason, setting type will be the primary consideration for selecting a sample. The following settings will be included in the pilot survey:

- Center Based Employment

- Children in segregated school settings
- Day Training & Habilitation
- Board and Lodging
- Supervised Living Facilities
- Boarding Care
- Nursing Home, Assisted Living
- Adult Foster Care
- Intermediate Care Facilities / Developmental Disabilities

While this list does not include all of the settings where people with disabilities can be found, the selected settings were selected to attempt to balance including as many people as possible while being mindful of budgetary and logistical constraints.

Where will surveys be conducted?

Face-to-face interviews will be conducted at a location that is convenient and comfortable for the participant. This may mean at the person's home, worksite, or a public setting. When possible, the person being interviewed will choose the interview location. Some participants may opt to complete an online version of the survey.

How long will the survey take?

The survey takes about 60 minutes to complete. This includes time for the person to get comfortable with the interviewer before starting the survey.

When will people be surveyed?

The Improve Group will start conducting interviews in early September. The interviews will continue through October 2014.

Who is conducting the survey?

Olmstead Sub-Cabinet

The Olmstead Sub-Cabinet was created by executive order to develop and implement Minnesota's Olmstead Plan. The Sub-Cabinet is chaired by Lieutenant Governor Yvonne Prettner Solon, and includes the commissioner or commissioner's designee from eight state agencies as well as two ex-officio members. The Sub-Cabinet is responsible for drafting the Olmstead Plan, inviting comments from the public, reviewing feedback and modifying the plan. The Sub-Cabinet will review and modify the plan every six months. The Sub-Cabinet has other responsibilities for certain tasks.

Olmstead Implementation Office

The Olmstead Implementation Office (OIO) was created by the Olmstead Sub-Cabinet to assure the "Promise of Olmstead" becomes a reality. The OIO is responsible for making sure the vision, goals, and time-sensitive tasks of the plan are achieved. Overseeing the Quality of Life Survey is one of the OIO's responsibilities. The OIO will report the survey progress and results to the Olmstead Sub-Cabinet.

The Improve Group

The Improve Group, an independent research and evaluation consulting firm located in St. Paul, is responsible for administering the pilot survey, as well as drafting recommendations for administering the baseline survey. The Improve Group has extensive experience conducting research to help improve services for people with disabilities, including Region 4 Mental Health Needs Assessment, to improve services for people with mental health needs in west central Minnesota.

Appendix D: Center for Outcome Analysis Survey Studies

Reliability Studies Related to the Personal Life Quality Protocol and Component Scales

Fullerton, A. Douglass, M. & Dodder, R. (1999). A reliability study of measures assessing the impact of deinstitutionalization. *Research in Developmental Disabilities, Vol. 20, No. 6,* pp. 387-400.

Fullerton, A. Douglass, M. & Dodder, R. (1996). *A systematic study examining the reliability of quality assurance measures.* Report of the Oklahoma State University Quality Assurance Project. Stillwater, OK.

Conroy, J. (1995, January, Revised December). *Reliability of the Personal Life Quality Protocol. Report Number 7 of the 5 Year Coffelt Quality Tracking Project.* Submitted to the California Department of Developmental Services and California Protection & Advocacy, Inc. Ardmore, PA: The Center for Outcome Analysis.

Devlin, S. (1989). *Reliability assessment of the instruments used to monitor the Pennhurst class members.* Philadelphia: Temple University Developmental Disabilities Center.

Conroy, J., Efthimiou, J., & Lemanowicz, J. (1981). *Reliability of the Behavior Development Survey: Maladaptive behavior section* (Pennhurst Study Brief Report No. 11). Philadelphia: Temple University Developmental Disabilities Center.

Conroy, J. (1980). *Reliability of the Behavior Development Survey* (Technical Report 80-1-1). Philadelphia: Temple University Developmental Disabilities Center.

Lemanowicz, J., Feinstein, C., & Conroy, J. (1980). *Reliability of the Behavior Development Survey: Services received by clients*. Pennhurst Study Brief Report 2. Philadelphia: Temple University Developmental Disabilities Center/UAP.

Isett, R., & Spreat, S. (1979). Test-retest and interrater reliability of the AAMD Adaptive Behavior

Dodder, R., Foster, L., & Bolin, B. (1999). Measures to monitor developmental disabilities quality assurance: A study of reliability. *Education and Training in Mental Retardation and Developmental Disabilities, 34, 1,* 66-76.

A sample of studies using the Center for Outcome Analysis Survey Tool to measure change over time

The Center for Outcome Analysis Quality of Life Survey tool has been used since the 1980s to track improvements in integration when people move out of institutions. The study is sensitive to changes over time, and can be used to track progress on integration. A sample of the studies, with brief descriptions, is included below.

Conroy, J.W., Seiders, J.X., & Brown, M. (2000, June). *How Are They Doing? Year 2000 Report of the Quality of Life Evaluation Of People with Developmental Disabilities Moving from Developmental Centers into the Community (The "Quality Tracking Project").* Final Report (Year 1). Submitted to California Department of Developmental Services. Rosemont, PA: Center for Outcome Analysis.

Study description: This study used the survey tool to measure outcomes over time for 2,400 people in California that were deinstitutionalized.

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

Study description: The study used the survey tool to measure outcomes over time for individuals participating in the 1990 National Consumer Survey mandated by the U.S. Congress.

Conroy, J., Fullerton, A., Brown, M., & Garrow, J. (2002, December). Outcomes of the Robert Wood Johnson Foundation's National Initiative on Self-Determination for Persons with Developmental Disabilities: Final Report on Three Years of Research and Analysis. Submitted to the Robert Wood Johnson Foundation as the Impact Assessment of the Foundation's National Initiative entitled Self-Determination for Persons with Developmental Disabilities. Narberth, PA: Center for Outcome Analysis.

Study description: Over this five year study of the Robert Wood Johnson Foundation's National Self-Determination Initiative for Persons with Developmental Disabilities, participants were shown to experience significant increases in integration.

REPORT TO THE OLMSTEAD SUBCABINET

HEALTHCARE AND HEALTHY LIVING 2I

AUTHORS:
MINNESOTA DEPARTMENT OF HEALTH

SUBMISSION DATE:
FEBRUARY 26, 2015

Summary Statement

This report provides a system analysis describing barriers that need resolution for transitioning youth with special health care needs to adult health care. It also includes a plan for addressing those barriers.

Background

As stated in Minnesota's Olmstead Plan, youth with special health care needs will receive the services necessary to make transitions to adult health care. As children with disabilities become young adults with disabilities, Minnesota must do a better system-wide job of helping youth with special health care needs receive the services necessary to make transitions to adult health care. With good transitions from youth to adult services, people receive ongoing access to coordinate care that can prevent institutionalization. According to the 2010 National Survey of Children with Special Health Care Needs, nationally only 40% of youth with special health care needs receive the services necessary to make transitions to adult health care. In Minnesota in 2010, 47.1% of youth made this transition59.

Action Item HC 2I

By September 30, 2014, complete a system analysis describing barriers that need resolution; develop a plan for addressing these barriers.

Deliverables Submitted by MDH

Below is an overview of the MDH deliverables completed and submitted to the OIO for HC 2I:

Deadline	Action	Item Submitted	Content	Date Submitted
9/30/14	Part 1: Complete a system analysis describing barriers that need resolution.	**Olmstead Benchmark Report** (which is the analysis)	The document outlines three barriers that need resolution.	10/8/14
	Part II: Develop a plan for addressing these barriers.	**Olmstead HC 2I Plan for Addressing Barriers**	Barriers, strategies, implementation mechanisms, target dates and responsible person.	Initial Plan: 1/23/15 Revised Plan: 2/20/15

The Olmstead Benchmark Report and the Olmstead HC 2I Plan for Addressing Barriers can be found on the following pages.

Olmstead Benchmark Report

October 8, 2014

Submitted by Barb Lundeen RN, PHN, MA Children and Youth with Special Health Needs

Action # 21

Definitions:

Children and youth with special health needs (CYSHN) are those who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. (Maternal and Child Health Bureau).

Transition has been defined as "the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult-oriented health care systems.

Background:

Health care transition planning for youth with disabilities, including those with chronic conditions, came to the forefront in 1989 when former Surgeon General Dr. C. Everett Koop convened a conference of family members and health professionals to focus on the health needs of youth as they transition from school to work and from home to independent living. In 2002 the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physician coauthored a consensus statement; "The goal of transition in health care for young adults with special health care needs is to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood." This process can be challenging, particularly for CYSHN. Currently one of the six core objectives of the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB) is that "all youth with special health care needs will receive the services necessary to make appropriate transitions to adult health care, work, and independence."

All youth need to be connected to programs, services, activities, and supports that prepare them to manage their physical, mental and emotional well-being and develop life skills to make informed choices. This is especially true for youth with chronic health conditions. The benefits of purposeful transition care are that it provides youth with ongoing access to primary care and subspecialist care, promotes competence of disease management, fosters independence, social and emotional development through teaching self-advocacy and communication skills, and allows for a sense of security for support of long-term health care planning and life goals. The employment rate for youth with special health needs is historically below the national average

for youth and young adults of similar ages without disabilities. The ability to manage one's health is critical to going to school and transitioning into employment.

The information and quotes found in this report are from the following group meetings:

- Community Transition Interagency Committee in Grand Rapids on April 10, Carlton May 7, and Minneapolis on September 10, 2014
- "Let's Talk About Transition" ARC sponsored meeting for professionals and parents in St. Cloud September 18, 2014
- South west Maternal Child Health Meeting in Olivia on September 22, 2014
- Governor's Council on Developmental Disabilities on October 1, 2014
- Minnesota Transition Community of Practice on October 3, 2014
- Youth Board meeting on October 6, 2014
- Care Coordination-Mapping the Current State for CYSHN on October 8, 2014
- Transitions grant quarterly reports from Family Voices of Minnesota. Meeting of the clinics in the grant project on May 1, 2014

Gap

A. Intentional Health Care Planning for Transitioning of Care. Youth with special health needs are not all receiving needed preparation from their health care providers about transition from pediatric to adult health care. According to the National Survey of Children with Special Health Care Needs only 52% on Minnesota youth with special health needs receive the services necessary to make appropriate transitions to adult health care, work and independence.

The role of parents may change when their son or daughter transitions to adult medicine. They may not be involved in all decision making. Many parents voice frustration and fear with their children leaving their pediatric provider. "I beg my pediatric specialists not to let my 18 year old go" said one parent. "Transition to adult services: It is a disaster. Like being shoved off a cliff." Another parent said "My son has 13 specialists." Youth, too are concerned about leaving their pediatric provider and finding a new clinician. "I don't know how to find a doctor that gets me and my mental health" said one youth. One hundred percent of youth from the PACER Advisory Board (ages 14-18) said that no physician has talked to them about transition. All of the youth agreed that they are most concerned with dealing with the pharmacy and refilling medications.

The MDH CYSHN Transition in Health Care eighteen month grant with Family Voices of Minnesota began August 2013. Family Voices of Minnesota is working with four clinics (Health Care Homes) in both rural and metro areas of Minnesota to incorporate the following National Health Care Transition Center's six core elements:

1. Transition policy-develop a practice health care transition policy and share with providers, staff, youth and families

2. Transition age youth registry-identifying transitioning youth (current/future) and enroll in a transition registry
3. Transition preparation –Assess and track all readiness for adult health care activities with youth and families.
4. Transition planning – address all health care transition needs/gaps setting goals together with youth and family.
5. Transition and transfer of care-transfer from pediatric to adult care.
6. Transition completion – transition/transfer is declared complete.

Got Transition, a cooperative agreement between the Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health, released The Six Core Elements of Health Care Transition, which define the components of transition support and are based on the AAP transitions clinical report. Three tool packages are available for practices, including one focused on youth transitioning out of pediatric care. Each package, available in English and Spanish, includes sample tools, feedback surveys, and measurement tools that are customizable and available for download. "There are transition tools available but we need to get them to the right providers." Family Voices of Minnesota

Parents who are in the transition project through this grant voiced positive experiences. "The adult practitioner came to the pediatric clinic four times and worked with the pediatrician, care coordinator and my family before my daughter was transitioned to adult medicine." She continued to say that "the care plan also transferred to adult medicine." Another parent from CentraCare said "the transition process has gone so easy". Parents voiced appreciating the transition tools. One St. Cloud parent said "there were things on the check list I never would have thought of discussing with my child."

A deliverable of the grant is to develop strategies to address special needs of the patient population including racial and ethnic disparities. A care coordinator reported concern that there is "another layer of parents who have English as a second language." Hennepin County Medical Center's (HCMC) transition model has successfully addressed the needs of families from diverse and linguistic groups by using community health workers.

Strategy:

- Each of the clinics will be expected to test tools from Got Transition and develop strategies to engage youth with special health needs and their families in transition programs and policies that can be spread to other clinics in Minnesota in the future.
- A tool kit that physicians can utilize will be available by December of 2014.
- A transition session including the tool kit will be presented to health care homes at the May 2015 HCH/ State Innovation Model (SIM)Learning Collaborative in St. Cloud.
- HCMC will report to the Learning Collaborative on their success with community health workers.

- Develop educational information and resources particularly for multicultural families. Present to parents at charter school and evaluate impact by parent satisfaction.
- Education and outreach for youth, families, and other caring adults. Underscore the interdependence between health and wellness, and employment through education and outreach.
- Provide training for youth and families regarding transition to adult health care systems.

B. Local Public Health Partnerships

Local public health nurses are not typically involved with families who have transition age children. They are, though, and integral part of the health care system. Staff from CYSHN has talked to public health nurses in the NE and SW portions of Minnesota. Another meeting is set for Oct. 23 in Bemidji to educate nurses on transition in health care and also on Olmstead.

Strategy:

- Continue to encourage local partnerships by attending local maternal child health meetings throughout Minnesota.
- Present at local Community Transition Interagency Committees and the Transition Community of Practice on the role of public health in youth transitioning.
- Encourage transition discussions to begin by age twelve.

C. Access to continuous and uninterrupted health insurance coverage. Despite the intent behind the Social Security Systems' employment support provisions such as Ticket to Work, the potential of losing financial benefits, and most important, health insurance discourages youth with disabilities from seeking employment. Failure to connect to the workforce in early adulthood has been linked to lower earnings and lower levels of employment in later life. Perceptions of the system contribute to keeping health care transitions and post-school transitions separate. Work and health are inextricably linked.

Strategy:

- Professional development for health care professionals that incorporate employment transition related outcomes.
- Provide health-care providers and other youth service professional development opportunities to gain the knowledge, skills and abilities needed to guide through a coordinated self-determined, cross discipline transition planning process.

Olmstead HC 2I Plan for Addressing Barriers

Name: Barb Lundeen PHN MDH Children and Youth with Special Health Needs	January 23, 2015	

RESPONSIBILITY #1: Complete a system analysis describing barriers that need resolution: develop a plan for addressing these barriers

Barrier from system analysis	Strategies	Implementation mechanism	Target date	Responsible person
A. Lack of intentional health care planning for transitioning of care It was found that providers are not discussing transfer of care to an adult provider Refer to final benchmark report dated Oct 8th, 2014	Each of the four clinics in the transitions in health care project with Family Voices of Minnesota (FVM) will test tools and develop strategies to engage youth and their families in transition programs and policies that can be spread to other clinics in Minnesota Develop educational information and resources particularly for multicultural families	As a MDH Grant recipient, Family Voices of MN will assist clinics to: • build strong teams of advocates for adopting a successful model of care for the transition of YSHCN • document strategies for working with adult partners • provide opportunities to meet adult physicians or become familiar with the physicians • Present their findings at the Health Care Home Learning Community. There will be 500 people attending the conference. • Develop a tool kit to be presented as part of learning days • Address disparity issues and the success of utilizing community health workers will be presented • Develop education and outreach	June 30,2015 May 13, 2015 May 13, 2015 June 30, 2015	Children and Youth with Special Health Needs (CYSHN) section at MDH along with Family Voices of Minnesota (FVM) Hennepin County Medical Center/FVM project

Name: Barb Lundeen PHN MDH Children and Youth with Special Health Needs			January 23, 2015	
RESPONSIBILITY #1: Complete a system analysis describing barriers that need resolution: develop a plan for addressing these barriers				
Barrier from system analysis	**Strategies**	**Implementation mechanism**	**Target date**	**Responsible person**
		for youth, families, and other caring adults.		
	Provide training for professionals working with transition age youth across the system.	Present to parents at a charter school and evaluate the impact of parent satisfaction.	Dec. 30, 2015	CYSHN staff
		A cohort from north western Minnesota and another from the metro will meet to discuss and develop strategies.	Dec 30, 2015	CYSHN staff along with other state partners form DHS, MDE and DEED
		Plan for and spread of the training	Dec. 30, 2016	
B. Lack of Local Public health involvement in transition	Continue to encourage Local Public Health to establish partnerships with education, human services, pediatric/adult health care providers and other local community resources for persons with disabilities.	Attend MCH areas around the state and discuss transition services for youth with special health needs Participate in Transitions Community of Practice. Encourage the involvement of local public health agencies in local community transition interagency committees.	Ongoing	CYSHN staff
C. Youth and	Professional	Health care transitions will be	Dec. 30, 2016	CYSHN staff

Name: Barb Lundeen PHN MDH Children and Youth with Special Health Needs			January 23, 2015	
RESPONSIBILITY #1: Complete a system analysis describing barriers that need resolution: develop a plan for addressing these barriers				
Barrier from system analysis	**Strategies**	**Implementation mechanism**	**Target date**	**Responsible person**
families often fear losing health insurance if they become employed	development for health care professionals that incorporate employment transition related outcomes	incorporated to the interagency cohort trainings		

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Olmstead Community Engagement Plan

Author: Olmstead Implementation Office for CE 2A, CE 1A, CE 1B, and OV 3A

Date Approved by Subcabinet: 3/10/2015 Date submitted to Court: 3/27/2015

2/27/2015

Contents

Olmstead Public Engagement

Introduction:

November 1, 2013 Minnesota submitted an Olmstead Plan to United States District Judge Donovan Frank. The Olmstead Plan is a requirement of the *Jensen v. Department of Human Services* settlement agreement, but it is also the right thing for the State of Minnesota to do. Minnesota's Olmstead Plan highlights seven areas that all contribute to a person's ability to live, work, learn and enjoy life in the most integrated setting appropriate to their needs and desires. At the center and embedded in the plan are two calls 1)to begin with the individual; and 2)for people with disabilities to be engaged in the development, processes and policies that affect their daily lives. The inclusion of the voices of the people with disabilities is paramount to the Community Engagement's outcomes.

Frequently when people think about planning, they focus on the things – the buildings, the programs, the vehicles, the transit or other systems. However, planning is really about people. It is about people in the communities that we call home. Where we work, live, learn and hopefully enjoy life. It is in these communities that we connect with one another.

As a result, the planning process must also be grounded in the needs of people, the locations where they live, work, and learn, as well as the broader community. It is where what we can do connects with how we live, work, travel and grow. And in order to understand the values, dreams and desires of people with disabilities as well as the broader community or a specific neighborhood or city, we need to engage the people from that context in discussion.

Minnesota is a state that has been regarded as a leader in serving people with disabilities. This collective success has been built on traditions of shared action by government, nonprofit and philanthropic organizations, community groups and business leaders, aiming to enhance our communities and state as a whole. This plan defines community engagement, outlines how we engage, why we need to create opportunities and how we will measure engagement. This shared tradition requires that we acknowledge that each person and organization is an asset and reflects a valid and important point of view.

Together, we create shared values, dreams and desires. Our broader community should be a reflection of these shared values, dreams and desires. The only way to achieve that outcome is through inclusive public engagement.

About the State of Minnesota

Minnesota is a vibrant and diverse state. It consists of nearly 5.5 million people, of which about 563,422 identify as having a disability. These 5.5 million people live in 87 counties. More than half of that population lives in the Twin Cities Metropolitan area.

The state is known for its strong natural and cultural assets – rivers, lakes, green space, vibrant arts community, and rich cultural action – as well as a civic tradition of shared action. That state also has a resilient economy with a range of businesses and organizations that have been able to weather the ups and downs of national trends.

Over the next several years, the state's population will continue to become older and more diverse. Currently about one third of those over age 65 report having a disability; as the population ages this number is also likely to increase. Not only is our population aging but we are also becoming more diverse in other aspects. It is estimated that by 2040 40% of the population, in the Twin Cities metropolitan area alone, will be persons of color[1].

I. What is Community Engagement?

From Outreach to Engagement

Planning, and the type of organizational change reflected in Minnesota's Olmstead Plan, requires collaboration to create shared values and outcomes. To truly foster that collaboration equitably, the Minnesota Olmstead Plan, calls for the development of guidelines and criteria for those using public dollars for projects or events to ensure that people with disabilities are incorporated in the planning processes. Additionally, it states that plans for facilities and events should be informed by attention to the input from people with disabilities. The Plan also calls for people with disabilities to have increased opportunities to hold leadership roles and to meaningfully participate in policy development. The state needs a full range of voices at the table to understand issues, explore alternatives, and create a shared action plan to address issues.

This will require a shift from the traditional outreach and participation processes to an engagement model that fosters shared problem solving, supportive partnerships and reciprocal relationships. Though one entity may have the authority or budget to complete an action item[2], success requires coordinated collaboration of a range of partners, which bring the range of perspectives and expertise to strengthen the process.

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 various stakeholders.

People are experts in assessing the long-term needs of their personal experiences and interactions with the places they live, learn, work and enjoy life. This community engagement plan recognizes people with disabilities as full and equal partners in the state's decision-making processes at all levels. Specifically, it outlines the responsibilities and commitments of the Olmstead Plan Subcabinet agencies and the Olmstead Implementation Office to engage the public and key constituencies in planning and policy development, and provides guidance for communities in the state to help establish consistency in best practices for engagement.

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[1] Metropolitan Council. (n.d.). *Thrive MSP 2040 Complete Plan.* Retrieved from Metropolitan Council: http://www.metrocouncil.org/METC/files/63/6347e827-e9ce-4c44-adff-a6afd8b48106.pdf

[2] Agencies that are not a part of the Olmstead subcabinet may use other terms to describe a task, project, goal, activity, etc.; However, as this is a part of the Olmstead plan we use "action item" throughout the document which is interchangeable with whatever term other agencies may utilize.

Principles for Engagement

Minnesota's Olmstead Plan places a high priority on community engagement as it is one of the seven domains of the plan. This plan serves as the base for four different but related action items within the Olmstead Plan.[3] The state's community organizations, and the historically underrepresented and under resourced communities they work for, are important resources and assets to our state that also deserve greater recognition. Collaborations between the subcabinet agencies, the Olmstead Implementation Office and community organizations should be a model for public engagement in our state.

Successful engagement efforts will reflect the following principles and values:

1. Engagement efforts provide information for state agency decision making. Efforts should be timed to provide an opportunity for people to influence the policies and plan content.
    - Participants should understand when and how their efforts will influence and change planning efforts and action item/policy development.
    - The experience should reflect shared learning and multi-directional problem-solving. Engagement should address issues that people with disabilities or the broader community have identified, not merely the action item-specific needs of the agency.
    - The time and investment of all participants is valuable.
    - Discussions and problem-solving should occur early in an action item process and on an ongoing basis to solidify long-term relationships.
    - Meetings, problem-solving sessions, and other in-person interactions should be planned with advance notice to participants, a clear understanding of what to expect at the meeting, opportunities to participate at other times, in other ways, promoted widely and via multiple means (web, email, newspapers, radio and television stations, community organizations, posting flyers in public places, etc.), at times and places where people naturally convene, with an opportunity to enhance community connections. Accommodations should be made for transportation, childcare, personal care attendants, etc.
2. Engagement efforts involve residents and communities as full and equitable partners in public decision-making. Some residents and communities may require different approaches to ensure participation.
    - Opportunities for participation should be flexible, appropriate to the scale of the action item or planning effort, and responsive to the needs of the participants.
    - Community members should understand the tangible benefits for their participation in an action item. Whenever possible and appropriate, funds should be made available to community organizations (primarily non-profit organizations) to participate and engage their communities.
3. Planning for engagement efforts should include input and direction from directly affected communities.
    - Each action item and planning effort will require different approaches. Effective engagement involves preliminary consultation about the community's values related to

[3] OV 3A page 32 of the Olmstead Plan, CE 1A, CE 1B, and CE 2A page 83 of the Olmstead Plan.

an issue, the appropriate method and venue for engagement, and establishing expectations for ongoing communication and engagement.
    - Each action item and planning effort should include an assessment of the affected communities and appropriate measures of success, inclusion, and culturally appropriate approaches and communication techniques.
4. Engagement efforts should work to mitigate existing racial, ethnic, cultural or linguistic barriers and include diverse races, cultures, genders, sexual orientations, and socio-economic and disability statuses. Engagement efforts should be culturally competent, in that they reflect and respond effectively to racial, ethnic, cultural and linguistic experiences of people and communities.
5. Engagement efforts will be coordinated to provide sufficient context about how all policy and systems plans work together. Materials will be presented in plain language, and with detail appropriate to the audiences. Translation of materials and interpretation services will be provided when necessary. Among the items participants should clearly learn:
    - Timeline for decision-making and current status of the process
    - Who has the power to make decisions?
    - When will decisions be made?
    - How will my input be used? How will I be able to track and watch my input affect the process?
    - How can I directly interact with decision-makers?
6. The Olmstead Implementation Office and state agencies will periodically report back to constituencies and communities regarding outreach and engagement efforts to communicate progress.
7. Whenever possible, people with disabilities and/or community organizations will serve as experts for planning and implementing outreach strategies.
8. Whenever possible and allowed they should be compensated/reimbursed for expenses.

Engaging Equitably

The disability community is historically an underrepresented group. It is also a group that is quite diverse as disability does not discriminate based on skin color, age, socio-economic status, ethnicity, etc. Anyone can join this group at any time; this places new emphasis on the importance of engaging communities equitably, to intentionally engage historically underrepresented and under resourced communities - such as communities of color, individuals with disabilities, aging adults, Lesbian, Gay, Bi-Sexual, Transgender, Queer, Intersex, Pansexual, Asexual, and Allies (LGBTQIPAA), and youth – in a way that more directly addresses existing social inequalities.

Equitable outcomes are shared outcomes – they reflect the values and needs of the community collectively – including the neighborhood, city, county, or broader community – as it relates to planning and policy making, whether broadly or on a specific action item. These outcomes specifically address communities traditionally left out of the decision-making process. Engaging equitably means approaches to problem-solving need to be flexible and accessible to people and recognize that a one-size-fits-all approach may be equal, but does not equip participants to be successful.

In public decision-making processes, community engagement is an intentional, strategic, purposeful process to connect and empower individuals and communities. It is multi-dimensional and flexible to meet residents where they are and engage diverse and historically underrepresented communities to achieve equitable outcomes. An accessible, respectful community engagement process is proactive, culturally appropriate, inclusive, and ongoing, with both short-term and long-term impact.

True community engagement goes beyond consultation to authentically facilitate community involvement in decision-making. It recognizes the value of building relationships and leadership capacity among agencies, community organizations, and residents. It provides ongoing relevance and awareness, and helps leverage community momentum and interest.

True community engagement results from intentionally organizing individuals and communities to understand issues, identify concerns and considerations, and engage in problem-solving. It cannot strictly begin and end with one or more self-contained action items, but needs to build upon each effort by deepening community connections and understanding. While enriched by participation by individuals, it must not strictly rely on volunteer efforts or people with means and time to participate, but must be structured with the understanding that accommodations and financial support may be required to deepen involvement. It is also understood that financial support may not be possible in many cases.

Why Create Opportunities for Community Engagement?

Community engagement efforts strengthen planning processes and policy development. Minnesota's Olmstead Plan supports robust community engagement efforts because they create better results. It also recognizes the value of long-term relationships between the Subcabinet, Olmstead Implementation Office, state agencies, and people with disabilities, local governments, law makers and the community at-large.

Community engagement provides valuable opportunities for planners, policymakers, and the public to interact and discuss key issues of public policy. Together, they connect the day-to-day experiences of the state's residents, the technical knowledge and expertise of government agency staff, and the understanding of state-wide needs.

Creating Additional Opportunities for Ongoing Community Engagement

Advisory bodies

The subcabinet agencies along with the Olmstead Implementation Office and others have various advisory bodies that provide key opportunities for stakeholder participation. These existing advisory bodies, along with additional groups, should continue to be utilized as a part of engagement efforts. Through the implementation of this plan these bodies can be enhanced by expanding their diversity and increasing opportunities for leadership throughout the activities in which they are engaged. They allow members, representing a cross-section of key stakeholder groups, to help shape policies and action items. Advisory bodies may conduct studies, recommend action to the subcabinet, agencies, or Olmstead Implementation Office, and/or provide expert advice.

Assure Inclusion

The Olmstead community engagement process will be a proactive public engagement process that provides public access to key decisions. The community engagement process should provide timely information about issues and processes to people with disabilities, affected agencies and other interested parties and segments of the broader community affected by plans, programs and action items, events and policies statewide.

In addition, the subcabinet, Olmstead Implementation Office and agencies will collaborate directly with the public and traditionally underrepresented populations (people with disabilities, people of color, immigrants, low-income populations, aging adults and youth), as well as community advocates, and partners in statewide public engagement. The Olmstead Community Engagement Plan acknowledges the importance of flexibility when planning engagement to meet the specific needs of Minnesota communities. Agency Staff will build relationships with community organizations to effectively plan for inclusive engagement opportunities.

Engagement opportunities will be structured to meet the needs of audiences, to assure participation is meaningful both to participants and decision-makers.

The Olmstead engagement process will be iterative, with periodic evaluation and adjustment to assure expected outcomes will be achieved. Technical assistance and training will be provided to agency staff, counties and local governments, as well as other interested stakeholders to ensure understanding of the Olmstead engagement process.

The Olmstead subcabinet and Olmstead Implementation Office will also provide information and opportunities to comment in multiple formats. Anyone having trouble accessing information should contact the Olmstead Implementation Office to inform them of any issues. These issues will be addressed by the office.

- To ensure compliance with the Americans with Disabilities Act (ADA), Olmstead meeting notices and comment opportunities will provide multiple input methods. Public meetings are to be held at ADA-accessible locations, and notices and information are published on the Olmstead website.
- Public meeting notices are published at least 14 days in advance to provide needed planning time for people who rely on public transit, Metro Mobility or special arrangements to get to events.
- Larger type materials, Braille or raised-print notices, recorded material, and other formats are available upon request.
- Material displayed on the Olmstead website will be accessible. Printed material is available in electronic formats for participants to use on personal equipment.
- Materials will be written in plain language, allowing for easier understanding and translation into languages other than English.

- Materials may be translated into languages other than English, based on needs of participants. Interpreters and/or captioning services will be made available when necessary at public events (including sign language interpreters).
- Amplification systems will be used at public events, whenever possible.
- Public notices may contain statements in languages other than English to encourage participation and provide instruction on requesting an interpreter at a public event.

Strategies

This plan identifies engagement strategies that reflect commonly used practices in planning efforts, as well as communications and engagement practices used by other government agencies and organizations.

Engagement strategies should embody two overriding principles: engagement is about building long-term lasting relationships, and it's important to be present in and connected to communities in order to build long-term relationships. This means participating in other community conversations, events and activities, even when the Subcabinet, Olmstead Implementation Office or subcabinet agencies do not have a specific role in an event of conversation.

General strategies for Community Engagement

- Leverage partnerships and feedback from Governor appointed disability councils, groups and boards.
- Collaborate directly with the public and traditionally underrepresented populations (people with disabilities, people of color, immigrants, low-income populations, ageing adults, and youth), as well as community advocates, and partners in public engagement. Collaboratively set goals and outcomes for engagement efforts.
- Appoint policymaker and technical groups to advise agency work on Olmstead items, both at the policy level and in operational divisions as appropriate. When necessary, include business and community interests on these advisory boards or create specific groups to address the needs and engage these interests. These boards should have a specific role in directing the activity they are advising and setting meeting agendas. Each meeting agenda should include a progress report on the action item.
- Create opportunities for the general public to engage in similar conversations and decision-making as advisory groups. Whenever possible, create opportunities for all these stakeholders to interact and discuss relevant issues together to advise the process and decision-making.
- Coordinate with the subcabinet, Olmstead Implementation Office, agencies and community-based engagement efforts in cities, counties, and other areas on related topics and major initiatives, to the extent possible.
- Sponsor periodic listening sessions and workshops to feature policies, key topics, and other content from the Olmstead Plan.
- Use online interactive spaces, including social media platforms, to gather feedback and foster discussion about Olmstead activities and policy plan content.

- Plan informal activities to provide members of the community with information and an opportunity to inform and influence planning processes. Informal activities would include reaching out to the disability community, being present at community events, and coordinating with other Olmstead related surveys.

Communication strategies for Community Engagement

- Assess desired methods for updating audiences and constituencies specifically affected by an effort. Build this regular reporting into the communications and outreach plan for each effort.
- Develop and implement a promotional campaign (includes web pages, social media content, new releases, newsletter articles, background for presentations, working with partners to disseminate content).
    - Create editorial calendar to highlight topics in various Olmstead products – including traditional and social media.
    - Develop and host content for the Olmstead web site.
    - Create content on the Olmstead web site to describe the key actions and policy topics. Make it prominent on the site. Update content regularly via editorial calendar. Highlight aspects that are timely.
    - Use the Olmstead web site to highlight content and illustrate efforts and discussion, and summarize progress and feedback.
- Create topic for electronic mailing system that stakeholders and the public can sign up for or be subscribed to.
- Work with action item staff to assign a point of contact for questions from the public and stakeholders. Communicate updates periodically through the Olmstead web site, newsletters, etc.
- Send updates and summaries regularly to local government agencies and external groups, as necessary.

Community Engagement Oversight

The Olmstead Implementation Office is responsible for oversight of the community engagement plan and will respond to inquiries regarding Olmstead community engagement activities and implementation of this plan. Any issues that have not been resolved through cooperative efforts between the Olmstead Office and subcabinet agencies responsible for participation processes will be brought to the subcabinet for review.

Olmstead Subcabinet agencies are responsible for integrating this plan into their work and providing funding for engagement efforts related to their Olmstead work. Agencies are also responsible for reporting on their engagement efforts to the Subcabinet through the Olmstead Implementation Office reporting structure.

Counties, Cities and other local governments are encouraged to adopt the principles and guidelines set forth in this plan and integrate them into their public work. Action items funded with public dollars may be asked to report their engagement activities and outcomes as well.

Measuring Success of Olmstead Plan's Community Engagement

At the beginning of any Olmstead related effort, the agency staff will perform an assessment of groups that will be directly affected or may have an interest. For statewide Olmstead efforts, that will always include a broad array of stakeholders from across the state. Audience assessments will specifically address groups that are historically underrepresented in planning and policy making efforts.

Following this initial assessment, staff will consult with community organizations, and other stakeholders to confirm the audience needs and to begin planning for engagement related to the effort. This will include discussion about goals for engagement and desired outcomes.

Once goals have been identified and/or established, a combination of qualitative and quantitative measures will be used to evaluate the success of the community engagement activities. Evaluation will take place on an ongoing basis throughout the action item. Periodic evaluations will be followed by mid-action item assessment to assure strategies will result in expected outcomes and staff will make necessary adjustments.

At the conclusion of an action item, staff from the agency leading the engagement effort will first survey participants to assess how well they engage their communities. The qualitative approach can include various approaches including individualized interviews, debriefing meetings, email correspondences, etc. The following elements should be included:

1. What methods and structure were used to make an engaging experience for participants?
2. How did participants feel their time and opinions were valued? Or not valued?
3. Did participants understand the goal of the outreach effort and their role?
4. How were participants contributions reflected in the final product?
5. Would people participate in another outreach activity?
6. How did participants get regular updates about progress on the action item?
7. At what points in the action item did participants get updates about progress on the action item?
8. Share participant opinions regarding the overall quality of their experience with the agency and the engagement effort.

Staff from the agency leading the engagement effort will also call together partner agencies for a meeting to debrief on the outreach efforts, including what worked, what didn't, lessons learned and what could be improved for future efforts. In addition, the agency staff leading the engagement effort will survey partners who were involved in setting goals and expectations for the effort to assess whether expected outcomes were achieved.

A number of quantitative measures will also be collected:

1. Number of people participating in community engagement activities
2. Number and diversity of organizations participating in action items and policy efforts
3. Number of individuals who participate in related discussions on the Olmstead or Agency web sites, social media platforms, and online information-gathering sites

4. Number of state, county, city and township governments whose staff and/or policymakers participated in action item efforts
5. Earned media related to action item efforts (and comparisons, as available)

These measures will be gathered by the Olmstead Implementation Office as a part of the status/implementation reporting process currently used by the subcabinet agencies. In addition, on an ongoing basis, Olmstead Implementation Office staff will work with members of the state disability community and representatives from different segments of the broader community to assess needs and measure the level of engagement in subcabinet operations. This may include, but is not limited to, convening focus groups, conducting surveys, convening independent review boards, and on-on-one interviews. These assessments will be presented to the full subcabinet during updates that are established to measure progress toward Olmstead community engagement goals.

Why Is There a Need For a Community Engagement Plan?

Guidance for Local Communities

This community engagement plan provides guidance for engagement on Olmstead efforts, as well as collaborative efforts with federal, state and local organizations. The Olmstead Implementation Office, under the subcabinet, will also be tracking best practices and highlighting community engagement work that supports the principles in this plan and expands the state's understanding of successful community engagement.

As identified in Minnesota's Olmstead Plan, the Olmstead Implementation Office will provide technical assistance and information resources to support opportunities for people with disabilities to serve in leadership roles and have meaningful participation in policy development.

When planning for engagement efforts, government agencies should create an inclusive list of all aspects of the community that may be affected or have a role in fulfilling the goals of the action item or event. At the beginning of this process, agencies should engage members of affected groups and collaborate on planning engagement efforts that will facilitate broad involvement and result in better, more equitable outcomes.

Agencies and/or local governments should also identify key staff resources to serve as points of contact for the public, as well as funds to support creating an appropriate environment for engagement. People need to feel welcome, that their participation is valued, and that their time is respected in order to engage fully.

In addition, as noted earlier in this plan, engagement efforts should follow these principles:

- **Equity:** residents and communities are partners in decision-making
- **Respect:** residents and communities should feel heard and their interests included in decisions.
- **Transparency:** residents and communities should be engaged in planning and decisions should be open and widely communicated.
- **Relevance:** engagement occurs early and often throughout a process to assure the work is relevant to residents and communities.
- **Accountability:** residents and communities can see how their participation affects the outcome; specific outcomes are measured and communicated.
- **Collaboration:** engagement involves developing relationships and understanding the value of residents and communities bring to the process. Decisions should be made with people, not for people.
- **Inclusion:** Engagement should remove barriers to participation that have historically disengaged residents and communities.
- **Cultural Competence:** Engagement should reflect and respond effectively to racial, ethnic, cultural and linguistic experiences of residents and communities.

Best Practices for Engagement

The principles, examples, and information included in this community engagement plan are based on an existing plan drafted by the Metropolitan Council. The Metropolitan Council's plan from which this is based is the result of collaboration and shared learning with partners both within the Twin Cities region and from the good work of communities around the country. Additional literature was reviewed as well[4] to ensure best practices were included.

The Olmstead Implementation Office will, in addition to this plan, maintain a toolbox on our web site highlighting best practices for engagement, and provide links to key information and resources on engagement. This will be a growing, living resource. The toolbox can be accessed at www.mn.gov/olmstead.

The Olmstead Implementation Office Needs Information

These worksheets should be used by planning and program staff to assist in assessing your process, purpose, audiences, potential barriers, impacts and strategies through the perspectives of the participants to inform the overall approach to creating an engagement plan for your action item. This will also provide the information that the Olmstead Implementation Office will need to conduct an assessment of what our community engagement work looks like and how well we engage communities.

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[4] Family Voices of Minnesota. (2014). *Developing a Structure for On-going Communication Between Families of Children, Youth or Young Adults with Disabilities and the Minnesota Department of Human Services.*
The Arc Minnesota. (2014). *Self Advocate Input and Involvement Report for the Disability Services Division.* St. Paul.

Engagement Planning Worksheet

This worksheet is a subjective tool. Fill out the worksheet as completely as you can. There are several places, identified with an asterisk (*) where it may be appropriate to consult with the Olmstead Implementation Office prior to finalizing any engagement plans. Olmstead Implementation Office staff can also help you identify existing community partnerships that may benefit your effort.

1. **Action item Name and Objective(s)**
   Briefly describe your action item and what the action item will accomplish. Include a timeline and any other process-related information that may affect engagement decisions. In your timeline, indicate opportunities to conduct mid-action item evaluations of engagement efforts.

2. **What is the purpose of engagement on your action item? What engagement goals does your action item hope to achieve?***

3. **Who will specifically be affected by your action item (both potential positive and negative impacts)? Specify how they will be affected.**
   Examples include: specific disability populations, cities, counties, neighborhoods. Use data when available to identify populations affected.

4. **Will your action item directly or indirectly address any of the following groups or issues?**
   People have many different identities and these identities don't always fit neatly into the categories that agencies have in place. This list is not meant to be comprehensive and is meant to cover a broad array of commonly noted identities or issues. Please check those that apply.

   - ☐ People with disabilities
   - ☐ Mental Health
   - ☐ Physical/mobility
   - ☐ Blind
   - ☐ Deaf/Hard of Hearing
   - ☐ Institutional racism, ableism or other disparity
   - ☐ Autism Spectrum Disorders
   - ☐ Other racial/ethnic groups
   - ☐ Aging Adults
   - ☐ LGBTQIPAA[5] communities
   - ☐ Developmental/Intellectual Disabilities
   - ☐ Communities of color
   - ☐ People who use a language other than English
   - ☐ Traumatic Brain Injury

   Describe specifically how:

[5] Lesbian, Gay, Bi-Sexual, Transgender, Queer, Intersex, Pansexual, Asexual, and Allies

5. **What do you know about public and stakeholder perspective on the issues involving this action item? What information will they need? How can we otherwise address any concerns?***

6. **What specific outcomes are anticipated with this action item? What decisions will result from this action item?**

7. **How can stakeholders be involved in the decision-making process?**

8. **Are there specific opportunities with this action item to promote inclusion, reduce disparities, or otherwise address equity considerations?***

9. **Are there specific opportunities with this action item to build leadership capacity in the community?***

10. **What resources will you need for engagement?**
    - ☐ Internal action item management
    - ☐ Lead outreach/engagement staffer
    - ☐ Other staff
    - ☐ Community resources
    - ☐ Funding

11. **Will you be using contracted services for this action item? Are there opportunities to support local or community-based professionals or organizations to do any work on this action item?**

12. **As part of the planning process, staff will likely meet with external stakeholders to discuss goals for engagement. Do you have recommended community stakeholders we should interview or meet with?**[6]

[6] Pages 1-16 of this document were adapted with permission from the Metropolitan Council's Public Engagement Draft Plan.

Quantitative Measurement Worksheet

This worksheet is a tool to capture quantitative data. This should be used by planning and program staff to assist in tracking the number of people you have participating in your process, how they are participating, as well as what diversity groups they may identify with. This may be used at any point during the process and notes should be made to reflect if participants are potentially counted multiple times during a process or not. For example: If there are three in person meetings and Pat is a person with a disability that participates in all three meetings, Pat could potentially be counted three times. It is preferable to have individuals counted only once however some modes of participation are not conducive to this type of tracking and that should be noted by the agency gathering the data.

Type	**Number Participating**	**Diversity Groups (check all that apply)** ***People have many different identities and these identities don't always fit neatly into the categories that agencies have in place. This list is not meant to be comprehensive and is meant to cover a broad array of commonly noted identities or issues. Please check those that apply.***
People		☐ People with disabilities ☐ Mental Health ☐ Physical/mobility ☐ Blind ☐ Deaf/Hard of Hearing ☐ Developmental/Intellectual Disabilities ☐ Autism Spectrum Disorders ☐ Traumatic Brain Injury ☐ Other racial/ethnic groups ☐ Aging Adults ☐ People who use a language other than English ☐ Institutional racism, ableism or other disparity ☐ Communities of color ☐ LGBTQIPAA[7] communities
Organizations		
Web sites, social media platforms, online information gathering sites		
State, county, city and township governments staff/policymakers		
Earned Media		

[7] Lesbian, Gay, Bi-Sexual, Transgender, Queer, Intersex, Pansexual, Asexual, and Allies

Qualitative Measurement Worksheet

This worksheet is a qualitative tool to capture the story of our community engagement work from the participant perspective. It should be used by planning and program staffs to assist in assessing how people with disabilities you have participating in your process feel about the engagement process. This is not for the opinions of the staff working on the action item. It should be used at the end of an action item, but could also be used as a part of a mid-point check in.

1. **What methods and structures were used to make an engaging experience for participants?**
2. **Explain how participants felt their time and opinions were valued? Or not valued?**
3. **Did participants understand the goal of the outreach effort and their role?**
4. **How were participant contributions reflected in the final product?**
5. **Would people participate in another engagement activity?**
6. **How did participants get regular updates about progress on the action item?**
7. **At what points in the action item did participants get updates about progress on the action item?**
8. **Share participant opinions regarding the overall quality of their experience with the agency and the engagement effort.**

II. Inclusion in Public Processes – CE 2A

The Minnesota Olmstead Plans calls for the state to "*evaluate, revise as necessary, and disseminate guidelines and criteria when public dollars are used for ensuring that people with disabilities are incorporated in public planning processes, and that plans for public facilities and events are informed by attention to inclusion of people with disabilities. The guidelines and plans for incorporating them in public processes will be reported to the Olmstead Subcabinet or their designee.*" (CE 2A from page 83 of the Plan)

Background

Engaging people with disabilities and other underrepresented groups leads to strengthened planning processes and policy development. It can create better results and connections for people and communities; and it can be a way for people to share knowledge and expertise. Minnesota has been recognized for the good work done when engaging people with disabilities in large publicly funded projects in the past, i.e. the Twins stadium now known as Target Field. However, this type of engagement does not always happen or it is not always as successful as the Twins example, therefore we need some guidelines and criteria to assist those working on these types of projects in their work.

What Can Be Done

The Olmstead Community Engagement Plan will be used as the base for the plan called for in the action item CE 2A. Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The Olmstead Implementation Office will provide technical assistance and training related to the engagement plan to counties, cities, and others involved in publicly funded projects as needed to ensure understanding.

In addition to these measures, the Olmstead Implementation Office is also working with the State Treasury and Bonding Office and Minnesota Management and Budget to determine appropriate data sources for the creation of a baseline measurement of publicly funded action items at the state level. This information will be the first step toward ensuring that people with disabilities are included and engaged in action items that are publicly funded and that their input is used in meaningful ways. This baseline measure will be established by June 30, 2015. In addition to the baseline measurement and goals to be set related to publicly funded projects cities, counties and other local governments will be provided with this community engagement plan and toolbox to aid them in engaging people with disabilities in their projects. The Olmstead Implementation Office will offer education sessions to train county and other local government staff at least two times per year on the Olmstead Community Engagement Plan. The purpose of these sessions will be to familiarize staff with the plan and its requirements as well as teach them to train others on the same material.

Inclusion in Public Processes Challenges

Many projects receive some level of public funding, however it is generally only the large projects like new public facilities such as sports stadiums that get a great deal of attention. It is important to include a wide variety of voices on all types of projects. At this time, we lack a broad data source that would identify all publicly funded facilities and events. Knowing that, we will start with those large projects that require bonding and revise this plan as other data sources become available.

As many counties and other local governments may not be familiar with the best practices for community engagement outlined in the Olmstead Community Engagement Plan it will be important to provide training for these groups.

Specific Goals and Timelines

Goal	Timeline
The OIO in collaboration with State Treasury and Bonding Office and Minnesota Management and Budget will create a baseline and set goals for identifying publicly funded projects.	By June 30, 2015
The OIO will provide training sessions on the Olmstead Community Engagement Plan for subcabinet agency staff beginning with agency leads at least quarterly.	Beginning by June 30, 2015
The OIO will provide "train the trainer" education sessions on the Olmstead Community Engagement Plan beginning with subcabinet agencies at least 2 times per year.	Beginning by June 30, 2015

III. Policy Development and Meaningful Participation – CE 1A

The Minnesota Olmstead Plan calls for *"the state to develop a plan to increase opportunities for people with disabilities to meaningfully participate in policy development and provide the plan to the Olmstead Subcabinet by December 31, 2014."* (CE 1A from page 83 of the Plan)

Background

Each agency has various groups and individuals that they work with to get input on disability related issues. These groups should continue to be used and can be even more effective and diverse by implementing the strategies included in the Olmstead Community Engagement Plan.

Engaging people with disabilities is an important part of the Olmstead Plan and leads to strengthened planning processes and policy development. It can create better results and connections for people and communities; and it can be a way for people to share knowledge and expertise.

What are Policy Development and Meaningful Participation?

The Minnesota Olmstead plan calls for increasing the capacity for people to exercise their right to participate in their community and in ways that are meaningful to that individual. There are likely as many ways to have meaningful participation in policy making as there are people in Minnesota, this plan addresses only a few ways in which we can do that.

Given that there are many ways to define meaningful participation this document and we cannot address them all at one time, this document uses the following definition for meaningful participation.

Meaningful participation assures that people with disabilities are included in planning processes and development of policies that affect their daily lives. This includes participation at all phases (assessment, planning, implementation or service delivery and evaluation). People with disabilities are engaged respectfully as experts and partners. Their contributions can be seen in the work, processes are transparent and barriers to participation have been removed wherever possible.

What Can Be Done

The Olmstead Community Engagement Plan will be used as the base for the plan called for in the action item CE 1A. Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The measurement processes within the Olmstead Community Engagement Plan will be used to assess engagement of people with disabilities and the level of meaningfulness of that engagement process. The Olmstead Implementation Office will provide technical assistance and training related to the engagement plan to ensure understanding.

The Olmstead Implementation Office utilizes an advisory council comprised of representatives from the 23 Governor appointed groups, councils and boards listed in the Olmstead Plan (page 133). Each of these groups has received invitations to designate a representative for the Olmstead Advisory group. As of the date of this plan, there are 6 members of this group. The group has been used to share input on different topics related to the Olmstead Plan and at different points in the process from planning and

development to final review and feedback throughout. We would like this group to expand and work on more action items going forward. Additionally, the OIO will work with the subcabinet and the agency representatives to seek additional funding that would be used to support this group. This could be in the form of a legislative request or grant proposals from private philanthropic organizations. At least one request will be made by December 31, 2015.

The combined membership of the Governor appointed groups, councils and boards is 150 people. Many are people with disabilities, family members, or advocates. These groups have a collective power that can be used to effect the transformational change intended by the Minnesota Olmstead Plan. The Olmstead Implementation Office will continue to work with these groups and others to affect change.

Measuring Policy Development and Meaningful Participation

Each subcabinet agency is required to submit status/implementation reports to the Olmstead Office regarding their action items on a bi-monthly basis. These reports are reviewed for compliance including whom, how and when people with disabilities have been included in the action item process.

In addition to the status/implementation reports, upon adoption by the subcabinet, the community engagement plan and toolbox will be disseminated to the subcabinet agencies for implementation. The worksheets included in the community engagement plan will then become a reporting requirement that will be submitted to the Olmstead Office for the purpose of measuring community engagement in policy development. Beginning with the September 2015 status reports, information related to engagement will be gathered from the worksheets and be used to create a baseline measurement by December 31, 2015. From this baseline goals will be set and this plan will be amended.

The Olmstead Implementation Office advisory group will serve as an additional measurement, which will be expanded over time. By 2019, the goal is to have 30 people with disabilities participating in the Olmstead Office advisory group. Following the implementation of the engagement plan additional measures may be developed to document the increased opportunities for people with disabilities to participate meaningfully in policy development.

The Olmstead subcabinet and Olmstead Implementation Office will work with the Governor's appointed councils, groups and boards to engage them in the creation of a plan that aligns one or more of their goals with a related action within the Olmstead Plan by December 31, 2015.

Policy Development and Meaningful Participation Challenges

As noted in the Olmstead Community Engagement Plan, engagement is a long-term commitment to build relationships with the community. Not all agencies have fully developed positive relationships with diverse communities. This may be a challenging new way to approach the work that they do and it will take time to develop the relationships necessary for robust community engagement in the future.

Additionally, individuals and community organizations should be compensated/reimbursed for expenses whenever possible. This may require agencies to change internal policies or find funding sources that may be different from what they are accustomed to. Often times additional funding may not be possible.

As there are many different ways for people to participate that they find meaningful and this plan cannot begin to address all of them; it is important that we continually review this plan and revise as needed to be sure that we are engaging people in a manner that is meaningful for them as well as the agencies.

Specific Goals and timelines

Goal	Timeline
In conjunction with the subcabinet and agencies the OIO will develop at least one funding proposal to support Olmstead Advisory Group.	By December 31, 2015
The OIO will create a baseline and set goals for increased engagement based on data collected from agencies starting two months after the adoption of the Olmstead Community Engagement Plan.	Anticipated completion by December 31, 2015
The OIO in conjunction with the subcabinet will increase number of members of the Olmstead Advisory group to 30 members.	December 31, 2019
The OIO will work with Governor's appointed councils, groups, etc. to create a plan that aligns one or more of their goals with an Olmstead goal.	December 31, 2015

IV. Self-Advocacy and Peer Supports– CE 1B

The Minnesota Olmstead Plan states that *"in consultation with people with disabilities, family members, and diverse community groups, the state will assess the size and scope of peer supports and self-advocacy programs; based on this information that state will set annual goals for progress. Recommendations, including funding and any necessary legislative changes, will be made to the subcabinet."* (CE 1B on page 83 of the Plan)

Background – Self-Advocacy

There are a number of self-advocacy training groups/programs throughout the state and nationally. These groups and training programs have their roots in the developmental and intellectual disability community. However, over the years they have expanded to include other disability groups as well. As noted by both anecdotal comments and research conducted by the Association of University Centers on Disabilities the future of these groups is dependent on four primary things.

- Infrastructure to support self-advocacy and peer supports
- Community Services and Supports
- Outreach and Communication
- Change in Public Perceptions

The Olmstead Implementation Office reviewed literature regarding self-advocacy and peer supports and consulted with people with disabilities, family members, community groups and state agencies in order to assess the size and scope of programs in Minnesota. A listing of these stakeholders is included at the end of this document. Stakeholders were asked to share experiences and recommendations during the planning process as well as throughout the writing of this plan.

We learned that groups are formed in a number of ways. Some are started by gathering individuals that share similar interests, while other form within or in conjunction with organizations. Groups range from informal discussions hosted on social media sites to more formal groups that provide training and support for self-advocates. Since there are so many types of groups and variations in how they operate it was difficult to find a source that listed everyone. We did find one source that provides some of this information in the form of a state-by-state listing of groups that can be searched at self-advocacy online. As of December 2014 Minnesota has 23 organizations listed on this site. Some larger groups stood out during the research for this plan.

- People First
- Self-Advocates Minnesota
- The Arc Greater Twin Cities Self-Advocacy Advisory Committee

In addition to these groups there are also training programs available to help people with disabilities better understand the policy making process and how to be most effective in sharing their story with others. While there are many programs, two stood out during the research for this plan.

- NAMI "In Our Own Voice"
- Olmstead Academy

Background – Peer Support Services

Peer support services differ in some ways from self-advocacy although there are also some similarities. Peer support services are primarily a product coming from the mental health community, although some feel that the concept could be applied more broadly across disability types. Certified Peer Specialists can be a billable service under Medicaid rules and have been allowed in Minnesota since 2007. There are four Medicaid Rehabilitation Services that can include the use of Certified Peer Specialists.

- Adult Rehabilitative Mental Health Services (ARMHS) certified by DHS
- Assertive Community Treatment (ACT) teams approved by DHS
- Crisis Response -Stabilization providers certified by DHS
- Intensive Residential Treatment Services (IRTS) providers licensed by DHS

Peer support specialists self-identify and work with their peers to assist them in their recovery process. Peer support specialists can perform a variety of tasks and in Minnesota, there are two different levels of certification, with separate qualifications for each level[8]. Continuing education is also required in order to maintain certification.

Currently the Minnesota Department of Human Services (DHS) has adopted the use of Recovery Opportunity Center's curriculum for the training program. 325 individuals have been trained and certified as Peer Specialists and based on past surveys of graduates 50-60% of graduates have been employed as a Certified Peer Specialist at one time.

Peer Support Services Challenges and Limitations

Without any, one of the four areas noted previously it is difficult for groups to continue, much less grow their numbers. Funding and infrastructure seem to be the biggest barriers for most groups. Others are bound by the constraints such as manageable group size or number of opportunities for participants to share their stories or work with others.

Many groups struggle with finding a regular meeting space, transportation, as well as competition from other advocacy groups. Some training curriculums, while providing outstanding information are also quite intensive for both participants and instructors limiting the number of times they can be offered.

Certified Peer Specialists may have a difficult time finding employment opportunities once they graduate as many providers do not offer these services as a part of their service options, or there are other barriers to employment such as transportation, background checks, etc. Low reimbursement rates may also deter providers from offering these types of services.

[8] More information can be found at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dDocName=dhs16_149185&RevisionSelectionMethod=LatestReleased

Measuring Self-Advocacy and Peer Supports?

As noted in the limitations section, there are several factors that hinder broad measurement at this time. That being noted three groups/programs were selected as the baseline measurement from which to set goals and work toward expansion of opportunities. These groups are a point from which to start but in no way represent the only opportunities for increasing self-advocacy and peer supports.

- Self-Advocates Minnesota (SAM) – 100 core participants
- Olmstead Academy - maximum of 21 participants per class
- NAMI "In Our Own Voice" – maximum of 16 participants per session

Self-Advocates Minnesota (SAM) has chapters throughout the state. While there are currently an estimated 100 core participants they touch the lives of many more. The goal is to increase the number of core participants in SAM to 150 by 2019.

The Olmstead Academy had its inaugural year, kicking off in the fall of 2014. This program was initially funded through a grant and most participants identify as having a developmental or intellectual disability, however, a legislative request has been submitted for funding to continue the program. Additionally, the program can be licensed to other groups and communities, such as those that have a primary language other than English or identify with a different disability type. The goal is to expand this offering to 6 groups/communities by 2019.

"In Our Own Voice" is a public education program created by NAMI (National Alliance on Mental Illness) in which two trained speakers share compelling personal stories about living with mental illnesses and achieving recovery, showing in person that there is hope for recovery. Presenters are trained how to effectively share their story with others to change attitudes and stereotypes regarding mental illnesses. Class size is limited to 16 participants per session. Participants are asked to present four times during the year following training with opportunity to present more often and to continue for more than one year. "In Our Own Voice" presenter trainings in Minnesota are dependent upon funding and grant renewals. Typically, NAMI Minnesota trains new presenters once per year with interest in training more often if funds are available. An Olmstead goal has been set to increase the training from 1 time per year to 2 times per year by 2016 and maintaining that going forward.

What Can Be Done

The Olmstead Implementation Office and subcabinet agencies will provide technical assistance to each of these programs as needed. The Olmstead Implementation Office will report on the progress toward the goals as a part of our annual report. Additionally, we will add links to our website to assist people in finding self-advocacy and Peer support services, groups and training. As noted in the principles for engagement section of the Olmstead Community Engagement Plan people and/or organizations involved in action items should be compensated/reimbursed for expenses. In order to provide compensation/reimbursement many agencies may have to make changes to internal policies and seek additional funding. It will be critical to include this in the planning process for any engagement activities. As the groups selected do not represent all of the possible opportunities for increasing self-

advocacy, the Olmstead Implementation Office will continually work with groups and organizations to explore the creation of additional partnerships in the future.

Peer Support Services is a highly complex area that requires further research to be conducted before setting goals. The Olmstead Implementation Office will continue to work with the Department of Human Services and other stakeholders to develop goals by June 30, 2015. Once those goals have been established this plan will be amended.

Specific Goals and timelines

Goal	Timeline
The OIO in collaboration with Self-Advocates Minnesota (SAM) will work to increase the core membership of SAM from 100 individuals to 150 individuals.	By December31, 2019
The OIO in collaboration with Advocating Change Together will work to expand the Olmstead Academy model to 6 other groups.	By December 31, 2019
The OIO in collaboration with National Alliance on Mental Illness (NAMI) will work to increase the training for the "In Our Own Voice" program from one time a year to two.	By December 31, 2016
The OIO in collaboration with the Department of Human Services will conduct further research on Peer Support Services and develop a baseline and set goals.	By June 30, 2015

V. Leadership – OV 3A

The Minnesota Olmstead Plan states that "*Design and implement opportunities for people with disabilities to be involved in leadership capacities in all government programs that affect them. These opportunities will include both paid and volunteer positions. Provide support, training, and technical assistance to people with disabilities to exercise leadership. This will lead to sustainability of the Olmstead Plan over time.*
By December 31, 2014 leadership opportunities will be identified and implemented." (OV 3A from page 32 of the Plan)

Background

Leadership is individual and can be difficult to define. It may be a paid position; it could be a volunteer position. Some roles may involve sharing experiences to inform decision makers, others may be in a decision-making role. Leadership roles are as diverse as the population. The Olmstead Office consulted with members of the Olmstead Office advisory group and other people with disabilities to find out what people felt a leadership opportunity is. It was determined that people define leadership roles differently. Some people see their role as a self-advocate as a leadership role. Some felt that their participation in advisory groups, councils and boards satisfied a leadership role. Some see employment with a state agency as a leadership role. Others were less defined but felt that the role needed to have decision-making capacity.

The Olmstead Plan has a separate action item related to increasing self-advocacy, however, it is applicable here as well as some individuals feel that self-advocacy is a leadership role. State agencies should set an example for the rest of the state in terms of including people with disabilities in leadership roles. Some ways this can be accomplished through would be through the use of advisory groups, councils and boards, as well as through increased employment of people with disabilities.

The Minnesota Governor's Council on Developmental Disabilities created a leadership training program called Partners in Policymaking®. This program was developed to teach parents and self-advocates *"the power of advocacy, and change the way people with disabilities are supported, viewed, taught, live and work."* (Minnesota Governor's Council on Developmental Disabilities) Through programs such as this and others, people with disabilities have learned that they can determine how they define a leadership role. Other groups such as the Minnesota Citizen Advocacy Academy and Courage Center have also held leadership trainings.

State agencies, Counties and local governments as well as private businesses will need to continue to think creatively as to how we can create greater opportunities for people with disabilities to take on leadership roles. Some people with disabilities have received Bush Foundation Fellowships or participated in the Blandin leadership program and these types of opportunities should be explored as additional routes to increased leadership opportunities.

What Can Be Done – Leadership #1 – Active Engagement with Governor Appointed Councils, Groups and Boards

The Olmstead Community Engagement Plan will be used as the base for the plan called for in the action item OV 3A. Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The Olmstead Implementation Office will also provide technical assistance and training related to the engagement plan to counties, cities, and others involved in publicly funded projects as needed to ensure understanding.

Additional leadership roles will be determined through a survey conducted with the Governor's Appointed Councils, groups, boards, etc. to ascertain:

- how many of their members are persons with disabilities,
- what types of roles they serve in,
- and what types of technical support/training is supplied by the group or may be required
- as well as how this impacts monitoring and reviewing of community services and support and other policy development.

This survey will be completed by May 1, 2015 with results informing additional goals to be set and incorporated into this plan.

The Olmstead Implementation Office will engage with each of the Governor Appointed Councils, Groups, and/or Boards and work with them to develop a plan for coordination around one or more of their goals with a related action within the Olmstead Plan by December 31, 2015.

What Can Be Done – Leadership #2 – Increase Participation of Self-Advocates

The Olmstead Community Engagement Plan will be used as the base for the plan called for in the action item OV 3A. Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The Olmstead Implementation Office will also provide technical assistance and training related to the engagement plan to counties, cities, and others involved in publicly funded projects as needed to ensure understanding.

In terms of self-advocacy, the Olmstead Implementation Office is working with the Minnesota Consortium for Citizens with Disabilities (MN-CCD) to track the number of self-advocates participating in Tuesdays at the Capitol, a weekly event held at the capitol to inform and educate self-advocates and legislators; as well as share personal stories with law makers. This will begin in January 2015 and go through the remainder of the 2015 legislative session. By June 30, 2015, goals will be set based on this information and incorporated into this leadership plan.

What Can Be Done – Leadership #3 – Increase State Agency Employment

The Olmstead Community Engagement Plan will be used as the base for the plan called for in the action item OV 3A. Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The Olmstead Implementation

Office will also provide technical assistance and training related to the engagement plan to counties, cities, and others involved in publicly funded projects as needed to ensure understanding.

Given the complexity of defining, what a leadership role is it is difficult to set one particular goal for increasing leadership opportunities. Although it is not the only type of leadership, one baseline for measuring increased leadership opportunities will be state agency employment. According to a recent Governor's executive order, approximately 2,635 current state employees identify as having a disability. The goal will be to increase that number to 3,540 by 2019.

As set forth in the executive order 14-14 this will be monitored and reported by Minnesota Management and Budget as well as individual agencies. This information will be shared with the public via agency websites as well as through the Olmstead Implementation Office reporting process. This group is also working to include opportunities for people with disabilities to gain access to state agency employment through internship programs that lead to long term employment.

Leadership Current Challenges and Limitations

As previously noted, leadership is defined by the individual and this plan does not address all of the different types of leadership opportunities that may be or could be available.

There are barriers to employment for people with disabilities that are currently being reviewed and worked on at the state level by a committee overseen by Minnesota Management & Budget (MMB), although it should be noted that this group will not be able to remove all barriers to employment.

Additionally, there is limited funding currently available to support individuals and/or groups when they participate in engagement activities making it difficult for some to participate in leadership roles. There are also social perceptions that create barriers to people with disabilities holding leadership roles. These limitations are not addressed in the scope of this plan.

What Can Be Done

The Olmstead Implementation Office will support the efforts being developed by Minnesota Management and Budget towards meeting the goals of the executive order. In addition the Olmstead Implementation Office will continue to review and monitor additional opportunities for leadership roles through the implementation of additional action items such as self-advocacy and peer supports and other groups such as advisory groups, councils and boards.

The Governor Appointed Group survey will be conducted and results will be used to set additional goals for increased leadership opportunities by May 1, 2015. Self-advocacy goals will be set by June 30, 2015 following data collection based on participation in Tuesday's at the Capitol and integrated into the plan as well.

Specific Goals and Timelines

Goal	Timeline
Minnesota Management and Budget, Office of Affirmative Action will monitor and share information related to progress on Executive Order 14-14, to increase state agency employment for persons with disabilities from 2,635 individuals to 3,540 individuals.	By December 31, 2019
The OIO in conjunction with the subcabinet will conduct a survey of all Governor's appointed disability councils, boards, groups, etc. to ascertain how many of their members are persons with disabilities, what types of roles they serve in, and what types of technical support/training is supplied by the group or may be required as well as how this impacts monitoring and reviewing of community services and support and other policy development.	By May 1, 2015
The OIO will work with Governor appointed councils, groups, etc. to create a plan that coordinates one or more of their goals with an Olmstead goal.	By December 31, 2015
The OIO in collaboration the Minnesota Consortium for Citizens with Disabilities (MN-CCD) will develop a baseline and set goals to increase self-advocacy using data collected during the 2015 legislative session "Tuesday's at the Capitol" sessions.	By June 30, 2015

Stakeholder Input

The following groups and/or individuals shared input related to this plan.

Olmstead Implementation Office Advisory Group – Consisting of representatives from the various Governor Appointed Disability Groups, Councils, Boards, etc.

The Arc Greater Twin Cities Self-Advocacy Advisory Committee

Advocating Change Together

Metropolitan Council

Centers for Independent Living

Minnesota Management and Budget Affirmative Action Office

Minnesota Consortium for Citizens with Disabilities

Subcabinet agencies

Advocate Aces

Shooting Stars

Believers in Self-Advocacy

NAMI-MN

University of Minnesota Research and Training Center on Community Living

Olmstead Dispute Resolution Process Work Plan

Author: Olmstead Implementation Office in collaboration with Department of Human Rights for QA 2A

Date submitted to Subcabinet: / / Date Approved by Subcabinet: / / Date submitted to Court: / /

2/24/2015

Contents

Introduction

The Olmstead Implementation Office (OIO) has been working to assist individuals to access existing dispute resolution processes among the agencies that comprise the Olmstead subcabinet.

This document provides an overview of the activities undertaken thus far, activities recommended to occur in the near future, and a proposed 2015 work plan for review by the subcabinet to provide guidance for activities going forward.

Current Plan

The current dispute resolution process includes the following components:

- The process currently operates out of the Olmstead Implementation Office (OIO) under the direction of the Olmstead subcabinet.
- The OIO team receives complaints, discusses the issues with the individual and works informally with them to resolve the complaint.
- The OIO team works with various agencies to establish working relationships for purpose of obtaining appropriate resources and finding resolutions to identified complaints.
- The majority of the complaints have been referred and resolved through the agencies' informal efforts.
- The OIO had several instances of complaints elevated to the Compliance/Legal Office of the respective agency or referred to outside referral sources.
- The OIO tracks and documents all complaints in a spreadsheet.
- The Olmstead Implementation Office will provide a summary report to the subcabinet.

Future Plan

The Minnesota Olmstead Plan (Plan) envisions individuals who believe that they have not received services or supports in accordance with the principles set forth in *Olmstead v. L.C.* will have a way to raise their concerns and address the problem.

Preliminary Feedback

In the course of implementing the current process above, the following issues of concern were identified:

- Existing dispute resolution processes were reported as ineffective in resolving Olmstead related concerns
- There is need for a comprehensive list of existing dispute resolution processes within agencies
- Individuals with Olmstead related concerns reported a need for consumer advocacy services
- The dispute resolution processes vary widely within the agencies in several areas including: timeframes for filing complaints, formality of the process, and impact on the individual to seek other legal relief
- It is unclear to individuals which dispute resolution process is the most appropriate for their situation

Recommendations

It is recommended that the subcabinet adopt the following actions:

- By March 31, 2015, establish a workgroup including the OIO and the Minnesota Department of Human Rights (MDHR) and other stakeholders as appropriate
- The workgroup will review the concerns identified and make recommendations to modify the dispute resolution process to address these areas.
- This may include contracting with a third party to develop and conduct a survey of all subcabinet agencies to outline existing processes, types of complaints, length of time to resolution, and complainant satisfaction.
- The workgroup will examine effective ways to educate the public about the various dispute resolution processes, ways to access those processes, and recommend a continuous improvement process
- The workgroup will include a plan to disseminate the report to the public, advocacy organizations and agencies.
- By December 31, 2015 the workgroup will report findings and recommendations for improving the dispute resolution process to the Subcabinet

Timetable

Activity	Time Frame	Responsible
Continue current dispute resolution plan	Present	OIO
Report lessons learned from dispute resolution plan	3/2015	OIO
Establish workgroup to develop report	3/2015	OIO/MDHR
Submit dispute resolution report	12/2015	OIO/MDHR
Convene public events on dispute resolution practices	2016	OIO/MDHR

Olmstead Plan: Baseline Data for Current Care

Health Care Research and Quality

January 2015

For more information contact:

Minnesota Department of Human Services
Health Care Research and Quality
P.O. Box 64986
St. Paul, MN 55164-2648
651-431-2648

Executive Summary

On January 28, 2013, Governor Mark Dayton issued an executive order establishing an Olmstead Sub-Cabinet to develop and implement a comprehensive Minnesota Olmstead Plan. The main purpose of the Olmstead Plan is to move the state forward, towards greater integration and inclusion for people with disabilities.

In accordance with objective 2G under the Healthcare and Healthy Living section of the Olmstead Plan[1], the Health Care Research and Quality (HRQ) Division within the Minnesota Department of Human Services has established baseline data for current care of people with disabilities. Specifically, baseline data for health care service use are being reported for medical, dental, chiropractic, and mental health care, for persons with and without disabilities enrolled in Minnesota's Medical Assistance (MA) program. The source of the data in this report is Minnesota Health Care Programs paid claims data, which does not include Medicare claims data.

HRQ selected several measures of health care utilization from the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HRQ also created measures for chiropractic care and certified peer support services.

Specific measures were chosen for three age groups: children aged 0-20, adults aged 21-64, and seniors aged 65 and older. For each measure examined, the rate of service use by MA enrollees with disabilities was compared with the rate of service use by MA enrollees without disabilities.

The findings are summarized below:

- Across all age groups, 48.3% percent of all comparisons (14 out of 29 comparisons) showed significantly *greater* service use among persons with disabilities than persons without disabilities.
  - For children, this percentage was 45.5% (5 out of 11 comparisons).
  - For adults under 65, this percentage was 63.6% (7 out of 11 comparisons).
  - For seniors 65 and older, this percentage was 28.6% (2 out of 7 comparisons).

- Across all age groups, 20.7% percent of all comparisons (6 out of 29) showed significantly *less* service use among persons with disabilities than persons without disabilities.
  - For children, this percentage was 27.3% (3 out of 11 comparisons).
  - For adults under 65, this percentage was 9.1% (1 out of 11 comparisons).
  - For seniors 65 and older, this percentage was 28.6% (2 out of 7 comparisons).

- Across all age groups, 31.0% percent of all comparisons (9 out of 29 comparisons) had non-significant differences in service use between the disabled and non-disabled populations.
  - For children, this percentage was 27.3% (3 out of 11 comparisons).
  - For adults under 65, this percentage was 27.3% (3 out of 11 comparisons).
  - For seniors 65 and older, this percentage was 42.9% (3 out of 7 comparisons).

[1] The approved version of the Olmstead Plan as of November 2013 can be seen at the following location: Olmstead Plan

In general, MA enrollees with disabilities used health care services at rates equal to or higher than MA enrollees without disabilities. This trend was more apparent among adults under 65, than among children and seniors over 65.

Introduction

On January 28, 2013, Governor Mark Dayton issued an executive order establishing an Olmstead Sub-Cabinet to develop and implement a comprehensive Minnesota Olmstead Plan. The main purpose of the Olmstead Plan is to move the state forward, towards greater integration and inclusion for people with disabilities.

This report presents baseline data for current health care of people with disabilities, in accordance with Objective 2G under the Healthcare and Healthy Living section of the Olmstead Plan. The Health Care Research and Quality (HRQ) Division of the Department of Human Services selected utilization measures of four different types of health care: medical, dental, chiropractic, and mental health. These measures are reported for persons enrolled in the Medical Assistance (MA) program. Rates of health care service use by MA enrollees with disabilities, or who are very likely to have disabilities, are compared with rates of service use by MA enrollees without disabilities.

Overview of Population

The population in this report includes all individuals who were enrolled in the MA program for at least one month during Calendar Year 2013. Individuals were placed into one of three age groups, according to their age as of December 31, 2013. Individuals aged 0-20 were classified as children. Individuals aged 21-64 were classified as adults. Finally, individuals 65 and older were classified as seniors.

MA enrollees were categorized by disability status, with each individual classified as either having a disability, or not having a disability. The classification of an individual by disability status was performed based on the eligibility type associated with MA enrollment, and the score the individual received on an algorithm used by DHS to identify persons who are highly likely to have a disability.

Additionally, the definition for disability included additional components for the children and seniors. Specifically, children were classified as having a disability if they had a paid Minnesota Health Care Programs claim during Calendar Year 2013 with one or several specified diagnosis codes or billing codes indicating a disabling condition or functional limitations. Seniors aged 65 and older were classified as having a disability based on scores on an assessment of their ability to carry out activities of daily living. Details of all three age-specific disability definitions can be found in Appendices A- C.

Overview of Utilization Measures

This report includes 17 measures of health care service use selected by HRQ based on their relevance to the domains of care specified in the Olmstead Plan. Fifteen measures in this report were developed by the National Committee for Quality Assurance (NCQA) and are known as Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS is a national set of standardized performance measures originally designed for the managed care industry. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

For more information on methods and technical specification of HEDIS measures, see the link below[2] from the National Committee for Quality Assurance (NCQA). Importantly, HEDIS is considered the gold standard in health care performance measurement. The 15 HEDIS measures included in this report are as follows:

[2] These materials can be seen at the following location: Measuring quality. Improving health care

- Adults Access to Preventive/Ambulatory Health Services (AAP)
- Comprehensive Diabetes Care (CDC)
- Colorectal Cancer Screening (COL)
- Cholesterol Management for Patients With Cardiovascular Conditions (CMC)
- Breast Cancer Screening (BCS)
- Annual Dental Visit (ADV)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Childhood Immunization Status (CIS)
- Human Papillomavirus Vaccine for Female Adolescents (HPV)
- Appropriate Treatment for Children With Upper Respiratory Infection (URI)
- Follow-Up After Hospitalization for Mental Illness: 7-Days (FUH-7 Days)
- Follow-Up After Hospitalization for Mental Illness: 30-Days (FUH-30 Days)

There were a number of factors that led HRQ to choose these particular HEDIS measures for certain age groups in this report. First, while there are many HEDIS measures, DHS currently only reports on a subset of 26 of these measures. DHS does not report on any of the hybrid HEDIS measures, which require resources for medical chart review. Second, many HEDIS measures are age-specific, and are not appropriate to report for all age groups. For example, the HEDIS measure "Childhood Immunization Status" references only children who are two years of age, and is not reported for adults or seniors. Similarly, the HEDIS measure "Colorectal Cancer Screening" is only reported for individuals who are between 50 and 75 years of age.

Finally, HRQ chose to focus on measures of the use of preventive, primary care, and screening services. These measures are consistent with the Olmstead Plan goals to support overall good health of people with disabilities, and to increase the health of people with disabilities so that the rates of chronic diseases such as heart disease and diabetes are comparable to the rates of those people without disabilities.

One domain of care that is explicitly mentioned in the Olmstead Plan, chiropractic care, did not have an associated HEDIS measure. Consequently, HRQ developed a measure for the use of chiropractic care that measures how many persons received an evaluation or a manipulation from a chiropractor over the course of a calendar year.

This report also includes a measure of the utilization of Certified Peer Support Services for mental health that was developed by HRQ, and is reported for adults under 65. A full description of Certified Peer Support Services can be found on the DHS website[3]. The number of MA enrollees receiving Certified Peer Support Services during Calendar Year 2013 was extremely small. However, individuals with disabilities were much more likely to receive these services than individuals without disabilities (see Figure 10).

[3] Certified Peer Support Services

Limitations

This report contains limitations that should be noted with respect to the interpretation of the report. Importantly, the source of the data in this report is Minnesota Health Care Programs paid claims data, which does not include Medicare claims data. Therefore, for persons who are dually enrolled in both MA and Medicare, use of health care services that are covered by Medicare may be underreported. This underreporting is expected to impact the rates reported for persons with disabilities in this report, but not the rates for persons without disabilities.

It should also be noted that this report addresses issues involving service use, which is not directly correlated with healthcare access. Therefore, conclusions about differences in healthcare access cannot be obtained from observation of differences in service use.

For More Information

For additional information, please contact Virginia Zawistowski at virginia.zawistowski@state.mn.us or Karen Schirle at karen.schirle@state.mn.us.

Table 1. Health care service use measures for children aged 0-20, Calendar Year 2013

Measure	Service use rates		Number of persons in numerator		Number of persons in denominator	
	Disability	Non-Disability	Disability	Non-Disability	Disability	Non-Disability
Well-Child Visits in the First 15 Months of Life	55.0%	57.0%	400	7,073	727	12,418
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life†	56.5%	60.1%	3,505	20,266	6,206	33,703
Adolescent Well-Care Visits	33.9%	32.9%	4,967	16,281	14,668	49,558
Children and Adolescents' Access to Primary Care Practitioners*	93.7%	89.9%	26,008	101,579	27,751	112,976
Childhood Immunization Status: Combination 3*	73.2%	66.0%	542	6,215	740	9,411
Human Papillomavirus Vaccine for Female Adolescents	17.3%	18.7%	125	680	722	3,638
Appropriate Treatment for Children With Upper Respiratory Infection†	88.2%	91.0%	3,620	24,383	4,105	26,799
Annual Chiropractic Evaluation*	3.2%	2.6%	1,653	9,964	52,138	386,828
Annual Dental Visit†	50.7%	54.9%	16,360	72,372	32,272	131,786

Measure	Service use rates		Number of persons in numerator		Number of persons in denominator	
	Disability	Non-Disability	Disability	Non-Disability	Disability	Non-Disability
Follow-Up After Hospitalization for Mental Illness: 7 days*	27.5%	19.3%	455	293	1,654	1,521
Follow-Up After Hospitalization for Mental Illness: 30 days*	50.8%	36.6%	841	557	1,654	1,521

Note 1: * denotes there was a significant difference between the two populations at α = .01, with greater service use by persons with disabilities.

Note 2: † denotes there was a significant difference between the two populations at α = .01, with greater service use by persons without disabilities.

Table 2. Health care service use measures for adults aged 21-64, Calendar Year 2013

Measure	Service use rates		Number of persons in numerator		Number of persons in denominator	
	Disability	Non-Disability	Disability	Non-Disability	Disability	Non-Disability
Cervical Cancer Screening†	52.0%	68.5%	21,393	27,245	41,115	39,797
Adults' Access to Preventive/Ambulatory Health Services*	95.0%	87.3%	87,656	63,623	92,317	72,846
Cholesterol Management for Patients with Cardiovascular Conditions	76.6%	81.1%	1,589	340	2,075	419
Breast Cancer Screening	61.4%	58.8%	7,041	1,579	11,468	2,687
Comprehensive Diabetes Care	75.4%	74.2%	13,529	3,839	17,953	5,172
Colorectal Cancer Screening*	54.9%	41.1%	13,030	3,188	23,737	7,749
Annual Dental Visit*	48.2%	40.6%	44,461	29,605	92,317	72,846
Annual Chiropractic Evaluation*	8.9%	7.7%	12,458	21,605	139,732	282,324
Follow-Up After Hospitalization for Mental Illness: 7-Day*	23.3%	15.3%	1,986	250	8,511	1,639
Follow-Up After Hospitalization for Mental Illness: 30-Day*	48.5%	29.6%	4,124	485	8,511	1,639
Certified Peer Services*	0.24%	0.01%	342	30	139,732	282,324

Note 1: * denotes there was a significant difference between the two populations at α = .01, with greater service use by persons with disabilities.

Note 2: † denotes there was a significant difference between the two populations at α = .01, with greater service use by persons without disabilities.

Table 3. Health care services use measures for seniors aged 65 and older, Calendar Year 2013

Measure	Service use rates		Number of persons in numerator		Number of persons in denominator	
	Disability	Non-Disability	Disability	Non-Disability	Disability	Non-Disability
Adults' Access to Preventive/Ambulatory Health Services*	95.4%	91.9%	28,643	14,547	30,036	15,833
Cholesterol Management for Patients with Cardiovascular Conditions	76.2%	79.5%	921	431	1,209	542
Breast Cancer Screening†	52.2%	55.3%	2,626	1,536	5,035	2,777
Comprehensive Diabetes Care†	76.6%	80.2%	3,797	1,752	4,956	2,185
Colorectal Cancer Screening*	52.0%	48.6%	4,717	2,900	9,069	5,968
Annual Dental Visit	35.2%	34.1%	10,587	5,403	30,036	15,833
Annual Chiropractic Evaluation	4.3%	4.5%	1,872	1,087	43,435	24,332
Follow-Up After Hospitalization (FUH) for Mental Illness: 7 days	21.3%		66		309	
Follow-Up After Hospitalization (FUH) for Mental Illness: 30 days	41.1%		127		309	

Note 1: * denotes there was a significant difference between the two populations at α = .01, with greater service use by persons with disabilities.

Note 2: † denotes there was a significant difference between the two populations at α = .01, with greater service use by persons without disabilities.

Note 3: Percentages and significance testing was not conducted for FUH for the non-disabled population due to an extremely small sample.

Adults' Access to Preventive/Ambulatory Health Services

Medical Care Measure: Calendar Year 2013

Adults' Access to Preventive/Ambulatory Health Services (AAP) measures the percentage of individuals who had an ambulatory or preventive care visit.

Individuals included in the denominator of the AAP measure met the following criteria:

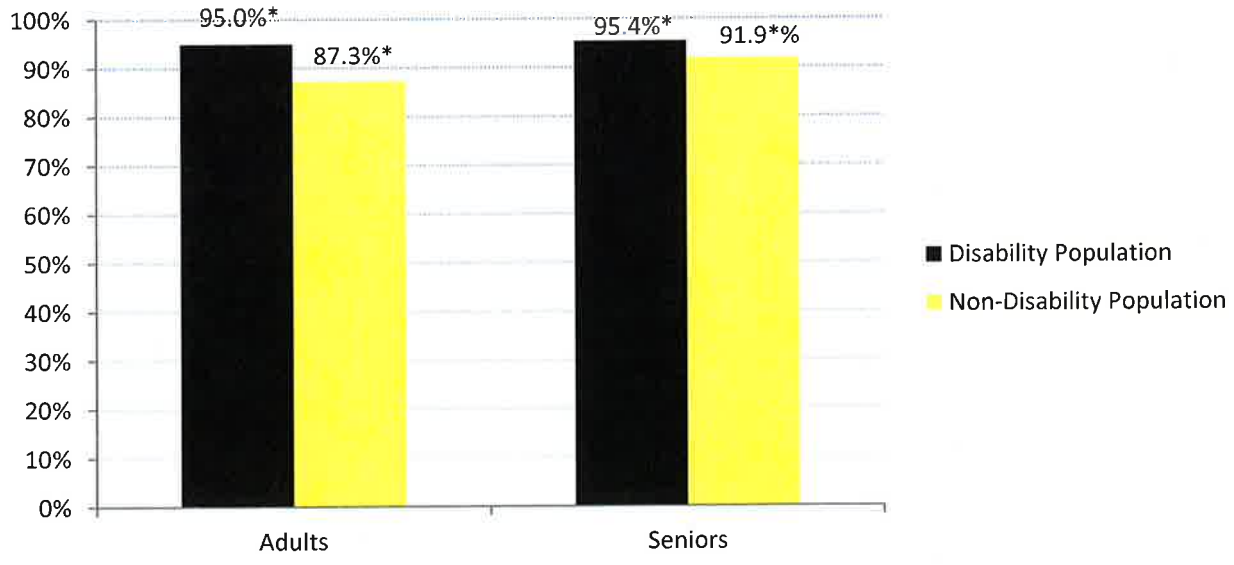
- Individuals age 21-64 (adults) or 65 and older (seniors) as of December 31, 2013.
- Continuously enrolled during the measurement year 2013. Medicaid beneficiaries may not have more than a single month gap in enrollment.

In the calendar year 2013, within the population of seniors, approximately 95 percent of persons with disabilities received an ambulatory or preventive care visit. By contrast, approximately 92 percent of persons without disabilities received such a visit. This difference was statistically significant.

In the calendar year 2013, within the population of adults under age 65, approximately 95 percent of persons with disabilities received an ambulatory or preventive care visit. By contrast, approximately 87 percent of persons without disabilities received such a visit. This difference was also statistically significant.

Figure 1 below shows a graph comparing the rate of Adults' Access to Preventive/Ambulatory Health Services by age group and disability status.

Figure 1: Utilization Rates for Adults' Access to Preventive/Ambulatory Health Services by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at α =.01.

Cholesterol Management for Patients with Cardiovascular Conditions

Medical Care Measure: Calendar Year 2013

Cholesterol Management for Patients With Cardiovascular Conditions (CMC) measures the percentage of individuals who were discharged alive for acute myocardial infarction (AMI, heart attack), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year:

- LDL-C screening.
- LDL-C control (<100 mg/dL).

Individuals included in the denominator of the CMC measure met the following criteria:

- Individuals age 21-64 (adults) or 65-75 (seniors) as of December 31, 2013.
- Continuously enrolled during the measurement year 2013 and the year prior. Medicaid beneficiaries may not have more than a single month gap in enrollment.
- Possessed at least one of the following:

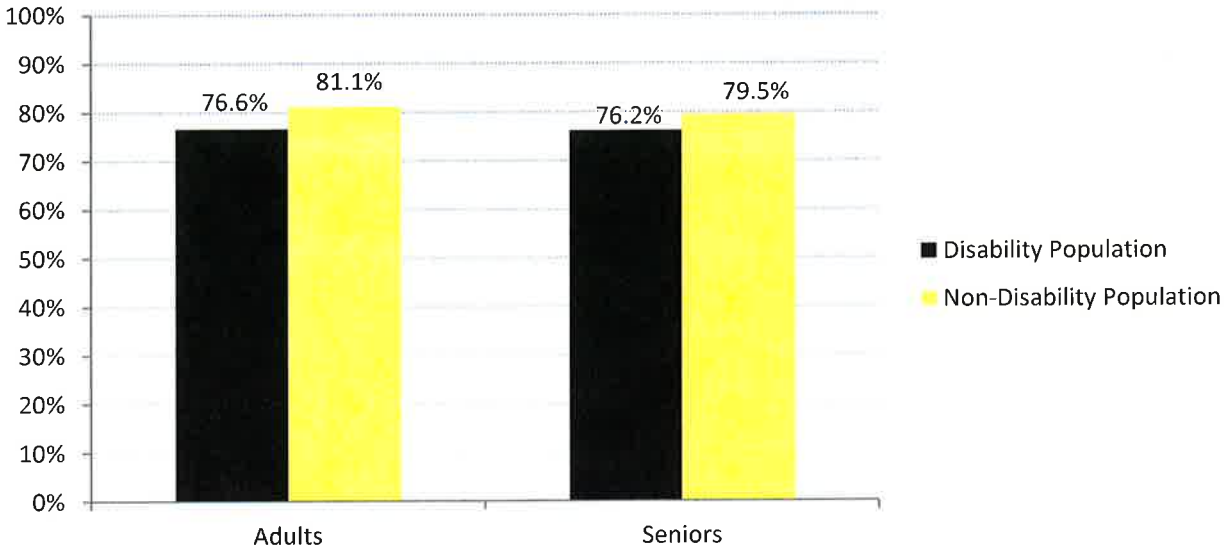
1. Discharged alive from an acute inpatient setting with an AMI.
2. Discharged alive from an acute inpatient setting with a CABG.
3. Members who had PCI in any setting.

In the calendar year 2013, within the population of seniors, approximately 76 percent of persons with disabilities received adequate cholesterol management. By contrast, approximately 80 percent of persons without disabilities received adequate cholesterol management. This difference was not statistically significant.

In the calendar year 2013 within the population of adults under 65, approximately 77 percent of persons with disabilities received adequate cholesterol management. By contrast, approximately 81 percent of persons without disabilities received adequate cholesterol management. This difference was also not statistically significant.

Figure 2 below shows a graph comparing the rate of Cholesterol Management for Patients with Cardiovascular Conditions by age group and disability status.

Figure 2: Utilization Rates for Cholesterol Management for Patients with Cardiovascular Conditions by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Breast Cancer Screening

Medical Care Measure: Calendar Year 2013

Breast Cancer Screening (BCS) measures the percentage of women who had a mammogram to screen for breast cancer during the measurement year.

Individuals included in the denominator of the BCS measure met the following criteria:

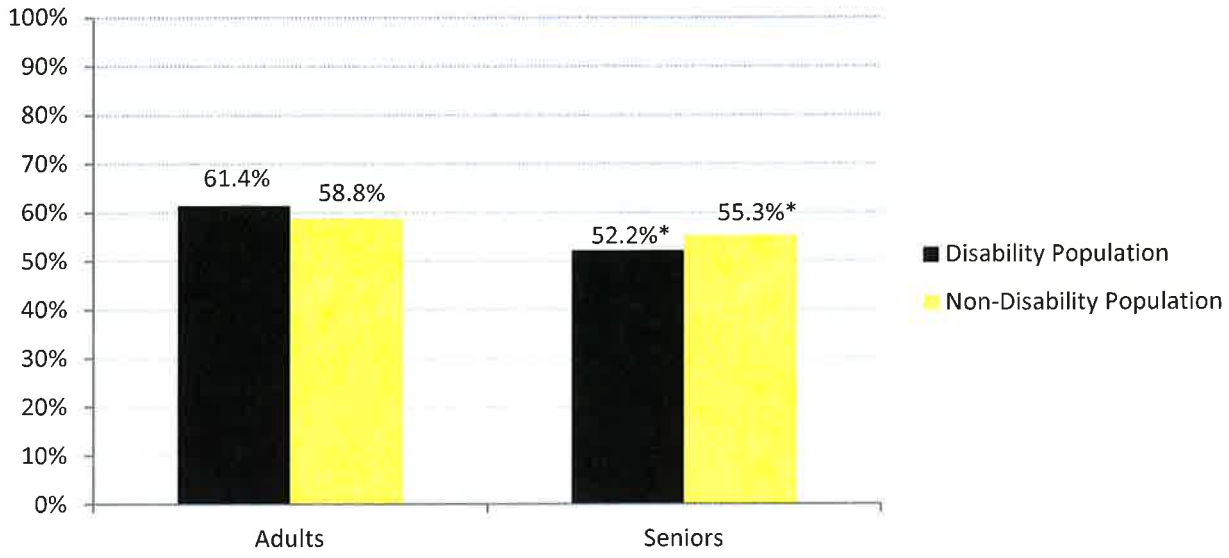
- Women age 21-64 (adults) or 65-74 (seniors) as of December 31, 2013.
- Continuously enrolled October 1 two years prior to the measurement year through December 31 of the measurement year. Medicaid beneficiaries may not have more than a single month gap in enrollment.

In the calendar year 2013, within the population of seniors, approximately 52 percent of women with disabilities received a breast cancer screening. By contrast, approximately 55 percent of women without disabilities received a breast cancer screening. This difference was statistically significant.

In the calendar year 2013 within the population of adults under 65, approximately 61 percent of women with disabilities received a breast cancer screening. By contrast, approximately 59 percent of women without disabilities received a breast cancer screening. This difference was not statistically significant.

Figure 3 below shows a graph comparing the rate of Breast Cancer Screening by age group and disability status.

Figure 3: Utilization Rates for Breast Cancer Screening by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Cervical Cancer Screening

Medical Care Measure: Calendar Year 2013

The Cervical Cancer Screening (CCS) measure the percentage of women who were screened for cervical cancer. Both of the following meet the criteria for such a screening:

- Women age 21-64 who had cervical cytology performed every 3 years.
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

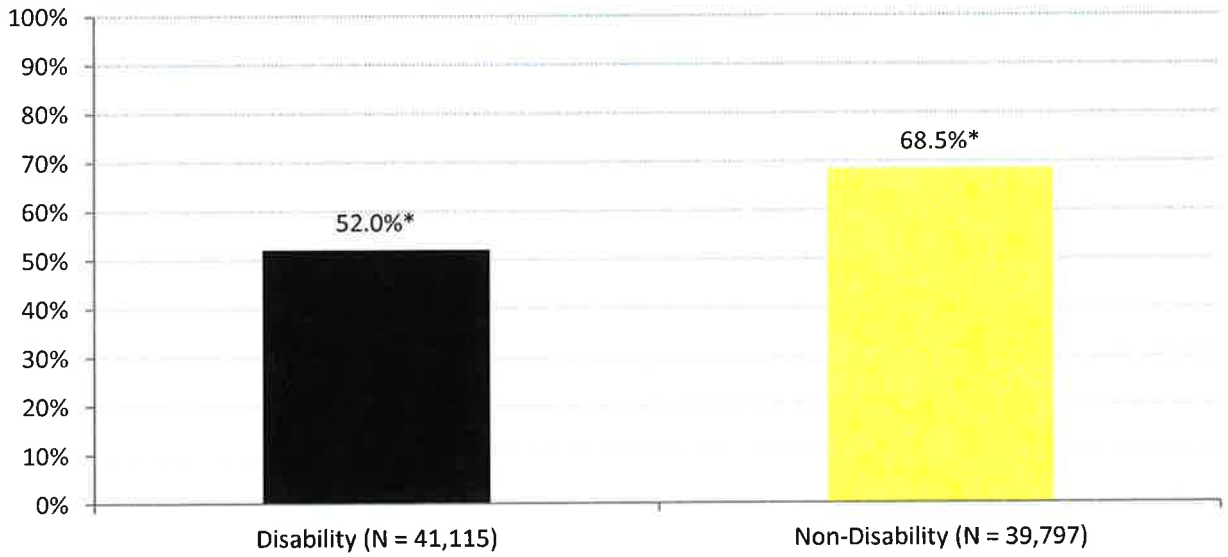
Individuals marked for inclusion in the denominator of the CCS measure met the following criteria:

- Women age 21-64 as of December 31, 2013.
- Continuously enrolled during the measurement year 2013. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, approximately 52 percent of women with disabilities received a cervical cancer screening. By contrast, approximately 69 percent of women without disabilities received such a screening. This difference was statistically significant and the only adult measure where the persons with disabilities had significantly less representation than the non-persons with disabilities.

Figure 4 below shows a graph comparing the rate of Cervical Cancer Screening by disability status.

Figure 4: Utilization Rates for Cervical Cancer Screening by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at α =.01.

Comprehensive Diabetes Care

Medical Care Measure: Calendar Year 2013

Comprehensive Diabetes Care (CDC) measures the percentage of individuals with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing

Individuals included in the denominator of the CDC measure met the following criteria:

- Individuals age 21-64 (adults) or 65-75 (seniors) as of December 31, 2013.
- Continuously enrolled during the measurement year 2013. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Individuals who were identified as having diabetes with at least one of the following methods:

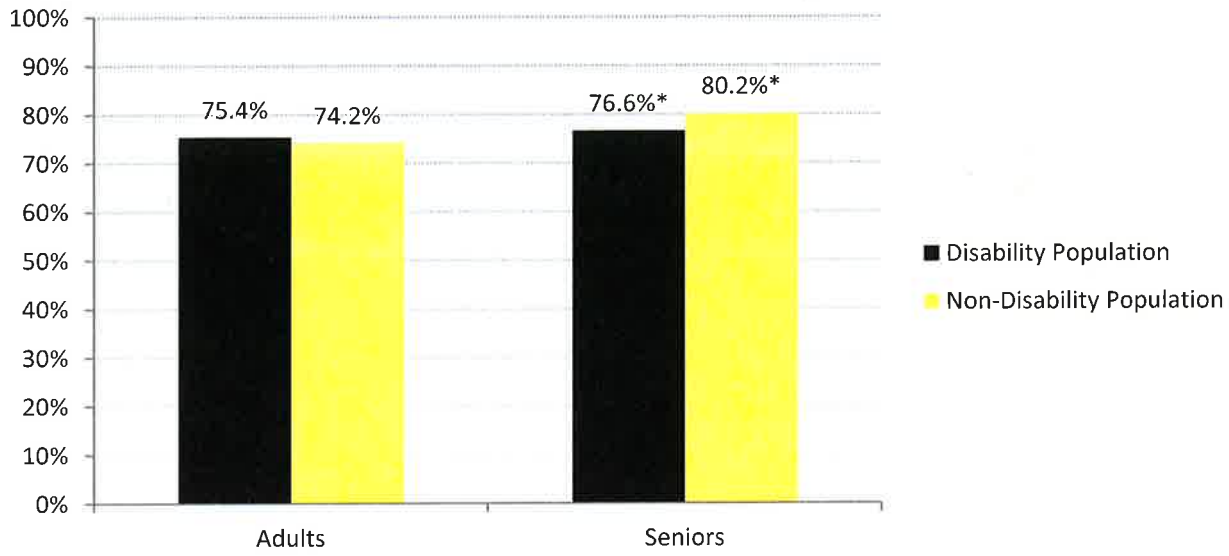
1. Possessed two or more outpatient or observation visits, or nonacute encounters on different dates of service with a diagnosis of diabetes.
2. At least one acute inpatient encounter with a diagnosis of diabetes.
3. At least one ED visit with a diagnosis of diabetes.
4. The individual was dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

In the calendar year 2013, within the population of seniors, approximately 77 percent of persons with disabilities received comprehensive diabetic care. By contrast, approximately 80 percent of persons without disabilities received comprehensive diabetic care. This difference was statistically significant.

In the calendar year 2013, within the population of adults under 65, approximately 75 percent of persons with disabilities received comprehensive diabetic care. By contrast, approximately 74 percent of persons without disabilities received comprehensive diabetic care. This difference was not statistically significant.

Figure 5 below shows a graph comparing the rate of Comprehensive Diabetes Care by age group and disability status.

Figure 5: Utilization Rates for Comprehensive Diabetes Care by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Colorectal Cancer Screening

Medical Care Measure: Calendar Year 2013

The Colorectal Cancer Screening (COL) measure gives the percentage of individuals who received one or more screenings for colorectal cancer. Any of the following meet the criteria for such a screening:

- Fecal occult blood test during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

Individuals included in the denominator of the COL measure met the following criteria:

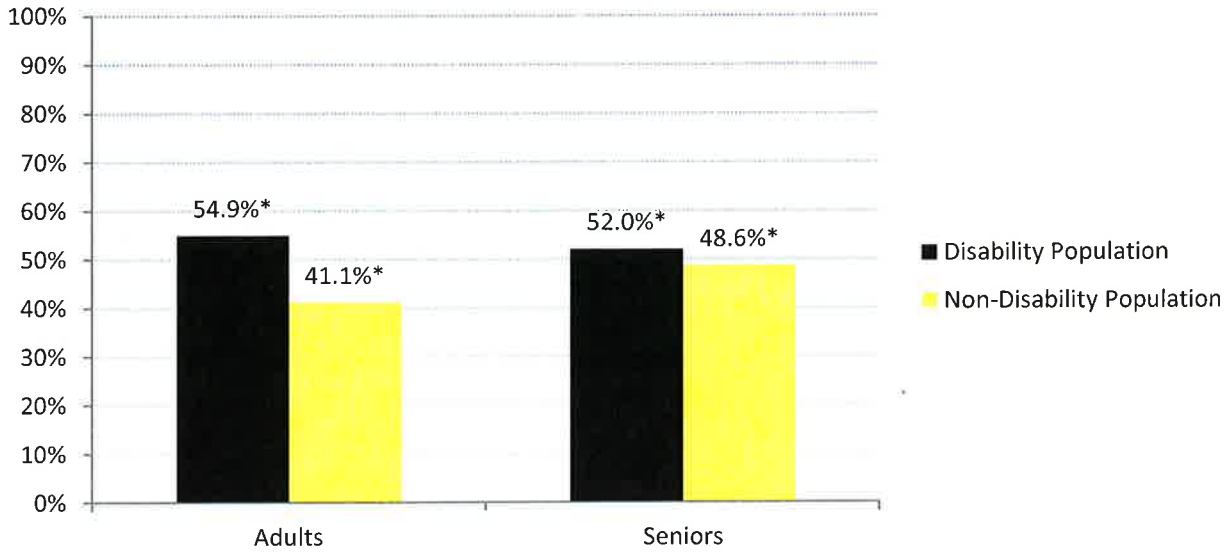
- Individuals age 21-64 (adults) or 65-75 (seniors) as of December 31, 2013.
- Continuously enrolled during the measurement year 2013 and the year prior. Medicaid beneficiaries may not have more than a single month gap in enrollment.

In the calendar year 2013 within the senior population, approximately 52 percent of persons with disabilities received a colorectal cancer screening. By contrast, approximately 49 percent of persons without disabilities received such a screening. This difference was statistically significant.

In the calendar year 2013 within the adult population, approximately 55 percent of persons with disabilities received a colorectal cancer screening. By contrast, approximately 41 percent of persons without disabilities received such a screening. This difference was statistically significant.

Figure 6 below shows a graph comparing the rate of Colorectal Cancer Screening by age group and disability status.

Figure 6: Utilization Rates for Colorectal Cancer Screening by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Annual Dental Visit

Dental Care Measure: Calendar Year 2013

Annual Dental Visit (ADV) measures the percentage of individuals who had at least one dental visit during the measurement year.

Individuals included in the denominator of the ADV measure met the following criteria:

- Individuals age 0-20 (children), 21-64 (adults), or 65 and older (seniors) as of December 31, 2013.
- Continuously enrolled during the measurement year 2013. Medicaid beneficiaries may not have more than a single month gap in enrollment.

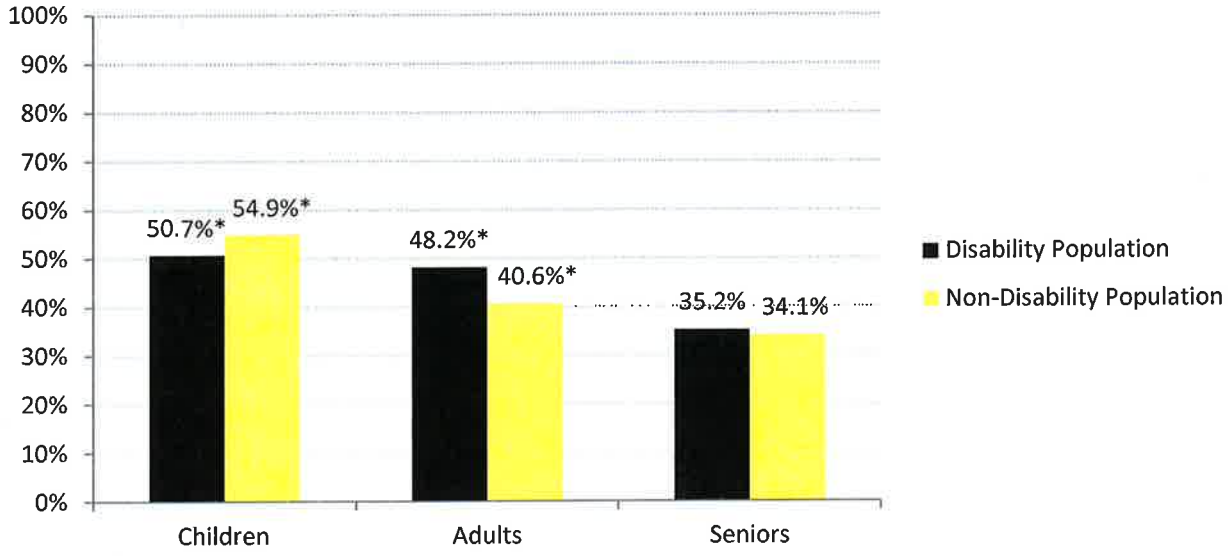
In the calendar year 2013, within the senior population approximately 35 percent of persons with disabilities received a dental visit. By contrast, approximately 34 percent of persons without disabilities received such a screening. This difference was not statistically significant.

In the calendar year 2013, within the adult population approximately 48 percent of persons with disabilities received a dental visit. By contrast, approximately 41 percent of persons without disabilities received such a screening. This difference was statistically significant.

In the calendar year 2013, within the child population approximately 51 percent of persons with disabilities received a dental visit. By contrast, approximately 55 percent of persons without disabilities received such a screening. This difference was statistically significant.

Figure 7 below shows a graph comparing the rate of Annual Dental Visit by age group and disability status.

Figure 7: Utilization Rates for Annual Dental Visit by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Annual Chiropractic Evaluation

Chiropractic Care Measure: Calendar Year 2013

Annual Chiropractic Evaluation (ACE) measures the percentage of individuals who had at least one chiropractic-related evaluation during the measurement year.

Individuals included in the denominator of the ACE measure met the following criteria:

- Individuals age 0-20 (children), 21-64 (adults), or 65 and older (seniors) as of December 31, 2013.
- Enrolled in Medical Assistance for at least one month during the calendar year 2013.
- Was associated with a procedure code that was in turn associated with evaluation services from a chiropractor or chiropractic manipulation during the measurement year 2013.

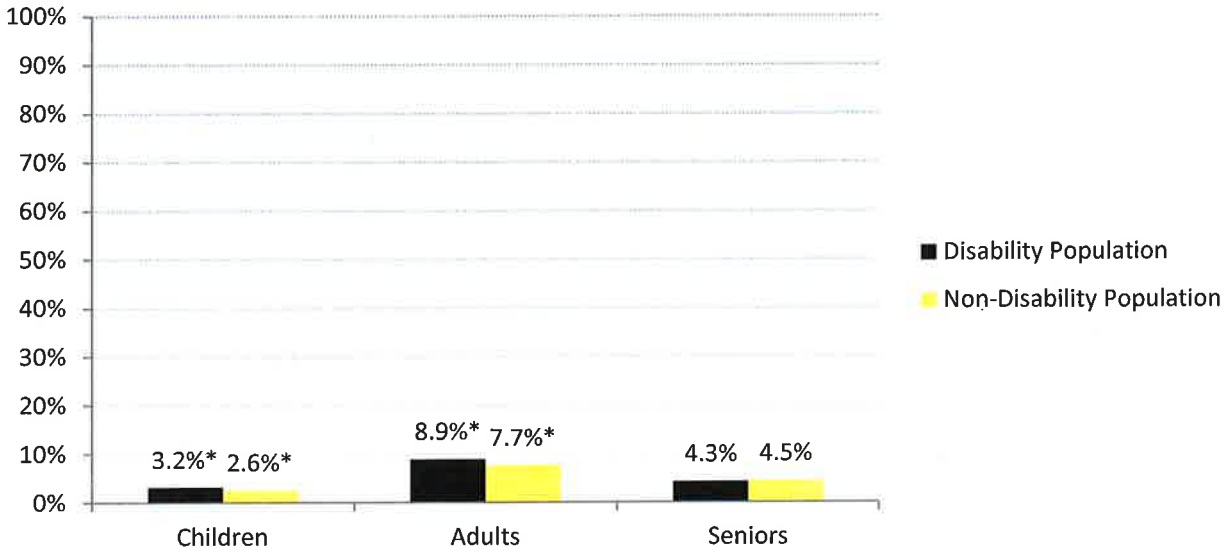
In the calendar year 2013, within the senior population, approximately 4.5 percent of persons with disabilities received a chiropractic evaluation. By contrast, approximately 4.3 percent of persons without disabilities received such an evaluation. This difference was not statistically significant.

In the calendar year 2013, within the adult population, approximately 8.9 percent of persons with disabilities received a chiropractic evaluation. By contrast, approximately 7.7 percent of persons without disabilities received a chiropractic evaluation. This difference was statistically significant.

In the calendar year 2013, within the child population, approximately 3.2 percent of persons with disabilities received a chiropractic evaluation. By contrast, approximately 2.6 percent of persons without disabilities received a chiropractic evaluation. This difference was statistically significant.

Figure 8 below shows a graph comparing the rate of Annual Chiropractic Evaluation by age group and disability status.

Figure 8: Utilization Rates for Annual Chiropractic Evaluation by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Follow-Up After Hospitalization for Mental Illness

Mental Health Care Measure: Calendar Year 2013

Follow-Up After Hospitalization for Mental Illness (FUH) measures the percentage of individuals who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 7 days of discharge.
- The percentage of discharges for which the member received follow-up within 30 days of discharge.

Individuals included in the denominator of the FUH measure met the following criteria:

- Individuals age 0-20 (children), 21-64 (adults), or 65 and older (seniors) as of December 31, 2013.
- Continuously enrolled during from the date of discharge through 30 days after discharge.
- Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement year.

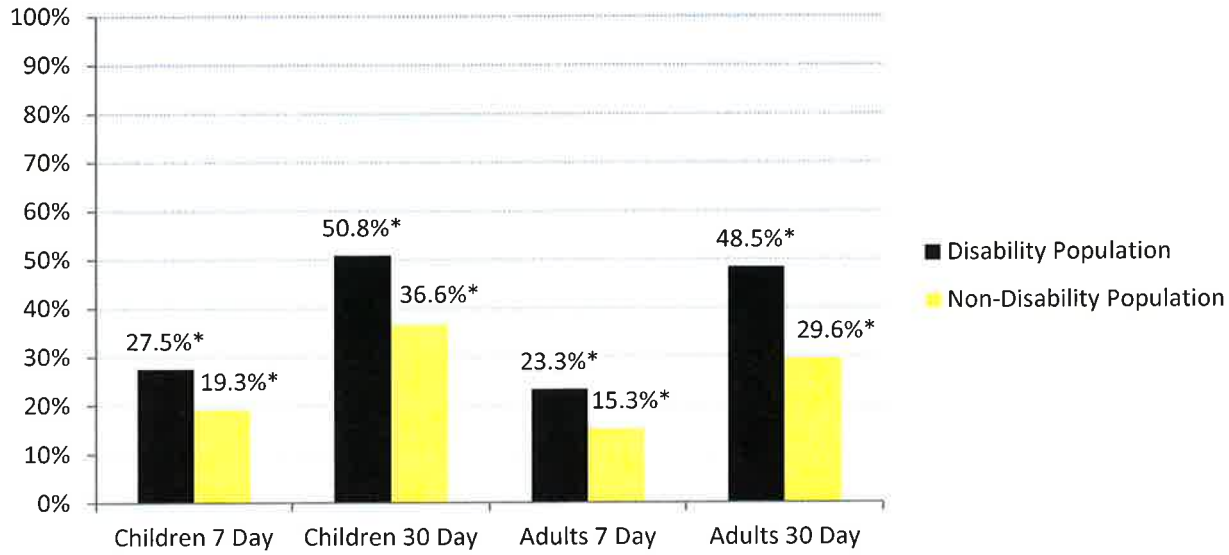
Within the calendar year 2013, approximately 28 percent of children and 23 percent of adults under 65 with disabilities received a follow-up within 7 days of discharge. By contrast, approximately 19 percent of children and 15 percent of adults under 65 without disabilities received a follow-up within 7 days of discharge. All differences were statistically significant.

Within the calendar year 2013, approximately 51 percent of children and 49 percent of adults under 65 with disabilities received a follow-up within 30 days of discharge. By contrast, approximately 37 percent of children and 30 percent of adults under 65 without disabilities received a follow-up within 30 days of discharge. All differences were statistically significant.

Within the calendar year 2013, approximately 21 percent of seniors with disabilities received a follow-up within 7 days of discharge (21.4%; Numerator= 66; Denominator=309). By contrast, within the calendar year 2013, approximately 41 percent of the seniors with disabilities received a follow-up within 30 days of discharge (41.1%; Numerator= 127; Denominator=309). Owing to the very small sample size of the FUH measure in the non-disabled population, comparisons with a non-disabled population could not be made for the senior age category.

Figure 9 below shows a graph comparing the rate of Follow-Up After Hospitalization for Mental Illness by age group and disability status.

Figure 9: Utilization Rates for Follow-Up After Hospitalization for Mental Illness by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Certified Peer Services

Mental Health Measure: Calendar Year 2013

The Certified Peer Support Services (CPS) measure gives the percentage of individuals who received self-help or peer services within the measurement year of 2013.

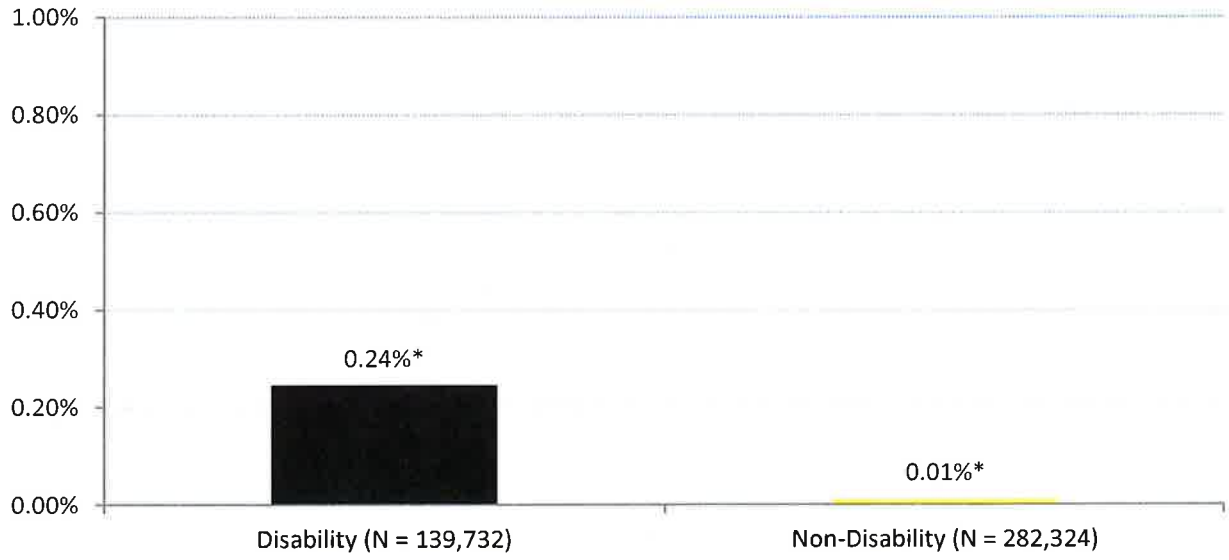
Individuals included in the denominator of the CPS measure met the following criteria:

- Individuals age 21-64 as of December 31, 2013 (adults)
- Enrolled in Medical Assistance for at least one month during the calendar year 2013 with a paid MHCP claim with a procedure code (H0038) for self-help or peer services

Within the calendar year 2013, a very small percentage of the population received certified peer services. Specifically, approximately 342 persons with disabilities received certified peer services. By contrast, approximately 30 persons without disabilities received such services. This difference was statistically significant, and the ratio of disability to non-disability individuals receiving services was large.

Figure 10 below shows a graph comparing the rate of Certified Peer Services by disability status.

Figure 10: Utilization Rates for Certified Peer Services by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at α =.01.

Well-Child Visits in the First 15 Months of Life

Medical Care Measure: Calendar Year 2013

Well-Child Visits in the First 15 Months of Life (W15) measures the percentage of children who turned 15 months old during the measurement year and who had six or more visits with a primary care provider (PCP) during their first 15 months of life.

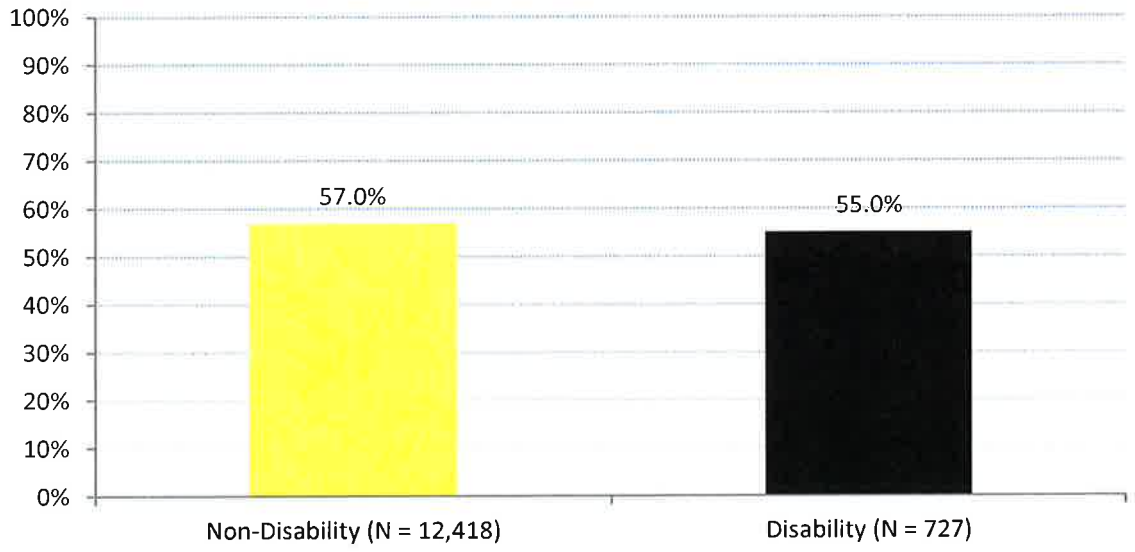
Children included in the denominator of the W15 measure met the following criteria:

- Children age 15 months during the measurement year 2013.
- Continuously enrolled during the time period from 31 days of age through 15 months of age. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, 55 percent of children with disabilities received at least six well-child visits. By contrast, 57 percent of children without disabilities received at least six well-child visits. This difference was not statistically significant.

Figure 11 below shows a graph comparing the rate of Well-Child Visits in the First 15 Months of Life by disability status.

Figure 11: Utilization Rates for Well-Child Visits in the First 15 Months of Life by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Medical Care Measure: Calendar Year 2013

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) measures the percentage of children three to six years of age who had one or more well-child visits with a primary care provider (PCP) during the measurement year.

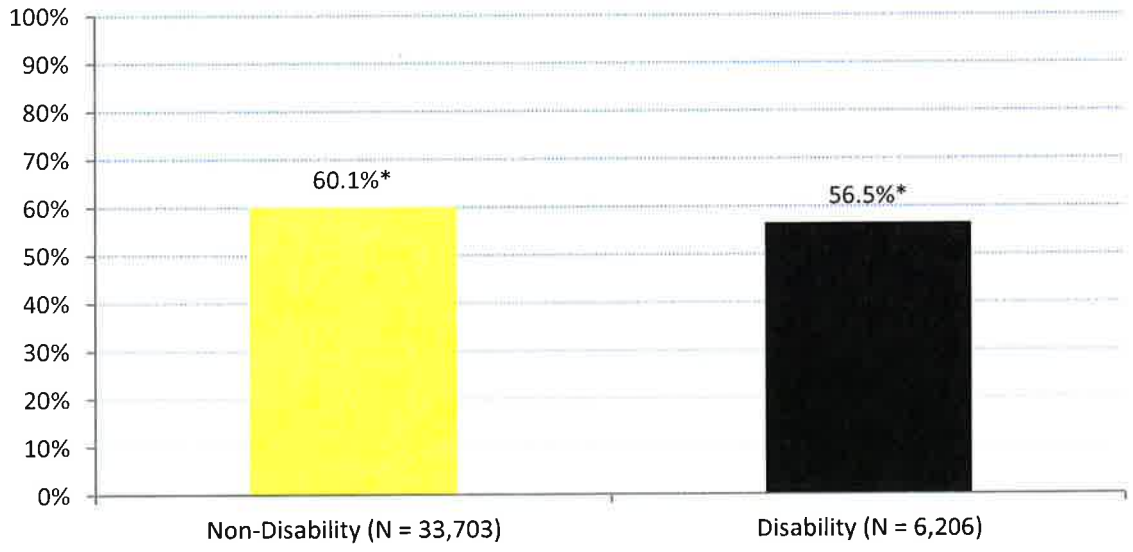
Children included in the denominator of the W34 measure met the following criteria:

- Children age three to six years as of December 31st of the measurement year 2013.
- Continuously enrolled during the measurement year 2013. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, approximately 56 percent of children with disabilities received at least one well-child visit with a PCP. By contrast, approximately 60 percent of children without disabilities received at least one well-child visit with a PCP.

Figure 12 below shows a graph comparing the rate of Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life by disability status.

Figure 12: Utilization Rates for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at α =.01.

Adolescent Well-Care Visits

Medical Care Measure: Calendar Year 2013

Adolescent Well-Care Visits (AWC) measures the percentage of children 12–20 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an OB/GYN practitioner during the measurement year.

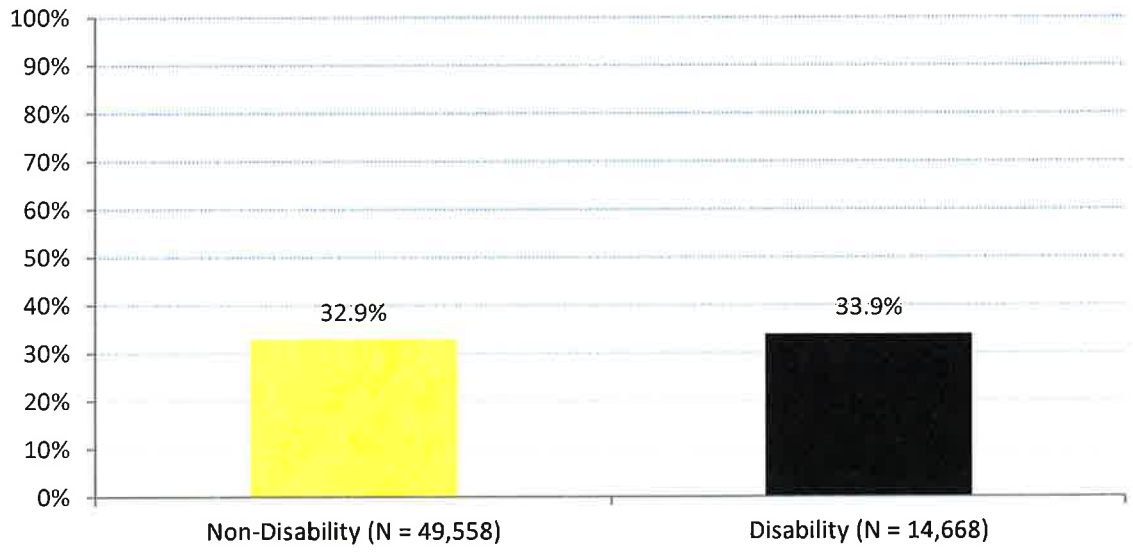
Children included in the denominator of the AWC measure met the following criteria:

- Individuals age 12-20 years as of December 31, 2013.
- Continuously enrolled during the measurement year 2013 and the year prior. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, approximately 34 percent of children with disabilities received at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner. By contrast, approximately 33 percent of children without disabilities received at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner. This difference was not statistically significant.

Figure 13 below shows a graph comparing the rate of Adolescent Well-Care visits by disability status.

Figure 13: Utilization Rates for Adolescent Well-Care visits by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Children and Adolescents' Access to Primary Care Practitioners

Medical Care Measure: Calendar Year 2013

Children and Adolescents' Access to Primary Care Practitioners (CAP) measures the percentage of children 12 months to 19 years of age who had a visit with a primary care provider (PCP).

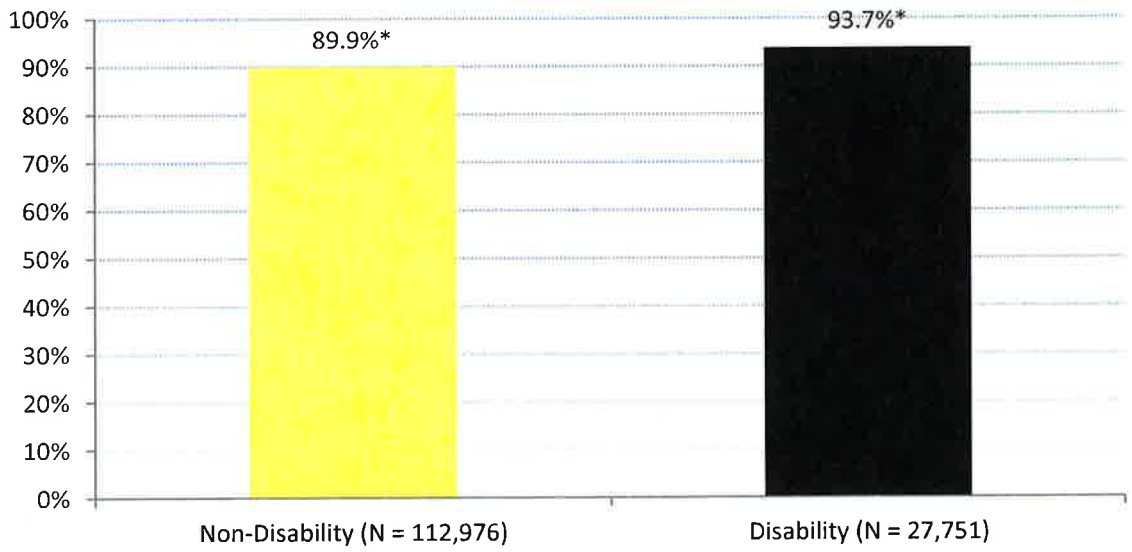
Children included in the denominator of the CAP measure met the following criteria:

- Individuals age 12 months to 19 years as of December 31, 2013.
- Continuously enrolled during the measurement year 2013 (for children age one to six) and the year prior (for individuals age seven to 19). Medicaid beneficiaries may not have more than a single month gap in enrollment during each year.

Within the calendar year 2013, approximately 94 percent of children with disabilities received a visit with a PCP. By contrast, approximately 90 percent of children without disabilities received a visit with a PCP. This difference was statistically significant.

Figure 14 below shows a graph comparing the rate of Children and Adolescents' Access to Primary Care Practitioners by disability status.

Figure 14: Utilization Rates for Children and Adolescents' Access to Primary Care Practitioners by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at α =.01.

Childhood Immunization Status

Medical Care Measure: Calendar Year 2013

Childhood Immunization Status (CIS) measures the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. For the purposes of this report, a single combination is analyzed, and is listed below:

- Immunization for DTaP, IPV, MMR, HiB, HepB, VZV, and PCV.

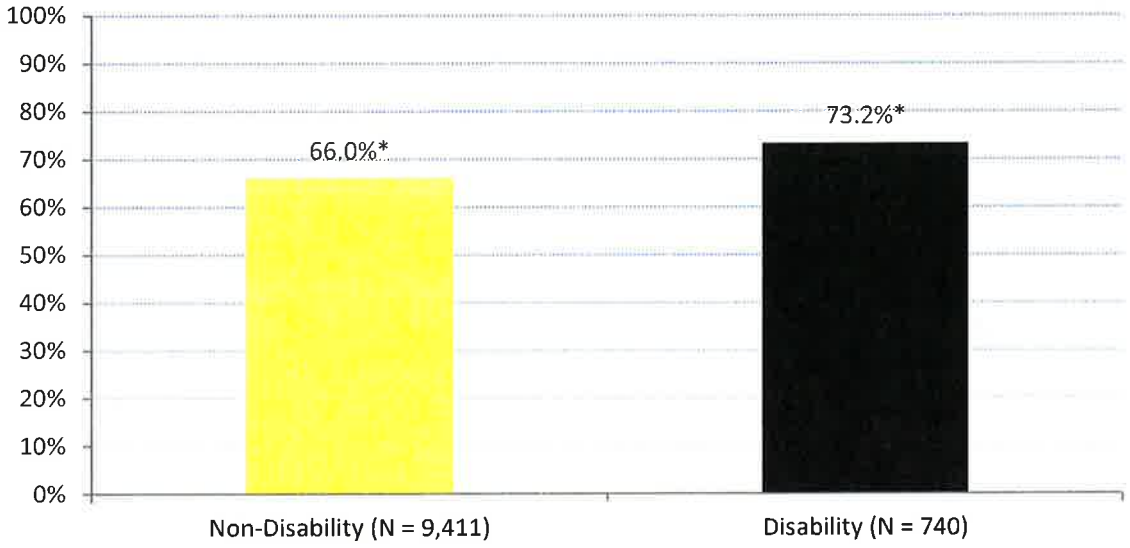
Children included in the denominator of the CIS measure met the following criteria:

- Children age two during the measurement year 2013.
- Continuously enrolled during the period 12 months prior to the child's second birthday. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, approximately 73 percent of children with disabilities received the aforementioned immunizations. By contrast, approximately 66 percent of children without disabilities received the aforementioned immunizations. This difference was statistically significant.

Figure 15 below shows a graph comparing the rate of Childhood Immunization Status by disability status.

Figure 15: Utilization Rates for Childhood Immunization Status by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at α =.01.

Human Papillomavirus Vaccine for Female Adolescents

Medical Care Measure: Calendar Year 2013

The Human Papillomavirus Vaccine for Female Adolescents (HPV) measure gives the percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

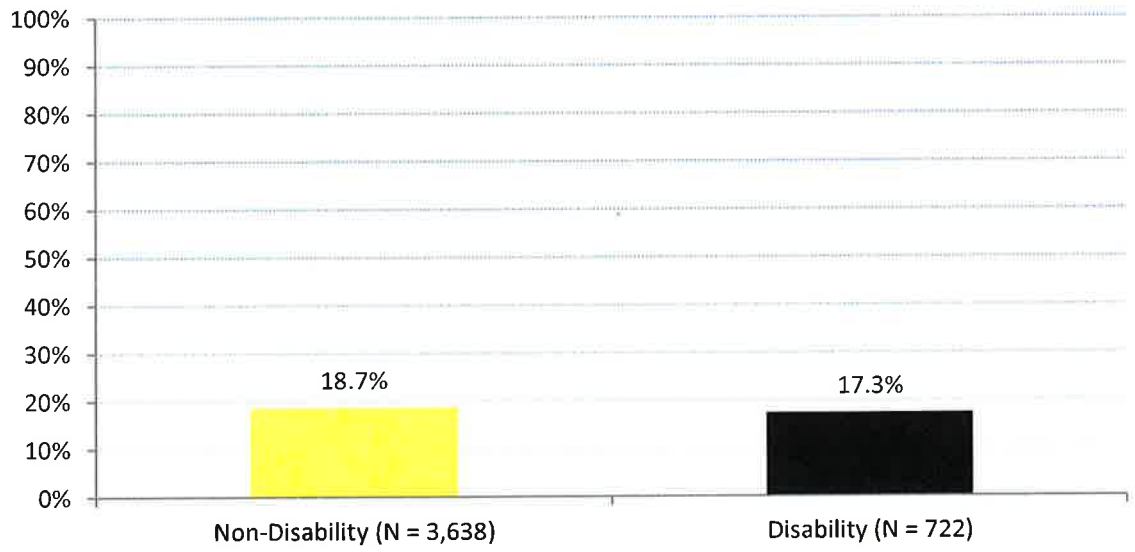
Children included in the denominator of the HPV measure met the following criteria:

- Females age 13 during the measurement year 2013.
- Continuously enrolled during the measurement year 2013 and the year prior. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, approximately 17 percent of female children with disabilities received a HPV vaccine by their 13th birthday. By contrast, approximately 19 percent of female children without disabilities received a HPV vaccine by their 13th birthday. This difference was not statistically significant.

Figure 16 below shows a graph comparing the rate of Human Papillomavirus Vaccine for Female Adolescents by disability status.

Figure 16: Utilization Rates for Human Papillomavirus Vaccine for Female Adolescents by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Appropriate Treatment for Children with Upper Respiratory Infection

Medical Care Measure: Calendar Year 2013

The Appropriate Treatment for Children with Upper Respiratory Infection (URI) measure gives the percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

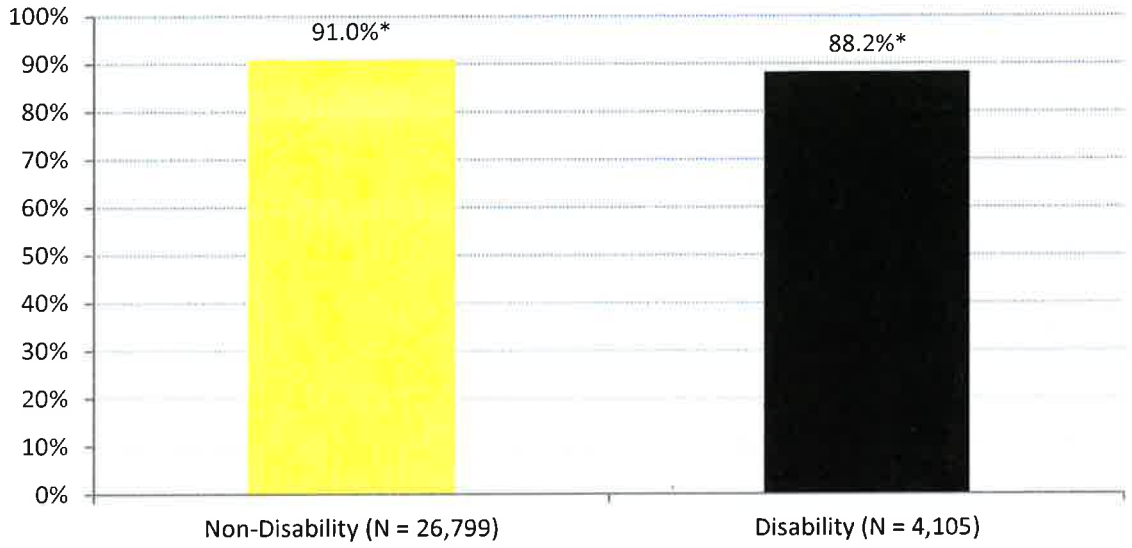
Children included in the denominator of the URI measure met the following criteria:

- Children aged three months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.
- Continuously enrolled during the measurement year 2013 and the year prior. No gaps in enrollment during the continuous enrollment period are allowed for this measure.

Within the calendar year 2013, approximately 88 percent of children with disabilities were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. By contrast, approximately 91 percent of children without disabilities were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. This difference was statistically significant.

Figure 17 below shows a graph comparing the rate of Appropriate Treatment for Children with Upper Respiratory Infection by disability status.

Figure 17: Utilization Rates for Appropriate Treatment for Children with Upper Respiratory Infection by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at α =.01.

Conclusion

On January 28, 2013, Governor Mark Dayton issued an executive order establishing an Olmstead Sub-Cabinet to develop and implement a comprehensive Minnesota Olmstead Plan. The main purpose of the Olmstead Plan is to move the state forward, towards greater integration and inclusion for people with disabilities.

The rates derived from this report will serve as a baseline for future studies, in order to monitor and evaluate the degree to which utilization changes over time for individuals with disabilities in receiving services. Ideally, improving access to services will be illustrated in corresponding changes to utilization rates of services over time.

Appendix A - Disability Classification for Children

Purpose:

To establish the denominator for health care utilization measures to be reported for action item 2G in the "Healthcare and Healthy Living" section of the Olmstead Plan, for children aged 0-20.

Background:

DHS Health Care Research and Quality Division (HRQ) is producing several measures of health care utilization in order to establish baseline data for medical, dental, chiropractic, and mental health care for persons with disabilities. Measures will be reported for persons enrolled in Medical Assistance with disabilities (as defined below), and for a comparison group of persons enrolled in Medical Assistance without disabilities.

Dates used:

Calendar Year 2013 (1/1/2013 – 12/31/2013)

Inclusions:

Persons enrolled in Medical Assistance (major program MA) at any point during the measurement year, and aged 0-20 inclusive as of the end of the measurement year (12/31/2013).

Exclusions:

Persons who are not enrolled in Medical Assistance at any point during the measurement year, and who are not aged 0-20 as of 12/31/2013.

Source of data:

DHS health care program enrollment and claims data

Definition:

MA child enrollees with disabilities will be defined as those who:

1. Have a paid claim during calendar year 2013 with one or several specified diagnosis codes or billing codes indicating a disabling condition or functional limitations, OR

2. Have been enrolled in MA with an eligibility type indicating disability at any point during the measurement year, OR

3. Have a score of 25 points or greater using a modified version of the algorithm developed at DHS for screening recipients as likely to have a disability, for the State Medical Review Team (SMRT).

Details:

1) Diagnosis codes and billing codes that indicate disabling conditions or functional limitations are listed in the following table:

Qualifier	Description
Epilepsy	Diagnosis code indicating Epilepsy: (345.00, 345.01, 345.10, 345.11, 345.20, 345.21, 345.30, 345.31, 345.40, 345.40, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.80, 345.81, 345.90, 345.91)
Cystic Fibrosis	Diagnosis code indicating Cystic Fibrosis: (277.00, 277.01, 277.02, 277.03, 277.09)
Developmental Disability	Diagnosis code indicating a significant degree of Developmental Disability: (318.0, 318.1, 318.2)
Congenital hereditary muscular dystrophy	Diagnosis code indicating congenital hereditary muscular dystrophy: (359.0)
Infantile Cerebral Palsy	Diagnosis code indicating Infantile Cerebral Palsy: (343.0, 343.1, 343.2, 343.3, 343.4, 343.8, 343.9)
Children 4 and over using diapers	Billing codes associated with children 4 and over using diapers: (T4529, T4530, T4531, T4532)
Children who buy wheelchairs or walkers	Billing codes associated with children who buy wheelchairs or walkers: (E1037, E1229, E1231-E1239, E0130, E0135, E0140, E0141, E0143, E0144, E0147-E149)
School based IEP service	HCPCS code indicating the child received a school based individualized education program (IEP) service: (T1018).
Cochlear device	HCPCS code indicating the child received or is currently using a cochlear implant: (L8614, L8615, L8616, L8617, L8618, L8619, L8627, L8628, L8629, L8621, L8622, L8623, L8624).
PCA services	HCPCS code indicating the child received personal care attendant (PCA) services: (T1019).

2) Medical Assistance eligibility types indicating disability are listed in the following table:

Eligibility Type Code	Description
15	1619A (Supplemental Security Income)
16	1619B (Supplemental Security Income)
BT	BLIND/TEFRA
BX	BLIND
DC	DISABLED/CHILD AGE 18 THROUGH 20
DP	EMPLOYED DISABLED WITH PREMIUM
DQ	DISABLED/QMB ONLY
DS	DISABLED/SLMB
DT	DISABLED/TEFRA

3) Modified SMRT Algorithm description:

The SMRT algorithm was designed at DHS to screen health care program enrollees based on diagnoses and services reported on claims, enrollee age, and other enrollee information, to identify those who are likely to have a disability. The algorithm was modeled after criteria used by the Social Security Administration for determining eligibility for Supplemental Security Income (SSI).

The algorithm considers 18 months of claims history, and weights each of several factors using a point system. A person who has at least 25 points is identified as being likely to have a disability

It should also be noted however, that this is a *modified* version of the original SMRT algorithm. Specifically, it is modified in order to prevent duplication with other aspects of the definition for disability noted in other sections. When there was conceptual overlap between the original SMRT algorithm and other qualifying criteria, that component was removed from SMRT.
The components of the SMRT algorithm are as follows:

1. **Inpatient Stays:** count of the number of months during which the recipient had an inpatient stay
    a. Greater than or equal to 10 months = 20 points
    b. 8-9 months = 10 points
    c. 4-7 months = 6 points
    d. 1-3 months = 2 points
    e. 0 months = 0 points
2. **Severe Mental Health:** count of the number of distinct dates of service for which there was a claim with a severe mental health diagnosis (ICD-9-CM diagnosis codes 295.00 – 297.9)
    a. Greater than or equal to 10 dates of service = 20 points
    b. 8-9 dates of service = 10 points
    c. 4-7 dates of service = 6 points
    d. 1-3 dates of service = 2 points
    e. 0 dates of service = 0 points
3. **Age:** recipient age as of the end of the measurement period
    a. Greater than or equal to 40 = 3 points
    b. Less than 40 = 0 points
4. **Chemical Dependency in conjunction with Mental Illness:** recipient has a diagnosis of chemical dependency (ICD-9-CM diagnosis codes 291.0 – 292.9 or 303.00 – 305.9) on one or more claims, AND a diagnosis of severe mental illness (ICD-9-CM diagnosis codes 295.00 – 297.9) on one or more claims; number of points assigned varies by recipient age
    a. Age is greater than or equal to 40 = 5 points
    b. Age is less than 40 = 2 points
5. **Presumptive Disability or Blindness:** recipient has a diagnosis on the list of presumptive disabilities on one or more claims
    a. Diagnosis code present = 8 points
6. **Homeless:** recipient has a diagnosis code indicating homelessness (ICD-9-CM diagnosis codes V60.0 or V60.1) on one or more claims
    a. Diagnosis code present = 3 points
7. **Group Residential Housing (GRH):** recipient has been in the GRH program during the 18 month look back time period

   a. Enrolled in GRH = 5 points
8. **Diabetes:** recipient has a diagnosis of diabetes mellitus (ICD-9-CM diagnosis codes 250.00 – 250.93) on one or more claims
   a. Diagnosis code present = 3 points
9. **HIV:** recipient has a diagnosis indicating Human Immunodeficiency Virus infection (ICD-9-CM diagnosis codes 042, V08, 079.53) on one or more claims
   a. Diagnosis code present = 4 points
10. **Quadriplegia and Other Paralysis:** recipient has a diagnosis indicating quadriplegia, hemiplegia, or other paralysis (ICD-9-CM diagnosis codes 342.00 – 342.12, 342.80 – 342.92, 344.00 – 344.42, 344.81 – 344.9) on one or more claims
   a. Diagnosis code present = 8 points
11. **Disability indicator in MAXIS:** recipient has a disability indicated in MAXIS; number of points assigned varies by recentness of the indication
   a. Indication 10 or more years ago = 0 points
   b. Indication 5-10 years ago = 3 points
   c. Indication 2-5 years ago = 5 points
   d. Indication within past 2 years = 10 points
12. **Emphysema:** recipient has a diagnosis of emphysema (ICD-9-CM diagnosis codes 491.20, 491.21, 492.0, 492.8, 506.4, 518.1) on one or more claims
   a. Diagnosis code present = 4 points
13. **Morbid Obesity:** recipient has a diagnosis of morbid obesity (ICD-9-CM diagnosis code 278.01) on one or more claims
   a. Diagnosis code present = 4 points
14. **Compassionate Allowance Diagnosis:** recipient has a diagnosis on the list of Social Security Administration list of Compassionate Allowances conditions on one or more claims
   a. Diagnosis code present = 25 points
15. **Developmental Disability:** recipient has a diagnosis of developmental disability (ICD-9-CM diagnosis codes 315.00 – 315.09, 315.1, 315.2, 315.31 – 315.32, 315.39, 315.4 – 315.5, 315.8 317, 319) on one or more claims
   a. Diagnosis code present = 8 points
16. **Rule 36:** recipient is living in a residential facility for adults with mental illness.
   a. Living in Rule 36 facility = 5 points
17. **ESRD:** recipient has a diagnosis of end stage renal disease (ICD-9-CM diagnosis code 585.6) on one or more claims
   a. Diagnosis code present = 25 points

Estimated size of the denominator:

The estimated number of MA enrollees aged 0-20 during Calendar Year 2013 who would be classified as disabled using this definition is 52,138. This number amounts to 11.9% of all MA enrollees aged 0-20 (438,966) during 2013.

Appendix B - Disability Classification for Adults

Purpose:

To establish the denominator for health care utilization measures to be reported for action item 2G in the "Healthcare and Healthy Living" section of the Olmstead Plan.

Background:

DHS Health Care Research and Quality Division (HRQ) is producing several measures of health care utilization in order to establish baseline data for medical, dental, chiropractic, and mental health care for persons with disabilities. Measures will be reported for persons enrolled in Medical Assistance with disabilities (as defined below), and for a comparison group of persons enrolled in Medical Assistance without disabilities. This analysis will be limited to persons aged 21-64.

Dates used:

Calendar Year 2013 (1/1/2013 – 12/31/2013)

Inclusions:

Persons enrolled in Medical Assistance (major program MA) at any point during the measurement year, and aged 21-64 inclusive as of the end of the measurement year (12/31/2013).

Exclusions:

Persons who are not enrolled in Medical Assistance at any point during the measurement year, and who are not aged 21-64 as of 12/31/2013.

Source of data:

DHS health care program enrollment and claims data.

Definition:

MA enrollees with disabilities will be defined as those who:

1. Have been enrolled in MA with an eligibility type indicating disability at any point during the measurement year, OR

2. Have a score of 25 points or greater using the algorithm developed at DHS for screening recipients as likely to have a disability, for the State Medical Review Team (SMRT).

Details:

1) Medical Assistance eligibility types indicating disability are listed in the following table:

Eligibility Type Code	Description
15	1619A (Supplemental Security Income)
16	1619A (Supplemental Security Income)
BC	BREAST AND CERVICAL CANCER PROGRAM (Effective 07/01/2002)
BD	BLIND/PRESCRIPTION DRUG (Effective 07/01/2002)
BQ	BLIND/QMB (QUALIFIED MEDICARE BENEFICIARY) ONLY
BS	BLIND/SLMB (SERVICE-LIMITED MEDICARE BENEFICIARY)
BT	BLIND/TEFRA
BW	BLIND/QWD
BX	BLIND
DC	DISABLED/CHILD AGE 18 THROUGH 20
DI	EMPLOYED DISABLED WITH NO PREMIUM (No longer used effective 01/01/04)
DP	EMPLOYED DISABLED WITH PREMIUM
DQ	DISABLED/QMB ONLY
DS	DISABLED/SLMB
DT	DISABLED/TEFRA
DW	DISABLED/QWD (No longer used.)
DX	DISABLED
1B	BLIND QUALIFYING INDIVIDUAL QI-1
1D	DISABLED QUALIFYING INDIVIDUAL QI-1

2) SMRT Algorithm description:

The SMRT algorithm was designed at DHS to screen health care program enrollees based on diagnoses and services reported on claims, enrollee age, and other enrollee information, to identify those who are likely to have a disability. The algorithm was modeled after criteria used by the Social Security Administration for determining eligibility for Supplemental Security Income (SSI).

The algorithm considers 18 months of claims history, and weights each of several factors using a point system. A person who has at least 25 points is identified as being likely to have a disability.

The components of the SMRT algorithm are as follows:

1. **Inpatient Stays:** count of the number of months during which the recipient had an inpatient stay
    a. Greater than or equal to 10 months = 20 points
    b. 8-9 months = 10 points
    c. 4-7 months = 6 points
    d. 1-3 months = 2 points
    e. 0 months = 0 points
2. **Severe Mental Health:** count of the number of distinct dates of service for which there was a claim with a severe mental health diagnosis (ICD-9-CM diagnosis codes 295.00 – 297.9 or 301.83)
    a. Greater than or equal to 10 dates of service = 20 points
    b. 8-9 dates of service = 10 points
    c. 4-7 dates of service = 6 points
    d. 1-3 dates of service = 2 points
    e. 0 dates of service = 0 points
3. **Age:** recipient age as of the end of the measurement period
    a. Greater than or equal to 40 = 3 points
    b. Less than 40 = 0 points
4. **Chemical Dependency in conjunction with Mental Illness:** recipient has a diagnosis of chemical dependency (ICD-9-CM diagnosis codes 291.0 – 292.9 or 303.00 – 305.9) on one or more claims, AND a diagnosis of severe mental illness (ICD-9-CM diagnosis codes 295.00 – 297.9) on one or more claims; number of points assigned varies by recipient age
    a. Age is greater than or equal to 40 = 5 points
    b. Age is less than 40 = 2 points
5. **Presumptive Disability or Blindness:** recipient has a diagnosis on the list of presumptive disabilities on one or more claims
    a. Diagnosis code present = 8 points
6. **Homeless:** recipient has a diagnosis code indicating homelessness (ICD-9-CM diagnosis codes V60.0 or V60.1) on one or more claims
    a. Diagnosis code present = 3 points

7. **Group Residential Housing (GRH):** recipient has been in the GRH program during the 18 month look back time period
    a. Enrolled in GRH = 5 points
8. **Diabetes:** recipient has a diagnosis of diabetes mellitus (ICD-9-CM diagnosis codes 250.00 – 250.93) on one or more claims
    a. Diagnosis code present = 3 points
9. **HIV:** recipient has a diagnosis indicating Human Immunodeficiency Virus infection (ICD-9-CM diagnosis codes 042, V08, 079.53) on one or more claims
    a. Diagnosis code present = 4 points
10. **Quadriplegia and Other Paralysis:** recipient has a diagnosis indicating quadriplegia, hemiplegia, or other paralysis (ICD-9-CM diagnosis codes 342.00 – 342.12, 342.80 – 342.92, 344.00 – 344.42, 344.81 – 344.9) on one or more claims
    a. Diagnosis code present = 8 points
11. **Disability indicator in MAXIS:** recipient has a disability indicated in MAXIS; number of points assigned varies by recentness of the indication
    a. Indication 10 or more years ago = 0 points
    b. Indication 5-10 years ago = 3 points
    c. Indication 2-5 years ago = 5 points
    d. Indication within past 2 years = 10 points
12. **Emphysema:** recipient has a diagnosis of emphysema (ICD-9-CM diagnosis codes 491.20, 491.21, 492.0, 492.8, 506.4, 518.1) on one or more claims
    a. Diagnosis code present = 4 points
13. **Morbid Obesity:** recipient has a diagnosis of morbid obesity (ICD-9-CM diagnosis code 278.01) on one or more claims
    a. Diagnosis code present = 4 points
14. **Compassionate Allowance Diagnosis:** recipient has a diagnosis on the list of Social Security Administration list of Compassionate Allowances conditions on one or more claims. This diagnosis list has been updated as of 2014 with information provided by Debra Wagner and Kathleen Hendricks
    a. Diagnosis code present = 25 points
15. **Developmental Disability:** recipient has a diagnosis of developmental disability (ICD-9-CM diagnosis codes 315.00 – 315.09, 315.1, 315.2, 315.31 – 315.32, 315.39, 315.4 – 315.9, 317, 318.0 – 318.2, 319) on one or more claims
    a. Diagnosis code present = 8 points
16. **Rule 36:** recipient is living in a residential facility for adults with mental illness (living arrangement of 52 or 57 or paid claim with procedure code H0019 for Intensive Residential Treatment Services)
    a. Living in Rule 36 facility = 5 points
17. **End Stage Renal Disease (ESRD):** recipient has a diagnosis of ESRD (ICD-9-CM diagnosis code 585.6) on one or more claims
    a. Diagnosis code present = 25 points

Estimated size of the denominator:

The estimated number of MA enrollees aged 21-64 during Calendar Year 2013 who would be classified as disabled using this definition is 139,732. This number amounts to 33.1% of all MA enrollees aged 21-64 (422,086) during 2013.

Appendix C - Disability Classification for Seniors

Purpose:

To establish the denominator for health care utilization measures to be reported for action item 2G in the "Healthcare and Healthy Living" section of the Olmstead Plan.

Background:

DHS Health Care Research and Quality Division (HRQ) is producing several measures of health care utilization in order to establish baseline data for medical, dental, chiropractic, and mental health care for persons with disabilities. Measures will be reported for persons enrolled in Medical Assistance with disabilities (as defined below), and for a comparison group of persons enrolled in Medical Assistance without disabilities. This analysis will be limited to persons aged 65and over.

Dates used:

Calendar Year 2013 (1/1/2013 – 12/31/2013)

Inclusions:

Persons enrolled in Medical Assistance (major program MA) at any point during the measurement year, and aged 65 and over inclusive as of the end of the measurement year (12/31/2013).

Exclusions:

Persons who are not enrolled in Medical Assistance at any point during the measurement year, and who are not aged 65 and over as of 12/31/2013.

Source of data:

DHS health care program enrollment and claims data

Definition:

MA enrollees with disabilities will be defined as those who:

1) Have been enrolled in MA with an eligibility type indicating disability at any point during the measurement year, OR

2) Have a score of 25 points or greater using the algorithm developed at DHS for screening recipients as likely to have a disability, for the State Medical Review Team (SMRT), OR

3) Possesses a classification of dependency based on scores on Activities of Daily Living (ADL) measures.

Details:

1) Medical Assistance eligibility type indicating disability is listed in the following table:

Eligibility Type Code	Description
DP	EMPLOYED DISABLED WITH PREMIUM

2) SMRT Algorithm description:

The SMRT algorithm was designed at DHS to screen health care program enrollees based on diagnoses and services reported on claims, enrollee age, and other enrollee information, to identify those who are likely to have a disability. The algorithm was modeled after criteria used by the Social Security Administration for determining eligibility for Supplemental Security Income (SSI).

The algorithm considers 18 months of claims history, and weights each of several factors using a point system. A person who has at least 25 points is identified as being likely to have a disability.

The components of the SMRT algorithm are as follows:

1. **Inpatient Stays:** count of the number of months during which the recipient had an inpatient stay
    a. Greater than or equal to 10 months = 20 points
    b. 8-9 months = 10 points
    c. 4-7 months = 6 points
    d. 1-3 months = 2 points
    e. 0 months = 0 points
2. **Severe Mental Health:** count of the number of distinct dates of service for which there was a claim with a severe mental health diagnosis (ICD-9-CM diagnosis codes 295.00 – 297.9 or 301.83)
    a. Greater than or equal to 10 dates of service = 20 points
    b. 8-9 dates of service = 10 points
    c. 4-7 dates of service = 6 points
    d. 1-3 dates of service = 2 points
    e. 0 dates of service = 0 points
3. **Age:** recipient age as of the end of the measurement period
    a. Greater than or equal to 40 = 3 points
    b. Less than 40 = 0 points
4. **Chemical Dependency in conjunction with Mental Illness:** recipient has a diagnosis of chemical dependency (ICD-9-CM diagnosis codes 291.0 – 292.9 or 303.00 – 305.9) on one or more claims, AND a diagnosis of severe mental illness (ICD-9-CM diagnosis codes 295.00 – 297.9) on one or more claims; number of points assigned varies by recipient age
    a. Age is greater than or equal to 40 = 5 points
    b. Age is less than 40 = 2 points
5. **Presumptive Disability or Blindness:** recipient has a diagnosis on the list of presumptive disabilities on one or more claims
    a. Diagnosis code present = 8 points
6. **Homeless:** recipient has a diagnosis code indicating homelessness (ICD-9-CM diagnosis codes V60.0 or V60.1) on one or more claims
    a. Diagnosis code present = 3 points

7. **Group Residential Housing (GRH):** recipient has been in the GRH program during the 18 month look back time period
    a. Enrolled in GRH = 5 points
8. **Diabetes:** recipient has a diagnosis of diabetes mellitus (ICD-9-CM diagnosis codes 250.00 – 250.93) on one or more claims
    a. Diagnosis code present = 3 points
9. **HIV:** recipient has a diagnosis indicating Human Immunodeficiency Virus infection (ICD-9-CM diagnosis codes 042, V08, 079.53) on one or more claims
    a. Diagnosis code present = 4 points
10. **Quadriplegia and Other Paralysis:** recipient has a diagnosis indicating quadriplegia, hemiplegia, or other paralysis (ICD-9-CM diagnosis codes 342.00 – 342.12, 342.80 – 342.92, 344.00 – 344.42, 344.81 – 344.9) on one or more claims
    a. Diagnosis code present = 8 points
11. **Disability indicator in MAXIS:** recipient has a disability indicated in MAXIS; number of points assigned varies by recentness of the indication
    a. Indication 10 or more years ago = 0 points
    b. Indication 5-10 years ago = 3 points
    c. Indication 2-5 years ago = 5 points
    d. Indication within past 2 years = 10 points
12. **Emphysema:** recipient has a diagnosis of emphysema (ICD-9-CM diagnosis codes 491.20, 491.21, 492.0, 492.8, 506.4, 518.1) on one or more claims
    a. Diagnosis code present = 4 points
13. **Morbid Obesity:** recipient has a diagnosis of morbid obesity (ICD-9-CM diagnosis code 278.01) on one or more claims
    a. Diagnosis code present = 4 points
14. **Compassionate Allowance Diagnosis:** recipient has a diagnosis on the list of Social Security Administration list of Compassionate Allowances conditions on one or more claims. This diagnosis list has been updated as of 2014 with information provided by Debra Wagner and Kathleen Hendricks
    a. Diagnosis code present = 25 points
15. **Developmental Disability:** recipient has a diagnosis of developmental disability (ICD-9-CM diagnosis codes 315.00 – 315.09, 315.1, 315.2, 315.31 – 315.32, 315.39, 315.4 – 315.9, 317, 318.0 – 318.2, 319) on one or more claims
    a. Diagnosis code present = 8 points
16. **Rule 36:** recipient is living in a residential facility for adults with mental illness (living arrangement of 52 or 57 or paid claim with procedure code H0019 for Intensive Residential Treatment Services)
    a. Living in Rule 36 facility = 5 points
17. **End Stage Renal Disease (ESRD):** recipient has a diagnosis of ESRD (ICD-9-CM diagnosis code 585.6) on one or more claims
    a. Diagnosis code present = 25 points

3) Classification of Dependency based on Activities of Daily Living Scores.

Case mix summary classifications are created using information obtained from the Minnesota Long Term Care Consultation Services Assessment Form (DHS-3428)[4]. Specifically, DHS uses branching logic to place individuals into different case mixes, depending on their combination of scores on activities of daily living (ADL). The full logic for placing individuals into classifications can be seen on DHS Case Mix Classification worksheet[5].

Additionally, DHS considered individuals who possessed dependency scores on certain individual ADLs to be disabled for the purposes of the Olmstead Plan. Those ADLs involved critical activities of life: toileting, transferring, and eating.

Case Mix Summary Classification	Description
D	Medium ADL
E	Medium ADL Behavior
F	Medium ADL Special Nursing
G	High ADL
H	High ADL Behavior
I	Very High ADL (Eating 3-4)
J	High ADL, Severe Neurological Impairment/3+ Behavior
K	High ADL, Special Nursing
V	Ventilator Dependent - EW
Toileting score greater than 0	Not toileting independent
Transferring score greater than 1	Requires help of at least one for transferring
Eating score greater than 1	Requires active assistance for eating

Estimated size of the denominator:

The estimated number of MA enrollees aged 65 and over during Calendar Year 2013 who would be classified as disabled using this definition is 43,435. This number amounts to 64.1% of all MA enrollees aged 65 and over (67,767) during 2013.

[4] This file can be obtained at the following location: Minnesota Long Term Care Consultation Services Assessment Form
[5] This file can be obtained at the following location: AC, BI, CADI, EW Case Mix Classification Worksheet

Appendix D - Consultation

Below is a list of DHS subject matter experts who have been consulted during the development of this report.

DHS Staff Name	Division	Area of expertise
Meg Heinz	Health Care Eligibility and Access Division	Eligibility Policy
Kathleen Hendricks	Health Care Eligibility and Access Division - State Medical Review Team	State Medical Review process
Jolene Kohn	Aging and Adult Services Division	Program and Policy management
Susan Kurysh	Purchasing and Service Delivery Division	ICD 9 and billing codes
Patrick Lee	Purchasing and Service Delivery Division	Benefits Billing codes
Rick Moldenhauer	Alcohol and Drug Abuse Division	Diagnosis codes for chemical dependency
Heather Petermann	Health Care Administration Policy Development and Implementation	Health Care Homes
Libby Rossett-Brown	Aging and Adult Services Division	Program and Policy management
Lisa Rotegard	Aging and Adult Services Division	Home and Community Based Services
Jenny Roth	Purchasing and Service Delivery Division	Benefits Policy
Jeff Schiff	Health Care Administration State Medicaid Medical Director	Children's Health
Barbara Skoglund	Health Care Eligibility and Access Division	Eligibility Policy
Jerry Storck	Adult Mental Health Division	Diagnosis codes for mental health conditions
Sarah Thorson	Disability Services Division	Children and youth with disabilities; waivered services
Debra Wagner	Health Care Eligibility and Access Division - State Medical Review Team	State Medical Review process

Appendix E – Glossary of Acronyms and Terms

The following is a description of various acronyms and terms listed in this report that are not defined within the report itself.

Acronym	Description
AMI	Acute myocardial infarction
PCI	Percutaneous coronary interventions
IVD	Ischemic vascular disease
LDL-C	Low-density lipoprotein cholesterol
CABG	Coronary artery bypass graft
ED	Emergency department
QMB	Qualified Medicare Beneficiary
SLMB	Service Limited Medicare Beneficiary
TEFRA	Tax equity and Fiscal Responsibility Act
ICD-9-CM	The International Classification of Diseases, Ninth Revision, Clinical Modification
MAXIS	System that processes information to determine eligibility for public assistance programs and mails benefits and notices to public assistance recipients. MAXIS is not an acronym.
QWD	Qualified Working Disabled
Rule 36	Rule 36 establishes standards for adult mental health residential facilities in Minnesota. Compliance with this rule is required for facilities that provide residential mental health treatment for more than four adults.

This information is available in accessible formats for individuals with disabilities by contacting your county worker. For other information on disability rights and protections to access human services programs, contact the agency's ADA coordinator.

Olmstead Plan: Work and Benefits Family Outreach Plan

Developed by the MN Department of Human Services in coordination with the MN Department of Employment and Economic Development and the MN Department of Education

July 1, 2014

1 TABLE OF CONTENTS

2 SUMMARY AND OVERVIEW

2.1 RELATED OLMSTEAD GOAL:

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

We will know we are making progress towards meeting the goal when we see progress in these population-level indicators:

- Increase in the employment rate of persons with disabilities so that it is comparable to the employment rate of persons without disabilities.
- Increase in the employment earnings of persons with disabilities so that they are comparable to the earnings of persons without disabilities.

2.2 STRATEGIC ACTION THE PLAN ADDRESSES – 3M:

By July 1, 2014 - establish **an outreach plan** for families illustrating the impact of integrated, competitive employment on individual benefits through the use of DB101 and work incentives.

2.3 RELATED STRATEGIC ACTIONS

Action #	Due Date	Details
1D	By 6/30/15	14-21 year old transition age students on SSI/SSDI (approx. 1000) will receive **benefits summary and DB101 estimator session** to inform employment planning choices and understand how integrated employment and benefits work together.
3A	By 8/31/14	Offer **enhanced training** on person-centered planning to ensure Employment First and employment planning strategies are incorporated.
3G	By 6/1/15	Develop an **improvement strategy** for educators and families about the economic benefits of integrated competitive employment.
1E	Beginning 7/1/15	**Expand** benefits summary and DB101 sessions to include 14-26 year olds (approx. 2,500) entering transition age services in public schools, disability waivers, or on MA-EPD.

2.4 ADVISORY COMMITTEE

Department of Human Services (DHS): Andrea Zuber, Lesli Kerkhoff, MaryAlice Mowry, Bekah Satre, Melinda Shamp, LaRone Greer; Department of Education (MDE): Jayne Spain, Sue Benolken, Department of Employment and Economic Development (DEED): Alyssa Klein, Abbie Wells-Herzog; Department of Human Rights (MDHR): Christina Schaffer; Contractors: Seth Levin and Molly Sullivan. Advisory Committee will continue to meet to implement the plan.

2.5 Outreach Plan Goals

- Improve competitive, integrated work outcomes for youth by improving communication with parents and families and embedding benefits planning and education into key transition processes.
  - Create more consistent messaging and coordinated benefits planning processes for families and their youth in transition.
  - Illustrate for families how work and benefits can go together to help their youth achieve higher education and competitive employment goals
  - Engage parents in on-going benefits planning so that benefits do not become a perceived barrier to competitive work for their child.
  - Educate on work incentives, Disability Benefits 101 (DB101) and Disability Linkage Line® (DLL) resources to help families through their transition process so they:
    - set integrated, competitive employment as an expectation and goal for their family member.
    - instill a vision of employment, build work skills, and create work experiences early on for their child.
    - advocate for their child to have competitive, integrated work a part of their plan.

2.6 Identified Assets to Leverage

DB101 Youth Content and Parent Tips	DLL Options Counselors
DB101 Partners Page	DLL Work and Benefits Specialists
DB101 Talk to an Expert	DLL Benefits Access
Get a Smart Start Training Curriculum and Video	Case Management system (VR, Individual Education Program (IEP) and County)
School and Work Getting Started Flyer	Existing Contracts
School and Work Scenario	DHS Benefits Data
Employment First 12 school district Competitive Employment Community of Practice sites.	Vocational Rehabilitation Services (VRS) employment planning process – parents involvement

2.7 Target Audience

- Primary: Youth 14-21 on Social Security Administration (SSA) Programs SSI and/or SSDI and their Parents/Caregivers.
- Secondary: 17 and 18 year old waiver participants NOT on SSI and their Parents/Caregivers (they will need to apply for SSA benefits at age 18).

2.8 Assumptions

- Employment First Strategies will develop messaging around competitive work as the first and preferred outcome.
- This plan will focus in on just the work and benefits planning and work incentives education.
- Communications tools will merge Employment First messaging with benefits planning and work incentive messaging for a cohesive parent strategy.

2.9 Timeline

This outreach plan covers the time period July 1, 2014-June 30th, 2015.

2.10 Roles

- DHS - Lesli Kerkhoff: Manage the work plan, coordinate meetings, and implement DHS/DLL and DB101 related work tasks.
- VRS - Alyssa Klein: Manage VRS related work tasks.
- MDE- Jayne Spain and Sue Benolken: Manage MDE related work tasks

3 OUTREACH OBJECTIVES, STRATEGIES AND ACTIVITIES

3.1 OBJECTIVE: INCREASE FAMILY AND YOUTH ACCESS TO INFORMATION WHICH ILLUSTRATES THE IMPACT OF INTEGRATED, COMPETITIVE EMPLOYMENT ON INDIVIDUAL INCOME AND BENEFITS THROUGH THE USE OF DB101 AND WORK INCENTIVES.

3.1.1 Strategy: Develop a core set of outreach and communications tools for the system to leverage and build consistent messaging.

a) Review other related Olmstead strategies and define opportunities for integrated messaging. (August-September,2014)
b) Develop draft outreach materials based on key messaging. (August-October, 2014)
c) Assemble a draft communication toolkit for distribution channels. (August-October, 2014)
d) Create and implement an evaluation strategy to assess the effectiveness of the communication tools. (September, 2014)
e) Test and refine the communication tools based on feedback. (October-November, 2014)
f) Develop a dissemination strategy for each key business area. (October-November, 2014)
g) Produce and distribute print materials to pilot sites and key channels. (November-December, 2014)
h) Make materials easily accessible through online information portals, i.e. DB101, Edocs. (December, 2014)

3.1.2 Strategy: Send a direct mailing to families of youth who are on SSI and/or SSDI and DHS programs.

a) Draft letter with tailored messaging for three different age groups: 14-15, 16-17, and 18-21. Letter will incorporate Employment First messaging, benefits messaging, and call to action to start planning now, call DLL or use DB101, and advocate for competitive work. (December, 2014)
b) Design the data pull for each mailing's targeted audience. (December, 2014)
c) Run data for 16 -17 year olds on SSI or SSDI, and mail designed letter and materials. (January, 2015)
d) Assess from DLL feedback and DB101 data overall effectiveness of the communication. Refine based on feedback. (February, 2015)
e) Stagger additional mailing to 18-21 (March, 2015) and then 14-15 (April, 2015).
f) Assess how to make mailings an ongoing annual communication DHS sends to families. (June, 2015)

3.1.3 Strategy: Leverage existing contacts and relationships to incorporate communications tools developed in 3.1

a) MDE and VRS each will develop a materials distribution strategy to leverage their channels to reach the target population. (December, 2014)
b) MDE, VRS will leverage existing agency contacts with parent advocacy groups and interagency teams to incorporate developed DB101 tools and parent communication tools (February, 2015)
c) DHS will leverage county case managers who work with youth in transition to utilize core communications tools with parents and reinforce core messaging. (March, 2015)

3.2 OBJECTIVE: INCREASE THE FAMILIES' AND YOUTH'S ACCESS TO PERSONALIZED INFORMATION ABOUT BENEFITS AND COMPETITIVE WORK.

3.2.1 Strategy: A benefits summary will be provided to approximately 1,000 youth on SSI and their families.

a) DHS will develop a School and Work Benefits Summary Form. (September, 2014)

b) Through the use of DB101 Talk to an Expert and the Disability Linkage line®, DHS will provide a benefits summary to support benefits planning and the use of the DB101 School and Work Estimator Session. (July, 2014-May, 2015)

c) VRS will work with parents to complete a Benefits Summary Form (aka Getting Started Worksheet) for youth on their program 14-21 on SSI. (start test sites (October, 2014)

d) DLL staff will provide technical assistance to professional users who need help in utilizing the DB101 tools. (on-going)

3.2.2 Strategy: VRS will provide customized assistance with a School and Work Estimator session for approximately 1,000 youth.

a) Identity two sites to test the process (August, 2014)

b) Develop proposed business process/guidance for VRS youth in transition workers to embed a benefits summary and a DB101 session into their work flow. (September, 2014)

c) Train start-up sites in the process and DB101 resources and tools. (October, 2014)

d) Start-up sites test the process (October-December, 2014)

e) Refine process based on feedback (December, 2014)

f) VRS transition staff statewide will receive training on the new process and DB101 resources and tools (January, 2015)

g) A DB101 School and Work Estimator session will become part of the VRS employment planning process for youth. (January, 2015)

h) VRS will distribute materials developed in 3.1 to new parents and youth enrolled in their services. (Start statewide January, 2015)

i) Training on DB101 process will become part of new staff training for VRS Transition staff. (February, 2015)

3.2.3 Strategy: Using the identified Competitive Employment Community of Practice (CE-COP) teams, MDE will introduce the Get a Smart Start and new outreach resources to assist youth and their families in learning how integrated competitive work impacts benefits. In addition, special education staff will learn how to embed benefits planning activities in the IEP process.

a) Special Educators and Work-based learning teachers/coordinators with the CE-COP teams will be encouraged to use DB101 resources, outreach materials and the *Get a Smart Start* Curriculum with their students. (October, 2014)

b) CE-COP team members will distribute materials developed in 3.1 to families. (November, 2014)

c) CE-COP team members will be given sample benefits planning strategies to include in the secondary transition planning process. Information will include benefits summary and DB101 estimator sessions. (December, 2014)

d) Participating CE-COP members will share best practices and guidance to inform MDE's statewide roll out strategy. (March, 2015)

e) MDE develops a statewide roll out strategy to share best practices, materials and resources and define benefits planning expectations for the IEP process. (April, 2015)

3.2.4 Strategy: Disability Linkage Line® staff will support families directly in completing a benefits summary and using the DB101 School and Work Estimator tools.

a) DLL will act as the go to place for private, customized help in completing an estimator session or learning more about work incentives, resources, and tools to support families in their planning. (ongoing)

b) DLL will provide benefits summary and run estimator sessions for parents who respond to the DHS mailings outlined in 3.1.1. (ongoing)

3.2.5 Strategy: Expand benefits summary and DB101 sessions to include 14-26 year olds (approx. 2,500) entering transition age services in public schools, disability waivers, or on MA-EPD.

a) Hold a strategic planning session to evaluate current strategies and define expansion strategies. (April, 2015)

3.3 OBJECTIVE: PREPARE SYSTEM TO EMBED DB101 TRAINING, RESOURCES, AND PLANNING TOOLS INTO CURRENT YOUTH IN TRANSITION PLANNING PROCESSES TO MAKE BENEFITS AND WORK PLANNING A CONSISTENT, ON-GOING PART OF A FAMILIES' EXPERIENCE ACROSS SYSTEMS.

3.3.1 Strategy: Support the Competitive Employment Community of Practice (CE-COP) school districts in integrating benefits planning into their communications, outreach and process.

a) Train school district's that incorporated DB101 into their strategic plans to improve Indicator 14 outcomes. (October, 2014-February, 2015)

b) For school districts committed to using the DB101 tools, assign a Disability Linkage Line Work and Benefits Specialists to provide on-going technical assistance. (October, 2014)

c) Make family outreach and education materials available for distribution in their programs. (December, 2014)

d) Follow up with participating schools to gather best practices and make learnings available to the other school districts. (May, 2015)

3.3.2 Strategy: Ready the DB101 structure to support a more coordinate process, and streamline work across the system.

a) Add *Share This Session* feature to DB101 so youth and parents can share estimator results with others. (November, 2014)

b) Develop the "User Vault" function to support a central place for process components. (March, 2015)

c) Redesign DB101 Partner Page to support training, outreach and process. (February, 2015)

e) Add to DB101.org Partners Tab key training and employment resources; including person-centered planning to ensure Employment First and employment planning strategies are incorporated. (December, 2014)

3.3.3 Strategy: Assess with VRS, MDE and counties how the DB101 vault can support a coordinated, streamlined process across business areas.

a) Hold a strategic planning process with partners, including CE-COP, to identify opportunities and commitments to use the vault to build a more coordinated process and improved experience for person across systems. (June)

4 MESSAGING

Goals & Action	Primary Messages	Secondary Message
SET EXPECTATIONS • Set integrated, competitive employment as the expectation and goal for their child.	Your child *can* work. Make competitive, integrated work an expectation for your child's future and part of the planning process.	• Integrated, competitive employment leads to a better quality of life all around, and provides for greater long-term financial stability. • Assist your child in developing skills that will lead to work. • Benefits are a bridge for your child to reach their goals and their potential, but benefits alone often can't do it. • People on Supplemental Security Income (SSI) are almost always better off working.
ENGAGE, PLAN, ADVOCATE • Encourage parents to instill employment vision, build work skills, and create work experiences early on for their child. • Parents advocate for their child to have competitive, integrated work in their plans, goals, etc.	Early work experiences are critical in determining future success.	• Encourage high expectations, and build work experiences. • Discover, encourage and support your youth's interests. • Acknowledge your child's strengths, interests, and preferences. • Use your social networks and family connections to connect to jobs or job experiences. • Give your child age appropriate responsibilities and tasks. Chores at home build valuable work skills for the future.
TAKE CONTROL OF BENEFITS • Illustrate that benefits are not a barrier to work – they can actually be a tool to reach education and work goals. • Educate on work incentives, resources and tools to help families see how benefits and work can go together and can support planning.	• You can balance benefits and work so your child is better off. • Use benefits and work incentives as stepping stones to assist your child in reaching integrated, competitive employment goals.	• There are programs to protect benefits for people who work. • Your child can work and keep healthcare. • Internships, part-time jobs, and short-term work can work together with benefits, so youth can get experience, more money and build towards their future. • There is a lot of BAD information out there about benefits and work. It is important for you to get the facts. • There is help available for you; the Disability Linkage Line and DB101.org are key resources.

4.1 CONTINUUM MESSAGING – PARENTS

Age	0 – 6	7-14	15-17	18-22
Work Messages	Your child has abilities and can live a full life, including work	• Your child *can* work; make work an expectation for your child's future. • Encourage and support your child's interests; interests can lead to employable skills • Encourage high expectations: expect your child to be a responsible, contributing member of the family • Chores at home build valuable work skills	• All people, regardless of disability, can work in the right job with the right supports • In addition to more money, work builds self-esteem, maturity, and important social connections • Encourage high expectations: expect your child to do some work experiences during or after school, or during the summer break • Students who work are more likely to be employed as adults • Teach your child that work is part of being an adult	• All people, regardless of disability, can work in the right job with the right supports • Teach your child that work is part of being an adult • In addition to more money, work builds self-esteem, maturity, and important social connections • Encourage high expectations: help your child decide on a career goal, make a plan, and take action to achieve the goal
Work & Benefits Messages	There are cash and healthcare benefits to help you care for your child if you have little income and assets	• There are cash and healthcare benefits to help you care for your child if you have little income and assets	• There are cash and healthcare benefits to help you care for your child if you have little income and assets • Once your child is 18 most benefit programs don't count your income and assets; your child may become eligible for benefits at age 18 • As an adult, your child can't make it on benefits alone. Benefits are a bridge for your child to reach their goals and their potential, but benefits alone often can't do it. • There are programs to protect benefits for people who work; your child can work and keep healthcare. • Internships, part-time jobs, and short-term work mean your child will build skills, have more income, and maintaining access to benefits • The key is to balance benefits and work. • There is help available for you; the DLL and DB101.org can answer questions.	• Now that your child is 18 or older most benefit programs won't count your income and assets; your child may become eligible for benefits • Your child can't make it on benefits alone. Benefits are a bridge for your child to reach their goals and their potential, but benefits alone often can't do it. • There are programs to protect benefits for people who work; your child can work and keep healthcare. • The key is to balance benefits and work. • There is help available for you; the Disability Linkage Line and DB101.org can answer benefit and work questions.

4.2 CONTINUUM MESSAGING -YOUTH

Age Range	7-14 years of age	15-17 years of age	18-22 years of age
Work Messages	• You have lots of talents that you can someday use in a job • There are many different careers you can have; start thinking now about what you like to do • Do chores at home to build skills that you can use at a job in the future	• All people, regardless of disability, can work in the right job with the right supports • Becoming an adult means more freedom and independence by having a job; start thinking about what career you want • Take advantage of work experiences offered by your school; these help you find what career is best for you • Start working now; have your own money, learn new skills, and meet new people	• All people, regardless of disability, can work in the right job with the right supports • Becoming an adult means more freedom and independence, which you get by finding a job that fits you • Decide on a career goal, make a plan, and take action to achieve the goal
Work & Benefits Messages	N/A	• Your parents may receive special benefits to pay for things you need. Benefits alone often aren't enough; work can get you more! • When you turn 18 most benefit programs don't count your parent's income and assets so you may become eligible. Beware - benefits alone often aren't enough; work can get you more! • Internships, part-time jobs, and short-term work mean you will build skills, have more income, and maintaining access to benefits • If you or your parents are worried about how work will affect benefits, then learn about the special program that allow you to work, have more money, and maintain access to needed benefits • There is help available for you; the Disability Linkage Line and DB101.org can answer benefit and work questions.	• Now that are 18 or older most benefit programs won't count your parent's income and assets so you may become eligible. Beware - benefits alone often aren't enough; work can get you more! • Benefits are a bridge for you to reach your goals, but benefits alone often aren't enough; work can get you more! • If you or your parents are worried about how work will affect benefits, then learn about the special program that allow you to work, have more money, and maintain access to needed benefits • There is help available for you; the Disability Linkage Line and DB101.org can answer benefit and work questions.

4.3 Call to Action

4.3.1 Youth

- Expect and plan for Competitive, integrated employment for yourself
- Get early work experiences
- Use DB101 and do a DB101 estimator session to learn how work and benefits go together
- Use work incentives to reach your goals and be better off.
- Advocate along the way – it is your goals, your plan, your life

4.3.2 Parents and Families

- Expect and plan for competitive, integrated employment for your child
- Help your child get early work experiences
- Use DB101 and do a DB101 estimator session to learn how work and benefits go together
- Use work incentives to reach your goals and be better off
- Advocate along the way – work with teachers, county case managers, VR and others to push for competitive, integrated employment

5 POSSIBLE COMMUNICATION CHANNELS

Entity	Channel	Notes
MDE	Secondary Transition Community of Practice, Community Transition Interagency Committees, Employment First Learning Communities, ParentsKnow Website; MDE Website, Special Education Directors, Related Service Personnel messages, State Special Education Advisory Panel	Low Incidence networks – Professionals that work with parents Special Education Directors - Mailings or during directors forums (4x year) Related services - professionals that work with parents- meetings and mailings
Schools	IEP Case Manager, Work Coordinators, Social Workers, Counselors, Transition Programs	
DHS	People on MADX, TEFRA, receiving case management services, CDCS Youth Pilot participants, People receiving Autism benefits	DHS could do direct mailing to families on DHS programs, or could build expectations into case management services
County	County Case Managers, Financial Workers	
DEED	VR/SSB Transition Workers, WFC	VRS Counselor distributes and informs; Expand info on "Developing Your Employment Plan" to include DB101 info. Leverage the DEED – CIL contract relationship to set expectations around benefits planning/DB101 into work.
Non-profits/Advocacy groups	PACER, CILS, ARC, Project Search (make it a criteria)	DEED has a contract with PACER and could ask that they do particular messaging or sessions with the messages we want CILS have youth transition workers
Medical Community	MN Physician publication	
Informal	Parent groups, workshops and networking	
Interagency collaboration groups	MN System of Interagency Coordination	Interagency State Committee

Youth →Parent: Support youth in educating and influencing their parents.
Direct to Parent: Communications directly to parents (mailings, websites, and articles)
Professional →Parent: Activate key channels to educate and communicate to parents

5.1 Tactical Channels (adoption strategy)

- Case Management Process
- IEP Process
- Pilot with Employment First Learning Community – 12 School Districts
- VR Youth In Transition Process – Part of Employment Plan
- Project Search process
- Parent Advocacy Contracts - DEED contract with PACER
- CDCS Youth Pilot Project
- Work Coordinators – YIT Curriculum

5.2 Direct Promotional Channels

- ParentsKnow Website
- MDE Website
- MN Physician Publication
- DHS recipients - mailing

5.3 Stakeholder Channels (training & DISTRIBUTION STRATEGY)

- MN System of Interagency Coordination (MNSIC)
- Secondary Transition Community of Practice
- Community Transition Interagency Committees
- Special Education Directors
- Related Service Personnel
- State Special Education Advisory Committee
- County Case Managers
- County Financial Workers
- Advocacy Groups doing parent training and youth in transition work
- PACER
- ARC

6 POSSIBLE MEASURES

Measurement	Source	Baseline	Goal: by 6/30/2015
# of School and Work Estimator Sessions completed	Google Analytics	91 sessions started	1,000
# of hits on DB101 content and trainings • Parent content • Youth content • Partner Page related Resources • Get a Smart Start with Youth	Google Analytics	• User age – 18-24 is 27.5% • Youth content 7041 page views • 421 Get a Smart Start with Youth	• User age – 30% • Youth content – 14,000 page views • Get a Smart Start Hits - 800
# of Benefits Summaries completed for Target	Resource House	5	1,000
Calls to DLL regarding youth 14-21	Resource House Report	304	1,500
# of materials distributed		N/A	7,500

7 RESOURCE NEEDS

7.1 BUDGET

Items	Detail	Estimated Cost	Possible Source
Contractors	Marketing, project manager, training	$95,000	DLL/DB101
Materials Development	Graphics, printing	$50,000	DLL/DB101
Distribution costs	Mailings	$30,000	DSD Division
DB101 change requests	To add new features, content and training to support process	$60,000	DLL/DB101

8 DATA - 2013

SOCIAL SECURITY DATA

Age	# on SSI or SSDI?
<5	2363
5-12	6593
13-17	4128
18-21	5253
22-25	4988

VRS DATA

Program	16-21 year olds served
Total # served	6,741
# on SSI, SSDI	1,396

DSD DATA

Program	14-21 years old
DSD Program on SSI or SSDI	5013

MDE DATA

Program	14-21 years old
Students with IEP 2013 Child Count Data:	40,414 (ages 14-21) 7,305 of the 40,414 are 18-21

9 SUMMARY OF FOCUS GROUP FEEDBACK

FOCUS GROUP PARTICIPANTS:

Six focus groups were held in 2010, two groups were conducted with professionals and four groups consisted of youth, young adults and parents.

MAJOR RELATED FINDINGS:

- The groups highlighted interest in a range of potential new content for DB101:
  - Advice on how to overcome resistance from others
  - To- do list timelines for filling out forms and applications
  - Youth showed limited knowledge of their benefits and potential loss and potential loss of benefits did not surface as a top of mind personal concern for most youth when considering taking a job.
- Overall many youth were excited about work and aspired to the independence it could offer.
  - Many were excited about the prospect of being able buy their own things
- Youth reported that parent's reaction to the prospect of them working varied significantly.
  - A substantial number of youth said their parents discouraged or even forbade work, fearing the impact it might have on benefits or due to concern that the experience would prove too psychologically stressful.
- Several youth said they tired working but had either quit or been fired
  - Reasons for quitting included being given unappealing chores, parental pressures, or practical considerations such as transportation.
- Youth in these groups sought a variety of practical advice and information to help them enlist the support of others.
  - Advice on how to explain their needs to teachers and employers who have not previous worked with individuals with disability
  - Advice on how to get parents to support their work incentives
  - Information on their rights, and advice on how to assert them
- Professionals sought information that would help assuage parental concerns about loss of benefits.
- The response of youth and professional indicate that parents are more likely than kids to be concerned about the impact of working on benefits.
  - Professional felt that parents need more information about how work can impact benefits
  - Some parents discourage their child from working for fear of losing disability benefits
  - Some parents consult with professionals to discuss the effect of work on their child's benefit
- Professionals said that their clients are more concerned with losing health coverage than income support when considering a job.
  - Many said that those who are living on their own are the most concerned group when it comes to a loss of medical benefits
- One parent in the group suggested adding a way to contact other parents in a similar situation for support.
- Parents and professionals were excited about being able to access benefits information in one location (DB101 Talk to an Expert)
- Professionals reacted positively to the potential of DB101 and the School and Work estimator to serve as a teaching device for them to motivate and prepare youth for a successful transition to work.

10 GLOSSARY

CILS	**Center for Independent Living** Centers for Independent Living are designed and operated within a local community by individuals with disabilities and provide an array of independent living services, including the core services of information and referral, independent living skills training, peer counseling, and individual and systems advocacy
DB101	**Disability Benefits 101 (www.db101.org)** An online resource and planning tool that gives you tools and information on health coverage, **benefits**, and employment. DB101 can help people plan ahead and learn how work and **benefits** go together.
DLL	**Disability Linkage Line®** a free, statewide information and referral resource that provides Minnesotans with disabilities and chronic illnesses a single access point for all **disability** related questions
IEP	**Individualized Education Program** An Individualized Education Program (IEP) is a written statement of the educational program designed to meet a child's individual needs. Every child who receives special education services must have an IEP.
MA-EPD	**Medical Assistance for Employed Persons with Disabilities (MA-EPD)** A program that gives health care coverage through Medical Assistance (MA) to employed people with disabilities. MA-EPD covers the same services as standard MA, but it allows you to have higher income and more assets than you could under standard MA or MA with a spenddown.
SSDI	**Social Security Disability Insurance (SSDI)** Wage replacement income for individuals who have worked and paid FICA taxes and who now have a disability meeting Social Security disability rules.
SSI	**Supplemental Security Income (SSI)** A Social Security Administration program that provides cash benefits to people with disabilities who have limited income and resources.
VRS	**Vocational Rehabilitation Services** State agency that helps people with disabilities prepare for, find, and keep jobs that are consistent with their skills, strengths, and interest
CDCS	**Consumer Directed Community Supports** Consumer Directed Community Supports gives people receiving waiver services more flexibility planning their services and supports.

Olmstead Transportation Forum Final Report

Submitted by Forum Planning Committee members

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Executive Summary

Safe, convenient, efficient and effective transportation is essential for people with disabilities to lead meaningful lives as actively included members of their chosen communities. On March 26, 2014 the Olmstead Transportation Forum, sponsored by the Minnesota Departments of Transportation and the Human Services, was held, in accordance to Minnesota's Olmstead Plan. The Forum kicked-off a renewed effort to bring people with disabilities into the transportation planning process. This event built upon past planning and community input and gave information about how to be involved in the future.

> Specifically, the Olmstead Plan includes the following action item:
>
> *By March 31, 2014 community members will be convened by DHS to identify access issues and determine strategies to improve access and flexibility.*
>
> Agencies and stakeholders convened a forum on March 26, 2014. This report included a summary of the forum.
>
> Strategies for addressing issues that have been compiled from several previous planning sessions were shared with the audience. The strategies presented are listed on page 10 of this report. Participants in the forum were asked to prioritize these strategies, or add new strategies.
>
> Attachment G on page 19 provides a record of the public comments that were made during the forum and those that were submitted by email. The comments were condensed to capture the main points made.

A hallmark of the Olmstead Plan is the commitment of State agencies to work together across traditional boundaries. The Forum planning committee included individuals from the Minnesota Departments of Transportation and Human Services (Health Care Administration, Aging and Adult Services Division, and Disability Services Division), the Minnesota State Council on Disability and the Metropolitan Council.

Leaders from sponsoring agencies gave opening remarks to set the context for the event. They observed that transportation services are paid through various State avenues and the Olmstead mandate to work in a more coordinated manner. They also spoke about the importance of having the community involved in shaping the system that serves them.

A panel of speakers discussed past planning processes and new opportunities for engagement. The three speakers talked about 2011 Greater Minnesota Transit Investment Plan process, the metro transit services and the Service Investment Plan, and Board on Aging's role with transportation, the 2013 Long-Term Services and Supports Gaps Analysis and the Minnesota Council on Transportation Access.

Forum participants were invited to respond to and prioritize a list of strategies for addressing transportation issues that had been derived from previous planning processes. They also were invited to

speak to any issues they see with transportation. The complete comments are included as an attachment to this report.

The Forum planning committee developed a short list of recommendations for moving forward.

- Use the opportunity of current influxes of transportation funding to make a difference in the lives of people with disabilities.
- Develop new approaches to community engagement to ensure that people with disabilities are engaged in the developing the next Transportation Investment Plan.
- Develop new practices in administering the Section 5310 program, beginning in 2014, to bring in new participants, encourage innovative approaches, and bring people with disabilities and older Minnesotans into the decision-making process.
- Coordinate, if not integrate, Olmstead Plan-related community engagement efforts to maximize participation by people with disabilities.

Background

A sufficient transportation system provides safe, convenient, efficient and effective movement of people and goods. It is a necessary feature of life in community. Transportation facilitates interaction with a variety of people, participation in community events, school attendance, employment, commerce, civic engagement, recreation and pursuit of interests. Without effective means of transportation people have limited options available to them and, potentially, a diminished quality of life.

Creating and maintaining a sufficient transportation system is a complex problem. That is, transportation is composed of many interconnected parts and multiple variables. Differing geographic areas to cover; variation in population density; variation in destination and time when transportation is needed; and individual requirements, such as available seating, short wait times, protection from weather, accessibility—all these factors lead to the complexity of the solution and the costs involved.

Americans with Disabilities Act and *Olmstead v. L.C.*

The Minnesota Human Rights Act, the Americans with Disabilities Act (ADA), and other laws prohibit discrimination against people with disabilities. The ADA guarantees equal opportunity for individuals in public accommodations, employment, transportation, State and local government services and telecommunications. People with disabilities may use transportation services that are part of the public transportation system, and/or through government services for people with disabilities. The ADA applies to both of those systems.

This requirement means more than ensuring *physical* access for people with disabilities: to comply with these laws, government entities may also be required to change the way they provide services or modify how programs are administered so that individuals with disabilities can participate and benefit. Regulations developed under the ADA also specifically require that government entities provide services

in the *most integrated* setting appropriate to the needs of qualified individuals with disabilities.[1] The United States Department of Justice (DOJ) explains that the *most integrated* setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible..."[2]

In *Olmstead v. L. C.*, 527 U.S. 581 (1999), the Court held that unjustified segregation of people with disabilities violates the ADA. Referred to as the Olmstead Decision, this means that states must offer services in the *most integrated setting*.

In its opinion, the Court emphasized that it is important for governments to develop and implement a comprehensive, effectively working plan to increase integration. From one perspective, the *Olmstead* decision is about how services are provided *by* the government *to* people with disabilities (that is, services must be provided in the most integrated setting). From another perspective, the *Olmstead* decision 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."[3]

An Olmstead Plan is a way for a government entity to document its plans to provide services to individuals with disabilities in the most integrated setting appropriate to the individual. Effective Olmstead Plans include analyses of current services, concrete commitments to increase integration (and to prevent unnecessary institutionalization), and specific and reasonable timeframes, among other components.

Minnesota began work to develop its Olmstead Plan in 2012 and completed the first plan in November 2013. The process included state agency staff, with input from individuals with disabilities, their families, other stakeholders and advocates, and nationally regarded experts. The Plan is a living document and will be continually modified and added to as the work of the Plan is implemented.

Transportation and Minnesota's Olmstead Plan[4]

The State has set an overall goal for the Minnesota Olmstead Plan. That is, people with disabilities are living, learning, working and enjoying life in the most integrated setting.

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[1] 28 C.F.R. § 35.130(d): http://www.ecfr.gov/cgi-bin/text-idx?SID=8e0a7c758dd371dfdf081d5c2f63a5a5&node=28:1.0.1.1.36&rgn=div5.

[2] 28 C.F.R. Pt. 35, App. A (2010): http://www.ecfr.gov/cgi-bin/text-idx?SID=3878071b2ac0b3880c5944edc741f1f3&node=28:1.0.1.1.36&rgn=div5#28:1.0.1.1.36.7.32.3.11. Also US DOJ, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L. C., Accessed August 30, 2013, http://www.ada.gov/olmstead/q&a_olmstead.pdf.

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

[4] A copy of the Olmstead Plan is available on-line: http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_180147.pdf

To achieve this goal the Plan addresses several areas:

- Employment
- Housing
- Transportation
- Supports and Services
- Lifelong Learning and Education
- Healthcare and Healthy Living
- Community Engagement

Transportation is included as its own section of the Plan because it is so integral to achieving the other community integration objectives of the Plan.

The Plan lays out four actions to meet the goal of ensuring that Minnesotans with disabilities have reliable, cost-effective and accessible transportation choices that support the essential elements of life such as employment, housing, education and social connections.

- Establish a baseline of transit expenditures and types of service provided across state agencies to better support people with disabilities.
- Engage community members to expand flexibility in transportation systems.
- Integrate Olmstead principles into existing transportation plans so that Minnesota's transportation policy supports integration and inclusion of people with disabilities.
- Engage the Minnesota Council on Transportation Access (MCOTA).

This report relates to the second action, engaging community member to expand flexibility in transportation systems, specifically to the Olmstead Transportation Forum that was held on March 26, 2014.

Olmstead Transportation Forum (March 26, 2014)

The March 26 Olmstead Transportation Forum was sponsored by the Minnesota Department of Transportation and the Minnesota Department of Human Services in accordance with the Minnesota Olmstead Plan.

The Forum was a two-hour event, with 128 registrants. There were two options for participation, in an attempt to make it accessible to as many people as possible. The event was offered via captioned videoconference with 15 sites statewide and was shown via web-streaming. Participants could make comments live, or send them in during the event via email to be read aloud during the event, or send them in after the event through the Minnesota Department of Transportation Olmstead webpage.

There were 40 people participating at a videoconference site in the Twin Cities, 27 at a site in Greater Minnesota, and 61 people participating via web-streaming. Fifty-one percent of the participants came

from government, 42 percent were some other kind of professional (mostly providers of services to people with disabilities), one percent identified as a person with a disability or advocate and five percent chose to not give a background.

The Forum was not intended to be a single effort to engage community members; rather, it was conceived as a kick-off to a renewed effort to bring people with disabilities meaningfully into the transportation planning process. The Forum acknowledged and built upon planning and community input that has happened in the past, and gave participants information about how to be further involved in the future.

Forum Planning Committee

People with disabilities use transportation services that are funded and administered through a variety of governmental organizations. The Minnesota Department of Transportation shares responsibility with local, regional, state, tribal and federal, private sector and other partners to operate and maintain an extensive multimodal transportation system that is used by the general public, including people with disabilities. The Minnesota Department of Human Services provides a transit, based on program enrollment, for non-emergency medical transport. Additionally, the Department provides or supports a wider array of transportation services, based on program enrollment, for specific populations such as people with disabilities or older Minnesotans. The Metropolitan Council is responsible for ensuring that transportation infrastructure equitably meets the demands of Twin City citizens, now and as the region grows. It is the region's federally-designated metropolitan planning organization and the region's primary regional transit provider. The Minnesota Council on Disability is a state agency that provides leadership to empower and strengthen the rights of Minnesotans. It collaborates with public and private sectors as a policy and technical resource advisor.

A hallmark of Minnesota's Olmstead Plan is the commitment to working together across traditional state government boundaries, such as state agencies, administrations, divisions and programs in order to achieve the Plan's goals. The Forum planning committee included people from all these entities with primary responsibility for planning for and providing transportation services that are vital to people with disabilities.

Planning committee members

Kristie Billiar, *MnDOT, ADA Unit*
Tom Gottfried, *MnDOT, Office of Transit*
Noel Shughart, *MnDOT, Office of Transit*
Kelly Christenson, *MnDOT, Office of Transit*
Steve Masson, *DHS, Health Care Administration*
Julie Marquardt, *DHS, Health Care Administration*
Lori Lippert, *DHS, Continuing Care Administration*
Gerri Sutton, *Metropolitan Council*

Joan Willshire, *Minnesota State Council on Disability*
Colin Stemper, *Minnesota State Council on Disability*

Opening Remarks

The Forum began with remarks from each of the sponsoring state agencies, including speakers from two administrations within the Department of Human Services

Julie Marquardt, Director of Purchasing and Service Delivery, Department of Human Services Health Care Administration

Welcome and thank you for coming. This event is sponsored by the Minnesota Department of Human Services and the Minnesota Department of Transportation. The Metropolitan Council and Minnesota State Council on Disability were partners in planning the event.

Safe and reliable transportation that gets you were you need to go is integral to us all. Despite how integral transportation is to our lives, we still struggle to ensure that everyone in Minnesota has access to adequate transportation. No place is this more true than it is for people with disabilities and older Minnesotans.

Medical Assistance covers the cost of getting to medical appointments, but that's only a small part of life. We know there are many issues with getting adequate transportation for all the things that important to people, and we hope that events like this will help us find solutions.

Loren D. Colman, Assistant Commissioner, Department of Human Services Continuing Care Administration

Transportation is a very complex problem—people live all over the place and each person has their own place to go, on their own schedule. Some forms of transportation work for some people, but not for others. It costs a lot to move people around, and it is difficult for individuals to afford. Public subsidies for transportation come from many different places, each with its own purpose and set of rules.

Olmstead Plan context: The Olmstead Plan is Minnesota's plan to provide supports and services to people with disabilities in ways that allow them to live inclusively in their communities. While Minnesota has been working for a long time towards supporting people with disabilities and older Minnesotans in the community, the Olmstead Plan is a formalized way of re-focusing our efforts in this direction. The Olmstead Planning process started with community listening sessions. The governor created the Olmstead Sub-Cabinet to ensure that all parts of state government are brought together to develop and implement the Plan. It is a 'living' document, meaning that it will evolve over time. People with disabilities are encouraged to stay involved in the development and implementation of this plan.

The powerful thing about the Olmstead Plan is that it requires government entities to work together. This event is a good example of that. Collectively we will find ways to improve our system. This is part of that process. We have about 100 people participating in this event. We want to hear what's working and ways we can improve.

Mike Schadauer, Director of Transit, Department of Transportation

The Department of Transportation's vision is a multimodal transportation system that connects the state's assets; provides safe, convenient and effective movement of people and goods; and is flexible and adaptable. This drives everything that we do. The Office of Transit works closely with local units of government in Greater Minnesota; the Metropolitan Council does this in the Twin Cities metropolitan area.

Planning activities which will provide opportunities for integrating principles laid out in Olmstead Plan: the 2015 Greater Minnesota Investment Plan (planning done in 2015 and published in 2016); Local Transit Coordination Plans which are developed by regionally with MnDOT support; and the Minnesota Council on Transportation Access.

The Forum convened community members to discuss transportation for people with disabilities, but it was not an isolated opportunity for community involvement in transportation planning, nor was it a solo event specific to people with disabilities. The Forum was designed with four intentions in mind:

- Build upon previous planning efforts
- Create an opportunity to prioritize transportation strategies
- Disseminate information about future engagement opportunities
- Get input to improve efforts to engage the community in the future

Previous Planning Processes

The Forum had two parts. During the first half, a panel of speakers talked about planning that has been done in the past and what had been learned through those processes. There has been a great deal of interest in transportation for people with disabilities in recent years, resulting in several opportunities for the public to give input on their experiences and preferences. For example, listening sessions that took place as part of developing the Minnesota Olmstead Plan, to give the public a chance to talk about what is important to them; several comments concerned transportation. Those can be found in Appendix C of the Olmstead Plan[5].

The planning committee gathered and disseminated documents summarizing the findings from key planning processes to the registered participants. These materials can be found in Attachments A-C.

- 2013 Long-Term Services and Supports Gaps Analysis: Transportation-Related Services
- Summary of Minnesota State Council on Disabilities Transportation Forums (2008-2012)
- Planning for Enhanced Transportation Access and Efficiency: Synthesis of 2011 Greater Minnesota Local Human Services Transit Coordination Plans

[5] http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_180147.pdf

Registrants also received a document giving examples of innovative transportation services. (Attachment D)

Noel Shughart, Minnesota Department of Transportation, Office of Transit

This presentation focused on the 2011 Greater Minnesota Transit Investment Plan process. (Attachment E)

The governmental agencies that have responsibility for designing, building and maintaining Minnesota's transit infrastructure rely upon community planning efforts to guide their investments. The Minnesota Legislature mandated that the Department of Transportation develop an investment plan to meet the transit needs in Greater Minnesota, with 90% of those needs to be met by 2025. The Greater Minnesota Transit Plan assesses how to invest to meet the transit needs and priorities in Greater Minnesota. The Department used a variety of methods to learn about these needs, through outreach and marketing activities.

Surveys were sent to 10,000 users of transit services in Greater Minnesota. Respondents were asked to rate the importance of five desired changes to service. One focus group of non-riders was held in each of the 12 Regional Development Commission regions. Participants discussed current traveling experiences, transit perceptions, marketing and future alternatives. Presentations were given to over 50 groups statewide. Those in attendance were asked to rank six potential changes in service. Structured interviews were held with 15 key stakeholders, including state agencies, local governments, chambers of commerce, social service agencies and citizens. Interviewees were asked about days and time of service, geographic coverage, cost-effective performance, and promotional needs and pricing. The planning project worked with a technical advisory committee which gave input, as did the representatives from the Regional Development Commissions.

There continue to be opportunities for the public to participate in planning. There are various advisory groups that individuals can join, and a new round of local human services transit planning will be starting in 2015. That effort is being developed now.

Cyndi Harper, Metropolitan Council

This presentation focused on the metro transit services and the Service Investment Plan. (Attachment F)

Metro Transit is the fixed route operating system of the Metropolitan Council. Metro Mobility and Transit Link are administered through the Metropolitan Council, but are not part of Metro Transit. Met Transit covers the seven metropolitan counties, encompassing 90 cities. It has 128 routes, light rail, commuter rail, and bus rapid transit.

Work is currently underway on the Service Improvement Plan which is a 10-15 year plan focusing on service improvements on local and express bus routes. The Service Improvement Plan will consider which evaluation measures and transit values should be used to prioritize these investments, as well as

the timing of and resources needed to make these improvements. It is important to note that these improvements all assume that additional funding becomes available.

To set priorities, Metro Transit seeks public engagement in a variety of ways, including stakeholder workshops, surveys, on-board brochures and signs, and a customer newsletter. It also combines information from prior public involvement activities and new daily information through the Customer Relations Department, with an on-going effort to serve traditionally underserved audiences. The Service Improvement Plan included a survey about individual travel patterns, specific service improvements, and overall goals and priorities. This was done from November 2013 through February 2014, resulting in 4000 responses.

Survey results fell into six main categories:

1. Improve core urban routes: less waiting on high ridership routes, more night and weekend service.
2. Improve suburban coverage and connections: riders don't want to have to travel downtown and transfer to travel between suburbs; add routes that connect to suburban transit centers and improve coverage.
3. Improve urban crosstown connections: fill in the grid, improve the span and frequency of existing routes, make it easy to travel between neighborhoods without having to go downtown and transfer, ensure local access to rail and BRT.
4. Improve express options: increase parking capacity at overcrowded park and rides, improve the span and frequency of existing routes, add express service to areas outside of the downtowns and U of M.
5. Faster travel times: customers riding all types of transit would like the trip to be faster. Ways to do this include fewer stops, eliminating boarding delays with off-board fare collection, and ways to bypass congestion.
6. Improve customer amenities: more comfortable waiting areas, basic route and way-finding info, ticket vending machines and bike racks.

Rolf Hage, Minnesota Department of Human Services, Continuing Care Administration and Minnesota Board on Aging

This presentation was about the Board on Aging's role with transportation, the 2013 Long-Term Services and Supports Gaps Analysis and the Minnesota Council on Transportation Access.

The Department of Human Service's Aging and Adult Services and the Minnesota Board on Aging focus on adults who are age 55, 60 or 65 (depending on program), regardless of income. Services for older adults are primarily services that are delivered to people in their own homes or in community settings. Although the intent is to support people living in their communities, living in the community often involves reliance upon transportation services that don't adequately support freely moving about in the community. For example, transportation services are often restricted to certain geographic areas which don't align with where an individual wants to go.

Transportation services for seniors are never going to reach 100% of the people, 100% of the time. Among other factors, disconnects between transportation providers, human services, and aging services entities creates barriers to users. People who rely upon transportation services and their advocates need to be educated about the issues of transit and become actively involved in planning and maintenance.

The Olmstead Plan provides an opportunity to focus interest and action regarding transportation so that the State can move incrementally to a better system. Providers and stakeholders need to be involved in parallel development and planning processes.

Summary of Public Comments

The second half of the Forum was set aside for public comments about common strategies that have emerged out of these past events, or about access issues people experience. (Attachment G)

The strategies that have been commonly identified through previous planning processes are:

- Improving coordination of services and resources
- Increasing awareness
- Implementing mobility management strategies
- Expanding services
- Reducing expenses and increasing efficiency
- Overcoming regulatory barriers

Several speakers commented on how the current systems are not adequately meeting people's needs and the negative impact that results. There were also questions about current services and planning opportunities. There were observations about how planning processes, this event included, do not bring in the full scope of perspectives—particularly people with disabilities.

Not many spoke to the strategies that were given, but those that did prioritized improving coordination, expanding services and overcoming regulatory barriers.

Synthesis

While the Olmstead Transportation Forum had participation from around the state by people from various perspectives, there was low participation by people with disabilities. Having people with disabilities involved in the implementation of the Olmstead Plan, and in the delivery of their services in general, is an essential goal of the Olmstead Plan and of this event. People with disabilities consistently express their desire to be part of the decision-making process as the systems that serve them are designed, and yet, efforts to engage them often fall short. Policy-makers and planners need to assess the approaches they traditional use and develop new practices that result in better engagement of the people most affected.

The planning processes and forums in the past have produced several documents that capture transportation barriers and issues, and strategies for addressing them. The same items, more or less, are identified consistently across all the planning efforts. In fact, the issues that are identified as being concerns for people with disabilities often are the same as those identified for the general population. The impact of the barriers, however, may be different for different groups or individuals.

For example, it is important to understand how poor transportation impacts people with mental illness. When transportation impedes access to things that support mental health recovery (e.g., therapy, medication, medical appointments, work) there can be serious mental health repercussions.

High on everyone's list are not enough service, insufficient routing, lack of coordination between systems, geographic limits to service, cost of the service and a system that in general is inflexible/regulation-bound. In addition to differential impact of transportation barriers, there may be different solutions that can be targeted to the population of people with disabilities or to individuals with disabilities. While some people with disabilities have challenges that set them apart from the rest of the populations, they also may have access to additional resources.

Despite policy efforts, many of the transportation issues that confound people with disabilities remain. One step in turning this around could be changing the way we measure transportation outcomes. The traditional measure of transportation success is "performance", but to meet the needs of people with disabilities, decisions can't be made solely on performance.

There is a tension between supply and demand. This is particularly true in rural Minnesota and suburb-to-suburb transportation. Simply finding more efficiencies will not be sufficient alone to close the supply/demand gap. In addition, external factors, beyond what was examined in the forum, affect the ability of people to obtain transportation. Finding solutions is likely going to require innovative responses that pull together new alliances and various resources, formal and informal. While the solutions may not be solely driven by state, or even local government, they may require policy changes to support greatly flexibility. For example, the private sector is already driving change in transportation with services like Uber and Lyft which connect riders to drivers.

Moving from a service-based transportation model to a client-based model could have cost consequences. At the same time, there are rapidly developing technologies that might mitigate the cost impact. There is currently existing technology that could facilitate coordination across the system.

Recommendations

While not typically the case, there are currently additional resources coming into the system to expand service over the next few years. In 2015, 40,000 hours of service will be added to Greater Minnesota transit. This opportunity should be seized, in part by altering State and local government's traditional planning practices, to make improvements to outcomes for people with disabilities.

The next Investment Plan process must include the disability community. One way to ensure this would be to have opportunities specific to people with disabilities. It also is helpful to dig down deeper than lumping all people with disabilities in one group, as the needs of people with different types of disability vary. Use a sampling approach, rather than trying to get full community participation. Use performance measures to see how well community engagement efforts are proceeding.

The next round of Investment Plan development will take place in 2015. A big piece of the plan is likely to be expanding services (nights and weekends), as this is consistently a highly-ranked priority. Any service expansion that results from this will take two years to be implemented.

The Section 5310 program was established by the Federal Transit Authority as a discretionary capital assistance program. In cases where public transit is inadequate or inappropriate, the program awards grants to private non-profit organizations to serve the transportation needs of elderly persons and persons with disabilities. The Minnesota Department of Transportation awards grants under this program annually. The 2014 solicitation is currently being developed and offers the opportunity for developing some new approaches to building the transportation infrastructure. The 2014 solicitation could be written to address some of the issues that were raised at the Forum. By distributing the solicitation more widely than has been done in the past, and providing technical assistance to entities that might not be aware of the program, would open the process to potential new partners and innovative approaches. Incorporating people with disabilities and older Minnesotans into the review process would be a significant step towards engaging the effected communities in the planning process.

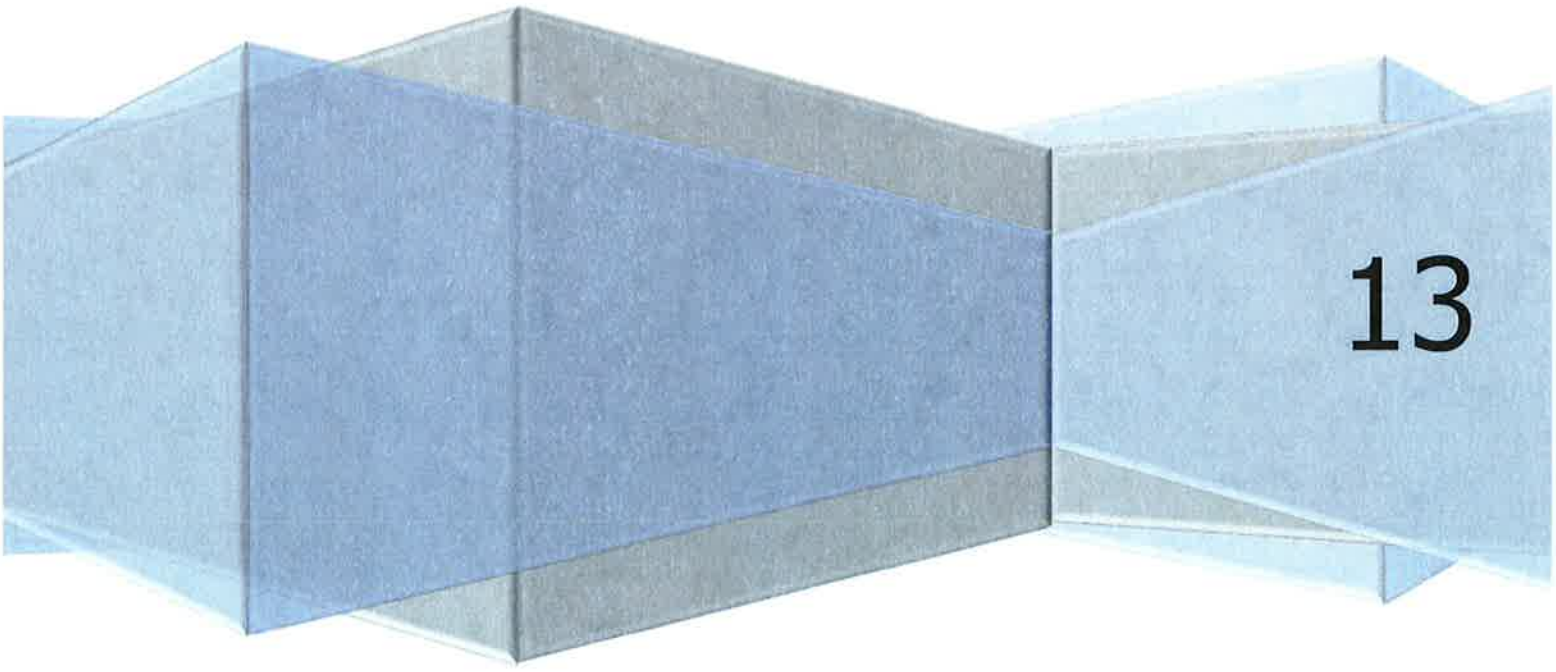
The Olmstead Plan includes many activities centered on greater engagement of the people with disabilities—related to transportation and other topic areas. When possible, taking a coordinated approach to these activities will increase the meaningful involvement of people with disabilities and reduce "participation fatigue".

Attachment A: 2013 Long-Term Services and Supports Gaps Analysis: Transportation-Related Services

MN Dept of Human Services

Long Term Services and Supports Gaps Analysis: Transportation-Related Services

Stump, Todd



Long-Term Services and Support Gaps Analysis, 2013

This report summarizes the status of transportation-related long-term services and supports for older adults, people with disabilities, children and youth with mental health conditions, and adults living with mental illnesses through calendar year 2012. It was developed in response to a legislative mandate (M.S. 144A.351) to biennially update the legislature on the effects of legislative initiatives to "rebalance" the state's long-term services and supports system.

The term *long-term services and supports* (LTSS) refers to on-going supports that an individual needs due to a chronic health condition or disability. These services can be delivered in a person's home, in another community setting, or in an institutional setting. Currently, long-term services and supports is the nationally recognized term for this range of services and is used by the federal government. The term *home and community-based services* (HCBS) refers to long-term services and supports that are delivered in homes or other community-based settings, not in institutional settings. Home and community-based services are a subset of long-term services and supports.

Beginning in 2001 and repeated in 2003, 2005, 2007 and 2009, the Minnesota Department of Human Services (DHS) has reported on the current capacity and gaps in long-term services and supports and housing to support *older adults* in Minnesota. The primary source of this report was a survey completed by the counties to describe the capacity for these services in their local areas. In 2012, the Legislature amended state statute to expand the scope of the survey and resulting report to include *people with disabilities, children and youth with mental health conditions* and *adults living with mental illnesses*.

As required by statute, this report includes demographic trends; estimates of the need for transportation-related long-term services and supports; summary of statewide trends in their availability; and recommendations regarding the goals for the future of transportation-related long-term services and supports.

Counties contributed data and comments on the changes that have occurred in the availability of services over the past two years. The most frequently identified gaps in service availability across these groups were chore service, companion service, respite care, transportation and adult day care. Counties were asked to report the availability of several Long-Term Services and Supports. Answers are *exceeds demand*, *meets demand*, *available but limited* or *not available.* Due to several counties reporting their results as part of collaboratives, such as Lincoln Lyon and Murray Counties (LLM), there were fewer responses than actual counties in Minnesota. For Disability Services, more counties reported as a county collaborative, resulting in lower N values for this survey.

A "gap" is defined as a service that is reported as being *available but limited* or *not available*. The table below indicates the services in which the highest percentages of counties reported as gaps during the past 5 Gaps Analyses, and where *transportation* fell within the top gaps:

Type of service	Rank	% of counties
2003 (72 counties)		
Transportation	**1**	**42%**
Chore service	2	28%
In-home respite/ caregiver supports*	3	22%
Adult day service	4 (tie)	21%
Home delivered meals	4 (tie)	21%
2005 (76 counties)		
Transportation	**1**	**55%**
Evening and weekend care**	2	50%
Chore service	3 (tie)	47%
Adult day service	3 (tie)	47%
In-home respite/ caregiver supports*	5	42%
2007 (79 counties)		
Transportation	**1 (tie)**	**63%**
Companion service	1 (tie)	63%
Chore service	3	62%
Respite care, in-home	4	51%
Respite care, out-of-home	5	47%
Caregiver/ family support training	6	46%
Adult day care	7	44%
2009 (87 counties)		
Non-medical transportation* **	**1**	**66%**
Chore service	2 (tie)	60%
Companion service	2 (tie)	60%
Respite care, out-of-home	4	58%
Medical transportation * **	**5**	**56%**
Respite care, in-home	6	55%
Adult day care	7	51%
Caregiver training & support	8	44%
2013 (87 counties)		
Chore service	1	65%
Companion service	2	64%
Non-medical transportation	**3**	**60%**
Medical transportation * **	**4**	**58%**
Adult day care	5	57%
Respite care, in-home	6	55%
Respite care, out-of-home	7	49%
Prevention/Early Interv (Beh/Cog Health)	7	46%

*In 2007, Transportation was split into two categories: *Medical* and *Non-Medical*

As evidenced by the table above, Transportation has remained among the top gaps reported by Minnesota counties. However, once we split this service into medical and non-medical, we found that other services exceeded medical transportation in regards to the least available service; with non-medical transportation serving as the greatest gap until 2013, when both

transportation-related services were passed by other LTSS. Perhaps this was the case in the two previous surveys.

I. Home and Community-Based Services, Barriers to Relocation and Other Survey Subject Matter

Counties were asked to report on any recent *changes* in home and community-based service (HCBS) capacity as well as the *current* service capacity in their county. Counties also reported on local issues or barriers related to HCBS capacity along with their county's priorities for HCBS development. The HCBS-related questions included *transportation, medical* and *transportation, non medical*. Secondly, counties were asked if there were any persons receiving services in their jurisdiction who could relocate from congregate settings and/or provider-controlled housing into their community if they had adequate supports available – and what barriers or issues prevented such relocation. *Access to transportation* was offered as an answer choice. Within the Disability Services survey, counties were asked if there was a systematic strategy to increase competitive employment and earnings for persons receiving disability services in their jurisdiction. *Access to transportation* was offered as an answer choice for this question, as well.

A. Aging and Adult Services

1. Changes in Service Capacity since January 2011, Transportation-related services (N=84)

	less available	no change	more available
Transportation (medical)	**20%**	**67%**	**13%**
Transportation, non-medical*	**15%**	**71%**	**11%**

2. Current Service Capacity as of January 2013, Transportation-related services (N=84)

	not available	available but limited	meets demand	exceeds demand
Transportation	**0.0%**	**58.3%**	**41.7%**	**0.0%**
Transportation, non-medical*	**2.4%**	**58.3%**	**36.9%**	**0.0%**

3. Description of Limitations for Transportation-related Service Gaps

Transportation, non-medical: Counties report that reimbursement rates, and in particular the elimination of reimbursement of non-load miles, has had an impact on the availability of transportation in their area. Transportation programs that utilize volunteers have been particularly impacted because fewer volunteers are willing to provide this service given the changes in mileage reimbursement. When volunteer programs do exist they prioritize providing medical transportation over transportation for non-medical needs. Access in rural areas, for out of county travel and evening and weekend travel continue to be barriers across

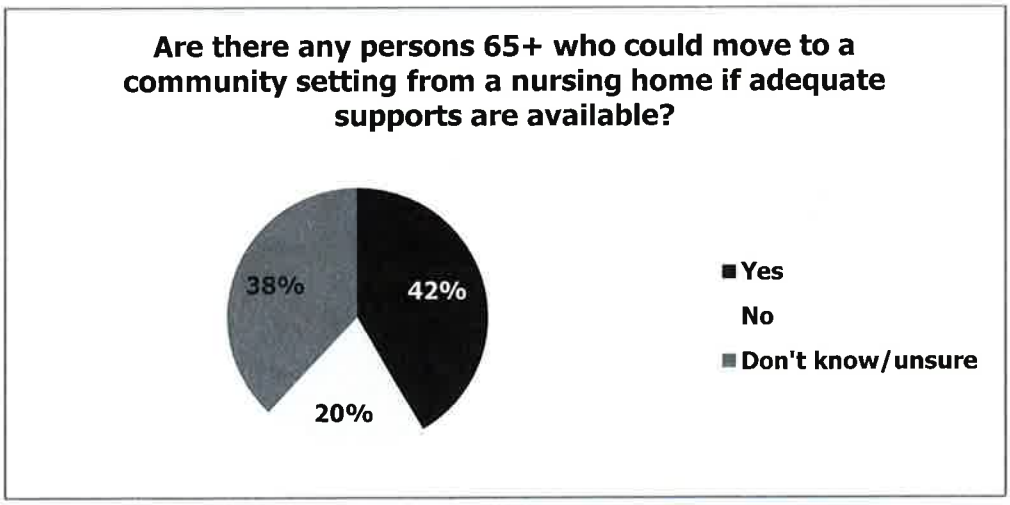
the state. In addition, many counties rely on the capacity of the local public transportation system and often reported limitations with the availability and accessibility of these systems. Older adults who are not eligible for public assistance face additional barriers to access affordable transportation. (See also Transportation, medical)

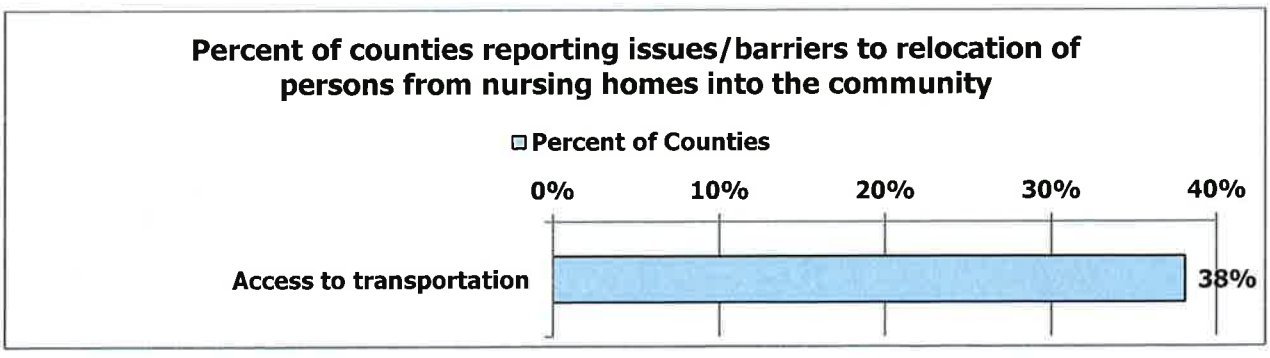
Transportation, medical: Counties face similar barriers to the availability of medical transportation as reported for non-medical transportation (see above). In general, counties report more resources are available for medical transportation. Many counties reported prioritizing the use of volunteer drivers for medical transportation.

4. Issues/Barriers Ensuring Home and Community-Based Support Options, 2013-2014 (N=84)

	Percent of Counties
Transportation for non-medical needs	**68%**
Distance/isolation	**61%**

5. Are there any persons 65+ who could move to a community setting from a nursing home if adequate supports are available, and what are the barriers/issues to such reloaction?





B. Adult Mental Health Services

1. Changes in Service Capacity since January 2011, Transportation-related services.

There were no specific transportation-related services listed on this portion of the survey.

2. Current Service Capacity as of January 2013, Transportation-related services.

There were no specific transportation-related services listed on this portion of the survey.

3. Description of Limitations for Transportation-related Service Gaps

While there were no HCBS on the survey specifically concerning transportation, the subject was referenced within descriptions of why certain services were gaps.

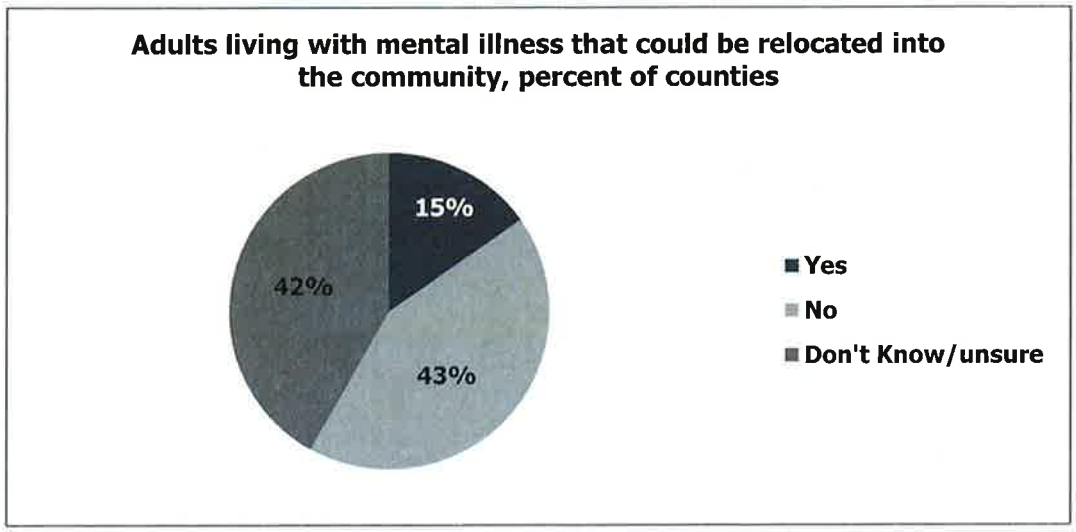
Respondents from rural and frontier counties often pointed to the practical issues intrinsic to their geography: low population density, high travel distances ("windshield time"), and professional workforce shortages. Here are some comments from Greater Minnesota:

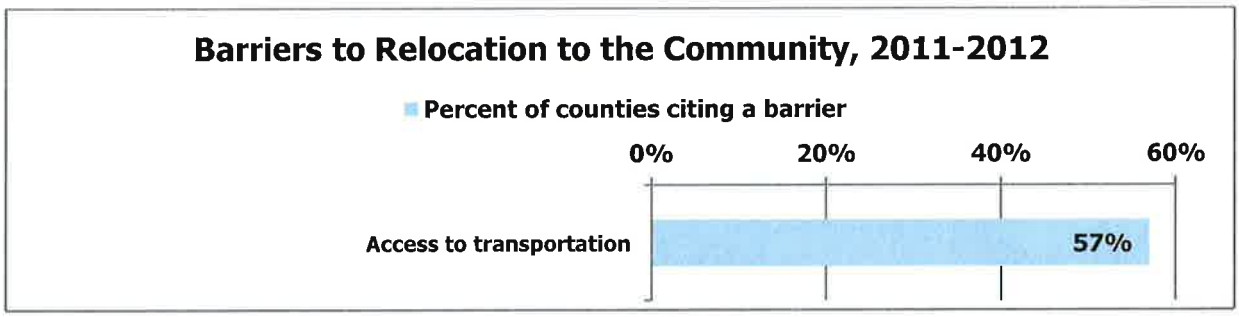
- "Individuals living in [G]reater Minnesota have to travel further for recovery oriented services options ... [and] Individuals in [our county] are very isolated from peer supports."
- "Transportation to programs is always an issue for us."
- "We have a lot of windshield time that is not covered."
- "[More] mental health professionals living and working in this area of the state would be most beneficial to ensure recovery-oriented service options."

4. Issues/Barriers Ensuring Home and Community-Based Support Options, 2013-2014.

There were no specific transportation-related services listed on this portion of the survey.

5. Are there any adults living with mental illness in your jurisdiction who could move to a community setting from a nursing home if they had adequate supports available, and what are the barriers/issues to such reloaction?


Adults living with mental illness that could be relocated into the community, percent of counties
15%
42%
43%
Yes
No
Don't Know/unsure


Barriers to Relocation to the Community, 2011-2012
Percent of counties citing a barrier
0%
20%
40%
60%
Access to transportation
57%

C. Children's Mental Health Services

1. Changes in Service Capacity since January 2011, Transportation-related services (N=84)

This question as not asked on the CMH survey.

2. Current Service Capacity as of January 2013, Transportation-related services (N=84)

There were no transportation-specific items within this survey. The only transportation-related service to appear in this section of the survey is below.

Inpatient Hospitalization Psychiatric Care				
	Exceeds demand	Meets demand	Available but limited	Not available
Children's Mobile Mental Health Crisis Response	3%	32%	27%	38%

3. Description of Limitations for Transportation-related Service Gaps

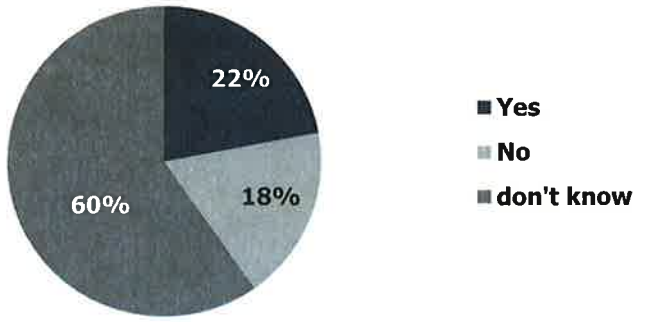
Despite the lack of transportation as a specific topic of the survey, it was cited as a barrier and/or issue for numerous services. Transportation to specific therapists is a barrier to accessing culturally appropriate services. Secondly, counties overwhelmingly responded that *lack of transportation to service providers* is a major obstacle (especially in rural counties). Some counties report that families must drive up to three hours each way to see a provider, necessitating them to take an entire day off from work for a single appointment. It is a barrier regardless of whether a child is covered under a Managed Care Organizations (MCO) and or the fee-for-service (FFS), particularly in areas where limited options exist with no public transportation necessitating reliance on family or volunteer drivers.

4. Issues/Barriers Ensuring Home and Community-Based Support Options, 2013-2014 (N=84)

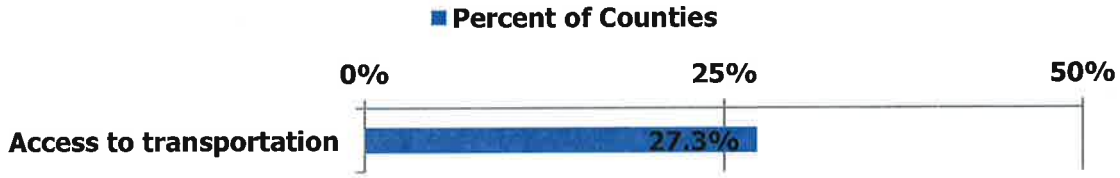
See number 3 above.

5. Are there any persons receiving residential treatment services who could move to a community setting from a nursing home if adequate supports are available, and what are the barriers/issues to such reloaction?

Figure 5. Individuals receiving residential treatment services who could move to community setting with adequate supports



Top Ten Barriers to relocating Individuals Within Residential Facilities to the Community



D. Disability Services

1. Changes in Service Capacity since January 2011, Transportation-related services (N=78)

	Added/ New	Expanded/ Improved	No Change	Decreased/ Eliminated
Transportation	1%	10%	79%	10%

2. Current Service Capacity as of January 2013, Transportation-related services (N=78)

Unlike the other three surveys, the Disability Services edition asked counties to report the age groups and waiver status of the populations impacted by the service availability (or lack thereof).

	Exceeds Demand	Meets Demand	Available but Limited	Not Available
Transportation	0%	33%	65%	1%

	Age 65 and Older	Under Age 65, on a Waiver	Under Age 65, NOT on a Waiver
Transportation	53%	67%	67%

3. Description of Limitations for Transportation-related Service Gaps

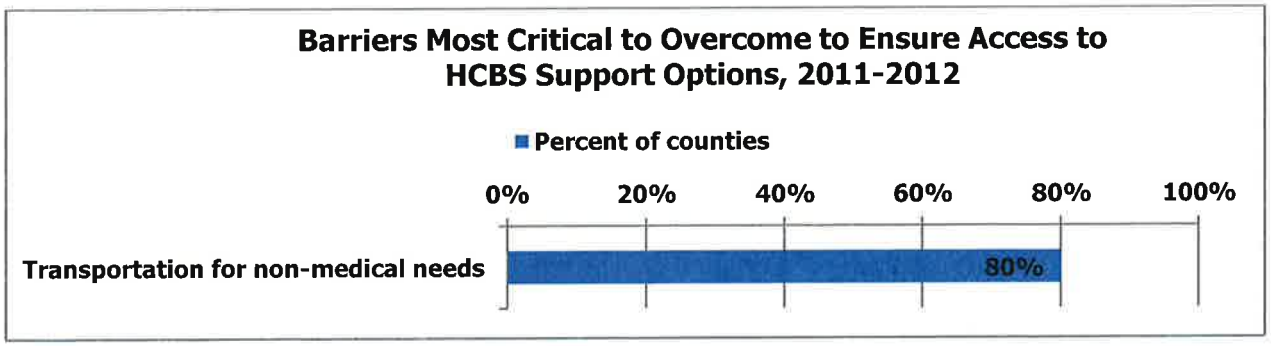
Of all services, transportation was reported as a gap by the highest percentage of counties at 66%. Comments specific to this service include:

- Lack of accessible transportation.
- Funding limitations impede number of individuals that can access service.
- Public mass transit on very limited routes, public individual transit is too limited and/or too expensive.
- Limited providers in rural areas, many rely on program-based transportation to get to work.
- Transportation systems are costly and funding to develop these systems is scarce.

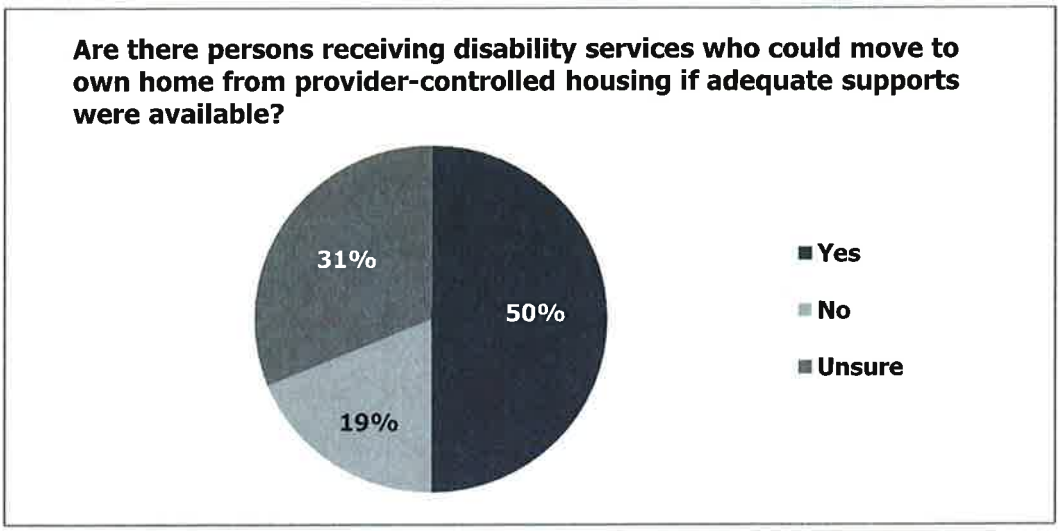
- One county reported that most of their transportation is provided by volunteer organizations which rely on older adults who may be less able to transport individuals with disabilities or behavioral health challenges.
- Scope, frequency, and on-demand transportation is limited.
- One county pointed out that health plans always require 24-hour notice and therefore emergencies are uncovered.
- Especially listed as a concern in rural and semi-rural counties.
- Transportation service is not always available to travel outside of a city or county, and hours are during traditional business hours only.
- Multiple counties mentioned "no load" miles as an issue that makes it difficult for counties that have long distances to travel to many services.
- Non-medical transportation is extremely limited.
- Transportation for participants at hospital discharge is challenging when a hospital is over sixty miles from their home.
- Division of Rehabilitation Services does not recognize the use of public transit as a viable option for work purposes and will not fund a consumer for work services to work if the client is dependent upon public transit.
- One county mentioned liability as a concern.
- Transportation can be difficult to coordinate between providers when attempting to promote resource sharing.

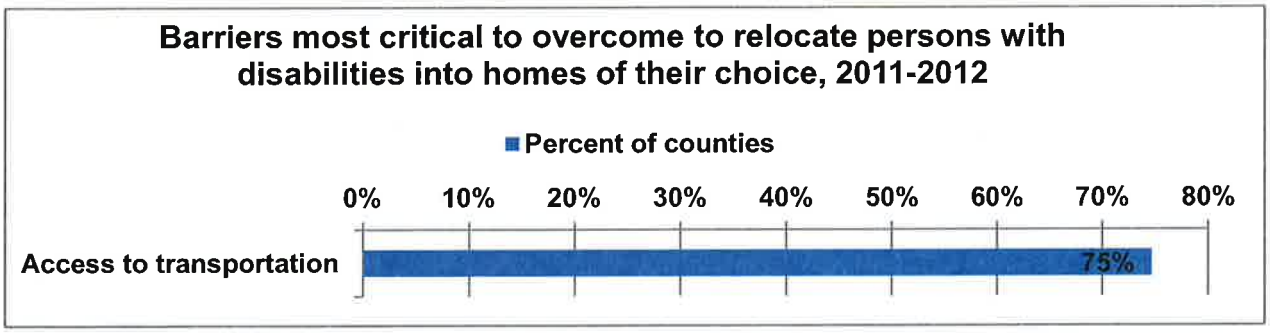
As for decreases in services since 2011, the most reported were, escending order: crisis respite, foster care, transportation (9% of counties reporting a decrease), respite, and adult companion services.

4. Issues/Barriers Ensuring Home and Community-Based Support Options, 2013-2014 (N=78)



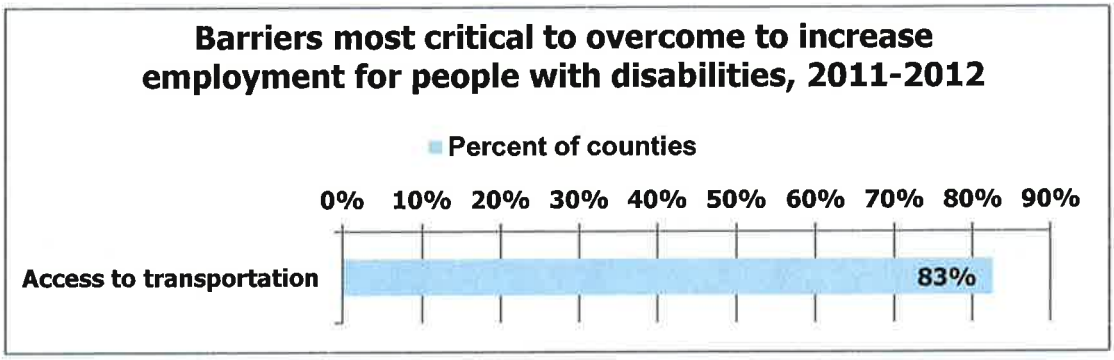
5. Are there any persons with disabilities who could move to a community setting from a nursing home if adequate supports are available, and what are the barriers/issues to such reloaction? (N=78)





6. Barriers most critical to overcome to increase employment for people with disabilities, 2011-2012 (N=78)

This question is specific to this particular survey.



Attachment B: Summary of Minnesota State Council on Disabilities Transportation Forums (2008-2012)

Minnesota State Council on Disabilities Transportation Forums – 2008-2010

Background

From 2007 – 2010 a series of public forums on the topic of transportation for people with disabilities occurred around Minnesota. These Transportation Dialogues were convened by the Minnesota State Council on Disability with support of Pathways to Employment (a collaboration of the Minnesota Department of Human Services, the Minnesota Department of Employment and Economic Development, and the Minnesota Department of Education and the Minnesota State Council on Disability), and local Centers for Independent Living.

The first event, in November, 2007, was held in St. Paul and attended by 84 key stakeholders. Attendees present represented state agencies, transportation providers, non-profit organizations, employers and consumers of transportation. The common goal was to discuss methods to improve transportation and eliminate the barriers that exist for people with disabilities as they attempt to utilize transportation when seeking employment opportunities.

The success of this event, coupled with the need to reach out to Greater Minnesota, prompted the Minnesota State Council on Disability to offer two more dialogues the following year (2008) in Crookston and Fergus Falls. Four more dialogues occurred in November 2009 in Marshall, Mankato, Brainerd, and Hibbing. To ensure the entire state was covered; a final transportation and employment dialogue took place in Rochester in June 2010.

The purpose of each dialogue was to hear from experts, both locally and nationally, regarding transportation issues, learn about road blocks to transportation and employment and create solutions and partnerships in the local communities.

This document summarizes the common themes that emerged from those events.

Transportation-related barriers to employment

Most common themes

1. Scheduling (includes frequency, days of the week, times throughout the day)
2. Funding
3. Lack of availability/routes

Additional recurring themes

1. Need more collaboration/communication
2. Affordability
3. Marketing/training/education/communication
4. Geographical disconnects/distances

Common issues for rural Minnesota

Most common themes

1. Scheduling (includes frequency, days of the week, times throughout the day)
2. Availability/routes
3. Geographic connections
4. Distances to travel, the time that requires and the subsequent impact on cost

Additional recurring themes

1. Marketing and training; people don't know the routes
2. Funding
3. Too few riders to be cost efficient
4. Affordability

Recommended policy changes

Most common themes

1. More funding
2. More collaboration at all levels, including between funding sources

Attachment C: Planning for Enhanced Transportation Access and Efficiency: Synthesis of 2011 Greater Minnesota Local Human Services Transit Coordination Plans

Minnesota Council on Transportation Access

Planning for Enhanced Transportation Access and Efficiency

Synthesis of 2011 Greater Minnesota Local Human Services Transit Coordination Plans

Prepared for:
Minnesota Council on Transportation Access

April 2012

Prepared by:
Center for Transportation Studies
University of Minnesota

Table of Contents

Executive Summary

The goal of transit coordination is to enhance transportation access and efficiency. Human services public transit coordination specifically aims to improve transportation access for people with disabilities, older adults, and individuals with low incomes. Coordination also encourages communities to make the most effective use of transportation resources funded through public and private sources. Local human services transit coordination plans are intended to improve a region's collective ability to provide transportation services to customers by bringing together diverse stakeholders to identify strategies to overcome local barriers to coordination.

To develop local coordination plans in Greater Minnesota, the Minnesota Department of Transportation (MnDOT) Office of Transit partnered with local planning organizations in Greater Minnesota's twelve economic development regions in 2011. These plans engaged diverse stakeholders in identifying strategies for regional transportation coordination and articulating specific projects that could advance coordination strategies in each region.

This synthesis highlights the themes found in the 2011 coordination plans, which include the need to improve the coordination of services and resources, increase public awareness, implement mobility management strategies, expand services, reduce expenses, and overcome regulatory barriers.

Strategies commonly identified to meet these needs in the future include convening regional coordination bodies, conducting educational campaigns, hiring mobility managers, expanding volunteer driver programs, and partnering for the joint purchase of vehicles. Regions would also like to encourage state and federal agencies to simplify procedures and allow more flexibility in the use of transportation dollars.

This synthesis also outlines the accomplishments and implementation challenges that have occurred throughout Greater Minnesota since the completion of the 2006 coordination plans. Accomplishments include raising awareness of transit coordination, expanding services and programs, coordinating services, and completing marketing initiatives. Common challenges included a lack of funding, leadership, local partnerships, and policymaker support. Policies and regulations were another barrier to coordination efforts.

Overall, the development of the local human services transit coordination plans in Greater Minnesota has identified coordination strategies that could be successfully implemented in many regions in the future. Continued support for these plans will advance coordination strategies throughout the state.

Full versions of the twelve local coordination plans completed in 2011 are available online at CoordinateMNTransit.org.

Background

The goal of transit coordination is to enhance transportation access and efficiency. Human services public transit coordination specifically aims to improve transportation access for people with disabilities, older adults, and individuals with low incomes. Coordination also encourages communities to make the most effective use of transportation resources funded through public and private sources. Strategies include minimizing duplicated services and facilitating the most appropriate and cost-effective transportation possible for each individual.

The key to successfully coordinating transportation is encouraging stakeholders from a broad range of organizations to work together. This involves agreeing on transit coordination challenges, identifying and implementing strategies to overcome barriers, and increasing the awareness of transit providers and users.

Local human services transit coordination plans are intended to improve a region's collective ability to provide transportation services to its customers. These plans are a federal requirement under the Safe Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU). A project must advance strategies identified in a locally developed coordination plan in order to be eligible for transit and human services federal funding programs that target people with disabilities, older adults, and people with low incomes. These funding programs include Transportation for Elderly Persons and Persons with Disabilities (Section 5310), Job Access and Reverse Commute (Section 5316), and New Freedom Initiative (Section 5317). Full descriptions of these federal funding programs are available in Appendix A.

To develop local coordination plans in Minnesota, the Minnesota Department of Transportation (MnDOT) Office of Transit partnered with local planning organizations in Greater Minnesota's twelve economic development regions in 2011. In areas without a local planning organization, MnDOT district staff assumed this role. The process did not include the Minneapolis/St. Paul metropolitan area or East Grand Forks, where plans were completed independently by local metropolitan planning organizations.

As part of the 2011 planning process, regional planning organizations convened stakeholders to define future coordination priorities and strategies. The planning process also assessed results of coordination plans previously completed in each region in 2006, including what strategies had been successfully implemented and those that had not moved forward. A full description and analysis of the 2011 planning process is available in Appendix B.

Full versions of the 2011 local coordination plans are available online at CoordinateMNTransit.org.

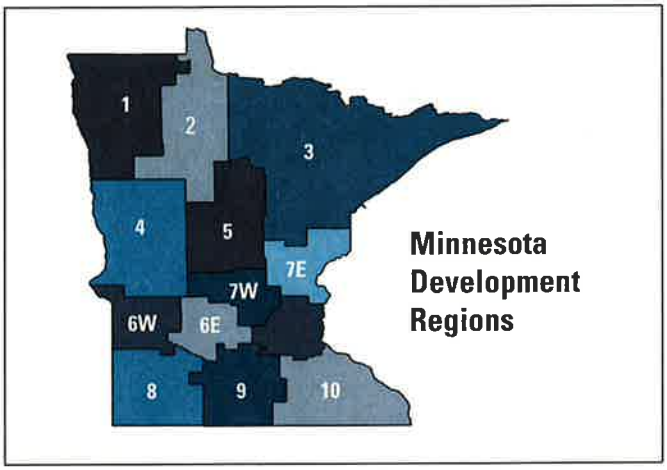


Figure 1 Minnesota's twelve Economic Development Regions (excluding the Minneapolis/St. Paul metropolitan area)

Regional planning organizations that participated in the planning process were:

- Region 1.....Northwest Regional Development Commission (RDC)
- Region 2.....Headwaters RDC
- Region 3.....Arrowhead RDC
- Region 4.....West Central Initiative
- Region 5.....Region Five Development Commission
- Region 6E.....Mid-Minnesota RDC
- Region 6W....Upper Minnesota Valley RDC
- Region 7E.....East Central RDC
- Region 7W....MnDOT District 3 and St. Cloud Area Planning Organization (APO)
- Region 8.....Southwest RDC
- Region 9.....Region Nine Development Commission
- Region 10.....MnDOT District 6 and the Southeast Minnesota Area Transportation Partnership

Each region engaged public, private, and human services transportation providers; social services agencies; and members of the public in the planning process. These regional stakeholders brainstormed coordination project ideas and refined them in a collaborative setting.

The final project lists in the 2011 plans reflect the input of these diverse groups and provide a five-year blueprint for future coordination efforts.

This synthesis highlights the strategies outlined in Minnesota's 2011 coordination plans and reviews the accomplishments and implementation challenges of the 2006 plans. Full versions of the twelve local coordination plans completed in 2011 are available online at CoordinateMNTransit.org.

Future Strategies: Themes of 2011 Plans

Strategies and projects identified by stakeholders in the 2011 plans can be grouped according to the following themes: improving the coordination of services and resources, increasing awareness, implementing mobility management strategies, expanding services, reducing expenses and increasing efficiency, and overcoming regulatory barriers.

Plan strategies and projects were developed individually in each region through a uniform planning process that convened face-to-face stakeholder meetings and engaged diverse sets of transportation providers, human services providers, and public officials. As part of the process, stakeholders examined a common set of strategies and ranked those that would be most helpful for their region. They then identified specific projects that could help move their chosen strategies forward.

Improving Coordination of Services and Resources

Many 2011 plans identified strategies and projects aimed at improving the coordination of specific services and resources among transportation providers. Coordinating these individual services and resources could help establish a foundation for more centralized regional coordination throughout Greater Minnesota. In addition, it could foster communication and cooperation between providers that have not networked with each other since the 2006 plans were finalized. Implementing these strategies and projects could also make it easier for both providers and customers to recognize what services are available and how to use them most efficiently.

Preferred strategies identified by multiple regions include:

- Centralizing call taking, scheduling, rider services, and information and referrals among transportation providers
- Creating a regional provider database
- Expanding on existing steering committees by convening a regional coordination body with representatives from public, private, and human services agencies
- Creating a call center and/or website that could provide regional information and ride-planning services
- Sharing vehicles, facilities, support services, and other resources among providers

Table 1: Regions' preferred strategies for coordinating services

Region	Centralize call taking, scheduling, etc.	Create regional provider database	Expand on regional steering committees	Create a call center or website	Share vehicles, facilities, or other resources
Region 1	X	X	X	X	X
Region 2	X		X		
Region 3	X	X	X	X	X
Region 4	X		X	X	X
Region 5	X	X	X	X	X
Region 6E	X	X	X	X	
Region 6W	X	X	X		
Region 7E	X		X	X	X
Region 7W	X	X	X	X	X
Region 8	X	X	X		X
Region 9	X	X	X	X	X
Region 10	X	X	X	X	X

Some regions also presented unique project ideas that could be applied in multiple regions. Region 3 (Arrowhead RDC) proposed the creation of a rural transit hub where smaller transportation agencies could bring passengers to a central location for pick-up by larger transit providers.

Region 8 (Southwest RDC) expressed the need for affordable technology and software that could help schedule and organize client rides. This technology could also facilitate communication among providers in the region and make it easier to share resources and information.

Increasing Awareness

Another common theme of the 2011 plans is the need to increase the awareness of riders, social service providers, and transportation providers. Nearly all plans mentioned that more education is needed throughout the state to help riders and providers understand the range of available transportation options and how to access them. Locally preferred strategies to improve awareness focused mainly on education, marketing, and training initiatives.

Coordinating services and resources could help providers and customers better understand what services are available and how to use them most efficiently.

Strategies identified by multiple regions include:

- Offering travel training to potential riders
- Educating regional officials and human services professionals about transportation resources and needs
- Conducting marketing campaigns and community outreach to the general public to increase knowledge and change perceptions about available transportation services
- Developing or improving training programs for drivers and volunteers to help them better assist and educate riders

Table 2: Regions' preferred strategies for improving awareness

Region	Offer travel training	Educate officials or other providers	Conduct marketing or educational campaigns	Develop a driver training program
Region 1	X	X	X	X
Region 2	X		X	
Region 3	X	X	X	X
Region 4	X	X	X	X
Region 5	X	X	X	X
Region 6E	X	X	X	
Region 6W	X	X	X	X
Region 7E		X	X	X
Region 7W	X			X
Region 8	X	X	X	X
Region 9		X	X	X
Region 10		X	X	

One example of a project idea to improve awareness comes from the Region 9 plan. The plan outlines a project involving the establishment of education roundtables to help transportation agencies, human services agencies, advocates, and community members determine how to educate the public about available options. The region's plan also proposed an open house that would convene transportation providers, existing customers, and potential customers.

The Region 6W (Upper Minnesota Valley RDC) plan suggests a campaign to market transportation services at schools, community organizations, daycares, and human services agencies. This could help parents become more aware of available transportation options for children.

Nearly all regions identified strategies to educate the public, local officials, or human services agencies to increase awareness.

Implementing Mobility Management Strategies

To meet the transportation coordination goals of enhancing access and efficiency, all regions proposed implementing new mobility management strategies or enhancing existing strategies in the 2011 plans. Both case management and systemwide mobility management strategies were recommended by a number of regions.

Implementing mobility management could help improve overall coordination and education efforts in each region. Case management strategies, such as hiring a mobility manager, could specifically assist agencies in consolidating business functions and securing new funding. For example, a mobility manager could work on creatively piecing together funding from a variety of sources—a strategy that many entities currently struggle with because they lack dedicated staff time.

All regions cited the need to implement mobility management strategies, either on a case management or systemwide level.

Eight regions suggested implementing mobility management on a case management level by hiring a mobility manager to oversee the education of riders about available services. Six regions proposed a systemwide approach to facilitate coordination among transportation and human services providers and ensure the availability of a range of transportation options. At least two regions cited needs for both types of mobility management.

Table 3: Regions' mobility management needs

Region	Case management mobility management	Systemwide mobility management
Region 1	X	
Region 2		X
Region 3	X	
Region 4	X	
Region 5	X	X
Region 6E		X
Region 6W	X	
Region 7E	X	
Region 7W	X	X
Region 8		X
Region 9	X	
Region 10		X

Expanding Services

The need to expand available transportation services to riders was another common theme of the 2011 plans. The most important outcome of expanding these services is improved transportation access for riders. Limited service hours in the early morning, evening, and on weekends throughout much of the state can make it difficult for many riders to access the transportation they need. In some rural areas, transportation services may be limited to certain days or times of day, making it difficult for riders to access convenient options.

Specific services that regions proposed expanding in the future include:

- Morning, evening, and/or weekend service
- Door-through-door service
- Service to smaller communities and rural areas
- Service that crosses county (or state) lines

The most important outcome of expanding services is improved transportation access for riders.

- Aides and escorts for specialized and new clients

Strategies to help meet expanded service goals include:

- Establishing or expanding volunteer driver programs
- Implementing subsidized taxi-based solutions
- Connecting regional population/trade centers with transportation routes
- Coordinating worksite or educational rides, or coordinating schedules with common shift start and end times

Table 4: Regions' preferred strategies for expanding services

Region	Expand volunteer driver programs	Implement taxi-based solutions	Connect regional population centers	Coordinate worksite rides or schedules with start/end times
Region 1	X	X		X
Region 2	X			
Region 3	X	X	X	
Region 4	X	X	X	X
Region 5	X		X	X
Region 6E	X			X
Region 6W	X	X		X
Region 7E	X	X		
Region 7W	X		X	X
Region 8	X			X
Region 9	X	X	X	X
Region 10	X	X		

Region 2 (Headwaters RDC) identified a project that would expand service to a specific population. The region's plan suggests working with public transportation, human services agencies, and volunteer drivers to create a 24-hour, 7-day-a-week service for individuals with a mental illness who have a medical emergency after service hours. This would involve a collaboration of public transit agencies, disability advocates, volunteer drivers, and human services agencies.

Reducing Expenses and Increasing Efficiency

Many regions identified the need to reduce expenses and increase efficiency in their 2011 plans. Funding is a common issue for human service transportation, and implementing cost-saving coordination strategies can help providers make the most of limited budgets while maintaining service to riders.

Cost-saving coordination strategies can help providers make the most of limited budgets while maintaining service.

Strategies include:

- Joint purchasing of vehicles to create savings and foster cross-agency consistency
- Coordinating the purchase of insurance, driver training, and substance abuse testing
- Contracting with a common carrier, such as a public transit agency, to allow clients of multiple agencies to ride on the same carrier's vehicles
- Outsourcing or consolidating business functions, such as accounting, billing, or dispatching

Table 5: Regions' preferred strategies for reducing expenses

Region	Joint purchasing of vehicles	Coordinate the purchasing of insurance, etc.	Contract with a common carrier	Outsource or consolidate business functions
Region 1	X	X	X	X
Region 2			X	X
Region 3	X	X	X	X
Region 4	X		X	X
Region 5	X			
Region 6E	X	X		
Region 6W			X	X
Region 7E	X	X		
Region 7W		X	X	X
Region 8	X		X	X
Region 9	X	X	X	X
Region 10	X		X	X

Region 1 (Northwest RDC) also proposed sharing mechanics between providers, a project idea that could be implemented in multiple regions. The Region 9 plan recommended the use of smaller vehicles for times of minimal demand.

Overcoming Regulatory Barriers

The need to overcome regulatory barriers—a commonly cited challenge facing regional coordination efforts—was another theme of the 2011 plans. Regulatory barriers often hinder coordination efforts by making it difficult for various agencies to pool resources or share clients.

Regulatory barriers from funding agencies can limit who is eligible to receive rides or constrain ridesharing due to data privacy regulations. The need for prior authorization makes it difficult to coordinate last-minute rides, and differences between various medical plans and their coverage limitations can make it difficult to schedule trips far enough in advance to coordinate rides. Billing and payments between agencies can be another challenge. Most agencies lack the staff time and resources to dedicate to solving these problems.

Regulatory barriers may include eligibility or medical plan requirements.

To overcome these obstacles, the Region 4 (West Central Initiative) plan suggested encouraging state and federal agencies to simplify procedures and allow more flexibility in the use of transportation dollars. Region 8 (Southwest RDC) proposed the use of a website to work with insurance companies to set up policies that make ridesharing easier.

Recent Progress: Themes of 2006 Plans

In 2011, plan steering committees from most regions examined the actions outlined in their previously completed 2006 coordination plans. They assessed previously proposed coordination strategies and determined whether "action," "some action," or "no action" had been taken on each initiative. Nearly all regions had taken at least some action on more than half of their 2006 initiatives. This discussion allowed stakeholders to examine what strategies had succeeded, identify strategies to continue pursuing in the future, and discuss the barriers to coordination each region had encountered.

Some themes of the 2006 plans were similar to those of the 2011 plans, such as coordinating resources, expanding services, and adopting mobility management techniques. Other 2006 plan strategies included pursuing additional funding for new vehicles or programs and making better use of volunteer drivers.

Table 6: Results from 2006 Local Coordination Plan strategic initiatives

Region	Total Number of Initiatives	Action	Some Action	No Action
Region 1	16	8	4	4
Region 2	10	6	3	1
Region 3	35	11	20	4
Region 4	15	5	8	2
Region 5	13	1	5	7
Region 6E	38	18	20	0
Region 6W	71	6	60	5
Region 7E	4	1	3	0
Region 7W	15	1	9	5
Region 8	112	23	48	41
Region 9 RDC	27	3	14	10
Region 10	9	2	5	2

Accomplishments

The 2006 plans raised awareness of transit coordination as a topic in Greater Minnesota. They also prompted many agencies to give more attention to coordination issues. After the creation of the plans, Greater Minnesota's twelve regions had a better understanding of their local coordination needs and service gaps. The planning process also helped stakeholders from a wide range of organizations form positive working relationships, often for the first time. This foundation was perhaps the most important success of the plans and helped state and local agencies work together more successfully in the 2011 planning process.

Individual accomplishments facilitated by the plans included the addition of new services and programs, the expansion of existing services, the coordination of services across agencies, and the completion of marketing efforts.

Expanded services and programs

Many regions experienced the most success with strategies aimed at expanding services to passengers and establishing new programs. Many public transit and nonprofit providers throughout Greater Minnesota added extra service hours, provided transportation on new days of the week, or offered services to new towns, cities, or counties that had previously been underserved.

Other examples of expanded services include:

- Purchasing additional transit vehicles to provide additional or specialized service (such as vehicles with wheelchair lifts for passengers with disabilities)
- Offering specific work-route and medical appointment transportation services
- Providing workshops and other trainings on how to use public transit
- Expanding volunteer driver programs to increase ride availability

Region 3 and Region 6E provide specific examples of how 2006 project ideas were implemented successfully. Both regions took action on projects to establish new programs. Region 3 (Arrowhead RDC) established its Rural Rides program, which funds staff at workforce centers in four counties. These staff members help low-income residents connect with volunteer drivers or co-workers who can take them to work. In Region 6E (Mid-Minnesota RDC), the creation of the SMART RIDE program—which includes bus, minivan, and volunteer driver service—has made service available 24 hours a day, seven days a week as long as there is a driver willing and able to volunteer.

Successfully coordinated services

Several regions also implemented efforts to coordinate services across agencies. Examples of coordinated services include:

- In Region 1 (Northwest RDC), two providers worked together to coordinate ride pick-up and drop-off locations
- In Region 2 (Headwaters RDC), providers created a web-based directory including locations, days, and hours of operation to facilitate information exchange and coordination
- Region 6E also encouraged coordination between school districts and public transit for students to attend after school events or activities
- Region 7W (MnDOT District 3/St. Cloud APO) facilitated increased communication between various volunteer driver programs to improve coordination
- Region 8 (Southwest RDC) identified opportunities for public transit agencies to coordinate services across county boundaries
- In Region 9, nonprofit agencies worked together to coordinate inter-county and long-distance rides to the Twin Cities or Rochester for medical appointments

In spite of these coordination successes, many regions acknowledge that there is more work to be done in this area in the future.

Agencies successfully coordinated rides to medical appointments and across county boundaries.

Completed marketing efforts

In many regions, marketing campaigns were conducted to educate riders about available services and increase overall ridership.

Specific initiatives included:

- Implementing marketing plans at the agency level
- Updating and distributing a brochure of transit providers
- Promoting transit services as user-friendly and cost effective
- Providing vouchers and gift certificates
- Identifying the misconceptions of potential riders

and developing strategies to address them
- Working to improve sources of information available through non-provider websites, databases, and phone directories
- Promoting the availability of passenger assistants or escorts for first-time or infrequent users
- Using social media to promote available services

Many regions successfully implemented marketing strategies that led to increased ridership, but they also reported a need to expand these educational efforts in the future. Several regions noted that marketing efforts were only completed on an individual agency level. In the future, many regions plan to conduct a more strategic, coordinated campaign including multiple providers. Many regions also found that a travel trainer or other specialized rider training would be helpful as part of future efforts to educate new users about available services. There is also a continued need for the education of local officials and human services agencies.

Marketing efforts included distributing a brochure, providing vouchers, and using social media.

Challenges

Although many strategies from the 2006 plans were implemented successfully, others encountered challenges. Some regions struggled to complete any action on some of their 2006 plan strategies, and other strategies were implemented but achieved limited results. Overall, the regions reported that challenges were not project-dependent, but the result of larger, more systemic issues that made it difficult to implement a wide range of strategies. Successful implementation typically hinged on the presence of a project champion, a stable source of funding, and strong regional support. This meant that strategies implemented successfully in several regions—such as mobility management—did not move forward in other regions where they had less support.

Examples of specific projects that had little or no action taken include:
- Holding regular meetings of a regional coordination body
- Creating an inventory or web-based provider directory
- Centralizing regional facilities or dispatch
- Sharing volunteers across agencies
- Standardizing volunteer driver training across agencies
- Developing a tool for user evaluation of services
- Increasing the use of technology, such as GPS, to improve tracking and management of vehicles

The most commonly cited barriers to successful implementation were a lack a funding, a lack of regional leadership or project champions, inflexible policies and regulations, and insufficient local partnerships. Many regions also struggled to educate and influence policymakers, in spite of increased efforts to communicate with local and state officials.

Funding

Many regions said that projects from the 2006 plans were not implemented because they lacked funding. Although federal funds through the Job Access and Reverse Commute and New Freedom programs are available to get projects started, other funding sources are needed to help programs remain stable and successful over the long term. Some projects rely on these specific federal funds repeatedly because there are so few other options. The lack of stable funding sources can also make it hard for local agencies to take over projects and coordination activities.

Funding is also often directed only toward specific initiatives, leaving a gap for ongoing or alternative activities. Some regions' plans state that more technical assistance to access funding streams and coordinate funding options—as well as more education about funding regulations—would be helpful.

Leadership

The lack of regional leadership or a project champion was also a barrier for regions when attempting to implement strategies from the 2006 plans. Regional leadership is needed to conduct large-scale efforts, develop regional standards and policies, search for available funds, and move implementation efforts forward. Based on the results of the 2006 plan strategies, stakeholders in several regions suggested that creating a regional coordinator position or holding regular meetings of a regional coordination body would help address this issue.

In multiple regions, ideas were not implemented because they lacked a project champion, and in some cases there was a lack of understanding regarding leadership roles. When reviewing the 2006 plans, stakeholders demonstrated varying understanding of the roles of state agencies and expectations of hands-on leadership

at the local level. Local stakeholders did not have a good understanding of what could or should have been done at the grassroots level, and agencies often did not take the initiative to get projects going independently.

Policies and regulations

Nearly all regions cited a need to overcome a variety of policy and regulatory barriers in order to more easily implement coordination strategies. Examples of specific policy and regulation challenges include:

- Inflexible state and federal funding policies
- Insurance policy challenges
- Inconsistent medical plan requirements
- Liability issues when sharing vehicles across agencies or using them for multiple purposes
- Prior authorization requirements from medical plans, which require prior approval from a health insurance provider before a passenger can receive transportation services
- Local restrictions against crossing county boundaries and federal regulations involved in crossing state lines
- Regulations that require extensive driver certification, drug and alcohol testing, and training

Inflexible funding policies, medical plan requirements, and liability issues can be regulatory barriers to coordination.

To overcome these challenges, some regions' plans suggest projects that would encourage insurance providers to revise policies so they facilitate rather than hinder coordination opportunities. At least one region's plan also proposed that state and federal agencies simplify regulations and procedures to allow greater flexibility in the use of transportation dollars.

Local partnerships

Another common obstacle for several regions was the lack of partnerships and networking among transit agencies and human services agencies. Human services agencies were not accustomed to transferring the management of their clients' transportation needs to transportation organizations. Human services representatives have also had limited or no participation in coordination efforts in some regions, making it difficult to form the partnerships needed to successfully coordinate rides and services. When reviewing the 2006 plan strategies, stakeholders in several regions identified a continued need for networking between different agencies to foster new ideas for working together, riding together, lining up billing and client services, and more.

Most regions reported that their efforts to educate legislators and local officials achieved limited results.

Policymaker support

Most regions increased their efforts to educate and communicate with legislators and officials at the state, county, and city level about barriers to coordination, but most achieved limited results. Regions held legislative forums focused on the need for funding, testified about the positive impacts of investing in rural transit, and attended state-level workshops to discuss coordination and funding. However, most regions reported that their efforts had made a minimal difference. Moving forward, several regions suggested the need for a regional committee or policy group that could help influence local and state legislators and spark discussions about coordination issues.

Conclusion

Findings from the 2011 plans highlight the many common coordination needs throughout Greater Minnesota's twelve regions and outline regional priorities for future action. All regions cited the need to improve the coordination of services and resources, increase awareness, implement mobility management strategies, expand services, reduce expenses, and overcome regulatory barriers in order to improve overall transportation access and efficiency.

To meet these needs, each region identified strategies and projects that could be starting points for future action and improvement. Many of the strategies were common to most or all of the participating regions. Some of the most frequently identified strategies include centralizing call taking and scheduling, convening a regional coordination body with representatives from a variety of stakeholder groups, educating regional officials about transportation resources and needs, conducting marketing campaigns and community outreach to increase the knowledge of the general public, and establishing or expanding volunteer driver programs to improve service and availability.

The development of the local human services transit coordination plans in Greater Minnesota has been valuable in developing relationships between local human services agencies and transportation providers and in identifying and implementing transit coordination strategies. Continued support for these plans will advance coordination strategies throughout the state. With reduced transit funding, it is essential to be creative about ways to derive maximum value from every taxpayer dollar. By continuing to improve transportation coordination in Minnesota, it is possible to reduce duplication of services and strive to give all Minnesotans access to transportation that meets their mobility needs.

Full versions of the twelve local coordination plans completed in 2011 are available online at CoordinateMNTransit.org.

Appendix A: Explanation of Federal Transit Funding Sources

Government spending that targets transportation for older adults, people with disabilities, or people with low incomes is distributed through a variety of transit and human services funding programs. Three specific transportation programs that mandate coordinated planning as a prerequisite for funding are the Elderly Persons and Persons with Disabilities (Section 5310), Job Access and Reverse Commute (Section 5316), and New Freedom Initiative (Section 5317).

Elderly Persons and Persons with Disabilities (Section 5310)

The Elderly Persons and Persons with Disabilities program is designed to serve older adults and people with disabilities. It is a capital assistance grant program that provides 80 percent federal funding for the purchase of wheelchair-accessible vans and buses. Eligible organizations include private nonprofits that serve older adults and people with disabilities, public bodies that coordinate services for older adults and people with disabilities, or any public body that certifies to the state that nonprofits in the area are not readily available to carry out these services. In Minnesota, the MnDOT Office of Transit funds approximately 30 to 35 new vehicle purchases annually through this program.

Job Access and Reverse Commute Program (Section 5316)

The Job Access and Reverse Commute (JARC) program was established to address the unique transportation challenges of people with low incomes seeking to obtain and maintain employment. Many jobs are located in suburban areas, and individuals with low incomes often have difficulty accessing these jobs from their urban or rural neighborhoods. In addition, entry-level jobs may require working late at night or on weekends—times when conventional transit services are often either reduced or nonexistent.

JARC-funded projects focus on connecting low-income workers to job sites or employment training opportunities. Eligible organizations include state or local governments, nonprofit organizations, operators of public transportation services, private operators of public transportation services, and tribal governments. The local match requirement is 50 percent toward operating and 20 percent toward capital funds. Examples of Greater Minnesota projects funded through JARC include extending the hours of a fixed-route system to cover the needs of nightshift workers or adding a volunteer driver program specifically targeted to transporting employees to and from job sites.

New Freedom Initiative (Section 5317)

The goal of the New Freedom Initiative is to increase transportation access for older adults and people with disabilities. It is intended to provide funding for new transportation services and public transportation alternatives beyond the requirements of the Americans with Disabilities Act. These services and alternatives must help individuals with disabilities and older adults access transportation. The local match requirement is 50 percent toward operating and 20 percent toward capital funds. In Greater Minnesota, New Freedom funds have been awarded to create mobility management positions, volunteer driver service coordinator positions, and travel training programs that target older adults and individuals with disabilities.

Appendix B: 2011 Planning Process Analysis

The goal of the 2011 plans was to identify coordination strategies to improve transportation services that meet the needs of older adults, individuals with disabilities, and individuals with low incomes. The 2011 plans were developed individually in each region using a uniform statewide planning process designed to facilitate the identification of these strategies. As part of the process, a wide range of stakeholders met to discuss the outcomes of the 2006 plans, review the needs of their communities, and identify strategies for future action.

Plan Process

The 2011 planning process combined a needs assessment with public outreach tools to identify strategies for improved human services transit coordination in every region.

Needs assessment

The needs assessment established baseline conditions for each region by analyzing demographic trends and identifying available resources for human services transportation. Key elements of the needs assessment included:

- Identifying and analyzing regional demographic and transportation trends
- Mapping transit-dependent demographic groups, existing transit services, and key regional destinations
- Developing an inventory of public, private, and nonprofit transportation provider capabilities and resources

Public outreach

Public outreach informed the strategies and projects identified in each plan. Outreach occurred through regional steering committee meetings and regional public workshops held in the spring/summer of 2011.

The plans' steering committees closely guided decision making in each region. Steering committee duties included evaluating strategies and assessing outcomes of projects identified in the 2006 coordination plans, developing project ideas and identifying priority strategies as part of the public workshop, and prioritizing project ideas identified at the public workshop for inclusion in the final plans.

Strengths

One of the biggest accomplishments of the process was achieving uniformity and consistency in coordination plans across all regions in Greater Minnesota—a great improvement from 2006. Leadership by MnDOT and state agency partners encouraged all twelve regions to use a similar process and template. This made the plans more readable and comparable across regions, helping to highlight regional coordination differences and similarities.

The process also encouraged representatives of diverse groups to join together in identifying specific projects that could advance coordination strategies throughout the state. Participating organizations included veterans' organizations, tribal representatives, and area agencies on aging. The final project lists reflect input of a broad range of regional stakeholders and provide a five-year blueprint for future coordination efforts.

The process helped establish relationships and ideas that can be continued or expanded on by each region in the future. Overall, stakeholders liked the process and expressed a desire to continue regional steering committee meetings to address coordination challenges.

Weaknesses/Challenges

Participants experienced a variety of challenges throughout the planning process.

One weakness was that certain stakeholder groups were not included in the planning process. For instance, public officials have traditionally been the agents of change within their communities, but these officials have not yet been heavily involved in the planning process. It is important to include this group in future planning because they could assist with implementation efforts.

Another issue is the level of participation that can be expected from county case managers and human services managers. Transportation is not a primary component of their jobs, so it was often difficult for them to dedicate substantial time to the coordination planning process. However, meetings attended by county human services managers were reported to be more productive. It was similarly difficult to get stakeholders from other related organizations (e.g., health plans, hospitals, and clinics) to an all- or half-day transportation meeting, especially if they had little prior education on the importance of transportation coordination.

Throughout the process, participants were often unclear about the differences between a coordination plans and an implementation plans. The coordination plans were designed to identify needs and strategies rather than specifically outline the steps for implementing

projects. Stakeholders often struggled with their desire to create implementation plans, which should lay out how to accomplish elements of the coordination plans.

An additional weakness of the process was that it did not capture information about any informal transportation coordination occurring in the regions.

In terms of project development, participants struggled to develop strategies for identifying potential partners and funding sources. Since the completion of the initial coordination plans in 2006, there has been a decrease in the amount of available dedicated funding. This limited funding environment forces agencies to be more creative, which is often difficult because of limited staff time and knowledge.

Developing a complete provider inventory was also a challenging task for each RDC, mainly because it was difficult to get transit providers to participate. The information being requested by the RDC was often something these organizations already reported to MnDOT, and many providers questioned why they needed to provide it again.

This synthesis represents highlights and findings from the local coordination plans developed by local planning organizations in partnership with the Minnesota Department of Transportation Office of Transit in Greater Minnesota's twelve economic development regions. It does not necessarily represent the views or policies of the University of Minnesota or the Center for Transportation Studies.

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Attachment D: Innovative Transportation Services for Minnesotans with Disabilities

Transportation for Minnesotans with Disabilities: Innovative Services

There is no "one size fits all" transportation solution for Minnesotans with disabilities. Communities work together to develop services that fit their unique needs and resources. This document describes innovative services that have been developed by some communities.

There are some strategies that are commonly used by communities across the country. These include:

- Vehicle sharing
- Volunteer drivers
- Travel training
- Community steering committees
- Mobility managers
- Collaboration between counties
- Collaboration between agencies
- Integration with existing travel services
- Technology
- Challenging traditional beliefs
- Marketing (aka "getting the word out")

Examples of Innovative Services in Minnesota

Newtrax, Inc. Metropolitan area
Merrick, Inc., and Phoenix Alternatives, Inc. (PAI), are nonprofits in the same geographical area using vehicle sharing to provide services to people with disabilities. In 2011 they formed a jointly owned separate entity, Newtrax, Inc., that owns and operates their vehicles. Newtrax vehicles pick up consumers at their homes and bring them to program sites. The two organizations consolidated routes, transported the same number of consumers, with 15 fewer vehicles, and saved money.

DARTS, Dakota County
DARTS has provided transportation services for people with disabilities since 1979. Its 35 vehicles provide Dakota County with Metro Mobility and TransitLink Services. It is involved in several vehicle sharing activities. One of these is a bus, purchased with federal funds administered through the county for transportation for consumers with disabilities and older adults. The bus is shared with the City of Farmington, and other community partners. All of DARTS drivers receive professional training. DARTS recently hired a mobility manager to coordinate travel in the county.

http://www.darts1.org

FAR North Transit Senior Medical Travel Program, Roseau County
This program is part of FAR North Transit, using all volunteer drivers to provide medical transportation within 200 miles of county lines. Trips are offered as needed to medical facilities in the region. Trips to the Twin Cities Metro Area are provided if approved by a county social worker. The program was started as a result of the Committee on Aging assessment that found this kind of transportation was needed in this very rural part of the state.
http://www.farnorthtransit.com/medical-travel.html

Arrowhead Transit, Northeastern MN
Serving eight counties, this is now the largest public rural transportation system in the country, with nearly 70 routes in and around the region. It has four dispatchers in eight counties, who help consumers determine the best transit option. All 87 of its buses are accessible. Arrowhead Transit provides a rural rides program, bus service, taxi services, and volunteer drivers. It also contracts for transit services with a number of agencies in its region.
http://arrowheadtransit.com

Transportation Resource Center (TRC) Benton, Morrison, Sherburne and Stearns
TRC is a project of Tri-County Action Program, Inc., (Tri-CAP). Its target populations are seniors and people with disabilities in Central Minnesota needing rides to medical appointments. A mobility manager helps people find rides through existing services. If that doesn't work, the manager makes a referral. Generally, volunteer drivers are used, but, if necessary the Center will contract with a local for-profit company with professional drivers. The mobility manager tracks the overall transportation network, to eliminate duplicate or overlapping trips by different organizations, allowing each organization to make the most efficient use of its resources. A New Freedom grant provides funding for agencies giving rides for medical appointments for older adults and people with disabilities. These agencies submit monthly statements to the TRC and are reimbursed for a portion of the cost. Tri-CAP partners with faith based organizations, the American Cancer Society and the Central Minnesota Council on Aging to coordinate TRC transportation services. It also works closely with medical facilities, assisted living facilities, and adult day centers in the area. TRC has no vehicles, relying on about 175 drivers from various
agencies. http://www.tricap.org/transportation_resource_center.html

Metro Bus Travel Training, St. Cloud
The St. Cloud Metropolitan Transit Commission offers travel training on the existing transportation system. Primary audiences are seniors, people with disabilities, and the general public. The program has training components: individual, step-by-step training sessions, and, larger community classes. St. Cloud Metro Bus has limited resources for

dial-a-ride services, which are easier to schedule. Even after recertifying consumers, the resources were not adequate. In offering the training, Metro Bus had to overcome caregiver and family beliefs that seniors and consumers with disabilities could not safely use fixed route transportation. The travel trainers had to market training services to overcome this belief. Metro Bus can provide special services, e.g., if a number of people need rides to the same place at the same time, they can take fixed routes to a central location, where a dial-a-ride bus will take them to their destination. The training program has allowed outreach to low income and minority populations. http://www.ridemetrobus.com/transit_center.php

Tri-Valley Transportation, Northwestern Minnesota
Also known as T.H.E. Bus (The Heartland Express), this is a program of the Tri-Valley Opportunity Council with offices in Crookston and Thief River Falls. They started providing travel training as a result of human service agency staff believing that consumers with disabilities and older adults did not know how to use fixed route transit. As a result, consumers used the more costly volunteer driver programs. The trainer works with both individuals and groups, and is open to the general public. The trainer also markets travel training, seeking to dispel the idea that it is only for people with disabilities and older adults. http://www.tvoc.org/services/transportation/travel-training/

SMARTLINK, Scott and Carver Counties
It began providing MA rides in their counties in 2010, resulting in SMARTLINK MA Travel. It has 33 accessible vehicles. If a consumer has a medical appointment outside the county lines, SMARTLINK MA Travel contracts with other carriers. One important part of providing efficient travel for all riders has been the installation of mobile data computers on buses. These computers show real-time positioning, allow instant dispatching to each bus driver, and thus improve efficiency. http://www.smartlinktransit.com

University of MinnesotaRouting Algorithms

Researchers in industrial and systems engineering departments, working with the University of Minnesota's Center for Transportation Studies, have developed an algorithm to improve vehicle routing and passenger assignments. It has been tested by two human service agencies in St. Paul, with a 12% improvement in routing and assigning. Using this algorithm, small nonprofit agencies can more efficiently schedule rides. These agencies cannot afford the larger databases used by larger transportation agencies. Further work is needed to refine the algorithm, and to make it user friendly. http://www.cts.umn.edu

Innovative Services Outside Minnesota

San Mateo County, California
Transportation Authority began an 18 month pilot program that would allow members

to take advantage of passenger vehicles not being used through an online registry. The pilot program began in January 2013. Members included cities, counties, and other public agencies. Initially, there were many legal hurdles and getting buy-in from insurance companies and risk managers. Forum members needed to sign in with the registry, listing vehicle availability. Members needing vehicles could look online to find what they needed. Then, the two members would need to have a written agreement between them. This has proven cumbersome. http://www.smcta.com

Taxi Programs

While expensive, taxicabs often provide the quickest response to a need for transportation. Here examples:

- Accessible Cambridge Taxicab Program, MA. In 2011 the City of Cambridge issued a Request for Proposals for accessible taxi dispatch and awarded the contract to the Checker Cab Company, the fields all calls for wheelchair accessible taxi rides. The cabs are available 24 hours a day, seven days a week. They operate as other taxis do, and consumers can hail them from the street. https://www.cambridgema.gov/license/Hackney.aspx

- Access Express, Cape Cod, RI, is a livery service, which is similar to taxi services. Livery service vehicles are not allowed to accept hails from the street and are less heavily regulated. The Cape Cod Regional Transit Authority contracts with the Habilitation Corporation, a for-profit company that provides day habilitation. The service operates seven days a week, from 5:00 a.m. to 2:00 a.m. http://accessexpress1.com/our-fleet.html

Attachment E: Shughart Presentation, "Public Involvement in the 2011 Greater Minnesota Transit Investment Plan"

Public Involvement in the 2011 Greater Minnesota Transit Investment Plan

March 26, 2014

Olmstead Workshop

Your Destination...Our Priority

Supporting Legislation

The commissioner shall develop a greater Minnesota transit investment plan that contains a goal of meeting at least 80 percent of total transit service needs in greater Minnesota by July 1, 2015, and meeting at least 90 percent of total transit service needs in greater Minnesota by July 1, 2025. The plan must include, but is not limited to, the following:

- –an analysis of ridership and total transit service needs throughout greater Minnesota
- –a calculation of the level and type of service required to meet total transit needs
- –an analysis of costs and revenue options
- –a plan to reduce total [unmet] transit service needs

Minnesota Statute 174.24 Subdivision 1a

Public Involvement: Public Outreach and Market Research

Market Research

- Onboard Surveys
- Focus Groups
- Structured Interviews

Public Involvement: Public Outreach and Market Research

Public Outreach

- Technical Advisory Committee (TAC)
- Plan Advisory Committee (PAC)
- Information sharing (visiting groups, website)
- Outreach Meetings and Stakeholder Presentations
- Public Hearing

Highlights:
On-Board Survey Results

- 10,000 surveys of users of current transit systems (Spring 2010)
- Level of satisfaction
  - Very: 68% (large urban lower)
  - Somewhat: 27% (large urban higher)
- Percent of transportation needs met
  - Overall: 68%

Highlights: On-Board Survey Results

Desired service changes

Desired Improvement	Statewide	Urban	Rural
Longer hours	34%	38%	27%
Less waiting time	23%	26%	19%
Cheaper fares	17%	15%	22%
Service on more days	13%	9%	20%
Service to more areas	13%	13%	13%

Focus Groups: Non-riders

- One focus group in each RDC region (12)
- 10 – 12 participants each
- Discussions focused on:
  - Current Traveling Experiences
  - Transit Perceptions
  - Marketing
  - Future Alternatives

Focus Group Highlights

- Used personal vehicles for trip; never thought of using transit
- Knowledge of existing service varied by area
- Fares are reasonable (if they had knowledge of the fare price)
- Thought more promotion was needed

Focus Group Highlights

- Main reasons for not using transit: Time, convenience and lack of independence
- Other barriers: safety, cleanliness, and availability
- Used personal vehicles for trip; never thought of using transit
- Yes to transit use – "in the future."

Structured Interviews

- 24 structured interviews with key stakeholders underway
- Purpose is to have an in-depth discussion about service priorities. Topics include:
  - Days and time of service
  - Geographic coverage
  - Cost-effective performance
  - Promotional needs and pricing

Stakeholder Presentations

- Conducted by RDC planners to over 50 groups statewide
- Over 700 people in total attendance
- Organizations included senior centers, transit agencies, tribal representatives, planning boards, elected officials, economic development orgs., etc.

Stakeholder Presentations

- 250+ comment cards submitted
- "Please rank the changes below in the order that would be most desirable to you or the organization you represent."

1. Service to more areas
2. Service more days of the week
3. Longer hours of service
4. Less waiting time
5. Cheaper fares

Investment Priority Activity

- Solicit direct input on preferences for priorities
- TAC (7 Mn/DOT district staff, 7 transit system reps) completed
- RDC Commissions (8 of 12 completed, others pending)

Investment Priority Activity

- Created two game board scenarios with limited dollars to spend
- Priorities included service expansion and service contraction

Investment Priority Activity: Preliminary Results- TAC

Expansion

- Add new service in rural areas within jurisdiction of an existing system
- Add new service in municipal areas within jurisdiction of an existing system
- Increase marketing

Contraction

- Reduce weekend service
- Reduce volunteer driver program operating subsidy

Investment Priority Activity: Preliminary Results- RDC

Expansion

- Add county to county service
- Expand volunteer driver programs
- Provide greater frequencies
- Add weekend service

Contraction

- Contract weekend service
- Contract route headways

Questions

Noel C. Shughart
Principal Planner
MnDOT Office of Transit
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Attachment F: Harper Presentation, "Metro Transit and the Disabled Community"

Olmstead Transportation Forum: Metro Transit and the Disabled Community

Cyndi Harper
Manager of Route Planning
March 26, 2014

METROPOLITAN COUNCIL

Metro Transit
a service of the Metropolitan Council

Introduction to Metro Transit

- Fixed route transit operating division of the Metropolitan Council
- Metro Mobility and Transit Link are also part of the Metropolitan Council, but not part of Metro Transit
- 128 routes, including a light rail line, a commuter rail line and a Bus Rapid Transit (BRT) line
- 81.4 million bus and train rides in 2013
- Service area includes parts of 7 metro counties, 90 cities

Metro Transit
a service of the Metropolitan Council

Persons with Disabilities Riding Metro Transit Buses and Trains

- Reduced fares available at all times
- All 988 vehicles are accessible; many are low-floor
- Disabled customers board buses first and exit last
- Facilities and bus stops meet ADA standards or being brought into compliance
- Customer Advocates give "How to Ride" presentations
- Transportation Accessibility Advisory Committee (TAAC)

Metro Transit
a service of the Metropolitan Council

Metro Transit Service Planning Approach

- Seek broad public engagement
- Understand transit demand patterns
- Apply transit service design principles that are the most effective
- Apply this approach to:
  - Region-wide service planning
  - Service Improvement Plan

Metro Transit
a service of the Metropolitan Council

What does effective and efficient transit service accomplish?

- Carries people
- Uses public resources in a cost-effective manner
- Supports efficient, sustainable development
- Provides a basic level of access region-wide

Metro Transit
a service of the Metropolitan Council

Urban Design Factors: Where is Transit More Effective?

- Locations that encourage higher population and activity density with a mixed-use land development pattern
- Places that are pedestrian-friendly and have a grid-pattern street network
- Areas with lower rates of auto ownership

Metro Transit
a service of the Metropolitan Council

Market Area	Typical Services
Area 1	Express, Urban Radial, Urban Crosstown, Downtown Circulator
Area 2	Express, Urban Radial, Urban Crosstown, Suburban Local
Area 3	Express, Urban Radial, Suburban Local, Circulators, General Public Dial-a-Ride*
Area 4	Peak Period Express, General Public Dial-a-Ride
Area 5	General Public Dial-a-Ride

** Market Area 3 Dial-a-Ride is appropriate in some circumstances*

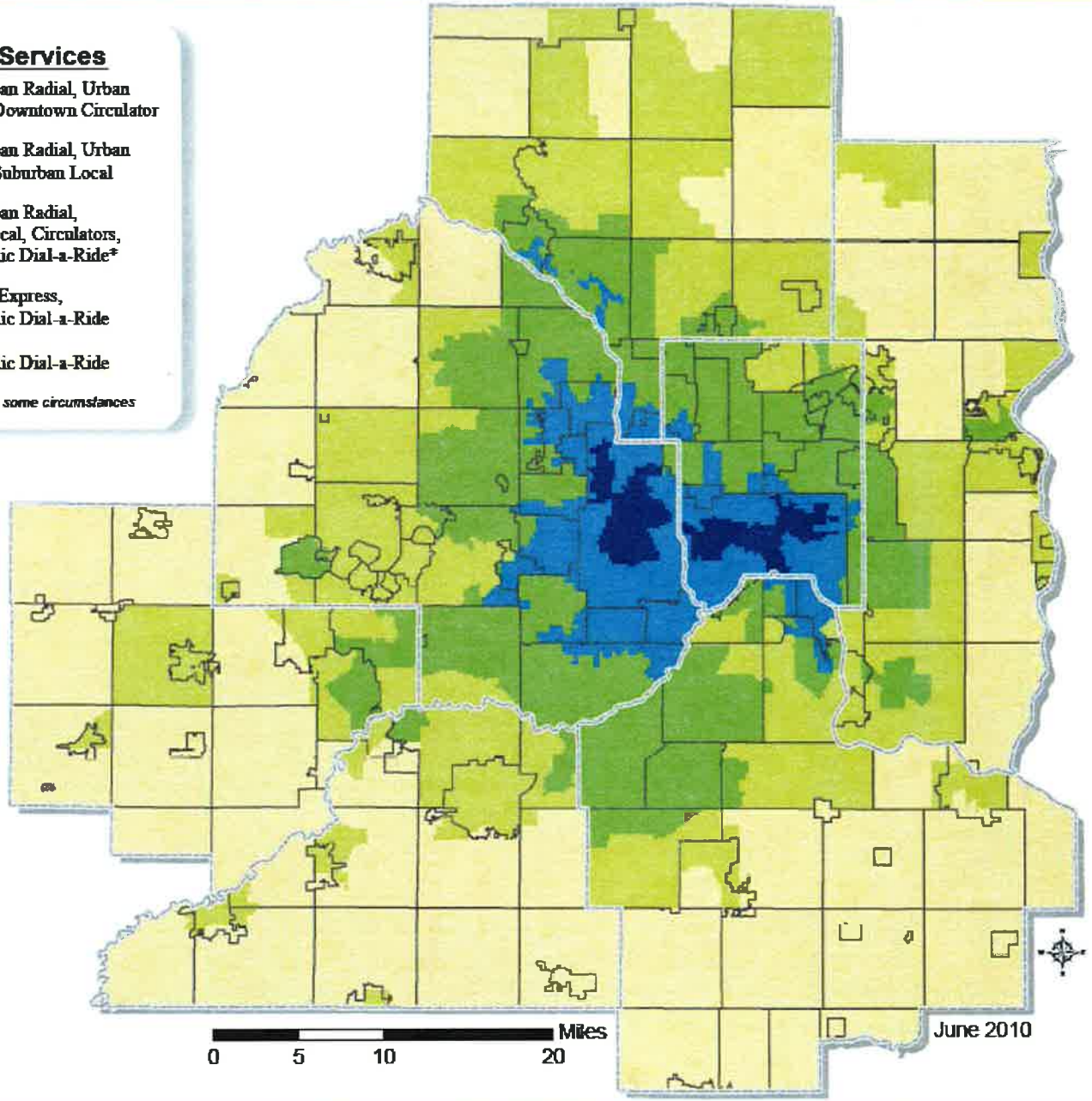

Figure 7-19: Transit Market Areas

- ADA paratransit service follows federal and state regulations in the regular route service area

- Additional details on market areas and service standards are available in **Appendix G**

- Market area geography was calculated at the census block group level.

Service Improvement Plan (SIP)

- What types of improvements should we make to expand the local and express bus network?
- How should we prioritize these improvements; what measures and values should we use?
- When should we make these improvements?
- What resources are needed to make these improvements?

8

Metro Transit
a service of the Metropolitan Council

SIP Public Engagement

- www.metrotransit.org/sip
- Stakeholder workshops, survey, on-board brochures and signs, customer newsletter
- Public input essential to development plan that meets region's needs
- Combine past input with focused effort to hear more variety of voices

Metro Transit
a service of the Metropolitan Council

SIP Survey

- Detailed survey asking for
  - Individual travel patterns
  - Specific service improvements
  - Overall goals and priorities
- Open Nov. through Feb.
- Received nearly 4,000 responses
  - 85% online, 15% paper
  - Successful promotion via Facebook, 1,500+ clicked the link

What We're Hearing

- SIP Survey
- Corridor Studies
- Thrive MSP 2040
- Customer Relations

→

- Higher Frequency on Core Urban Routes
- Better Suburb to Suburb Connections
- More Urban Crosstown Routes
- New Express Service
- Faster Travel Times
- Improved Customer Amenities

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SIP Evaluation and Prioritization

- Can't meet all needs cost-effectively
- How to select and prioritize service improvements
  - Performance metrics: Cost effectiveness, ridership, productivity, subsidy
  - Improved access to transit and access to destinations
  - Focus on communities most reliant on transit
  - Linkage to planned development projects

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SIP Next Steps

- Review survey and other customer feedback and draft a plan (Spring, Summer 2014)
- Public review and comment (Fall 2014)
- Finalize SIP (Late 2014)

Metro Transit
a service of the Metropolitan Council

Thank you.

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METROPOLITAN COUNCIL

Metro Transit
a service of the Metropolitan Council

Attachment G: March 26, 2014 Olmstead Transportation Forum—Public Comments

Comments made during the March 26 Olmstead Forum. (Comments have been condensed to capture the main points made.)

- Speaker would like to see database of the results from the 10,000 surveys that Noel Shughart referenced, specifically, the number of respondents who were people with disabilities, age groups, and economic status.
- Sidewalks and streets need to be cleared and maintained. Even if the bus is accessible, the sidewalk to the bus is not.
- Consumers could not have gotten to the Duluth videoconference site for this event using public transit.
- There was a lack of involvement from Greater Minnesota in this event.
- In the Arrowhead Region, getting to health care that is vital to people with disabilities is costly due to insufficient, affordable public transportation.
- Many of the issues with transportation are local issues could be solved locally, but cost is the limiting factor. Local entities don't have the resources for the fixes.
- People with disabilities need Metro Mobility past 7:30 p.m.
- It is going to require a "collective effort" to get transportation for people with disabilities. It requires a statewide effort to improve coordination and that involves a paradigm shift because so much planning and implementation is done at a local level.
- Speaker talked about her daughter who has a serious and persistent mental illness. She recently landed a job, which she is thrilled about, but what is a 19 minute car ride will take her two hours to get there by Metro Mobility.
- Speaker critiqued the panelists. She felt Noel Shughart's presentation lacked framework and context. She wanted to know how many of the 10,000 surveys came from Greater Minnesota and advocated for including rural communities in planning. She suggested that funds be re-directed from park and rides (which serve people who have cars) to expanded bus services. Presenters did not explain the strategies that were listed for people to respond to which made it difficult for people who use the services to know what they mean and to respond.
- Allow Metro Mobility to cross county lines to reduce waiting times.
- Currently $11 billion is invested in transportation for people with disabilities and older Minnesotans. It is often used to purchase vehicles. Is there any data about how they are used?

- Metro Transit does not adequately serve the NE metro area. The Metropolitan Council looks at capitol costs and operating costs—where are there enough population and enough employment to support the system? There is a lot of water and not many people in that part of the metro area.

- Beltrami County only as Dial-a-Ride and that is available only Monday-Friday and some Saturdays. Only runs to 5 p.m. This limits social and occupational possibilities. People will need transportation as the move out of group homes. We need to expand services.

- Unreliable transportation really affects mental health service access and mental health stability. A problem with volunteer drivers is that they often cancel, resulting in consumers missing medical and other appointments. In some cases, if a person misses an appointment their provider won't continue to see them. If a person can't get medications in a timely manner, they may slip into a mental health crisis.

- Physically disability adults rely on these drivers to get to jobs. Speaker dreads the day when her car gives out because she'll no longer be able to get to work. Her work is the key to her independence.

- People using wheelchairs feel like they are too much work for drivers so drivers don't want to serve them.

- Speaker from Renville County observed that the population density is so low that it is considered a "frontier" county. She seconded the previous idea of not paying for park and rides for people who have cars. She thought volunteer drivers worked okay. People choose to live in these remote areas because there is affordable housing and that can make the difference for people with disabilities who have low incomes. Speaker also was concerned that this event was not adequately advertised to people involved with mental health.

- Opportunity Partners provides transit and support services. They have 80 vehicles and a contracted provider for Metro Mobility. The speaker was directed to contact the Minnesota Council on Transportation Access to explore becoming a non-medical transportation provider.

- There was a lack of participation at this event by people of color.

- There can be problems between transit drivers and riders, especially if there are cultural differences.

Comments submitted by e-mail during the March 26 Forum:

- Are there resources available to connect and car pool to help individuals get from one city to another? A speaker responded that Duluth does have a carpooling system, but it is used only 2

or 3 times a year. Information about it can be found on the internet by searching "Rideshare Duluth

- I need more information about the strategies for improving transit in order to respond. Noel Shughart responded by going through the list.
- Metro Mobility is constantly late. It may take 1.5 to 2 hours for a one-way trip. It seems as though the routing the driver uses is more about his convenience than mine—I live near the garage.
- More information needed about Transit Link. Responder gave more information:
  - Previously called "Dial-a-Ride"
  - Has a 30 minute response time
  - Available to the general public
  - Intention is to provide a ride solution for each of the seven metro counties
  - Fare: less than 10 miles is $2.25; more than 10 miles is $4.50-$6.75
- Transit planning leaves out NE Metro. Many people with disabilities live there.
- Need for more citizens to be active. How can citizens become more involved? Responders suggested: put comments on the Department of Transportation website; contact your local transportation provider—all local transit systems have advisory groups; when planning events happen, take the opportunity to participate. There are currently vacancies on the Metropolitan Council's Transportation Accessibility group. The ADA transition plan will be updated this year—look for announcements in May. Keep an eye on the Olmstead Plan as that will continually be updated. Go to Metro Transit website to see opportunities for transit planning: metrotransit.org
- Marshall Transit (Lyon County) would be the best people to contact for information about gaps in services in Lyon County. It is a truly rural area.
  - Coordinating with the disparate populations is a challenge.
  - Getting to medical or employment appointments is expensive, and often not worth it.
  - Even transit in larger cities has limited hours.
- Montevideo (Chippewa County) needs work on coordination and ride sharing.

- There has been a lot of feedback at the Olmstead Transportation Forum around the need for more government-funded options (more routes, more vehicles, more stops, more frequency). In order to keep in line with the spirit and intent of Olmstead to further integration, instead of creating more programs specifically for people with disabilities, I would suggest the group working on this issue familiarize themselves with the notion of 'Abundant Community' (www.abundantcommunity.org) so that the part of our action plan supports and incents regular community resources. Examples include:
    - Working with cities to allow and promote the Pink Mustache people to operate legally, explaining this charge and exploring ways we can collectively improve this issue across community and populations (www.lyft.me).
    - Work with communities of faith and other organizations who have masses of volunteers who could drive but are reluctant because of the liability and the insurance premiums. Brainstorm ideas like working with insurance companies, or figuring out a way to offer insurance subsidies for willing drivers.

Comments submitted by e-mail to the Department of Transportation Olmstead web page after the March 26 Forum:

- The Minnesota Statewide Independent Living Council (MNSILC) wishes to make a number of comments on the transportation needs of Minnesotans with disabilities. Whenever MNSILC does a forum in Minnesota or visits areas of Minnesota where we have opportunities to talk with consumers, we hear comments about transportation needs. This happens routinely regardless of whether the topic of conversation is directly about transportation or another area.

  Transportation is key to people with disabilities being able to live in communities and further that being communities of their choosing. The needs for efficient, effective transportation are the same as all Minnesotans. People with disabilities have some specific additional issues: the need for accessible transportation, a greater dependency on public transportation because of the nature of their disability, and the limits to independent living that lack of this effective, efficient transportation places on their lives.

  During the recent forum, the difficulty of hearing from individuals with disabilities was mentioned. MNSILC would like to point out that transportation systems that meet specific needs cannot be designed without feedback from consumers. The goal of any transportation system is to get individuals where they need to go in an efficient and effective way. To this end, 1.Sufficient time must be taken to give adequate notice when feedback is needed

  2.Communications must be done in a way that is multi-modal. While we live in a world filled with quick, easy computer contact, the facts are that many individuals with disabilities cannot afford computers. They are consistently among the poorest of poor in national studies. Further,

there are many places in Minnesota that have poor to no coverage for connections. This means there is heavy reliance on print materials and notices in many areas and specifically among people with disabilities.

3.Collaboration is essential. Many state councils, agencies, and organizations have constant contact with individuals with disabilities from all over the state. Develop the relationships with these groups so when you need feedback, there is a methodology already in place to begin hearing from consumers all over the state.

Communication about transportation is critical to people with disabilities. As mentioned above, this communication may require time, multi-modal opportunities, and collaboration. When changes occur in systems or new systems are developed, how you communicate with consumers will be key to them knowing what is available and how to use it. This impacts their ability to improve employment, housing, daily life activities, community involvement and social opportunities.

Cost-effective, reliable, and accessible transportation needs are the same for people with disabilities regardless of where they live. Further, the needs of people with disabilities for transportation are the same as for that of the general population. Definitions and standards need to be consistent across communities in Minnesota. In addition, incentives might be needed to encourage communities to develop or improve systems that would benefit individuals with disabilities.

It may be necessary for current programs to be evaluated to see if they are functioning as intended. Reasons for poor functional quality need to be assessed and dollars need to be directed to those programs that offer good quality service.

It is critical that barriers to transportation are eliminated. There are transportation systems in place all over Minnesota that need to have key barriers removed. Then these systems would serve people with disabilities in their communities in a way that is greatly improved.

Metro: Improve the efficiency and effectiveness. Late arrivals, long commutes for short distances impede the ability of Minnesotans to locate and maintain employment, travel to medical appointments effectively, or participate in social opportunities with family and friends. In addition travel between communities is often impaired if using general transportation systems by having to go downtown and back out to reach a community that may only be a short travel distance by auto. By increasing standing orders and scheduling those first, then filling in with one-time requests, Metro Mobility might be able to provide more reliable trips for those who are obtaining an education or employed. Current practices put jobs at risk and increase anxiety for riders and their families/caretakers.

Outstate: Many existing transportation systems operate on business hours. This does not effectively serve Minnesotans with disabilities. They may not access employment opportunities unless those jobs operate between the existing time frames of service. The same is true of medical appointments, social opportunities, community involvement and personal business needs. Further, existing transportation systems often serve limited areas. An individual in community M may not be able to take advantage of a job opportunity in community J because it is just across a county line. Even though that driving distance may be as little as 20 minutes, there is no way for the person to get to the job.

We encourage you to consider the needs of Minnesotans with disabilities for efficient, effective transportation to support their ability to live independently in the community. We would be happy to answer any questions you may have on this topic. You can contact our Coordinator, Pam Taylor, at mnsilc1215@gmail.com Thank you.

- This is not necessarily a new idea; it was discussed previously as part of Collaborative Action Network Developing Opportunities (CAN DO) efforts 6-7 years ago. There doesn't seem to exist any inventory of publicly funded transportation assets: bus cards, autos, vans, buses, (hopefully not planes & trains) etc. that health and human services provider organizations use to purchase, lease, and maintain.

  As noted at the transportation hearing, NFs, ICFs/DD, HWS, Assisted Living, HCBS settings, DT&Hs, IRTS, ACT, etc. . . . all have receive(d) state and/or federal funding (and continue to receive more) for these purposes. Many of these publicly funded transportation assets are handicap accessible and only used for a few hours each day . . .

  This apparently occurs because there is no coordination, communication or collaboration . . . each provider organization buys, maintains and uses them for their own (maybe limited) purpose(s).

  For example, what if a provider's van became a dial-a-ride resource during certain hours or days? Maybe it wouldn't be the provider's van, but a state vehicle for the provider's use at certain times and community use at other times? (Treating the van like a conference room--available to all qualified users and which can be reserved for standard trips and occasional trips.)

DHS-6810B-ENG 8-14

Minnesota Department of Human Services

Positive Support Transition Plan Instructions

Positive Support Transition Plan, DHS-6810 (PDF)
or https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810-ENG

Positive Support Transition Plan Review, DHS-6810A (PDF)
or https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810A-ENG

The following instructions provide the requirements for the creation, review and reporting of Positive Support Transition Plans as identified in Minnesota Statute, section 245D.06, subdivision 8.

Minn. Stat. §245D.06, subd. 8 requires that the positive support transition plan forms and instructions supersede the requirements in Minnesota Rules, parts 9525.2750; 9525.2760; and 9525.2780. Minn. Stat.§245.8251 requires that the commissioner of human services shall, within 24 months of May 23, 2013, adopt rules governing the use of positive support strategies, safety interventions, and emergency use of manual restraint in facilities and services licensed under Minnesota Statutes, chapter 245D. The forms and instructions required under Minn. Stat. §245D.06, subd. 8 will be replaced in part or in full upon promulgation of the new rule required under Minn. Stat. §245.8251.

This information is available in accessible formats for individuals with disabilities by calling 651-431-4300, toll-free 866-267-7655, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

Table of contents

Chapter 1: Positive Support Transition Plan Required

Minnesota Statute, section 245D.06, subdivision 5 prohibits the following procedures, known as behavior interventions, as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience:

1. Chemical restraint
2. Mechanical restraint
3. Manual restraint, except in an emergency
4. Time out
5. Seclusion
6. Aversive procedures
7. Deprivation procedures

These prohibitions are effective January 1, 2014 for Minnesota Statutes, chapter 245D-license holders. Under previous regulations, teams may have used one or more of the prohibited procedures. License holders may continue to use certain prohibited procedures during a one-year phase out process if they are included in a positive support transition plan (PSTP)[1] created according to the terms of these instructions and developed using DHS form-6810. Chapter 3 identifies applicable procedures and standards for their use.

PSTPs must be written using DHS form-6810. Instructions for completion of the PSTP are included within form-6810 and this document. The creation of a Positive Support Transition Plan is required to:

- Eliminate the use of prohibited procedures identified in Minnesota Statutes, chapter 245D
- Avoid the emergency use of manual restraint
- Prevent the person from physically harming self or others

A Positive Support Transition Plan directs the actions of a service provider; it outlines the support and procedures providers they will use with the persons they serve. A PSTP is required when a person and their team identify a need for the therapeutic fading of a prohibited procedure. A PSTP also is required after a person receiving services requires multiple uses of an emergency use of manual restraint in a given year. License holders who do not use a prohibited procedure or the emergency use of manual restraint after Jan. 1, 2014 do not need to create a PSTP. Expanded support teams are encouraged to fade the use of the prohibited procedure as soon as possible but no less than 11 months after the creation of the PSTP. The external support team must determine timelines for the fading of the emergency use of manual restraint.

[1] Minn. Stat. §245D.06 subdivision 8

Chapter 2: Creation of a Positive Support Transition Plan

Upon identification of the need for a PSTP, the expanded support team has 30 days to finalize an initial PSTP. **A qualified designated coordinator, behavior analyst or behavior professional, as defined in Minnesota Statutes, chapter 245D,** must write the positive support transition plan in consultation with the person and their expanded support team.

Initial PSTP

Complete all questions in Parts A-G. Definitions of terms are located within the PSTP template. Additional guidance for each part follows:

Part A

Complete all sections of Part A. The team must identify the frequency with which reviews will occur. Positive Support Transition Plans must be reviewed, at minimum, on a quarterly (every 90 days) basis.

Part B

Part B identifies the prohibited procedures a team has identified the need to continue to use on a limited basis, as well as the emergency use of manual restraint. If the team has identified more than one target intervention, number the interventions. Identify an alternative intervention to use in place of each target intervention. If identifying multiple alternative interventions, identify which alternative intervention is replacing which target intervention.

Identify a data collection method used to monitor the incidence of target interventions. For information on data collection methods, see the appendix on data collection.

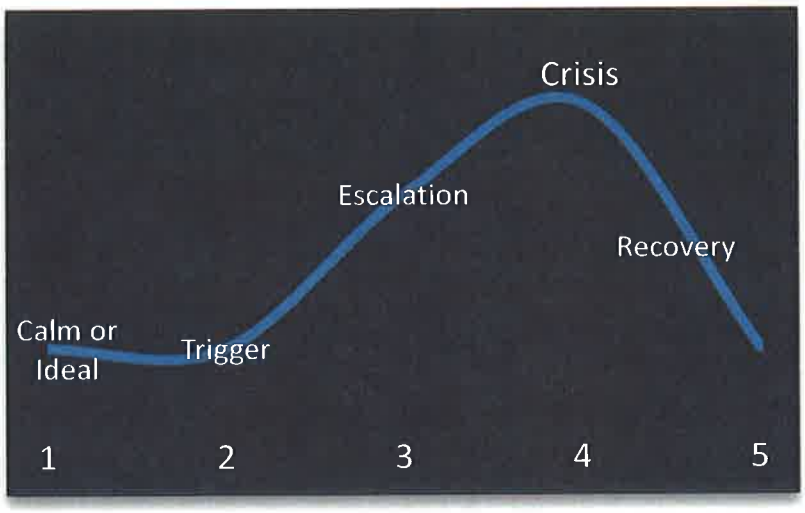
Part C

Target behaviors are the specific actions a person has performed that have resulted in the need for a behavioral intervention and are identified for elimination. To avoid the need for future behavioral interventions, the team must work to eliminate the underlying cause of the target behavior; in this case, the action that precipitated the intervention is the underlying cause. If the team has identified multiple target behaviors for elimination, number the target behaviors. Identify a positive, alternative behavior for each target behavior. If the team identifies multiple alternative behaviors, then it must identify which alternative behavior is replacing which target behavior.

Identify a data collection method used to monitor the incidence of target behaviors. For information on data collection methods, see the appendix on data collection.

Part D

Part D utilizes a crisis model as a framework for completion of a crisis support plan. For the purposes of positive support transition planning, the Minnesota Department of Human Services uses a crisis framework comprised of five stages as depicted in the picture below:



DHS uses this framework in order to promote a common understanding and reporting of crises — times when behavioral interventions can be necessary. For the purposes of the PSTP, "crisis" refers to situations that exceed a person's resources and coping mechanisms *and* has the potential to endanger the health and safety of their self or others. The framework also is meant to assist expanded support teams to perform their own preliminary analysis of reoccurring crises.

The calm or ideal stage indicates what normal or calm functioning would look like for a person. "Calm or ideal" varies for every individual or event. In this stage, teams identify the person's optimal state and support strategies to help the person maintain this state. Some support strategies include the use of psychotropic medication, counseling, emotional regulation training, skill building and participation in preferred activities.

The trigger stage indicates situations, words, people, decisions, critical periods, etc., that set a person or event toward an escalation and toward a crisis. The idea behind crisis prevention is that a team should assist a person to either avoid or cope with triggers. The person and their team must decide which method of crisis prevention is best suited for each trigger. Teams identify proactive and reactive ways to support a person when encountering triggers. Proactive strategies focus on strategies to use before a known trigger/antecedent will be encountered. Reactive strategies focus on strategies to use after encountering a trigger/antecedent.

The escalation stage refers to the happenings, events, behaviors that typically occur after a trigger and before a crisis. This is a critical period in which there is an opportunity to assist a person and avoid a crisis. De-escalation techniques, counseling strategies, PRN medication, crisis lines, etc., may be effective for a person in this stage.

The crisis stage is the stage when things are at their worst. As stated above, crises typically exceed a person's resources or coping mechanism. Because crises endanger the health and safety of someone, some sort of behavioral intervention typically is necessary. When a crisis poses a risk of injury to someone, and all other intervention methods have failed, the crisis becomes an emergency safety situation. According to Minnesota Statutes, chapter 245D guidelines, this is the only stage in which the emergency use of manual restraint (EUMR) is allowed. For license holders who do not use EUMR, another intervention strategy must be identified, such as calling a crisis line or 911.

The recovery phase refers to the period just after a crisis. This is when people or events are on their way back to the calm or ideal phase. The goal of the recovery stage is to assist a person toward the calm or ideal stage. Strategies for support may include debriefing the person, suggesting the person call a friend or ally, giving the person space, etc.

Not every crisis follows this set pattern. Some crises move straight from a trigger phase to a crisis stage. Sometimes a de-escalation phase can escalate back into another crisis. Every crisis can be unique. Part D of the PSTP identifies ways to support the person in each phase. Strategies will vary from person to person, as different intervention methods will work for some people and not for others. Information provided in this portion of the PSTP should identify what a person typically "looks" like in each stage. This could include information about the person's typical affect, behaviors, expressions, sounds or words they typically exhibit in each stage.

Part E

A minimum of two (2) quality indicators must be identified in Part E of the PSTP. Quality indicators are reportable or observable outcomes that are important to or for the person. To the extent possible, quality indicators should be chosen that reflect things the person's target behaviors prevent them from accessing/achieving. One (1) quality indicator must be chosen from two (2) different categories listed below:

1) **C**ommunity Membership
2) **H**ealth, wellness and safety
3) **O**wn place to live
4) **I**mportant Long-term relationships
5) **C**ontrol over supports, and
6) **E**mployment earnings and stable income

Use Part E to identify which category an indicator belongs. Identify how data will be collected on each quality indicator.

Part F

Informed consent is required before the use of a prohibited procedure. See Chapter 4 of these instructions for further guidance.

Chapter 3: Standards for behavioral interventions

Positive support transition plans must phase out any existing plans for the emergency or programmatic use of an aversive or deprivation procedure prohibited by the provisions of Minnesota Statutes, chapter 245D[2]. Procedures incorporated into a PSTP must **not**:

1. Be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse or mental injury, as defined in Minn. Stat. §626.556, subd. 2
2. Be implemented with an adult in a manner that constitutes abuse or neglect as defined in Minn. Stat. §626.5572, subd. 2 and 17
3. Be implemented in a manner that violates a person's rights and protections identified in Minn. Stat. §245D.04
4. Restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing, or to any protection required by state licensing standards and federal regulations governing the program

[2] Minn. Stat. §245D.06, subd. 8

5. Deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin
6. Be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment or services provided by the program
7. Use prone restraint. "Prone restraint" means use of manual restraint that places a person in a face-down position. This does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, and the person is restored to a standing, sitting, or side-lying position as quickly as possible
8. Apply back or chest pressure while a person is in a prone position as identified in (7) or in a supine or side-lying position
9. Be implemented in a manner that is contraindicated for any known medical or psychological limitations of a person
10. Use corporal punishment such as hitting, pinching, or slapping
11. Require a person to assume and maintain a specified physical position or posture as an aversive procedure, for example, requiring a person to stand with the hands over the person's head for long periods of time or to remain in a fixed position
12. Totally or partially restrict a person's senses
13. Present noxious smell, taste, substance, or spray, including water mist, as an aversive stimulus
14. Deny or restrict a person's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the person's functioning. When the temporary removal of the equipment or device is necessary to prevent injury to the person or others or serious damage to the equipment or device, the equipment or device must be returned to the person as soon as possible.

When the following procedures are incorporated into a positive support transition plan, they must meet the following conditions:

1. Mechanical Restraint
    a. The person's primary care physician must be consulted to determine whether implementing the procedure is medically contraindicated.
    b. Use of mechanical restraint that results in restriction of two or fewer limbs or that does not restrict the person's movement from one location to another requires the following procedures:
        i. Staff must check on the person every 30 minutes and document that each check was made
        ii. The person must be given an opportunity for release from the mechanical restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes that the mechanical restraints are used

iii. Efforts to lessen or discontinue the mechanical restraint must be made at least every 15 minutes. The time each effort was made and the person's response to the effort must be noted in the person's permanent record

c. Use of mechanical restraint that results in restriction of three or more of a person's limbs or that restricts the person's movement from one location to another must meet the conditions of items (1) and (2) and the following additional conditions:
   i. Efforts to lessen or discontinue the mechanical restraint must be made at least every 15 minutes. The time each effort was made and the person's response to the effort must be noted in the person's permanent record.
   ii. A staff member shall remain with a person during the time the person is in mechanical restraint and shall take the action specified in item (i)

d. The use of mechanical restraints that prevent/impair a person's ability to remove a seat belt during transport in a motor vehicle

2. Manual Restraint procedures must meet the following conditions:
   a. The person's primary care physician must be consulted to determine whether implementing the procedure is medically contraindicated
   b. The person must be given an opportunity for release from the manual restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes
   c. Efforts to lessen or discontinue the manual restraint must be made at least every 15 minutes, unless contraindicated. The time each effort was made and the person's response to the effort must be noted in the person's permanent record.
   d. The procedures must comply with other standards in Minn. Stat. §245D.061

3. Time-out procedures must meet the following conditions:
   a. When possible, timeout procedures must be implemented in the person's own room or other area commonly used as living space rather than in a room used solely for time out
   b. When possible, the person must be returned to the activity from which the person was removed when the timeout procedure is completed
   c. Persons in timeout must be continuously monitored by staff
   d. Release from a timeout is contingent on the person's stopping or bringing under control the behavior that precipitated the timeout and must occur as soon as the behavior that precipitated the timeout abates or stops. If the precipitating behavior has not abated or stopped, staff members must attempt to return the person to an ongoing activity at least every 30 minutes.
   e. If timeout is implemented contingent on repeated instances of the target behavior for longer than 30 consecutive minutes, the person must be offered access to a bathroom and drinking water
   f. Placement of a person in a room for timeout must not exceed 60 consecutive minutes from the initiation of the procedure

g. Timeout rooms must:
    i. Provide a safe environment for the person
    ii. Have an observation window or other device to permit continuous visual monitoring of the person
    iii. Measure at least 36 square feet and be large enough to allow the person to stand, to stretch the person's arms, and to lie down
    iv. Be well lighted, well ventilated, and clean

4. Seclusion
    a. The use of seclusion must only be used in emergency safety situation as a response to imminent danger to the person or others
    b. The use of seclusion must only be used when less restrictive interventions are determined to be ineffective
    c. The use of seclusion must end when the threat of harm ends
    d. The person must be constantly and directly observed by staff during the use of seclusion
    e. The use of seclusion must be used under the supervision of a mental health professional or the designated coordinator
    f. Staff must contact the mental health professional or designated coordinator to inform them about the use of seclusion and to ask for permission to use seclusion as soon as it may be done safely, but not later than 30 minutes after initiating the use of seclusion
    g. When the use of seclusion ends, the person must be assessed to determine if the person can be safely returned to ongoing activity
    h. Staff must treat the person respectfully throughout the procedure
    i. The staff person who implemented the emergency use of seclusion must document its use immediately after the incident concludes
    j. The room for seclusion must be well lighted, well ventilated and clean. It must have an observation window which allows staff to directly monitor a resident in seclusion, fixtures that are tamperproof, electrical switches located immediately outside the door, and doors that open out and are unlocked or are locked with keyless locks that have immediate release mechanisms
    k. Objects that may be used by a person to injure the person's self or others must be removed from the person and the seclusion room before the person is placed in seclusion

DHS is in the process of promulgating a new rule that will govern the use of safety interventions and replace Minnesota Rules, parts 9525.2700 through 9525.2810. The requirements in this chapter apply until the same requirements become effective as part of the new rule.

Chapter 4: Informed Consent

Written informed consent must be obtained from the person receiving services or the person's legal representative acting within the scope of their authority before implementing the following:

1. A prohibited procedure or the emergency use of manual restraint
2. A procedure for which informed consent has expired. Informed consent must be obtained annually for the emergency use of manual restraint
3. A substantial change in the positive support transition plan

If the team is unable to obtain written informed consent, the procedure must not be implemented.

Chapter 5: Positive Support Transition Plan Review (Form-6810A)

Complete Positive Support Transition Plan Review DHS-6180A (PDF) at each formal review. Review frequency is identified in Part A of Form-6810 and must be no less frequent than every 90 days (quarterly).

Based on the review of a person's data regarding target interventions, target behaviors and quality of life, the team will decide if the PSTP needs revising. If the team does agree to revise the PSTP, the new plan must be in place within seven (7) working days of the review.

A completed form DHS-6810A must be placed in a person's service recipient record. A copy of the completed form must also be sent to DHS.

Requests for assistance

Teams must request assistance if a PSTP has been in place for six months and there is not a decrease in the incidence of target interventions. Assistance can be requested through another service provider when facilitated by the case manager or through the behavior intervention report form (DHS Form-5148).

Chapter 6: Revising the Positive Support Transition Plan

PSTPs containing a prohibited procedure should end as soon as possible, but must terminate 11 months after the implementation date. PSTPs may be updated during the 11-month period, but the initial termination date must stand. PSTPs can be updated at any time. Guidelines for revising PSTPs are as follows:

Substantial changes in the PSTP require a revised plan and consent from team members. Substantial changes include:

- Changes to target interventions (PSTP Part B)
- Changes to target behaviors (PSTP Part C)
- Inserting a prohibited intervention to the crisis plan (PSTP Part D)
- Changing quality indicators (PSTP Part E)
- Changes to frequency of PSTP review (Part A)
- Terminating the Positive Support Transition Plan

Designated coordinators may update the following items without consent:

- Updating medication information in Part A of the PSTP
- Changing data collection methodology in Parts B, C or E of the PSTP

Each time the PSTP is revised, note the date the plan was revised in Part A and complete Part F.

Chapter 7: Positive Support Transition Plan Termination

PSTPs that include a prohibited procedure must terminate within 11 months of implementation. PSTPs that include the emergency use of manual restraint terminate based on the recommendations of the expanded support team.

PSTPs may be terminated before the initial 11-month time limit. PSTPs may end when a prohibited technique has been phased out or the emergency use of manual restraint appears no longer to be necessary. Upon termination, any procedure prohibited by Minnesota Statutes, chapter 245D cannot be used. Termination of the PSTP signals the cessation of a target intervention, not necessarily a target behavior. It is expected that the team will continue to utilize positive support strategies to support the person, such as maintaining their safety, independence, freedom and reduce the instance of identified target behaviors. In the event that a positive support transition plan has terminated and an emergency use of manual restraint is utilized, the team must create a new PSTP according the timeline in Minn. Stat. §245D.06, subd. 8.

Notification must be sent to DHS when a Positive Support Transition Plan is terminated using the Positive Support Transition Plan Review Form (DHS Form-6810A)

Chapter 8: External Reporting

Copies of a person's PSTP must be sent to the following individuals/entities:

1. The person's legal guardian/authorized representative
2. The person's case manager
3. Service providers involved in the implementation of the strategies in the PSTP
4. The Department of Human Services

Additionally, each use of an Emergency Use of Manual Restraint (EUMR) must be reported according to the provisions of Minn. Stat. 245D.061. License holders must fully complete a Behavior Intervention Report Form, DHS Form-5148 to report each EUMR and the procedures below within the provided timelines:

Reporting of procedures via the Behavior Intervention Report Form (DHS-5148)

Procedure	Report Frequency via form-5148	Report Timeline
Mechanical Restraint	Weekly (Every 7 days)	15 working/business days after report timeframe
Mechanical Restraint – Seat Belt Clips/inhibitors	Weekly (Every 7 days)	15 working/business days after report timeframe
Manual Restraint, not emergency use	Each Incident	15 working/business days after incident
Emergency Use of Manual Restraint	Each Incident	15 working days after incident
Time out	Weekly (Every 7 days)	15 working days after report timeframe
Seclusion	Each Incident	15 working days after incident
Aversive Procedures	Weekly (Every 7 days)	15 working days after report timeframe
Deprivation Procedures	Weekly (Every 7 Days)	15 working days after report timeframe
Psychotropic PRN Administration when used to avert or in response to a target behavior	Each Incident	15 working days after incident
911 Calls	Each Incident	15 working days after the incident

The expanded support team must determine a report frequency for procedures not included in the table above.

A complete copy of the completed Behavior Intervention Report Form (DHS Form-5148) must be sent to each member of the expanded support team within 24 hours of submission.

Appendix

Definitions

Aversive procedure

The application of an aversive stimulus contingent upon the occurrence of a behavior for the purposes of reducing or eliminating the behavior (Minn. Stat. §245D.02, subd 2b).

Aversive stimulus

An object, event or situation that is presented immediately following a behavior in an attempt to suppress the behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines (Minn. Stat. §245D.02, subd. 2c).

Baseline

Ann initial set of critical observations or data used for comparison or a control

Behavior Intervention

Any application of a restraint and/or restrictive or penalty technique that staff uses in response to a person's displayed behavior

Chemical Restraint

The administration of a drug or medication to control the person's behavior or restrict the person's freedom of movement and is not a standards treatment or dosage for the person's medical or psychological condition (Minn. Stat. §245D.02, subd 3b)

Coordinated Service & Support Plan

"Coordinated service and support plan" has the meaning given in Minn. Stat. §256B.0913, subd. 8; Minn. Stat. §256B.0915, subd. 6; Minn. Stat. §256B.092, subd. 1b; and Minn. Stat. §256B.49, subd. 15, or successor provisions

Crisis

A situation perceived or experienced by a person that exceeds the person's resources and coping mechanisms and has the potential to endanger the health and safety of an individual. "Crisis" comprises both "Incidents" and "emergency safety situations."

Deprivation procedure

The removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration or intensity of the response. Oftentimes the positive reinforce available is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer (Minn. Stat. §245D.02, subd 5a).

Designated Coordinator

The person providing oversight and evaluation of the license holder's responsibilities assigned in a person's coordinated service and support plan. Additional responsibilities and qualifications for the designated coordinator are provided in Minn. Stat. §245D.081, subd. 2

Emergency safety situation

Unanticipated behavior by an individual that places the individual or others at serious threat of violence or injury if no intervention occurs and that requires and emergency safety intervention

Emergency safety intervention

The use of a behavior intervention as an immediate response to an emergency safety situation

Expanded support team

The members of the support team and a licensed health or mental health professional or other licensed, certified, or qualified professionals or consultants working with the person and included in the team at the request of the person or the person's legal representative

Incident

"Incident" means an occurrence that affects the ordinary provision of services to a person and includes any of the following:

1. Serious injury as determined by section Minn. Stat. §245.91, subd. 6
2. A person's death
3. Any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition, or the mental health status of a person that requires calling 911 or a mental health crisis intervention team, physician treatment, or hospitalization
4. Any mental health crisis that requires the program to call 911 or a mental health crisis intervention team
5. An act or situation involving a person that requires the program to call 911, law enforcement, or the fire department
6. A person's unauthorized or unexplained absence from a program
7. Physical aggression by a person receiving services against another person receiving services that causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing and spitting
8. Any sexual activity between persons receiving services involving force or coercion as defined under Minn. Stat. §609.341, subd. 3 and 14
9. Any emergency use of manual restraint as identified in Minn. Stat. §245D.061
10. A report of alleged or suspected child or vulnerable adult maltreatment under Minn. Stat. §626.556 or 626.557 (Minn. Stat. §245D.02, subd. 11)

Legal representative

The parent of a person who is under 18 years of age, a court-appointed guardian or other representative with legal authority to make decisions about services for a person. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

Manual Restraint

Physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint. (Minn. Stat. §245D.02, subd. 15a)

Mental Health

A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community (definition taken from the World Health Organization)

Most Integrated Setting

A setting that enables individuals with disabilities to interact with nondisabled person to the fullest extent possible (Minn. Stat. §245D.02, subd 20a)

Outcome

The behavior, action or status attained by a person that can be observed, measured and determined reliable and valid (Minn. Stat. §245D.02, subd 21a)

Positive support strategy

A strategy that emphasizes teaching a person productive, alternative strategies/behaviors for dealing with times of stress without the use of aversive or punishing procedures

Positive Support Transition Plan (PSTP)

The plan required by Minn. Stat. §245D.06, subd. 5 to be developed by the expanded support team to implement positive support strategies to:

1. Eliminate the use of prohibited procedures as identified in Minn. Stat. §245D.06, subd. 5(a)
2. Avoid the emergency use of manual restraint as identified in Minn. Stat. §245D.061
3. Prevent the person from physically harming self or others as in Minn. Stat. §245D.02, subd 23b

The plan will identify baseline, triggers, escalation, crisis and recovery stages for an individual and contain positive, person-centered strategies to intervene during each stage of crisis. The positive support transition plan replaces behavior support plans and/or individual program plans containing the use of a controlled procedure under Rule 40.

Psychotropic Medication

"Psychotropic medication" means any medication prescribed to treat the symptoms of mental illness that affect thought processes, mood, sleep or behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder. Other miscellaneous medications are considered a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior (Minn. Stat. §245D.02, subd. 27)

Punishment

The contingent application of a penalty consequence that is either aversive or depriving in nature, and deters, reduces or eliminates undesired behavior. The consequence imposes a cost, loss, burden or presentation of noxious conditions

Quality indicators

Reportable or observable outcomes that are important to or for the person

Restrictive Measures

Any measure that restricts or suspends the individual rights of a person served

Seclusion

The placement of a person alone in a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room (Minn. Stat. §245D.02, subd 29)

Support team

The service planning team identified in section Minn. Stat. §256B.49, subd. 15 or the interdisciplinary team identified in Minn. R., 9525.0004, subp. 14. (Minn. Stat. §245D.02, subd. 34)

Target interventions

Previously used behavioral interventions targeted for elimination

Target behavior

Observable or reportable actions that previously have resulted in behavior interventions and are identified for elimination. Examples of target behaviors are physical aggression towards others, self-injurious behavior, property destruction, elopement, behavior that endangers self or others (fire starting, etc.)

Team

See Expanded Support Team

Working Days

Working days is synonymous with "business days"; it excludes weekends and holidays

Data Collection

Parts B, C and E of the Positive Support Transition Plan require the identification of a data collection method. Data collection is important for the determination of the success of any plan. Examples of data collection methods are identified on form DHS-6810; below is a description of those methods.

Frequency Count

A method of counting the number of times an event occurs during a given period. Frequency count is the most common measure utilized for tracking events. Each time an event occurs, it is recorded on a data sheet. Frequency counts work well for measuring low-to-medium rates of interventions, behaviors and quality of life indicators, but not as well for high frequency or long-lasting events.

Duration Recording

Measures the length of time an event occurs. This method works well when the length of an intervention, behavior or quality of life indicator is a primary concern (e.g., low frequency behaviors that are displayed more than momentarily, interventions that occur less frequently but for long durations or quality of life indicators that occur less frequently but for long durations). The onset and offset need to be clearly defined.

Time Sampling

A method of spot-checking to determine if an event is occurring at specific times. This method is suited for times when continuous observation is not possible or feasible or when an event occurs so frequently that it is difficult to track using frequency count. It is used by recording the presence (+) or absence (-) of an intervention, behavior or quality of life indicator at specific points in time. Time periods should be divided into equal intervals.

Interval Recording

Divides the observation time into equal intervals and the event is recorded as either occurring (+) or not occurring (-), at *any* time during each interval. Similar to time sampling, interval recording is suited for high frequency event recording during continuous observation periods.

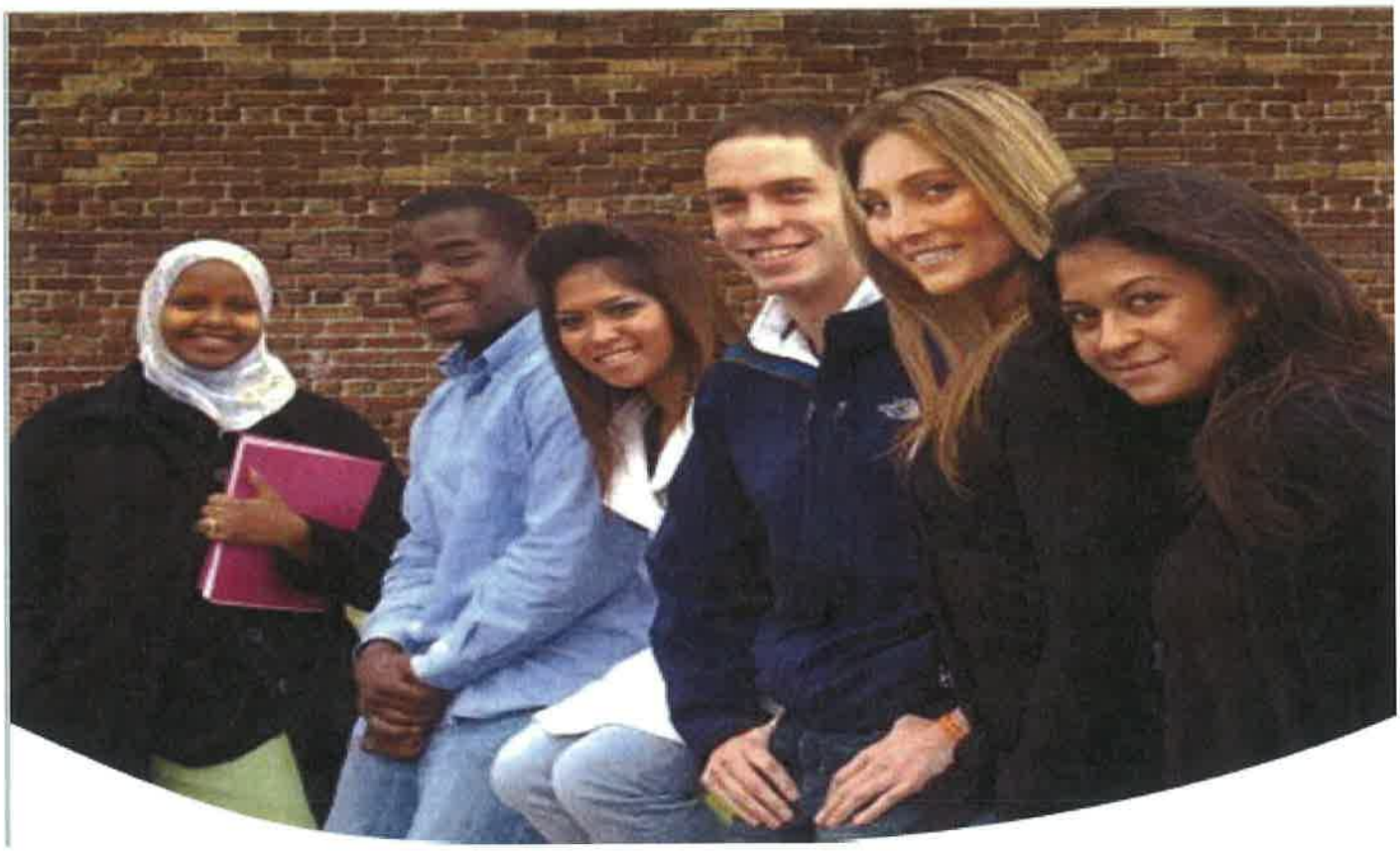
Rating Scale

Measures the intensity of an event. When using the rating scale method, the observer selects a numerical rating representing the level of intensity from a series of defined values such as 0 (calm), 1 (agitated), or 2 (aggressive).

Permanent Product

Measures the outcome or product of an event. This method is used for times when it is not easy or possible to observe an event, but the outcome or product can be observed. Examples of permanent products include taking out the trash, making a bed, refraining from self-injury (no visible marks) or receiving a paycheck, etc.

NOTE: If you are having a difficult time accurately recording the intensity, duration or incidences of a target intervention, target behavior or quality of life indicator, you may want to consider changing your data collection method. If the person already is working with a psychiatrist or behavior analyst, either professional should assist in the selection of data collection method.



POSTSECONDARY RESOURCE GUIDE

SUCCESSFULLY PREPARING STUDENTS WITH DISABILITIES FOR THE POSTSECONDARY ENVIRONMENT

Minnesota
STATE COLLEGES
& UNIVERSITIES

IMAGE REDUCED VERSION

Table of Contents

THE POSTSECONDARY CHOICE

The transition from high school to life after high school can be an exciting time in the life of a young person. It can also be a time of tremendous challenge, especially for students with disabilities. The new phase of postsecondary education is filled with dramatic and significant changes. Preparation done in advance will help students have a better understanding of what lies ahead so that they can ultimately achieve their goals and dreams.

Students choose to continue their education after high school for multiple reasons. For many, the ultimate goal of pursuing higher education is to achieve a fulfilling career. Jobs and careers are important, but education beyond high school provides many other benefits. Higher education changes a person. It gives individuals an opportunity to experience greater independence, meet new people, explore interests, learn more about themselves and increase their understanding of the world. It also gives students the opportunity to improve computer literacy, research and communication skills, critical thinking, and the ability to work in teams. These are all highly valued skills to employers and will improve the chance for success in the workplace.

If you are a parent, teacher, counselor or friend, your role will change after your student graduates from high school. You will no longer be involved in each decision that affects him or her. The best thing you can do now is to give good advice and put your student on the right path. This guide, along with your mentorship, will help you prepare your student for their next educational steps.

We hope the information in this guide will be a helpful resource to all those involved in the transition journey to better understand how students can enter and thrive in the world of postsecondary education and eventually in the world of work.

PLANNING FOR COLLEGE WHILE STILL IN SCHOOL

COLLEGE ENROLLMENT TIMELINE/CHECKLIST FOR HIGH SCHOOL STUDENTS

The transition from high school to postsecondary education can be a smooth one with less anxiety and fewer surprises if you as a special education student and your family plan strategically and consistently throughout your high school experience. A tool that can assist with this process is a series of checklists that should be followed and reflected on from the freshman to senior years so that you are mentally, academically and socially ready for the changes you will experience in the postsecondary setting. If you are starting this in a later year of high school, review the checklists from previous years and implement as many of the preparations as possible. Thinking ahead, no matter what year you are in high school, will ultimately help you reap huge benefits in the transition process.

FRESHMEN YEAR

- Start a graduation file to organize information related to work, school activities, and future plans so that necessary records and notes are in a centralized location, such as Google Docs, where you won't lose the paper copy.
- Learn about and accept your disability.
- Practice explaining to others the educational needs that stem from your disability.
- Review and adjust your future goals in all of your Individualized Education Program (IEP) transition areas.

- Participate in your IEP meetings.
- Discuss your graduation plans, graduation status and transition goals.
- Understand your strengths and weaknesses.
- Utilize your strengths and develop strategies to compensate for your areas of weakness.
- Learn what your accommodations are, and use them when needed to discover what helps you be academically successful.
- Enroll in high school classes that meet your postsecondary goals. These may include more rigorous classes that are considered college prep courses, or they could be special education classes that teach learning strategies which can lead to more academic independence.
- Learn and use organizational and time management strategies.
- Begin career exploration that may include career aptitude and interest inventories.

SOPHOMORE YEAR

- Review freshman year checklist.
- Continue to build your graduation file. Contents may include high school activities such as awards or recognitions, a list of hobbies or leisure activities, and immunization records.
- Actively plan your IEP Meetings with your case manager, and plan to speak on your own behalf.
- Set academic goals that are achievable.
- Practice requesting your own accommodations rather than relying on your case manager.
- Use the GPS tool at http://gpslifeplan.org to set goals and design future plans.
- Investigate other service providers with your case manager who can offer assistance after graduation such as Vocational Rehabilitation, Social Security, mental health counselors or a school or county social worker.
- Begin to explore colleges, programs/degrees and entrance requirements.
- Discuss with your counselor college options, career choices and preparation for college entrance exams.
- Begin career exploration activities such as skill inventories, career aptitude and career investigation.
- Build your resume through school activities and volunteer experiences, as most scholarship and entrance applications place importance on student involvement.

JUNIOR YEAR

- Review freshman and sophomore year checklists.
- Continue to build your graduation file. New items may include college applications, scholarship applications and letters; support service and other agency contacts and letters, ACT, SAT or Accuplacer scores; recommendation letters with the names and addresses of those writing the letters; any new resume items including volunteer and other activities and job experiences.
- Assist your case manager in planning and running your IEP meeting and writing your IEP goals.
- Learn when, if and how to discuss the educational needs related to your disability with your instructors.

- Invite outside services providers to your IEP meetings such as Vocational Rehabilitation, social workers, Center for Independent Living, Social Security, mental health counselors, etc.
- Explore assistive technology that may be helpful now and at the postsecondary level.
- Practice self-advocacy skills (see self-advocacy chapter).
- Develop organization and time management skills so that you become as academically independent as possible. This may include using a planner, folders, a calendar or your phone so that you plan ahead for assignments due and activity involvements.
- Narrow your career choices and match them to postsecondary programs.
- Attend college fairs, open houses and/or weekend college retreats.
- Plan in-depth visits to several postsecondary institutions through the admissions or disability services offices.
- Discuss with postsecondary admissions departments about scholarships and financial aid programs. Find out from your parents if their workplace offers scholarships.
- Schedule assessment tests needed for college entrance requirements including the ACT, SAT or placement tests.
- Prepare for assessment tests that colleges require by attending preparatory classes, using purchased materials or online practice tests.Take the armed forces ASVAB test, if applicable.

SENIOR YEAR

- Continue to build your graduation file. New items may include college applications, FAFSA and financial aid information, high school transcripts, disability documentation such as your last IEP or 504 Plan, and most recent evaluation and/or additional items that build on prior file information.
- Lead your IEP meetings and lay out your written postsecondary plan.
- Make your senior year as close to the postsecondary experience as possible:
  - ✓ Use a planner to record assignments and appointments.
  - ✓ Utilize a systematic plan for organizing class materials.
  - ✓ Take challenging academic classes without modifications, if possible.
  - ✓ Request and use only the accommodations available at the postsecondary level.
  - ✓ Consider the options for assistive technology and learn how to use it.
  - ✓ Complete assignments on time.
  - ✓ Use your self-advocacy skills by speaking to the appropriate person when you need assistance rather than going immediately to your case manager.
- Understand the differences between high school and college. (See page 27)
- Complete college applications and submit with entrance fees. Most can be completed online. Earlier is better, but check college websites for deadlines.
- Discuss scholarship opportunities with your counselor and admissions staff. Search the web, but never pay for a scholarship search as this should be FREE.
- Have discussions with your family and counselor about financial aid and your college debt load.

- Apply for financial aid by completing the Free Application for Federal Student Aid (FAFSA) online before the priority deadline at the college you will be attending.
- Visit colleges before accepting admission. Plan to meet with admissions and disability services staff while on each campus. In the meeting with disability services, discuss documentation requirements and how the accommodations you need will be provided.
- If necessary, retake the ACT, SAT or Accuplacer exams.

14. Schoenbauer, Education Beyond High School, 2006.

ASSISTIVE TECHNOLOGY

Assistive technology (AT) is equipment or systems that help students with disabilities become more efficient and independent by performing functions that may otherwise be difficult or impossible. Colleges often offer a wide array of AT, so it is helpful for you to learn and use it while you are in high school. Types of AT include alternative textbooks, screen readers, speech-recognition programs and note-taking systems. Alternative input devices include alternative keyboards, electronic pointing trackballs and touch screens. Other AT products include screen enlargers or screen magnifiers, talking and large-print word processors and Braille embossers. Assistive technology can be demonstrated at locations such as the State Services for the Blind, PACER, the Courage Center and your local Centers for Independent Living.

PREPARING FOR COLLEGE ENTRANCE EXAMS

Preparation for college entrance exams, whether it be the ACT, SAT or Accuplacer placement tests, is a very helpful practice. Preparatory information is available in high school counselor offices, on testing websites, or can be purchased; some students also choose to enroll in entrance exam preparatory classes. Any preparation that can be done before taking the exam can increase your test scores. ACT or SAT scores are usually a part of college admissions criteria. Lower scores may also result in students having to register for developmental/pre-college classes when entering the first year of college. Some helpful preparatory websites include: ACT Online Prep (www.actstudent.org/onlineprep); SAT Practice (sat.collegeboard.org/practice); and Accuplacer Test Prep (testprepreview.com/accuplacer).

MINNESOTA CAREER FIELDS AND PATHWAYS INFORMATION

Setting career goals can be difficult. Many students enter college without a defined major in mind and often change their major several times. This is normal! However, the more you are goal and career oriented both in high school and in college, the more likely you will be successful. The Minnesota Career Fields and pathways document is available in the Resources section to assist in the process of thinking through career paths that are available to you in Minnesota.

10. Minnesota Department of Education, Minnesota Career Fields and Pathways Chart, 2010.

SELF-ADVOCACY

An important skill necessary for postsecondary success is the ability to self-advocate. Self-advocacy involves being able to speak and act on your own behalf, asking for help when it is needed, making informed decisions, and taking responsibility for these decisions. Being a self-advocate involves understanding yourself and your own disability, knowing your individual strengths and weaknesses, and being aware of your educational and personal needs. It also involves being able to express this information to others when necessary.

While in high school, many of your life decisions were made by parents, teachers, counselors and other professionals. Having support is also important in higher education, but you will be the one to determine when assistance is needed, provide the relevant information, and make the final decision of what is best. Your strongest advocate is you!

UNDERSTAND WHY YOU HAVE RECEIVED SPECIAL EDUCATION SERVICES

Do you know your own disability and why you received additional assistance while in high school? Can you explain without assistance from others your educational needs and the accommodations you have used successfully? While in high school, review your Individualized Education Program (IEP) or 504 Plan and your three-year evaluation or medical documentation with your case manager or counselor so you understand this aspect of yourself. Ask for a more active role in discussions about your educational goals and choices so you have a better understanding of your own disability and educational needs.

UNDERSTAND YOUR STRENGTHS AND WEAKNESSES

Develop a realistic understanding of your strengths, weaknesses, needs and preferences. Determine the skills you do well right now. What skills do you need to improve?

Most educational counseling offices can administer various interest and a career inventories to help you learn more about yourself. The results from these assessments can verify strengths and weaknesses that may assist you in choosing a career or field of study, especially when career paths are revealed that you never knew existed that match your strengths and interests.

LEARN FROM OTHER COLLEGE STUDENTS

If you have the opportunity, discuss with successful college students about the transition to college. They will be a good source of information as they answer your questions from a student's perspective. They can also ease your fears about the changes you will face at the postsecondary level.

LEARN HOW TO DISCUSS EDUCATIONAL NEEDS WITH INSTRUCTORS

In college, you will need to discuss your disability and educational needs with the disability services staff if you want to receive accommodations. Later, you may also need to discuss the implementation of some accommodations with your instructors. It is helpful to talk to your instructors about your accommodations while you are in high school so you will be comfortable with these conversations when you enter college. This will also help you learn when it is appropriate to discuss your educational needs, how much information to share, and the purpose of sharing information.

Some students are nervous about discussing the implementation of accommodations with college instructors. Realize you are not the first person to have this conversation. It may be difficult at first, but you will build confidence over time. Most conversations with college instructors about accommodations will be positive and helpful. However, if there are difficulties, you may find it necessary to include others, such as a professional from the disability services office, to assist in the request. Advocating is a reminder to others about the importance of providing an accessible campus for all students, both now and in the future.

12. Pocock, Lambros, Karvonen, Test, Algozzin, Wood and Martin, Successful Strategies for Promoting Self-Advocacy Among Students with LD, 1013.

WISE STUDENT ADVICE: LEARN SELF-ADVOCACY

Advice from a special education major:

"I received special education services all through high school. I discussed with my case manager during IEP meetings that I wanted to attend a community college after graduation and pursue my goal of becoming a special education teacher. My case manager realized that I needed to learn self-advocacy skills and how to take care of my needs independently if I was going to be successful in college. We determined that I would discuss with my high school instructors on my own the accommodations that I may need for each of my classes. I learned that I didn't need all of the accommodations for every class, but when I did need them, I had the conversation with my instructor. My case manager also drilled home that I needed to be organized with my homework, so I kept track of my assignments and made sure I got them completed on time because I knew that would be an expectation for college. I thought I would struggle more in my senior year with this added level of pressure on me, but I didn't! I also knew I had the support of my case manager to discuss any needs or if I had risks of failure."

PRACTICAL LEARNING STRATEGIES

College courses can provide academic challenges to students, especially students unprepared for the academic rigor experienced at the postsecondary level. Students who have learned practical strategies while they are in high school will have a smoother transition to college because the skills that have been learned can be implemented. In addition, these strategies will help students become more independent and active leaners, which is especially needed in the postsecondary environment. Consider the following as you refine your study skills in preparation for college courses.

LEARNING ASSESSMENT

Do you know how you learn best? Consider taking a learning assessment to discover your preferred mode of learning. Instructors may not provide information to you in your preferred mode, but if you understand yourself and how you learn, you, the student, can adapt classroom material to a method that will help you more readily absorb and retain information.

- Auditory learners find strategies such as recording lectures, listening to audio textbooks and studying aloud very helpful in the learning process.
- Visual learners should review notes and PowerPoints, highlight, color code and rewrite notes into visual forms, such as flashcards, charts, diagrams or mind maps.
- Kinesthetic learners learn by "doing," so adding physical movement to study time is essential. This could include pacing or taking a walk while studying from index cards, reading textbook while pedaling a stationary bike, listening to music, keeping one's hands busy with a stress ball, studying with others by verbally reciting and discussing the content, and taking a five-minute break for each 30 minutes of study.

MEMORIZATION TECHNIQUES

Memorization techniques are very important skills to have while in college, as the amount of information to be memorized increases in the postsecondary environment. New vocabulary, complex processes and the fast pace of learning new material are just some of the reasons memorization skills are crucial for college students.

- Stay interested. Keep your attention and focus on the material you need to learn.
- Time. Make a determined effort to carve out quality study time that is free of distractions.
- Memorization order. Memorize the information from general to specific.
- Organize. Sort or arrange the information you need to remember in groups, such as how they are similar or different.
- Visualize. Use a visualization technique, such as a mind map or picture.

- Relate. Form associations between new ideas you wish to remember and things you already know.
- Repeat. Rephrase information in your own words and use multiple senses to help you encode information. See it, say it, and write it.

STUDY SKILLS

How you approach your studies in college will have a direct effect on your academic success. Remain positive, remind yourself of the goals you have set, and use effective study methods such as these listed below.

- Study in one-to-three hour shifts, taking a break every 30 minutes to stretch or drink a beverage.
- Study when you feel well rested and relaxed, making sure to study during the time of day when you are most productive and alert.
- Study the more difficult information first when you are the freshest, saving for last the homework and projects you most enjoy or are not as strenuous.
- Stay nourished with healthy foods so you have energy and your brain can function well.
- Study before and after class. A good strategy is to read the text assignment before class and review your class notes while they are fresh in your mind.
- Study two or three hours for each hour of class you attend.
- Meet with instructors during their office hours if you are having difficulty learning new material.
- See a tutor from the college tutoring center, join a study group or use an online tutoring service that may be available for the course.

TEST TAKING STRATEGIES

To do well on tests, you need to know the material and be mentally prepared to show your knowledge of the subject. Try the following strategies for taking tests in college.

BEFORE A TEST:

- Review over time the material presented in class before the date of an exam. The more prepared you are, the more confident you will be; cramming is not an efficient learning method.
- Learn the exam format before the test if possible so you know if the test questions are multiple choice, short answer, true/false or essay.
- If you are anxious, try some stress-reduction techniques: take a walk, listen to music, or write down your anxieties 10 minutes before taking a test. (Harms, W. Writing About Worries Eases Anxiety, 2011.)

- Arrange for testing accommodations before an exam if it is an effective accommodation for your disability. Testing accommodations may include extra time, a quiet place, audio and enlarged print.

DURING A TEST:

- Think positively! Remind yourself that you studied hard and prepared for the test. If allowed, use scratch paper to write down what you think you will need to remember, such as formulas, facts or names.
- While taking the test, read the directions carefully, look over the sections of the test and budget your time for each section.
- Do the section of the test that you know the best first.
- Concentrate on your own test, not what others are doing.
- Read each question carefully before answering so you are sure to understand the question completely.
- When stuck on a question, cross off the answers you know are wrong. If you are not sure of the answer, move on to the next test question.
- Before you hand in your test, look it over to be sure you did not miss anything.

AFTER A TEST:

- After your test is graded, carefully read any comments from your instructor so you understand any mistakes you may have made.
- Ask your instructor for clarification for anything you still don't understand.
- Look back at your book and notes, and jot down information you learned from the test.

15. Study Guides and Strategies, Ten Tips for Terrific Test Taking.
5. Harms, Writing About Worries Eases Anxiety, Improves Test Performance, 2011.

NOTE TAKING

Note taking is an essential skill in college that can only be refined through practice. Because tests usually cover material that was presented in class, it is important to study from a good set of notes. There are many methods and systems for taking notes, so experiment and find a system that works for you.

- Take notes that are clear and concise, which is more effective than long, complicated notes.
- Organize your notes for each class session by writing the name of the class, topic and date that the notes were taken.
- Leave space on the page to add key words or other information. You can try taking notes on the right side of the paper and leave a wide margin on the left side.
- Audio record the lecture so that you can listen to the material again using a digital recorder or smartpen.

- Review your notes soon after class and rewrite sections that are unclear. Add missing information. Highlight the most important information for later study. This will also help you know if you need to check the book, the recording of the lecture, or with your instructor for further content clarification.

11. Pauk and Owens, *How to Study in College,* 2007.

TIME MANAGEMENT

Learning how to manage your time effectively is absolutely essential to success in college. An effective time management plan includes prioritizing tasks, implementing due dates, breaking down assignments, and scheduling times to be in class, study, work, do errands and attend appointments.

- Choose a time management system. This could be a planner, assignment log or a calendar in paper format, phone application or computer application. Choose one that will work for you, and use it daily.
- Prioritize your tasks and handle the top priorities first.
- Set realistic goals. It is common to underestimate how long an assignment will take to complete, so it is best to start assignments well before the due date.
- Use your planner to break down assignments. Determine all of the steps needed in order to complete an assignment and include those steps in your planner.
- Overcome stumbling blocks and procrastination. Evaluate the time spent on leisure activities such as video games, movies or texting with friends since it may have a negative effect on your study time. Be proactive in scheduling your leisure activities so they don't take over the time you have allowed for study.
- Check your planner daily. Update what you have completed, and track your progress so you can make adjustments as needed. Don't forget to reward yourself for working hard and completing your projects.

READING STRATEGIES

In college, you will be responsible for reading assigned textbooks, supplemental materials and online resources, so it is important to use effective reading strategies for comprehension. Common reading tips may include the following:

- Read in a quiet, well-lit area with comfortable seating.
- Take breaks to rest your eyes and your mind.
- Read aloud or use audio books to improve concentration.
- Take notes from the reading assignment and highlight important concepts.
- Take note of unfamiliar vocabulary and generate a list for study.

Read with a Purpose, Using the SQ3R Strategy

- **Survey.** Preview the assignment/material to be studied by scanning the text quickly to discover the central concept. From your preview, formulate an overall picture and purpose of what you are going to study.
- **Question.** Question what you need to learn in terms of what, why, how, who, and where to support the central concept. Write these questions in the margins of your textbook or at the top of your study notes.
- **Read.** Read specifically to answer the question. Most paragraphs contain one or more main ideas in support of a concept. Locate and highlight them with a marker, make notes in the margins, and pay attention to bolded or italicized type, graphs and illustrations.
- **Recall.** Pause periodically to recall in your own words the important ideas you have read.
- **Review.** See if you answered all of your questions and understood the new material. Go back and re-read difficult parts you may have missed in the recall. If there are review questions in the material, make sure you can answer them all.

13. Robinson, *Study Guides and Strategies: SQ3R Method,* 1970.

CHOOSING AND PAYING FOR COLLEGE

Students who are considering the option of attending a college should first have an idea of a career pathway and postsecondary training needed to obtain that career. Once this is determined, the next important step is to choose the college or training program that is right for you. A variety of colleges and training options are available, so you will want to research college websites and visit campuses to select the one that meets your educational and personal needs.

When researching your selection, keep in mind the level of education your career goal requires, such as a certificate, associate degree, bachelor's degree or master's degree, and then match this to a reputable program that awards the certification you will need for your chosen career. There are also short-term training options available such as workshops and noncredit-based courses for technical skills required in jobs such as welders, forklift operators and boilermakers. To narrow your search of choices, decide what you are looking for in a school and determine whether you prefer a small college, large university or online option. Other considerations include distance from home, size of the community, availability of dormitories or other housing options, and ease of transportation. For further information, check out the Minnesota State Colleges and Universities' website at www.mnscu.edu and the "GOMN" guide.

OPTION 1

MNSCU COMMUNITY AND TECHNICAL COLLEGES – PUBLIC

- Offer specific career and technical programs and also offer courses that fulfill the first two years of a four-year degree or "generals."
- Considered "Open Enrollment" – Admission requirements are minimal such as having a high school diploma or GED.
- Students can earn certificates and associate degrees.
- Offer many services including advising and counseling, tutoring and disability services.
- All are regionally accredited.
- Many have matriculation agreements so students can begin a course of study and complete the degree at a four-year institution.
- May have articulation agreements for students to receive college credit for training received during high school.
- Are public colleges and are the most affordable option.
- Usually do not have dormitories.

OPTION 2

MNSCU FOUR-YEAR UNIVERSITIES AND THE UNIVERSITY OF MINNESOTA – PUBLIC

- Students are usually required to complete general education requirements that include science and math and sometimes a foreign language.
- Usually have more stringent admission requirements than a community or technical college.
- Grant associate, bachelor's and master's degrees and higher.
- Offer services including advising, tutoring and disability services as well as more extensive services including health clinics, exercise facilities, counseling and career placement offices.
- All are regionally accredited.
- Tend to be more expensive than two-year colleges.
- Public colleges are the most affordable universities.
- Usually provide dormitories and food service.

OPTION 3

PRIVATE COLLEGES AND UNIVERSITIES

- Students are sometimes required to complete general education requirements that include science and math and sometimes a foreign language.
- Some may have more stringent admissions requirements than community or technical colleges.

- Grant certificates, bachelor's and master's degrees and higher, depending on the college.
- Some offer specialized training and certificates in various careers.
- Services usually available such as advising, tutoring, and disability services. Some may also offer more extensive services including health clinics, exercise facilities, counseling and career placement offices.
- Some may not be regionally accredited, so many credits may not transfer.
- Are more expensive than public colleges and universities.
- Includes for-profit and not-for-profit private institutions.
- Dorms and food services are usually available at non-for-profit institutions; dorms usually not available at for-profit colleges.

8. McNair and Solomon, *A Practical Guide for People with Disabilities Who Want to Go to College,* 2010.

COLLEGE & UNIVERSITY ENTRANCE REQUIREMENTS

In order to gain admission to a particular college or university, your high school and exam achievements must match the entrance requirements of the college or training school. These requirements apply to all students, including students with disabilities. A college admissions department will be able to identify the specific standards required for their institution, which may include some or all of the following admission criteria:

- A minimum high school GPA and/or class rank.
- High school diploma or GED.
- Transcript that meets requirements of core courses, such as a foreign language, mathematics, science and English.
- Score level on an application essay.
- Score level on standardized tests such as the ACT or SAT.

Course placement tests may also be a part of the college's admission requirements and can include these items:

- Accuplacer test of reading, writing and math/algebra
- Foreign language testing
- Math testing
- Music performance tests

PAYING FOR COLLEGE

FINANCIAL AID

Many students will need financial assistance to pay for college expenses. These expenses may include tuition, fees and possibly housing and food costs. College financial aid assistance is available for most students and is based on family income, which is

determined through the online submission of the **Free** Application for Federal Student Aid (FAFSA), which is available at www.fafsa.ed.gov. The FAFSA and other required documents should be submitted to your college financial aid office as early as possible before your freshman year of college. Make sure you check with your school for any priority application deadlines. Once your FAFSA has been reviewed and you have been admitted, you will receive a financial aid award from the college. Your award letter will describe the types of financial aid you qualify for, including loans, grants, scholarships and work-study options.

TYPES OF FINANCIAL AID

- **Scholarships –** Monetary awards in the form of scholarships can be awarded from colleges, both public and private, as well as organizations. Scholarship money never has to be repaid. Usually you will need to apply for scholarships, but not always. Check your college's websites and other sources for scholarship options. Remember: You should never pay for information on scholarships.
- **Grants –** Grants are like scholarships, except they usually come from the government or organizations and are based on financial need. Grants usually need to be applied for, which may involve completing the FAFSA and submitting your request to a specific college for financial aid assistance. The Pell Grant is a common federal grant – information about meeting the eligibility requirements is available at www.2.ed.gov/programs/fpg/eligiblity.html.
- **Loans –** Money loaned to students while they are in college is money they will have to repay once they have stopped attending a postsecondary school at least half-time. Federal Direct Loans come from the government with a low interest rate. A credit check or cosigner is not required, but the amount funded can be limited. Private and Alternative Loan programs usually require a credit check process as well as a cosigner. These loans may also have higher interest rates. Caution: All monies received through the forms of loans must be repaid once students have graduated or stopped attending college. Students need to fully understand the level of debt that they will experience and strive to keep the amount of loans to a minimum.
- **Work-Study –** Students who apply for financial aid at a college or university may be awarded the option to be employed on a campus and receive work-study funds. These funds are underwritten by the government so that students will have additional money for college expenses. Students earning work-study money are receiving a paycheck for the work they provide through a campus job. These monies do not have to be repaid.

VISIT COLLEGE CAMPUSES

After you have selected colleges that fit your needs, visit a campus before applying. This is your opportunity to determine if the college is a good fit for you. Does it meet your academic needs? Does it provide the services you require? Do you like it? You may also choose to use the college exploration worksheet located in the Resources section to

provide assistance as you compare colleges. In addition to the facts, this is your opportunity to see how you feel about the college and see if you can imagine yourself as part of the college community.

8. McNair and Solomon, *A Practical Guide for People with Disabilities Who Want to Go to College,* 2010.

FAMILY ROLES IN POSTSECONDARY PLANNING

Families, caregivers and adult mentors play a key role in the success of their young adults. This is true for the high school years, and it continues to be the case as their children transition to the postsecondary environment.

The role of parents changes when their son or daughter transitions to the postsecondary setting. As a parent, you will no longer be involved in every decision concerning your child's education. In addition to developing valuable life skills, your young person will have an opportunity to experience greater independence, meet new people, explore their interests, and increase their understanding of the world. Sometimes, students must be given the opportunity to fail and learn from these failures. At other times, the student needs that opportunity to shine. Your continued support and encouragement will help your son or daughter find success in the midst of transition.

Many topics should be considered in family discussions to assist in the transition process and to determine skills that need to be developed before your child attends college. During high school, the tendency is to focus on academic requirements for college admission. However, it is just as important that college students are prepared emotionally and socially and have developed competent life skills in order to be a successful college student.

Family conversation topics are detailed in the next few pages to assist you in determining the needs of your son and daughter. You will find questions for your student followed by important things to consider. Make a note of the areas of need for your student.

ORGANIZATION AND TIME MANAGEMENT

Do you wake up in the morning and get started on your own? Can you prioritize tasks that need to be accomplished? Do you have a method for organizing your work and keeping track of assignments and deadlines? Can you break large tasks/assignments into smaller, more manageable components? Do you procrastinate on your school work to the point that assignments are not done well or at all?

College students are responsible for being at class each day, meeting deadlines, and organizing and prioritizing tasks. Classes are frequently spaced throughout the day and different days have different schedules. Postsecondary students need to have a method for

organizing their life activities, which includes attending class, studying, working, sleeping, doing laundry, grocery shopping, keeping medical appointments, having fun and more! Many organizational tools can be utilized, but they need to be looked at daily. It is essential that students begin working on assignments early without being reminded so that coursework will not be late, as many college instructors will not accept late work. Time management is essential for college students, too. This includes managing a schedule and a workload with multiple priorities. The worksheets in the Resource section include tools for time management and organization.

MONEY MANAGEMENT

Do you have skills in handling money? Do you understand how credit cards work? Do you have a checking and/or savings account? Are you able to stick with a budget?

Independently managing your own money is an important and necessary life skill. Meals, activity fees, insurance, school logo clothing and a host of other non-educational cost can be overwhelming to students, so sticking to a determined budget along with wise shopping skills is essential to live within your means.

FINANCIAL AID AND SCHOLARSHIPS

Have you talked to your high school counselor about possible scholarship opportunities? Have you discussed with college admissions staff about financial aid packages or work programs? Have you submitted your FAFSA if you are attending college in the fall?

College can be very expensive, but there is often help available through college financial aid and scholarships. Financial aid needs should be discussed early, and an application for financial assistance should be submitted to the campus four to six months before courses begin. Loans, grants and other assistance are available, and students should understand the differences and the ultimate cost for their education. Large amounts of debt accrued while in college can be difficult or overwhelming to repay later.

DATA PRIVACY

Do you understand that you are in charge of your private information once you enter college? Are you prepared to enter into academic conversations with professors without assistance from others?

Students who attend college are adults and are given many rights including a right to privacy. Postsecondary institutions must comply with federal state privacy laws, including the Family Education Rights and Privacy Act (FERPA) and the Minnesota Government Data Practices Act (MGDPA). Because of these laws, private information is only available to a postsecondary student and not to others who may have an interest in the student,

unless the student has signed a release of information. Although a student can sign a release so that a parent or someone else has access to their private information, most faculty prefer speaking with the student directly about course and grade concerns rather than to parents. All college staff are accountable for compliance with privacy laws and realize the student needs to understand the conversation and take ownership of his or her own education.

VRS, SSI OR MENTAL HEALTH SERVICES

Have you had discussions about postsecondary education support services with your case manager? Do you know if you qualify for Social Security (SSI) or Vocational Rehabilitation Services (VRS)? If you use the services of a mental health counselor or therapist, do you know how these services will be provided at the new location if you go away to college?

Social Security benefits and Vocational Rehabilitation Services are available to students with disabilities and will require application to the program. Some universities provide clinical therapy services but if this is not a campus service, your doctor or therapist can suggest professionals in a new location if you are going away to college.

MEDICAL NEEDS

If on medication, can you self-administer? Can you self-advocate for special dietary or environmental concerns? Do you know who to contact for medical or dental emergencies? Can you complete insurance forms without assistance?

Many campuses have health clinics on site, while others have arrangements with clinics within the community. Some assume health and dental care are solely a student's responsibility. Pre-arrangement plans can be made between a family and the college, but ultimately the student will need to initiate assistance should the need arise; it is the student's responsibility to self-administer medication.

PERSONAL CARE ATTENDANTS OR PARAPROFESSIONAL ASSISTANCE

Are you accustomed to being accompanied to some or all of your high school classes by a paraprofessional? Do you have medical needs that require dorm or classroom assistance?

Colleges do not provide paraprofessional assistance, even when students received this service in high school. All students, even those with behavioral issues, will be held to the college's code of conduct, which sets a high standard for campus behavior. Students with medical concerns may hire a personal care attendant (PCA) or nurse to assist them in class or in the dorm. This should be discussed with your college disability services provider so that the role of the PCA is understood by all involved.

EATING AND EXERCISE

Do you have an understanding of nutritional foods and the need for regular exercise? If you live in an apartment on your own, do you know how to plan meals on a tight budget or how to prepare some simple, healthy meals? Do you exercise on a regular basis?

It is common for college students to gain 15 to 25 pounds during the freshman year, largely due to poor eating habits. Junk food and quick meals often replace healthy and nutritious ones. Poor eating habits and lack of exercise can cause a student to be less energetic and nonproductive and can lead to overall poor health.

CLUBS AND ORGANIZATIONS

Have you thought about the involvement you would like to have at the postsecondary level? Have you researched what options are available at the college you would like to attend? Are you willing to join groups when you know few or none of the other members? Have you made contacts with any members from a club or organization during a campus visit?

The college experience can be greatly enhanced by successful social interaction among students. Colleges offer a wide variety of recreational and social activities including clubs and organizations, but it is up to the student to take the initiative and join. Involvement will not be forced, so students must accomplish this on their own.

CLOTHING AND HYGIENE

Do you know how to separate clothing for washing? Do you understand washing and drying temperatures for various fabrics? Do you shower regularly and use deodorants and perfumes appropriately?

Too much odor can socially isolate a student more quickly than almost anything else. It is important that students take the initiative to wash themselves and their clothing regularly. To avoid ruining expensive or favorite clothing, the student should be well practiced in the use of a washing machine and dryer.

HOME ALONE

If going away to college, have you ever spent extended time away from home? Can you manage all the tasks of daily living without parental assistance such as cleaning, grocery shopping and paying bills?

For students who leave home to attend college, homesickness and/or the need to care for oneself can be overwhelming. Living in a dorm or an apartment is far different and more demanding than living at home and doing a few chores. Students should be encouraged to

learn and use home living skills while in high school so that they can live successfully on their own.

TECHNICAL AND COMPUTER SKILLS

Do you feel comfortable using a computer for writing assignments or web searches? Are you able to perform technical functions on your own? Are you able to type 30-40 words per minute? Do you know where you can go on campus for technical assistance?

College students are expected to submit papers that are word processed. They also need technical skills to maneuver student platforms and online services. Being able to keyboard or use assistive technology at a sufficient speed will aid in timely assignment completion. Students who lack computer experience or skills should take a class in high school or use educational software to improve computer skills. They should know where to seek assistance on a college campus.

MAJOR OR CAREER GOAL

Have you thought about the major you will pursue at the postsecondary level? Do you know if the major you have in mind is available at the postsecondary institutions you have contacted or visited? Do your personal and academic strengths align with the major you are considering? Do others who know you best agree with your career goals? Do you understand the kind of coursework required for this major?

The more a student understands his or her career path and the desired major, the more likely a student will choose a college that matches that goal. Every major is not available at every postsecondary institution, but most of this information is readily available on college websites. Many pathways are also available to students to earn a degree, including the option to begin general education classes at a community or technical college and finish at a four-year university.

POSTSECONDARY EDUCATION OPTIONS INCLUDING ADULT BASIC EDUCATION (ABE)

Have you taken placement tests at your high school? Do you know what the resulting scores mean? Do you know about ABE options if your scores are low or if you feel you would benefit from more educational assistance?

Some students may not be academically prepared to attend a postsecondary institution right out of high school, which may become evident after taking a placement test. Adult basic education (ABE) classes are often available, free of charge, to assist students with building up their skills in reading, writing, math and computers.

An "Open Letter to Parents of Students with Disabilities About to Enter College" by Jane Jarrow is available at www.arkahead.org/pdf/letterfromjane.pdf. This letter provides helpful

information to parents from the perspective of a parent who also works in the disability service field.

14. Schoenbauer, *Education Beyond High School,* 2006.

DOCUMENTATION AND DISCLOSURE

DISCLOSING A DISABILITY

Disclosure means to share personal information about your disability with others so you can receive accommodations. Disability information is disclosed at the postsecondary level when you meet with the disability services staff, preferably before the semester begins, so that accommodations are in place for you to use when needed. When to disclose is your choice, but sooner is better.

IEPs AND 504 PLANS END WHEN STUDENTS GRADUATE FROM HIGH SCHOOL

When special education students were in elementary through high school, the Individuals with Disabilities Education Act (IDEA) required that students were provided with appropriate services. An Individualized Education Plan (IEP) or 504 Plan was developed each year and was implemented by teachers and other special education professionals addressing the educational needs stated in the evaluation. However, once students graduate from high school, the Individualized Education Plan (IEP) or 504 Plan comes to an end. Because of this, it is up to a student to make the decision whether or not to disclose/reveal information about a disability at the postsecondary level.

PRIVACY OF DISABILITY

Privacy is a concern for many students who may be hesitant to disclose a disability. However, the information from your disability service file does not appear on your college transcript and the contents of your file are kept securely. You should consider all of this information when and if you choose to disclose.

REQUEST FOR DOCUMENTATION

Documentation is usually requested by college disability service providers when accommodations are requested. This documentation may include records from a professional, such as a medical doctor, psychologist or other qualified diagnostician. High school information, such as an Individualized Education Plan (IEP) and last three-year evaluation or Section 504 plan, may help identify services that have been effective and may qualify as sufficient documentation. However, this is not always the case. If a new evaluation or further information from a medical doctor or psychologist is needed, the cost for this service is paid for by the student.

ESSENTIAL COMPONENTS OF COLLEGE DISABILITY DOCUMENTATION

Most college disability services staff will want documentation to include this information:

- Signed, dated and typed letter on professional stationery from a certifying professional such as a medical doctor, psychologist or neurologist who has credentials for diagnosing a disability.
- Clearly stated diagnosis.
- Description of assessment and relevant history.
- Description of functional limitations or educational impact.
- Current enough documentation to determine present impact and validate the accommodation request.
- Recommendations for accommodations, including what has been helpful in the past.

This information, in addition to your input and the requirements of your course or program, are the basis for determining effective and appropriate postsecondary accommodations.

WISE STUDENT ADVICE: KNOW WHAT WORKS BEST FOR YOU

Advice from a social work major:

"I am a student registered through disability services. I have a Traumatic Brain Injury (TBI) and currently have a 3.85 GPA. I am very proud of this! As I've learned to deal with my TBI, I've realized how important it is to ask for help. I really needed to get over my pride and now that I have, this has helped me tremendously. Some of the strategies I've used to be successful here is to really understand my disability and how it affects me. I've learned I cannot take 8 a.m. classes, no back-to-back classes, and I even try to take classes every other day. Breaks are essential for me. I've also learned that taking a stress relief course or some kind of less intense class with my other more difficult classes help to even my class load. I've taken yoga and piano courses that have been relaxing for me. I'm okay with all of this, because I know it is essential to helping me be successful here at Central Lakes College. I couldn't have done all this without the guidance and support from disability services."

ACCOMMODATIONS IN COLLEGE

Reasonable accommodations are available to postsecondary students who are willing to disclose a disability. An accommodation is a support that gives students an equal opportunity to participate and benefit from college, which has been authorized by the Americans with Disabilities Act (ADA). Accommodations are developed and approved through the college disability services (DS) office, but keep in mind that the names of the offices and the staffing models may be different from one campus to the next, depending

on the size and type of institution. Most of the information you will need to find about the DS office should be available on the college website.

If you choose to meet with a DS professional in order to receive accommodations, you will usually be required to provide documentation. This documentation gives the DS personnel information to support the accommodations you are requesting as well as give a history of accommodations you have used successfully in the past. Any specific questions should be directed to the DS office at your campus.

ACCOMMODATIONS GRANTED ON A CASE-BY-CASE BASIS. SOME EXAMPLES BELOW:

1. Changes to a classroom environment or task that can include the following examples:
    - Extended time or quiet place to take an exam
    - Assistance with lecture notes, such as a note-taker, web notes, permission to audio record lectures or use of a smartpen.
    - Materials and/or books in alternative formats such as audio, large print or digital format.
    - Use of a dictionary or spell checker.
2. Removal of architectural barriers, such as adapting a classroom or lab to meet the needs of a student who uses a wheelchair.
3. Exceptions to policies, practices or procedures with examples that include these accommodations:
    - Priority registration.
    - Accessing assignments early.
    - Early access to the course syllabus.
4. Provision of auxiliary aids and services that include the following examples:
    - Providing a sign language interpreter.
    - Closed circuit television (CCTV).
    - Screen-reading software.
    - Voice-activated software.

MEETING WITH DISABILITY SERVICES PERSONNEL

In order to receive accommodations, it is your responsibility to make an appointment to meet with the DS professional. At the meeting, which is sometimes called an intake or interview, be prepared to talk about yourself, your educational goals and your disability. You should also be ready to answer questions about your ability to access programs, activities and services of the college.

REASONABLE ACCOMMODATION PROCESS

Your meeting with the DS professional is an interactive one with the objective of ensuring equal access, the removal of architectural barriers, and the provision of reasonable and appropriate auxiliary aids and services. What will be considered in the process?

- Disability: Do you have a physical or mental impairment that substantially limits a major life activity?
- Qualified: Do you meet the college course of program requirements?
- Known: Is there adequate documentation that is current and supports the requested accommodations? Was the documentation provided by a qualified assessor?
- Further considerations: Does the requested accommodation fundamentally alter a program or the academic standards of a course or program? Does the accommodation impose an undue financial or administrative burden on the institution? Are you a threat to yourself or others?
- Result: The result of the process is the availability of reasonable accommodations

QUESTIONS FOR DISABILITY SERVICES PROFESSIONAL

When you meet for an intake interview, you should also have questions ready for the DS professional so that you can gain a better understanding of the particular program. Questions could include the following:

- How many students are registered to receive disability services on campus?
- Once an accommodation plan is implemented, how are the services provided?
- How are instructors notified of recommended accommodations?
- When do I need to meet with disability services? Do I need to request accommodations for each term I am registered?
- What technology is available for use by students with disabilities? Is the technology available for use in the classroom?
- What support is available for learning to use adaptive technology?
- What additional services are available on campus for student success, such as tutoring or help with time management?

DIFFICULTIES WITH ACCOMMODATIONS

If you are having difficulties with the implementation of any of your accommodations, you should notify the DS staff as soon as possible. Communicate your needs and be flexible, as things do not always happen as expected or are not implemented in the same way as they were in high school. Successful accommodations come from open and timely collaboration between the college staff, faculty and you the student.

ACCOMMODATIONS VS. MODIFICATIONS

Students with disabilities transitioning directly from high school to college might be used to services that will not translate well to the college environment. Course modifications that alter the fundamental requirements of a course will not be allowed. For example, for many courses regular attendance is required and may be a part of the course grade. Assignment due dates also will not be automatically extended as an accommodation, but will be handled on a case-by-case basis. While extra time on tests is a common accommodation in college, modification of tests will usually not be an option. For example, rephrasing questions or reducing the number of choices on a multiple choice test will not be allowed. If a student is accustomed to these types of course modifications in high school, the best approach is to start slowly and take fewer credits, at least initially.

ACCOMMODATIONS NOT PROVIDED BY DISABILITY SERVICES

In accordance with the law, there are some modifications and services that colleges do not provide as a reasonable accommodation that may include the following services:

- Individually prescribed deserved such as wheelchairs, hearing aids or glasses.
- Personal services, such as a private tutoring transportation or personal-care attendants (Note: Tutoring services may be available elsewhere on campus for all students.)
- Modifications that lower or change course standards or program standards and would change the essence of a program, such as allowing a student in an auto mechanics program to take a written test on repairing an engine, or allowing a student in a public speaking class to substitute a written paper for an oral presentation, and/or services which are unduly burdensome, administratively or financially.

OTHERWISE QUALIFIED: MEETING ACADEMIC REQUIREMENTS AND STANDARDS

Disability accommodations depend on whether you are considered "otherwise qualified." A student with a disability is otherwise qualified when he or she can meet the same academic requirements and standards as non-disabled students. All students are required to meet an instructor's expectation regarding class participation, work standards, attendance and ability to demonstrate knowledge. Students also need to adhere to general college policies, including the college code of conduct and satisfactory academic progress. When course accommodations are being developed, consideration is given to the necessary requirements and standards of the course.

POSTSECONDARY TECHNICAL STANDARDS

The term "technical standard" refers to nonacademic criteria that are essential to participation in a college course or program. Examples of technical standards may include

the ability to manipulate materials in a laboratory, the ability to recognize colors or patterns, or even behavioral requirements. If technical standards are necessary for demonstration of mastery, and if reasonable accommodations are provided as appropriate, programs may establish standards of eligibility criteria even if physical tasks and/or levels of achievement will likely be impossible for some persons with a disability.

POSTSECONDARY EDUCATIONAL OPTIONS

Students with disabilities concurrently enrolled in high school and college under Postsecondary Enrollment Options (PSEO) must meet the requirements of the college. Reasonable accommodations are determined by the college, but the school district may provide auxiliary services, such as additional tutoring outside of the classroom. For more information on PSEO or concurrent enrollment, students should meet with a PSEO admissions representative or with disability services prior to enrollment.

17. United States. *The Americans with Disabilities Act Handbook.* 1990, 2008.
16. United States. *Section 504, Rehabilitation Act of 1973.*

WISE STUDENT ADVICE: PARTNER WITH DISABILITY SERVICES STAFF

Advice from a nursing major

"Working with disability services is one of the most important things that I have found to be very helpful to me in my college experience. I would like to share some advice for those who are wondering how disability services can help them in their college experience.

The first suggestion is to see what services are offered at the college of your choice. There are more options that are offered at college than there are at high school. For example, I have an accommodation for note-taking and to help me with this I use a smartpen that records audio and notes I write on a special type of notebook. When I am done with class, I can upload the information to my computer at home and all my lectures and notes are available for me to listen to as many times as I need. When taking tests, I use a private room and have access to a program that reads the tests to me at my preferred speed level. This is very helpful for someone who may be an auditory learner. What I like about the private rooms is that they are quieter than when I was in high school and I am able to concentrate better.

My final suggestion is to get to know the staff. It is important to know the staff because they will get to know you and your learning style. As you get to know the staff, you will know who to approach and feel comfortable bringing up any concerns. I had an experience with a concern where a new teacher was starting and I explained to this teacher that I had accommodations and that with test-taking I would prefer to take the test in the private room in the Academic Support Center. This teacher did not understand and did not follow my accommodations. I brought this concern up with one of the staff members at the Academic

Support Center and this staff member emailed this instructor to explain more about what their services were and what my accommodations were. When talking with this instructor again, everything was clearer for both of us and my accommodations were followed. This is a great example of how staff members are always willing to help with anything."

DIFFERENCES BETWEEN HIGH SCHOOL AND COLLEGE

If you thought going from elementary school to high school was a big change, get ready! The difference between high school and college can be overwhelming, yet exciting. In college, you have the freedom to make more of your own decisions and are in charge of what you do. You also need to be responsible and accountable; understanding the differences between high school and college will assist you to be prepared for these changes.

The following is a comparison between high school and college, based on information compiled by the Minnesota Association for Developmental Education. Not every possible area or scenario has been covered, but there is enough information so you can get a strong sense of how colleges operate.

FOLLOWING THE RULES IN HIGH SCHOOL

- Attending high school is mandatory and usually free.
- Your time is structured by others.
- You need permission to participate in co-curricular activities.
- Adults will remind you of responsibilities and help you set priorities.
- You are not responsible for knowing what it takes to graduate.
- You are usually corrected if your behavior is out of line.

BEING RESPONSIBLE IN COLLEGE

- Attending college is voluntary and is expensive.
- You manage your own time.
- You must decide whether to participate in co-curricular activities.
- You balance your own classes with the help of an advisor.
- Graduation requirements may change, and you are responsible for knowing what applies to you.
- You are expected to take responsibility for your actions as well the consequences for your decisions.

HIGH SCHOOL CLASSES

- You have limited class choices and the school creates your schedule.
- Generally classes have no more than 35 students.
- You proceed from one class directly to the next.

- You usually spend six hours a day in classes.
- Attendance is taken.
- Textbooks are provides a little or no expense.
- Required classes are the same for all students.
- Modifications that change course rigor, volume or outcomes may be offered based on an IEP.
- You will do most of your studying in class.

COLLEGE CLASSES

- You choose your classes and set your schedule.
- Classes may have more than 100 students.
- You often have several hours between classes which may be scheduled throughout the day and evening.
- You attend 2-4 classes per day, usually 12-16 hours per week.
- Attendance may or may not be taken, but professors know who misses.
- Textbooks are expensive. The cost is your responsibility.
- Classes are based on a field of study and requirements vary.
- Modifications that change rigor, volume or outcomes will not be offered.
- You will do most of your studying outside of class, at least 2-3 hours outside of class for each hour in class.

HIGH SCHOOL TEACHERS

- Teachers remind students of incomplete work.
- Teachers approach students if they feel they need help.
- Teachers are often available for conversation before, during or after class.
- Teachers have been trained in teaching methods to assist in imparting knowledge to students.
- Teachers provide you with information you may have missed if you were absent.
- Teachers present material to help you understand what is in the textbook.
- Teachers often write information on the board to be copied in your notes.
- Teachers impart knowledge and facts, sometimes drawing direct connections and leading you through the thinking process.
- Teachers often take time to remind you of assignments and due dates.
- Teachers bear much of the responsibility for your learning.

COLLEGE PROFESSORS

- Professors may not remind students of incomplete work.
- Professors are usually open and helpful but most will expect you to initiate contact if you need assistance.
- Professors expect and want you to attend scheduled office hours.
- Professors have been trained as experts in their particular areas of research.

- Professors expect you to get from classmates any information you may have missed when absent.
- Professors may not follow textbooks. You are expected to read on your own. Lectures enhance information from the book.
- Professors may lecture non-stop, expecting you to identify the important point in your notes. When professors write on the board, it may be to amplify the lecture, not to summarize it. Good notes are a must.
- Professors expect you to think independently and make the connection between topics.
- Professors expect you to read, save and refer to the course syllabus to keep track of due dates and assignments.
- You bear the responsibility for your learning while professors serve as guides, mentors and resources.

STUDYING IN HIGH SCHOOL

- You may study as little as 0-2 hour per week and this may be to get ready for a test.
- You often need to hear or read material only once to learn all you need about a topic.
- You read short assignments that are then discussed in class and often retaught in class.
- You are frequently told what you need to learn from assigned readings.

STUDYING IN COLLEGE

- You may need to study at least 2-3 hours for each hour of class.
- You will need to continually review class notes and text information to learn course materials.
- You may be assigned large amounts of reading and writing that may not be discussed in class.
- It is up to you to understand what must be learned from reading assignments. Lectures and assignments proceed from the assumption that you have already read the material.

TESTS IN HIGH SCHOOL

- Testing is frequent and covers small amounts of material.
- Makeup tests are often available.
- Teachers may rearrange test dates to avoid conflict with school event times.
- Teachers frequently conduct review sessions.
- Mastery is usually seen as the ability to reproduce what you were taught in the form in which it was presented to you.

TESTS IN COLLEGE

- Tests may be infrequent and cover large amounts of material and could be cumulative. You, not the professor, organize the material to prepare for a test.
- Makeup tests are often not available.
- Professors in different courses usually schedule tests without regard to the demands of other courses or outside activities.

- Professors usually do not offer review sessions, and when they do, they expect the student to come with questions and be an active participant.
- Mastery is often seen as the ability to apply what you have learned to new situations or to solve new kinds of problems.

HIGH SCHOOL GRADES

- Grades are given for most assigned work.
- Good homework grades may help to raise poor test scores.
- Extra credit options are usually available to raise your grade.
- Initial tests are usually not counted, especially if they are low.
- You may graduate as long as you have passed all required courses with a grade of D or better.

COLLEGE GRADES

- Assigned work may or may not be graded.
- Tests and major papers provided the majority of the grade, but a grade may be lowered if homework is not done.
- Extra credit options are usually not available to raise a course grade.
- First tests reveal expectations of the instructor and are usually part of the final grade.
- You may graduate only if your average in classes meets the departmental standard, typically a 2.0 (C) or better.

SPECIAL EDUCATION IN HIGH SCHOOL

- Individuals with Disabilities Education Act (IDEA) applies to high schools.
- Students receive special education and related services based upon identified needs.
- Behavior can be viewed as a manifestation of the disability, and different behavior standards are allowed.
- Accommodations and modifications are communicated to the teachers by the case manager.
- Modifications that change course rigor, volume or outcomes may be offered based on an IEP.
- Services are delivered to the student.
- The school informs the parents of your progress.
- The case manager and/or parent act as your advocate.
- Schools are required to identify students with disabilities through free assessments.
- Services may include individually designed instruction, curriculum modifications and accommodations based on an IEP.
- There are regular meetings to discuss your progress.
- Assessment, physical therapy and personal care are provided by the high school.
- School personnel seek you out and decide what services and support you can receive.
- You receive service in a special education classroom or from a related service provider.

- Documentation is coordinated by a school psychologist or appointed staff person. The high school staff develops an IEP from documentation, and testing is provided and paid for by the school.
- IDEA provides the mandate and funding to schools for in-school special education services as well as transportation/buses to school, physical, occupational, speech therapy, and tutoring.

DISABILITY SERVICES IN COLLEGE

- State law, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) apply to colleges.
- Disability services are available.
- You must meet the college's behavioral conduct standard.
- Modifications are usually not available, and you must request and discuss accommodations yourself.
- Modifications that change rigor, volume or outcomes will not be offered.
- You must request services through the disability service office.
- The school cannot communicate with your parents without your permission.
- You need to be your own advocate.
- You are responsible for disclosing your disability, providing current documentation and paying for an assessment if needed.
- Reasonable accommodations for access are available. The 504 Plan IEP end upon high school graduation.
- You are responsible to monitor own progress.
- You are responsible for arranging and paying for personal services and medical care.
- You must request help; no one will come to find you.
- You receive access services from a designated person or office, and the services model may differ from college to college.
- You must provide information about your disability (documentation), and colleges can set their own guidelines for documentation. After high school, you may be requested to pay for a new evaluation if one is needed.
- Colleges are requested to offer reasonable accommodations and support services, not services of a personal nature. Tutoring is usually not offered through disability services, but it generally a service available to all students. It is your responsibility to arrange for the transportation and therapy you need.

9. Minnesota Association for Developmental Education. *College Readiness: Understanding the Differences between High School and College, 2004.*

WISE STUDENT ADVICE: USE COLLEGE SERVICES

Advice from a special education major:

"I transitioned to a community college the fall after I graduated from high school. I registered with the disability services office right away and easily understood how to request accommodations when they were needed in my college courses. I took classes at two different community colleges and two different four-year MnSCU colleges and

eventually earned my degree in special education. I am now a special education teacher and I have a lot of personal experiences to help my students. I would advise students who are starting college to take advantage of the help that is offered and listen to your teachers about the skills needed outside of high school. Follow through with you accommodations and use them. Stay focused on school and on what you need to get done so you can get your education completed more quickly and easily."

TRANSITION TO EMPLOYMENT

Just as there is a transition from high school to postsecondary education, there is also a transition from postsecondary training to beginning your chosen professional career.

Finding a job is your responsibility and sometimes can be difficult. Employment statistics state that by 2018, 70 percent of the jobs in MN will require some postsecondary training beyond high school. A person with advanced skills and qualifications for jobs will have more career options and the opportunity to choose among a variety of places to work and live. They are also more likely to receive important benefits such as medical or dental insurance, paid time off, bonuses, and retirement plans. Labor statistics show that earning potential is much higher and unemployment is much lower for those who attend postsecondary training or education than for those who only have a high school diploma or GED. Advanced training has other benefits. This may include better schedules, working environments, and advancement potential.

1. Carnevale, Smith, and Strohl, *Help Wanted: Projections of Jobs and Education Requirements through 2018,* 2010.

POSTSECONDARY CAREER AND JOB PLACEMENT

Many students have entered a particular field of study based on the numbers of graduates from a program who are able to secure competitive employment after graduation. Most colleges and universities have job placement and career development offices that can assist students in securing a position in their field. College job placement offices usually offer individual and group assistance in career assessment and exploration, job search techniques, as well as resume writing and interviewing skills. Many of these offices have video and multimedia resources as well as one-on-one assistance. Employers also are aware of specific college programs and will post job openings on the college job placement website. Networking with other program graduates and college alumni who have connections to employers is a powerful way to get interviews and job offers in a competitive market. Minnesota has a comprehensive network of work force centers that can help job seekers find employment. These centers offer job search guides, workshops, training, as well as networking and job clubs. Centers are located throughout the state, and additional information is available at Minnesota's Department of Employment and Economic Development website: mn.gov/deed/job-seekers.

ONLINE PLACEMENT SERVICES

Minnesota has many other services and programs available to assist job seekers:

- Minnesota Department of Employment and Economic Development: mn.gov/deed
- Career One Stop: www.careeronestop.org

Other websites are also available for job searches, including individual company websites and temporary position sites. Additional supports are available during the job search such as Supported Employment Programs and Centers for Independent Living. Your local Vocational Rehabilitation office may also be able to provide assistance and will have information about support services available during the job search.

ON-THE-JOB ACCOMMODATIONS

Once you have been offered a position of employment, accommodations can be requested if you need them. You will need to take the lead in requesting and arranging the accommodations. There are service providers who can assist with designing effective accommodations for the workplace, including a vocational counselor, a medical professional or the company human resources manager. The human resources manager is a resource for discussing effective accommodations you have accessed in prior jobs or at a postsecondary institution. Remember, however, that many of the accommodations used at the postsecondary level will not be applicable or appropriate for employment. The manager may ask you to provide current documentation, so having updated disability information is usually essential. It is important to remember that the ADA and Section 504 of the Rehabilitation Act are civil rights laws that state that employers cannot discriminate against persons due to a disability. However, these laws do not automatically entitle a person with a disability to a specific job since all potential employees have to meet the required qualifications and performance standards for the job.

NOW IS THE TIME

It is your investment in postsecondary education that will lead you to that great job and a progressive career path. Time taken now to research your career options and develop an education and career plan will help you reach the goals you have established for your adult life.

18. United States Department of Labor: Office of Disability Employment. The Why, When, What, and How of Disclosure in an Academic Setting, After High School.

RESOURCES

MINNESOTA CAREER FIELDS, CLUSTERS & PATHWAYS CHART EXPLANATION

A link to the full image of the diagram is located at tiny.cc/mg9dmx.

MINNESOTA PROGRAM OF STUDY

The Minnesota Career Fields, Clusters & Pathways chart graphically depicts the organizing framework of the foundation knowledge and skills, career fields, career clusters, and career pathways that Minnesota will use for developing programs of study in career and technical education. Once developed, learners at various levels (high school, collegiate, or workforce training level) will then be able to choose from several individual programs within a program of study in order to attain the specific knowledge, skills and abilities needed to pursue a career of their choice.

Programs of Study are sets of aligned programs and curricula that begin at the high school level and continue through college and university certificate, diploma and degree programs. The following are some of the key elements that underlie the definition:

- Competency based curricula tied to industry expectations and skill standards;
- Sequential course offerings that provide strategic entry and exit points as needed throughout a lifetime – this leads to manageable "stepping stones" of skill building, high school graduation and postsecondary education completion;
- Flexible course and program formats convenient for learner segments;
- Course portability for seamless progression;
- Multiple entry and exit points to support continuing education, returning adults, and dislocated workers;
- Connections between high school and postsecondary education, skill progression, and career opportunities that align academic credentials with job advancement in high-skill, high-wage or high-demand occupations.

FOUNDATION KNOWLEDGE AND SKILLS

Foundation Knowledge and Skills represent the base from which to build work and college readiness.

Academic and Technical Literacy Skills

Employability; ethics; systems; teamwork; career development; problem solving; critical thinking; Information Technology application; legal responsibilities; communication; safety, health, and environment; social studies; math; science; English; and personal finance make up the foundation knowledge and skills your educational experience will provide you to use on your job!

CAREER FIELDS

Career fields are the organizing structure for the 16 career clusters and 81 pathways. The fields represent the broadest aggregation of careers. Students are normally exposed to career field exploration in middle school and early high school. Career fields have been identified as:

- Agriculture, Food, & Natural Resources
- Arts, Communications, & Information Systems
- Engineering, Manufacturing, & Technology
- Health Science Technology
- Human Services
- Business, Management, & Administration

CAREER CLUSTERS WITH CAREER PATHWAYS

Career clusters represent a grouping of occupations and broad industries into a national classification of 16 clusters that are based upon common knowledge and skills. Career clusters include hundreds of occupations that may be grouped into pathways around which educational programs of study can be built.

Career Pathways represent an organization of related occupational areas within a specific career cluster. Each of these pathways has identified knowledge and skills validated by industry from which programs and programs of study are developed.

Below are the career fields and clusters listed with their associated career pathways:

- Career Field: Agriculture, Food, and Natural Resources
    - Career Cluster: Agriculture, Food, and Natural Resources
        - Animal Systems
        - Agribusiness Systems
        - Environmental Service Systems

        - Food Products and Processing Systems
        - Natural Resources Systems
        - Plant Systems
        - Power, Structural, and Technical Systems
- Career Field: Engineering, Manufacturing, and Technology
    - Career Cluster: Architecture and Construction
        - Construction
        - Design and Pre-construction
        - Maintenance and Operations
    - Career Cluster: Manufacturing
        - Production
        - Manufacturing Production Process Development
        - Maintenance, Installation, and Repair
        - Quality Assurance
        - Logistics and Inventory Control
        - Health, Safety, and Environmental Assurance
    - Career Cluster: Science, Technology, Engineering, and Mathematics
        - Engineering and Technology
        - Science and Math (investigative, informational and Educational)
    - Career Cluster: Transportation, Distribution, Logistics
        - Facility and Mobile Equipment Maintenance
        - Health, Safety, and Environmental Management
        - Logistics Planning and Management Services
        - Sales and Services
        - Transportation Operations
        - Transportation Systems and Infrastructure Planning, Management and Regulation
        - Warehousing and Distribution Operations
- Career Field: Arts, Communications, and Information Systems
    - Career Cluster: Arts, Audio/Video Technology and Communications
        - Audio and Video Technology and Film
        - Journalism and Broadcasting
        - Performing Arts
        - Printing Technology
        - Telecommunications
        - Visual Arts
    - Career Cluster: Information Technology
        - Information Support and Services
        - Network Systems
        - Programming and Software Development
        - Web and Digital Communications
- Career Field: Business, Management, and Administration
    - Career Cluster: Marketing, Sales, and Service
        - Buying and Merchandising
        - Distribution and Logistics
        - E-Marketing

        - Management and Entrepreneurship
        - Marketing Communications and Promotion
        - Marketing Information Management and Research
        - Professional Sales and Marketing
    - Career Cluster: Hospitality and Tourism
        - Lodging
        - Recreation, Amusements and Attractions
        - Restaurants and Food/Beverage Services
        - Travel and Tourism
    - Career Cluster: Business, Management, and Administration
        - Administrative and Information Support
        - Business Analysis
        - Business Financial Management and Accounting
        - Marketing
        - Human Resources
        - Management
    - Career Cluster: Finance
        - Banking and Related Services
        - Business Financial Management
        - Financial and Investment Planning
        - Insurance Services
- Career Field: Human Services
    - Career Cluster: Education and Training
        - Administration and Administrative Support
        - Professional Support Services
        - Teaching and Training
    - Career Cluster: Government and Public Administration
        - Revenue and Taxation
        - Foreign Service
        - Governance
        - National Security
        - Planning
        - Public Management and Administration
        - Regulation
    - Career Cluster: Human Services
        - Consumer Services
        - Counseling and Mental Health Services
        - Early Childhood Development and Services
        - Family and Community Services
        - Personal Care Services
    - Career Cluster: Law, Public Safety, Corrections, and Security
        - Correction Services
        - Emergency and Fire Management Services
        - Law Enforcement Services
        - Legal Services
        - Security and Protective Services

- Career Field: Health Science Technology
  - Career Cluster: Health Science
    - Biotechnology Research and Development
    - Diagnostic Services
    - Support Services
    - Health Informatics
    - Therapeutic Services

COLLEGE EXPLORATION QUESTIONS

In this next section, you will find information that will be important to know as you explore colleges. Use this as a reference list that you can gather the information asked in these sections and make a better determination of the college that best meets your needs.

GENERAL COLLEGE INFORMATION

This is the list of general college information that you should keep track of to make your final decisions using:

- College name
- Admissions contact person name
- Office number
- Phone number and email
- Website address
- Size of the college
- Average ACT and SAT scores needed
- Size of the town or city the college is located
- Average class size

GETTING THERE AND GETTING AROUND

These are the things to consider for getting to your prospective campus and getting around the area:

- Miles from home
- Access to building with underground or skyway tunnels
- Campus Transportation
- Public transportation type
- Accessible parking
- Urban or rural town or city

ADMISSIONS REQUIREMENTS

This is a list of questions you should find out about admissions at your prospective college:

1. Is the college highly or moderately competitive or open enrollment?
2. What is the minimum ACT or SAT score accepted?
3. Is there an admissions interview?
4. Is there a modified admissions for students with disabilities?
5. Do they require an early application?
6. Does this require high school science?
7. Does this require high school language?
8. Does this require letters from high school teachers?
9. Is there a placement test required?
10. Does this require my high school class ranking?
11. Does this require high school math?
12. Are there alternative courses available?

DISABILITY SERVICES

This is a list of things you should collect about the disability services office at your prospective college so you don't have to collect the information after you have made your decision:

1. Disability Director's name
2. Office number
3. Phone and email information
4. How are accommodations provided?
5. What other services are provided through disability services? This bullet list is an example of things you may need to ask about depending upon your disability:
   - Testing
   - Note taking
   - Audio books
   - Assistive Technology
   - Tutoring
   - Special Advisors
   - Diagnostic testing
   - Special classes
   - Support Groups
6. Other areas of concern (make notes about anything else you may need)
7. How are instructors notified that students in their course are receiving accommodations?
8. How many disability staff are available to assist students?

HOUSING AND FOOD SERVICE

This is a list of things to you may need to find out about for housing and food services:

- Is there an open campus food service?
- What is the cost of the food service?
- If this doesn't have on campus food service, does this have an off campus with approved special accommodations service?
- Are there private dorm rooms?
- What is the procedure if you have food service concerns for allergies?

MAJOR AND DEGREE SERVICES

This is a list of the majors and degree services you may wish to know about, depending upon where you are looking to go to college:

- Majors and minors
- 2 year degree AA, or AS or AAS
- Certificates
- 4 year bachelor's degree BA or BS
- Course transferability
- Internships available
- Job placement office

SPECIALIZED COURSE INFORMATION AND OFFERINGS

- Is there an introduction to the college course?
- Are there college preparatory classes in reading, writing and or math?
- Are there career courses and programs?
- Are there study skills courses?
- Are there technical courses and programs?
- Are there certificates available in some programs?

FINANCIAL CONSIDERATIONS

- Are the fees high, moderate or low?
- Are there scholarships?
- Are there grants?
- Are there loans?
- Are there work study or campus jobs?

SERVICES AND ACTIVITIES

This is a list of the services and activities of interest that you may want to become aware of when you look at prospective colleges.

- Advising and counseling services
- Student Support services like TRIO programs
- Peer support groups
- Clubs or organizations of interest
- Clinical psychologist on campus
- Exercise facility
- On campus health services
- Face to face or online tutoring
- Job placement office
- Computer help desk
- Sport activities participant or spectator
- Supplemental instruction program

DISABILITY SERVICES

- Who is the disability director?
  - Office number, phone number and website
- How are accommodations provided?
  - Testing
  - Note taking
  - Audio books
  - Assistive technology
  - Other of concern
- Are any other services available through disability services?
  - Tutoring
  - Special advisors
  - Diagnostic testing
  - Special classes
  - Support groups
- How are instructors notified that students in their courses are receiving accommodations?
- How many disability staff is available to assist students?

2. Daley, Grott, and Robillard, *Tools for Transition*, 2007.

TRANSITION RESOURCES

The following items are other web-based resources to assist you in your transition to college.

TRANSITION WEBINARS

Four captioned videos have been created for you or your family to watch. The titles of these videos are in the following list and one link is provided that will take you to the playlist of all four webinars: tinyurl.com/transitionwebinars.

1. Practical Learning Strategies Webinar
2. Planning for College While Still in High School
3. Family Roles in Postsecondary Planning
4. Differences Between High School and College

JOB AND CAREER INFORMATION

- Career Planning and Assessments gpslifeplan.org/career
- Job Skills Assessments, Careers, Job Profiler ww1.onetoonline.org
- iSEEK Resources for People with Disabilities www.iseek.org/guide/disabilities
- MN Workforce Center Career Counselors www.PositivelyMinnesota.com/wfc

COLLEGE INFORMATION AND FINANCIAL AID

- Educational Planning, Study Strategies for ADHD and Learning Disabilities, Learning Styles, and Selecting Courses www.gpslifeplan.org/education
- Financial Aid, Transfer, and Career Exploration www.CareerOneStop.org
- Preparing for College: An online Tutorial from DO-IT www.washington.edu/doit
- Students with Disabilities Preparing for Postsecondary Education. Know your Rights and Responsibilities, US Department of Education Office for Civil Rights. www.ed.gov/about/offices/list/ocr/transition.html

GETTING HELP

- ADA Publications and Fact Sheets adata.org/ada-national-publications
- Auxiliary Aids and Services for Postsecondary Students with Disabilities www2.ed.gov/about/offices/list/ocr/docs/auxaids.html
- College Selection and Application www.GetReadyForCollege.org/selecting
- Free and Inexpensive Adaptive Technology Resources www.adaptech.org/en/downloads
- MN State Agency Programs and Services mndisability.gov

REFERENCES

1. Carnevale, A. P., N. Smith, and Strohl, *Help Wanted: Projections of Jobs and Education Requirements through 2018.* Georgetown University Center on Education and the Work Force, Georgetown University, 2010.
2. Dailey, David, Lindsay Grott, and Georgia Robillard, *Tools for Transition*. Duluth, MN: Northern Bridge, 2007.
3. Dunn, Kenneth, and Rita Dunn, *Teaching Students through Their Individual Learning Styles.* Reston, VA: Reston, 1978.
4. Goings, Scott, and Steven Frantz, *Serving Students with Disabilities: Accommodations and Inclusion.* [PowerPoint]. Saint Paul, MN: Minnesota State Colleges and Universities, 2014.
5. Harms, W., *Writing About Worries Eases Anxiety, Improves Test Performance.* University of Chicago, IL, 2011. Retrieved from http://news.uchicago.edu/article/2011/01/13/writing-about-worries-eases-anxiety-and-improves-test-performance.
6. Jarrow, Jane, *An Open Letter to Parents of Students with Disabilities About to Enter College.* Ark-AHEAD, 2008. Retrieved from http://arkahead.org/letterfromjane.htm.
7. Keeley, Meg, *The Basics of Effective Learning: Memory and the Importance of Review.* Newtown, PA: Bucks Community College, 1997. Retrieved from http://faculty.bucks.edu/specpop/topics.htm.
8. McNair, Roody, and Arlene Solomon, *A Practical Guide for People With Disabilities Who Want to Go to College,* Philadelphia, PA: Temple University, 2010. Retried from http://tucollaborative.org/pdfs/eduction/college_Guide.pdf.
9. Minnesota Association for Developmental Education. *College Readiness: Understanding the Differences between High School and College.* 2004.
10. Minnesota Department of Education, *Minnesota Career Fields and Pathways Chart*. Saint Paul, MN: Minnesota Department of Education, 2010.
11. Pauk, W. and R. Owens, *How to Study in College.* Boston, MA: Houghton, Mifflin, 2007.
12. Pocock, Al, Stan Lambros, Meagan Karvonen, David Test, Bob Algozzine, Wendy Wood, and James Martin, *Successful Strategies for Promoting Self-Advocacy Among Students with LD. Intervention in School & Clinic*, Thomson Reuters, 2013.
13. Robinson, Frances Pleasant, *Study Guides and Strategies: SQ3R Method*. New York: Harper and Rowe, 1970.
14. Schoenbauer, Steve, *Education Beyond High School*. Duluth, MN: Northern Lights Special Education Cooperative, 2006.
15. Study Guides and Strategies, *Ten Tips for Terrific Test Taking.* Retrieved from http://www.studygas.net/tsttak1.htm.
16. United States. *Section 504, Rehabilitation Act of 1973.*
17. United States. *The Americans with Disabilities Act Handbook.* 1990, 2008.
18. United States Department of Labor: Office of Disability Employment. *The Why, When, What, and How of Disclosure in an Academic Setting, After High School.* Retrieved from http://www.dol.gov/odep/pubs/fact/wwwh.htm.

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Recommendations for Improving Oral Health Services Delivery System

Health Care Administration

February 2014

For more information contact:

Minnesota Department of Human Services
Health Care Administration
P.O. Box 69083
St. Paul, MN 55164-0983
(651) 431-4210

Legislative Report

Minnesota Department of **Human Services**

This information is available in accessible formats to individuals with disabilities by calling (651) 431-2106

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $10,000.

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Table of Contents

I. Executive Summary

In 2013 the Minnesota Legislature directed the Commissioner of the Department of Human Services to complete a study on dental access and reimbursement. They directed DHS to consult with dental providers enrolled in Minnesota Health Care Programs (MHCP) and submit recommendations for improvement.

Between September 2013 and December 2013, DHS and consultant researchers interviewed 57 providers and other stakeholders to gain their perspectives in nine topic areas. A major factor driving this study is reduced MHCP participant access to dental services. In 2010, for instance, less than half (47 percent) of adult MHCP participants had visited a dentist in the last year.

Among child MHCP participants in 2012, only 28 percent had received preventive dental services from a dental provider in the last year and only about 14 percent received treatment. This rate for children is a decrease from 2010 when the same measures were 37 percent and 19 percent, respectively. Unfortunately, the rates for children have been decreasing over the past three years, suggesting current policies and practices are not effective in ensuring MHCP recipients, particularly children, are receiving adequate dental care.

There are barriers to dental providers serving MHCP patients:

- low reimbursement rates,
- payment and administrative complexity, and
- a limited adult benefit set that providers at times find conflicting with adequate standards of care.

Other access challenges include

- variable access in different regions of the state,
- inadequate use of allied dental health professionals,
- special needs of some participants,
- a lack of coordination between oral health and other health services, and
- limited use of portable delivery systems and teledentistry.

Stakeholders overwhelmingly supported raising fee-for-service base rates to increase the number of providers serving MHCP participants. There was also strong support for simplifying administrative practices.

There was lack of consensus on other issues. Many stakeholders favored

- enhancing training and educational supports to attract dentists to serve in underserved areas,
- promoting innovative services, and
- developing standards of care.

Some of the elements stakeholders recommended are within DHS's scope, and some are not. After analysis of stakeholder and other state and national information, DHS staff agreed on three

recommendations to improve access and ensure cost-effective delivery of services. This report also describes the specific strategies associated with these recommendations.*

Recommendation 1: The legislature should increase base payment rates for dental services and refine the payment structure to encourage provider participation in Minnesota's Health Care Programs.

Recommendation 2: DHS should continue to collaborate with other entities to support an evidence-based, integrated service delivery system that uses preventive services, portable delivery systems, teledentistry, a comprehensive adult benefit set and an expanded workforce to increase access and enhance cost-effectiveness.

Recommendation 3: To improve administrative structures and processes, the state should adopt elements of the single administrator model that have been successful in other states – streamlining administrative processes and strengthening efforts to prevent fraud and abuse.

* A summary of the recommendations and strategies appears in the conclusions.

II. Legislation

To address recent concerns about access, cost and financing, the 2013 Minnesota Legislature directed the DHS Commissioner to complete a study on dental access and reimbursement.[1]

The legislature required DHS to

- study the current oral health and dental services delivery system for state public health care programs to improve access and ensure cost-effective delivery of services.
- consult with dental providers who serve Minnesota Health Care Programs enrollees, including providers who serve substantial numbers of low-income and uninsured patients and are currently receiving enhanced Critical Access Dental (CAD) provider payments.
- make recommendations on modifying service delivery and reimbursement methods, including changes to the CAD provider payments under Minnesota Statutes, section 256B.76, subdivision 4.

DHS's Purchasing and Service Delivery division, Health Care Administration was responsible for completing the study. This resulting report provides recommendations in ten areas. The first nine areas were required by statute. DHS added the tenth area.

1. **Funding and access** "Targeting state funding and critical access dental payments to improve access to oral health services for individuals enrolled in Minnesota Health Care Programs who are not receiving timely and appropriate dental services;"
2. **Innovative service delivery** "Encouraging the use of cost-effective service delivery methods, workforce innovations and the delivery of preventive services, including, but not limited to, dental sealants that will reduce dental disease and future costs of treatment;"
3. **Geographic access** "Improving access in all geographic areas of the state;"
4. **Teledentistry and mobile dental equipment** "Encouraging the use of teledentistry and mobile dental equipment to serve underserved patients and communities;"
5. **Administrative model** "Evaluating the use of a single administrator delivery model;"
6. **Compensation related to disparities** "Compensating providers for the added costs of serving low-income and underserved patients and populations who experience the greatest oral health disparities in terms of incidence of oral health disease and access to and utilization of needed oral health services;"
7. **Coordination with other health services** "Encouraging coordination of oral health care with other health care services;"
8. **Preventing fraud** "Preventing overtreatment, fraud and abuse;" and

9. **Reducing administrative costs** "Reducing administrative costs for the state and for dental providers."

10. **Other recommendations for improving access.**

III. Introduction

The Minnesota Department of Human Services (DHS) provides an array of health care services to people with low incomes through its Minnesota Health Care Programs (MHCP). MHCP includes Medical Assistance (MA), MinnesotaCare and several smaller programs, such as the Minnesota HIV/AIDS program and programs for people who are dually eligible for Medicaid and Medicare.

The MA (Minnesota's Medicaid) program is by far the largest component of MHCP. Each state establishes and administers their own Medicaid programs and determines the type, amount, duration and scope of services within broad federal guidelines. For all MHCP enrollees, services, including dental services, must be medically necessary and meet community standards of care.[2]

The Centers for Medicare and Medicaid Services (CMS) manage Medicaid at the federal level and provide approximately half of the funding for MA services in Minnesota. Federal policy requires states to cover certain mandatory benefits; states may choose to provide other optional benefits.

Federal policy requires that states cover children's dental services and gives states the option of providing adult dental services. Like other states, Minnesota provides children's services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Pregnant women also receive comprehensive dental services.

Minnesota has elected to provide limited dental services to other adults with benefits outlined in statute. The provision of dental services reflects the important role that dental services and oral health play in a person's overall health.[3] Stakeholders have worked for decades to improve dental services and preserve a level of coverage for adults. During this time, Minnesota's dental services system has experienced many changes in program financing, benefits and service delivery.

This report follows up on many issues discussed in a March 2013 report of the Minnesota Office of the Legislative Auditor (OLA), *Medical Payment Rates for Dental Services*. OLA's comprehensive report

- described the state's dental rate setting system,
- identified payment rate and access problems and
- presented four broad recommendations for addressing these problems:
    1. improve administration and DHS-provider communication,
    2. coordinate payment and rate-setting policies
    3. increase rates and

4. create a new benefit and payment structure for people with special needs.*

DHS began working on several of these issues following the OLA report. Some key recommendations — such as increasing rates — are not within the purview of DHS. The legislature has set and defined rates and dental benefits in the statute.

Report Overview
This report addresses each of the ten recommendation areas the legislature and DHS identified.

- Section 1 includes legislative items one and six (funding and access and disparities).
- Section 2 examines innovative service delivery; geographic access; teledentistry and mobile equipment; and coordination with other health services.
- Section 3 considers an administrative model that reduces administrative costs and prevents fraud and abuse.

The report primarily presents recommendations related to DHS's role in the dental service system. However, if actions directly affect DHS's ability to carry out its recommendations and if collaborative efforts are called for, this report also makes recommendations to the legislature and other stakeholders. It should also be noted that for the purposes of this report, "oral health" and "dental services" are used interchangeably.

Methodology and Scope
DHS's Purchasing and Service Delivery (PSD) division asked Management Analysis & Development (MAD) to assist with interviewing stakeholders to obtain input across all topic areas and with responding to six of the study's topic areas.

DHS, in consultation with the Dental Services Advisory Committee (DSAC), prepared responses to items related to innovative service delivery. DHS is the owner and author of this report.

- The project began in September 2013. MAD consultants conducted limited background research and worked with DHS staff to develop a list of key people and organizations involved in oral health service provision, policy, research, administration and education.

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* OLA recommendations:
- DHS should improve its information system, MN-ITS, to better support dental providers' inquiries of patient eligibility and state restrictions on benefits.
- DHS should ensure that service authorization criteria and benefit changes are more clearly defined and communicated to dental providers.
- The Legislature and DHS should better coordinate payment policies and rate-setting for MA dental services.
- As part of this effort, the Legislature should increase fee-for-service payment rates for dental services.
- The Legislature and DHS should implement a separate benefit and payment structure for Minnesota's MA population with special needs.
- DHS should more closely monitor MA recipients' access to dental services.

- During September and October, MAD consultants interviewed 57 stakeholders representing all of the groups mentioned above.* DHS staff sat in on nearly all of the interviews. MAD conducted some interviews in person and some over the phone.
- In October and early November, MAD and DHS staff analyzed information.
- In mid-November, MAD and DHS staff completed a draft report.
- In January, DHS staff finalized the report.
- In February 2014, DHS presented the report to the legislature.

DHS' recommendations are based on

- capacity to increase MHCP recipients' access to oral health services;
- ability to improve the efficiency and effectiveness of DHS MHCP service delivery;
- support among stakeholders, as evidenced in the interviews; and
- support from the data and literature, which included a limited review of reports, statutes and research.

This project focused primarily on input from dental providers about each of the study's topic areas, as directed in the study legislation. It also focused on *recommendations*.† This study did not evaluate the quality of care, compare the effectiveness of different dental service providers and administrators or compare the value of fee for service (FFS) versus managed care dental services.‡

Access Overview

The MHCP population experiences one of the greatest contributors to disparities in access and oral health outcomes: low incomes and assets.

Low incomes are associated with higher rates of dental caries (cavities), for example, and less frequent service use.[4]

- In 2010, less than half (47 percent) of adult MHCP participants had visited a dentist in the last year.
- Among child MHCP participants, only 28 percent received preventive dental services

* Appendix A contains a list of stakeholder interviewees.

† See the 2013 OLA report for an extensive review of challenges associated with MHCP payment policies and rates for dental services in March 2013. This DHS report is not intended to duplicate the OLA report. Rather, it expands the discussion of issues raised in the OLA report to focus on provider-informed recommendations and address the nine topic areas required by statute.

‡ For information on FFS vs. MCO, see "PCG: Report on the Value of [MHCP] Managed Care, as Compared to Fee for Service" at http://www.leg.state.mn.us/docs/2013/mandated/130629.pdf.

from an enrolled dental provider in federal fiscal year 2012, and only about 14 percent received treatment.* On both these measures Minnesota is ranked well below the national average.[5]

- Statewide, 32 percent of FFS MHCP participants reported that finding a dentist was "a big problem" for them in 2009.[6]

Table 1 identifies MHCP-covered children's utilization from 2010 through 2012. The data, which includes children in both fee for service (FFS) and managed care, indicates a downward trend that has continued for the past three years and suggests that current policies and practices are not effective in maintaining or promoting access to dental services.

Table 1: Minnesota Indicators for Medicaid Participants (continuously enrolled for 90 days) Birth through Age 21[7]

Measure	FFY 2010 n=436,388	FFY 2011 n=453,536	FFY 2012 n=456,735
Percentage receiving any dental services	42	41	33
Percentage receiving at least one **preventive** dental service (by or under the supervision of a dentist)	37	37	28
Total receiving dental **treatment** services (by or under the supervision of a dentist)	19	18	14
Total eligible (age 6–9) receiving a sealant on a permanent molar tooth	17	15	11

*includes fluoride varnish treatment provided by non-dental providers

Many factors affect MHCP access:

- **Participants' inability to find a dentist who will accept MHCP patients** was a primary reason in 2002 that people did not visit a dentist.[8] In this study, stakeholders overwhelmingly blame low base payment rates for dental services as a barrier to providers participating in MHCP but cited other barriers such as the administrative complexity of the MHCP dental program, a restricted adult benefit set that sometimes conflicts with what the provider believes to be an adequate standard of care and too many cancelled appointments. These findings are consistent with research in other states.[9]

- **Participant perception of the need for care**. In a 2009 survey, the most common reason respondents gave for not visiting a dentist was that the respondents did not perceive they or their child needed care.[10]

* Of children continuously enrolled at least 90 days.

- **No regular place of care**. Many MA patients are seen on a one-time or emergency basis rather than having an ongoing relationship with a dentist. Fidelity to a provider can be compounded by the fact that MA patients may move more frequently due to housing challenges or other factors.

- **The need to travel for care**. Residents of rural areas may have to travel long distances for dental care; rural and urban residents may live in areas with relatively few dental providers nearby, although the problem appears more common in many rural counties.

- **Participant challenges.** MHCP enrollees may experience access issues related to

    - disabilities,
    - language barriers,
    - difficulty navigating the MHCP or dental service system,
    - lack transportation or child care or
    - immediate health and living concerns that take precedence over dental care.[11]

Due to limited access to dentists, several stakeholders discussed the need to expand access to allied health professionals licensed in the state to provide dental services, particularly those who, as a requirement of licensing, must serve low-income and public-program patients.

The numbers reported in the table above also do not include any dental care that was not billed to MHCP, such as dental care provided free of charge by a provider through charity care. Such services would not be reported to DHS.

IV. Dental Services System Overview

Administrative Structure
Minnesota's structure for enrolling, monitoring and paying dentists has many layers. These include federal regulators, DHS, eight managed care organizations (MCOs) and multiple dental administrators. One MCO, HealthPartners, is both a health plan and a dental administrator.

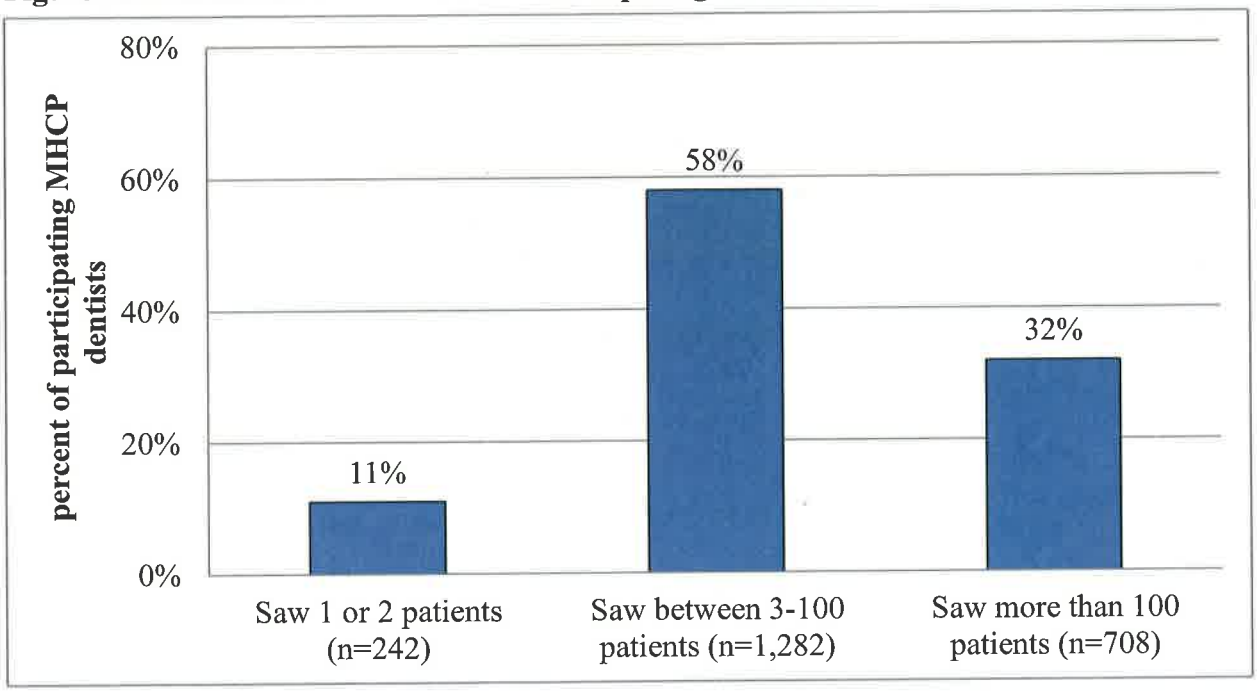
- Dental services are provided through FFS and managed care.
- DHS directly administers dental services provided under FFS, paying according to a base FFS fee schedule.
- DHS provides capitated payments to the eight MCOs, who then enter into contracts with dentists for care provision.
    - Each MCO determines its administrative processes and the rates it pays through its contracts with dentists.
    - MCOs must at least provide the same service scope and payment as FFS.
    - Many MCOs subcontract with a vendor to administer dental services on their behalf.

Enrollees
In 2012, the total number of adults enrolled in the MHCP program for at least 90 continuous days was 547,260.

- Approximately 80 percent were enrolled in a dental MCO and 20 percent were enrolled in FFS.[12]
- Participants in the FFS system are primarily people with disabilities but also include other populations, such as American Indians and undocumented persons.
- Some people also receive services through FFS on a temporary basis because they are awaiting assignment to a MCO or may have temporarily lost their MCO enrollment (e.g., they did not pay their premium on time).
- Approximately 71 percent of all MHCP participants are families with children, 19 percent are people who have a disability or are blind and 10 percent are 65 and older.[13]

Providers
Minnesota had 3,396 licensed dentists in 2011. About 75 percent of them were enrolled as MHCP providers and approximately 65 percent were participating in the program (that is, had submitted at least one MA claim in the year). Eleven percent of participating dentists, as illustrated in Figure 1, saw only one or two patients during the year.

Figure 1: 2011 MHCP Patient Load—Participating Dentists



- Dentistry is usually practiced in small offices; nearly 90 percent of dentists provide care primarily through a private practice or organization.[14]

- The OLA reports that four percent provide care through community-based care for underserved populations, including community health centers, Federally Qualified Health Centers (FQHCs), rural health centers or other nonprofits.

- The remaining dentists practice in instructional settings or in one of the five state-operated dental clinics.

In addition to dentists, Minnesota has one of the largest number of allied professionals, including dental assistants, hygienists, dental therapists and advanced dental therapists (Alaska is the only other state with a dental therapist workforce). These allied practitioners each have a distinct scope of practice and different levels of autonomy to work outside of a traditional dental office model under the general supervision of a dentist.

Benefits and Costs

Nationally, dental benefits make up less than five percent of Medicaid payments.[15] In Minnesota, Medicaid dental costs are about three percent of the MHCP budget.

MHCP provides comprehensive services to children and pregnant women. Children's services include, for example, relief of pain and infections, restoration of teeth, maintenance of dental health, non-cosmetic orthodontic services and other medically necessary services. In addition, dentists must follow the CMS-required age-related standards for child and teen check-ups as part of EPSDT.

Adult dental services are limited to those services listed in statute.*[16] Statutory specifications are detailed, such as how many teeth cleanings (prophylaxis) or x-rays a person may receive in a year. In the managed care system, each MCO must provide the minimum benefit set but may provide others, though DHS does not pay for additional benefits. DHS pays MCOs for dental care as part of the overall health services capitation rate for each MHCP participant; dental services are not separately capitated or carved out.

Access and Reimbursement Issues

Minnesota has taken many steps to address the sometimes-competing goals of improving access, controlling costs and encouraging providers to participate in MHCP. However, despite program changes, provider participant rates have remained constant.[17] As described in later report sections, these steps include

- **Adjustments to base FFS and MCO rates.**[18] Rates have fluctuated over time, with several three to five percent increases and three percent decease to FFS rates in the last decade. Most recently, the 2013 legislature approved a five percent increase to FFS base rates that was also applied to managed care.

- **Changes in adult services.** The legislature reduced the adult benefit set in the 2009 session, eliminating coverage of some services such as crowns.†[19] In the 2013 session, the legislature expanded the non-pregnant adult benefit set to restore several areas of coverage. For example, coverage now includes on-site delivery in extended care facilities, additional staff time to accommodate patients with behavioral challenges and up to four additional cleanings under certain circumstances.‡DHS also conducted an in-depth legal review and interpretation of statute and rule that resulted in restoration of coverage for some services such as those related to dentures (denture relining, rebasing or repair).

- **Establishment of the Critical Access Dental (CAD) Payment Program.** The CAD payment program provides increased payment rates for specific providers who serve low-income and underserved populations and meet other criteria. Criteria for provider participation have changed over the years as part of state efforts to reduce costs or increase access.

- **Rule 101**. Rule 101 requires dental providers who serve members of other state-sponsored health care programs to participate in MHCP and accept, on a continuous basis, new patients who are MHCP recipients. Generally, a dentist may limit acceptance of new MHCP recipients if the MHCP recipient caseload is at least 10 percent of the provider's annual active caseload, compared to a 20 percent cap for other medical providers.[20]

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* See Appendix B for list of services.

† The National Academy for State Health Policy notes that because of its "optional" status, adult dental coverage is often one of the first areas states turn to when making Medicaid reductions.

‡ For example, for patients "who are physically disabled or reside in a facility (including nursing homes) or group home setting" or "who have a medical condition that puts them at high risk for complications" or have "cognitive impairments that render cooperation with daily oral care challenging, with or without periodontal disease."

- **Management of DHS Direct Care and Treatment clinics.** Minnesota's five Direct Care and Treatment clinics (formerly State Operated Services) provide direct services to people with developmental disabilities, severe or persistent mental illness or brain injury who are unable to obtain care from other providers. Clinics are located in Brainerd, Cambridge, Faribault, Fergus Falls and Willmar.

- **Identification of barriers to access.** Minnesota and many other states have long generated lists of oral health access barriers, such as low reimbursement rates, low dentist participation in public programs, complicated administrative processes, cultural barriers and a lack of good data. Several people interviewed for this study said stakeholder lists of problems and solutions have been fairly consistent over the years.

- **Expanded services beyond dental offices.** The state has several initiatives to expand services in settings beyond dental offices through allied oral health professionals and other pilot projects and collaborations. For instance, DHS and the Minnesota Department of Health (MDH) participate in a *Medicaid Oral Health Learning Collaborative* to improve children's access and use of services within Medicaid programs.[21] MHCP also covers fluoride varnish treatments administered by non-dental providers. MHCP has covered dental therapist services since September 1, 2011.

State and DHS initiatives take place against a backdrop of DHS efforts to reform MHCP to provide services that are more person-centered, better coordinated across service settings, more effectively align financial incentives and have a stronger focus on evidence-based practices.*

Stakeholder Roles
A myriad of stakeholders are involved in establishing rates, shaping policy, administering the program and providing services.

- The legislature determines MHCP dental services payment rates and services, which also must be approved by CMS.

- DHS administers the program, as later described in some detail.

- Dentists and other providers deliver care.

- Counties and other community organizations provide outreach and support through their efforts to connect MHCP recipients with care they need.

- Many providers focus on MHCP participants or underserved subpopulations, such as community clinics and special MCO initiatives.

- MHCP participants and their behaviors are also a major element of the service system.

- DHS formally receives stakeholder input from the legislatively-mandated Dental Services

* See list of recent DHS programs in Appendix C.

Advisory Committee (DSAC). This 13-member group, a subcommittee of the Health Services Advisory Council, consists of a variety of dental providers, representatives from health plans and public health, health researchers and a consumer. The role of this advisory committee is to provide clinical guidance to enhance the department's ability to design dental care benefits and coverage policies for MHCP. One of DSAC's stated purposes is to work with DHS to support evidence-based coverage policy so that decisions regarding services paid for by public programs are based on the best available quality of care and cost effectiveness research.

- Organizations involved in representing or monitoring dental providers include the Minnesota Dental Association and the Minnesota Board of Dentistry.

- Other Minnesota stakeholders include dental service administrators and managed care organizations (MCOs), the Minnesota Oral Health Coalition (MOHC),* non-traditional service sites (e.g., schools and nursing homes) and those involved in dental provider educational systems.

* MOHC is a membership-based organization dedicated to promoting sound public oral health programs and policies in Minnesota. It was established in partnership with the MDH's Oral Health Program and helped produce the state's first-ever Oral Health Plan: Advancing Optimal Oral Health for All Minnesotans.

V. Section 1: Funding and Access

Background and Findings
This section focuses on ways to determine an appropriate reimbursement and payment structure that will encourage provider participation. The major finding of this section is that the legislature needs to raise base reimbursement rates to better compensate providers to incent them to participate in MHCP, thereby improving access. Increased rates are not the only way to improve access but are a fundamental step.

Dental Services Program Funding
MHCP dental programs are funded primarily through a mix of federal and state sources.

- The federal share is determined through a formula that takes into account the state's per capita income each year. The federal government currently pays 50 percent of MA costs in Minnesota.

- The state's share is supported through General Fund appropriations and a two percent provider tax imposed to fund the state's Health Care Access fund.[22]

- Additional funding comes from counties, enrollee monthly deductibles and copays and other state and federal funding, such as MDH grants.

Expenditures for dental services accounted for approximately three percent of total MA in 2011, or approximately $130.8 million in 2011.[23] Expenditures are largely impacted by the number of individuals enrolled in MHCP, the length of enrollment and the type and volume of services provided.

Provider Payment and Rate System
Federal law requires that state payment rates be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[24] States may develop their rates based on the cost of providing service, a review of what commercial payers pay in the private market or a percentage of what Medicare pays for equivalent services. CMS must approve the state's methodology. The dental services payment and rate system, like its administrative structure, is complex. There are various payment types and adjustments depending on the type of provider, whether the provider is in the FFS or MCO system and whether the legislature changed payment rates in a given year. Major aspects are described below.

- **FFS**
  In the FFS system, the state pays providers according to base FFS rates. Dentists bill the state, and the state reimburses them at a level determined by state law. Current state law requires that rates be based on the median of 1989 usual and customary charges submitted by dentists in the region.[*25] Rate increases and decreases are achieved through legislation and have modified the originally calculated base rate over time.

  Dental FFS rates are the same across all regions of the state. Some FFS providers are also eligible for supplemental payments. For example, community clinics receive add-on payments of 20 percent of rates.[26] These clinics are nonprofit, tribal, Indian Health Service or publicly owned clinics established to provide health services to low income or rural population groups.[27] In 2011 DHS made payments to 130 community dentists and 14 clinics.

- **Managed Care**
  DHS pays the MCOs a predetermined monthly amount per enrollee (capitation) to cover the costs of the enrollees' health care. This includes dental care. The capitated payments are intended to limit the state's financial liability while providing an incentive to the MCOs to control costs.[†] The dentist bills the MCO and is reimbursed according to the dentist's contract with the MCO. In other words, DHS does not set or administer MCO rates to dentists; MCOs and dentists negotiate payment rates and enter into contracts. The OLA reported that in the state's larger managed care programs, the average MCO payment rate was 121 percent of the FFS rate. MCOs are also required by contract to ensure access to all services.

- **Critical Access Dental (CAD) program**
  The CAD program provides supplemental payments to approximately 375 dentists working in 75 clinics across the state. The program targets practices that serve a high number of MHCP participants and allocates increased reimbursement to them, bringing a provider's total payments closer in line with commercial market conditions.[28] CAD pays providers an additional 35 percent of what they would otherwise be paid under MA and 30 percent under MinnesotaCare.

  This program was created by the legislature in 2001 and applies to payments made through FFS and MC. The FFS add-on payment is made at the time the claim is

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[*] Dental services are paid for at the lower of (1) the submitted charge or (2) the prevailing charge. The prevailing charge is defined as a specified percentile of all customary charges statewide for a procedure during a base year. current prevailing charge for dental services is the 50th percentile of 1989 submitted charges, minus either 20 percent or 25 percent, depending upon the type of service. Since 1992, the legislature has imposed several across-the-board adjustments to the base rates for dental services that have increased or decreased rates, including a 3 percent decrease in all rates in 2011. State-operated dental clinics were exempt from this reduction.

[†] Whether MCOs or the FFS system is actually more cost effective is a subject beyond the scope of this report. However, see "PCG: Report on the Value of Minnesota Health Care Programs (MHCP) Managed care, as Compared to Fee-for-Services." Quality initiatives related to dental services appear to be far behind similar efforts in general health care services.

processed, while managed care payments are made on a quarterly basis calculated through reports provided to DHS by the MCOs. CAD payments primarily go to non-profit clinics, including community clinics (who also receive the 20 percent add-on payment) and other providers that serve thousands of the state's most vulnerable populations.

- Historically CAD providers had to have a non-profit status. Other entities were added in July 2013.* Despite the changes, the current CAD program leaves out many dental providers in private practice who are serving MHCP recipients in their communities but are unable to meet the qualifications of designation. Additionally, private practice dental clinics, as one criterion necessary for designation, must attest that at least 50 percent of their patients are MHCP recipients. However, this measure is not something that DHS can verify.

- **Other payment systems**
  A number of additional payment rate systems have been created, such as those for FQHCs, Rural Health Centers, community and public health clinics and dental trend payments. All of these payment rate systems are intend to increase access for dental services for underserved populations. As previously noted, the state also funds five state-operated dental clinics.

Major Issues

- **Multiple Payment Types**
  Each of Minnesota's many payment types was developed through "separate and independent processes rather than through a systematic, coordinated assessment of appropriate payment rates to ensure dentist participation and patient access statewide."[29] Payments fluctuate by year and different processes are used in determining and administrating each payment type.† As the OLA concluded in its 2013 report:

  > Minnesota uses a myriad of policies and methods to reimburse MA dental providers. These payment methods and policies are poorly coordinated and inconsistently applied across MA programs … The Legislature and DHS should better coordinate payment policies and rate-setting for [MA].[30]

  As noted earlier in this report, dental providers are paid under legislatively mandated FFS rates and negotiated MC rates. Providers may receive add- on payments if

* Effective July 1, 2013, two additional dental practice types were made eligible for critical access provider status: city owned and operated hospital-based dental clinics and private practicing dentists who are enrolled with MHCP, as long as they meet certain criteria, such as private practicing dentists must be located within a Health Professional Shortage Area (HPSA) and more than 50 percent of the dentist's patient encounters must be with patients who are uninsured or covered by MA or MinnesotaCare.
† The dental services administrative structure and process as discussed in Section 3.

- they are a community health clinic
- they are CAD designated, with their FFS claim payments and quarterly payments from each MCO with whom they contract.

For many providers, these multiple streams of payment are difficult to track and challenging to predict. For example, MCOs make CAD quarterly; however, many providers receive a lump sum or have adjustments made through payment of future claims. As a result, it is difficult for providers to verify their CAD payments are correct and even more difficult to tie those payments back to specific patient encounters. Moreover, because the CAD payments in managed care are quarterly, payments are delayed. In addition, there have been instances where MCO reporting issues have caused all providers MCO CAD payments associated with that MCO to be delayed by up to nine months.

- **Impact of rate increases**
  Stakeholders overwhelmingly favored rate increases to improve provider participation and access. Although the legislature did increase the base rate for dental services by five percent in 2013, most stakeholders indicate this was not sufficient.
  - Research and interviews indicate that insufficient rates, plan complexity and administrative issues deter MHCP provider enrollment.[31]
  - Research also indicates that access increases as rates become closer to market rates, although results are somewhat mixed.
  - Some studies suggest that rate increases must be made in conjunction with other changes such as simplified administration including use of a single administrator model.*
  - When rate increases result in improved access, Medicaid claims and costs can rise; in some cases, increases have been substantial.[32]

  An underlying issue in this balance between costs and improved access is whether the state considers dental care to be an essential part of health care services, "optional" or an unnecessary service.

  Another element in rate increases is the Critical Access Dental (CAD) program. As noted, to incent providers serving a high volume of low income participants. CAD pays its providers substantially higher rates for procedures than are made to other providers rendering the same service, to incent providers serving a high volume of low income participants.

* See Appendix D for more detail on studies on the impact of rate increases.

CAD payments and increases help sustain some safety-net providers who serve underserved populations.

- At the same time, DHS research and the OLA findings suggest that increased CAD funding and other rate increases have not improved rates of provider participation in MHCP, and data indicates fewer MHCP recipients, particularly children, are not receiving necessary dental services.

- In addition, the CAD payments are tied only to the business structure of the dental clinic (e.g., non-profit community health clinic) or the volume of MHCP patients served.

- Designation as a CAD clinic and CAD payments are not based on any quality of care measures. In fact, previous research and a few stakeholders also indicated that the program prompted some CAD providers to over-treat patients.[*33]

- Stakeholders varied widely in their opinions of whether the CAD program was effective, and several stakeholders expressed concerns that approximately half of the current CAD payments go to one dental provider group.

- **Dental provider costs**
  Because dentists are not required to report on actual costs of care, very little data exists or has been reported regarding the actual costs of providing dental care to MHCP enrollees. Some stakeholders reported they knew what their monthly operating costs were, but they were unable to separate out these costs by procedure or indicate their break-even point or report administrative costs as a percent of operational costs. All agreed, however, that the current system does not adequately compensate them for the cost of care.

  One reason dentists are not required to document their costs is that the reimbursement system is based on usual and customary fees charged rather than costs or resources used.[†34] The state's method of paying dentists based on charges is out of step with how MCHP pays for many other services. For example, DHS pays MHCP physicians several other MHCP FFS services using a version of the Resource-Based Relative Value Scale (RBRVS). Medicare began using RBRVS in 1992 for physician and other professional services. Payments are determined according to the cost of resources needed to provide services, and rates are adjusted for geographical differences. It has been adapted for Medicaid in many states, as well as for worker's compensation in Minnesota.[35]

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[*] Several respondents also indicated the problems with the HPSA designation which is a factor in CAD determination. For example, if a dental provider is located in a non-HPSA area that is on the border of a HPSA area and a majority of its clients from HPSA areas, this provider would not be eligible for CAD. Also, an existing provider serving a large number of underserved people in an area could be denied CAD because the provider's presence means the area is not a HPSA area; if the provider were a new provider coming in to the area, the provider would qualify for CAD, at least until the next review.

[†] Usual and customary charges are a dentist's regular, non-discounted charge for a service as listed on MHCP claims. The ADA defines as usual and customary payments as "the fee an individual dentist most frequently charges for a specific dental procedure independent of any contractual agreement."

- **Effectively targeting funding**
  Several stakeholders indicated that it is difficult for the state to target funding to improve access when there is no agreed-upon definition of access, no evidence-based set of adult benefits and no evidenced-based standards of care. What is an appropriate treatment for patients based on their diagnosis and needs? There appears to be little or no industry standards in this area, so practices vary widely. Moreover, because many people have no dental insurance or have commercial insurance with high deductibles and co-insurance, the patient's willingness to pay their cost-sharing portion heavily influences treatment decisions. Patients covered under MHCP do not have the same cost-sharing concerns as those with no dental insurance or high deductible and co-insurance commercial plans.

  Interviewees did appear to agree that the current limited adult benefit is too limited.* A few people said the current benefit set was established in haste based on budget concerns rather than practitioner consensus. Interviewees suggested these areas of expansion to the current adult benefit set:

  - Periodontics
  - Frequency of examinations and diagnostic testing (e.g., radiographs) are aligned with medical necessity for a given patient and evidence-based standards
  - Comprehensive benefit set. This would require the legislature and all other stakeholders to acknowledge that oral health is an essential part of health services and not an "optional" health service for adults.

- **Compensation Related to Disparities**

  - **Oral Health Disparities**
    In addition to general reimbursement issues, the legislature asked DHS to provide recommendations for compensating providers for any added costs of serving people experiencing oral health disparities. The legislative language for this study broadly refers to oral health disparities in terms of MHCP patients and populations who have a higher incidence of oral health disease and lower access and use of services. MHCP-specific data in this regard is limited. Table 2 shows utilization data based on the percentage of people who receive any dental service. Other stakeholders, DHS, MDH and national information sources have associated oral health disparities, such as incidence of dental caries, oral health disease and communication barriers with demographic and socio-economic factors such as age, race, income and educational levels.[36]

* Issues associated with a lack of care standards are discussed in Section 2.

Table 2: Percentage of MHCP recipients who receive dental services by various factors, 2012

DESCRIPTION	PERCENTAGE
Race category	
White	38%
Black	38%
Hispanic	42%
Asian-Pacific Islander	39%
Native American	39%
Unknown	36%
Disability Status	
Not Disabled	38%
Disabled	44%
Blind	39%
Rural/Urban Status	
Urban	39%
Rural	37%
Unknown	43%
Managed Care vs. FFS	
Managed Care	42%
FFS	29%

- When asked to identify who experiences disparities, interviewees most frequently referred to people with disabilities. For example, some stakeholders and related research point to special access issues for some people who have developmental disabilities, are frail elders or have particularly complex conditions.[37] However, the utilization data does not corroborate that perception; more disabled recipients (42 percent) received a dental service in 2012 than non-disabled recipients (38 percent).

- Utilization data indicates no disparity between whites and non-whites on the measure of whether or not the person received a dental service in that year.

- Little difference was also noted between rural and urban areas; however, those in managed care (42 percent) were much more likely to receive a dental service in 2012 than those in FFS (29 percent).

- **Added costs**
  There is little or no recent quantitative data about the "added costs" incurred by providers serving the MHCP population and subpopulations. However, stakeholders cited many examples of ways they believed it is more costly to serve people experiencing oral health disparities. For example, it can take extra time to:

  - address high behavioral needs for some people (as noted, the 2013 legislation added coverage of behavior-related services for adults in addition to children).
  - address complex oral health needs among people who have difficulty maintaining oral hygiene, do not see a dentist frequently or who are older and have years of accumulated needs and dental work.
  - use interpretation or translation services. MHCP generally provides coverage for medical service language interpretation and translation. However, providers need to arrange for these services and cover the costs if an expected patient does not show up for an appointment where the provider has arranged for language services.
  - communicate with clients. When an interpreter is involved, providers need to account for extra time required by the interpreting process during an appointment. Providers may need extended time with other patients to explain procedures or care, or counsel them regarding oral health behaviors.
  - coordinate care. Providers noted the need to develop care plans and coordinate oral and other health services.

Recommendations and Strategies

Recommendation 1: The legislature should increase base payment rates for dental services and refine the payment structure to encourage provider participation in Minnesota's Health Care Programs.

All interviewees strongly encouraged the state to raise the base payment rates, so they at least cover overhead costs, which are estimated to comprise 60 to 65 percent of overhead cost and so dentists do not lose money through their participation in MHCP.[38]

- The current method of basing rates on 1989 charge data does not seem reasonable.
- Stakeholders and researchers indicate that current MA rates are often 30 to 50 percent of current usual and customary costs.
- Compared to other states, Minnesota pays lower rates.
- The OLA's extensive and recent research also concluded that Minnesota's rates are too low and the legislature should increase FFS rates.[39]
- In addition, the multiple and uncoordinated payments for dental services under MHCP should be simplified as was noted by the OLA and many interviewees.

Strategies
To increase reimbursement and simplify the payment system, DHS recommends that the legislature and dental stakeholders pursue the following strategies.

- **The legislature should give DHS the flexibility to tie rate increases to access or quality outcomes.**
    - The current dental payment system is based only on fees charged. Yet DHS has modified payment systems for several other services to link payment to outcomes.
    - For dental services, performance indicators might include utilization levels (such as percentage of MHCP participants receiving preventive care), changes in patient outcomes (such as a reduction in dental caries) or indicators of providers delivering comprehensive care (such as rates of preventive and restorative services by provider).
    - For providers unable to meet the expectations, DHS could provide support and create non-punitive corrective action plans.
    - An impediment to tying rate increases to performance indicators is that this adds a new

layer of complexity to the reimbursement system. However, some complexity is called for if the result is documented improvements in access and outcomes.*

- **The legislature should simplify and refine the payment system by incorporating the Critical Access Dental (CAD) payments into the overall rate structure.**
  - Stakeholders interviewed for this study and the OLA study called for a simplified payment system. The system for determining CAD eligibility and reimbursement is complicated and confusing, said some stakeholders, while others noted significant issues with the HPSA designation requirement for private practice dentists.†
  - Additionally, CAD designation is not based on quality of care or cost-effective care measures. Sufficiently raised rates can eliminate the need for a separate CAD program, especially because historical changes in the CAD rates have not affected access.
  - Increased, uniform rates may encourage private practice dental providers to participate in MHCP or increase the proportion of MHCP patients they see.

In the future:

- **DHS should lead discussions regarding ways in which the state could more similarly pay MHCP physicians and dentists** (i.e., incorporating components of a resource-based system in dental service payments).
  - There appears to be general agreement that oral and other health services should be better coordinated, yet payment systems remain completely separate, with different processes and bases of payment. Unlike MHCP physician services, for example, dental payments are based on fees charged. A fee-based system does not take into account whether the fees are related to efficient or effective care.
  - Consequently, more than three quarters of all public and private payers—including Medicaid programs—have changed their systems to adopt components of the Medicare Resource-Based Relative Value Scale (RBRVS) used to pay physicians.[40]
  - The state would need to better understand MHCP costs and resources and possible implications before moving in this direction. However, an RBRVS system could rationalize payments per the value and resources used in service provision and promote integration of oral health services with other services.
  - A resource-based system is likely to be quite unpopular with dentists. In a recent survey only 13 percent of Minnesota dentist respondents favored an RBRVS approach.[41]

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* See Section 2 for more on development of measures and standards of care.

† See discussion of HPSAs in Section 2

- **DHS, MDH and others should collaborate to assure that oral health disparity information is efficiently and effectively gathered**

  - More information is needed regarding oral health disparities. This includes better information regarding disparities experienced by MHCP subpopulations proposed interventions, including input from MHCP participants and local communities.

  - DHS and MDH have numerous health disparity initiatives, but oral health appears largely left out of these efforts. These efforts could be expanded to collect data on oral health issues.

  - Other projects are focused on oral health but do not include much MHCP information.

  - Many providers also have important health disparity information that has not been compiled and shared.

  - Examples of possible expanded collaborations include putting more emphasis on oral health in the DHS Annual Health Care Disparities report, expanding dental focus in ongoing Olmstead Plan* implementation and adding oral health indicators to DHS's "Measures that Matter" and the Managed Care Public Programs Consumer Satisfaction Survey.

  - A stronger focus on MHCP enrollee data could also be added to MDH Health Disparities Task Force activities and MDH oral health plans.

  - DHS coordination with other efforts and agencies would facilitate an efficient and broad-based look at disparities.

* The state's Olmstead Plan for people with disabilities includes some information on dental services, including a plan for more data collection. The data timeline is 1) By December 31, 2014 establish baseline data for current care (medical, dental, chiropractic and mental health) of people with disability; develop an implementation plan to further assess, develop and respond. 2) By August 1, 2015 and biannually thereafter, measure how health care access and service are changing over time. Analyze the data to identify policy, practice and program changes that need to be made so that improvement happens more quickly; establish plans to make these changes.

VI. Section 2: Improving the Model of Service Delivery

Background and Findings
This section describes findings about how dentistry lags behind other health care systems in developing access and quality measures and developing standards of care. Although oral health is an integral part of overall health, dental and other health services are rarely integrated. Innovative approaches such as teledentistry and portable delivery systems and an expanded workforce with more experience in serving MHCP participants would help to increase MHCP participant access to care. Although some of these improvements are largely out of DHS's scope, DHS can continue to collaborate with other entities on overall efforts to develop an improved system. This system would be evidence-based, integrated and focused on prevention. It would also use innovations in service delivery (e.g., portable delivery systems and teledentistry) and an expanded workforce to increase access and enhance cost-effectiveness.

Access and Quality Measures and Standards of Care
A first step in improving access is developing consistent measures of access and standards of care, as several stakeholders noted. CMS, states, agencies and providers define access in various ways and have struggled to improve measurement. State efforts are driven in part by lawsuits claiming that Medicaid rates are insufficient. The Medicaid access requirement forces states to assure that payments are "sufficient to enlist enough providers so Medicaid participants have approximately the same access to care as people not using Medicaid.[*] Related to all health services, CMS reports that only a few states use data to determine if they meet the access requirement.

Within and outside of government, common access measures include utilization of services, availability of providers, prevalence of oral health disease and number of complaints or reported barriers (Table 2).

- CMS, for example, monitors states' dental services by whether children age six to nine receive any preventive care or have a sealant on a permanent molar.

- The Dental Quality Alliance (DQA) developed a set of services ("Measure Set 1") to evaluate children's use and access to certain services, as well as care continuity and per member per month costs.[†] These validated measures are categorized by utilization,

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* The Medicaid access requirement in 42 USC Sect. 1396(a) (30) (A) (also referred to as the equal access provision) requires states to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(I)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." CMS's proposed rule on states' measurement of access provides an overview of current access issues at www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10681.pdf.

† In 2008, CMS asked the American Dental Association (ADA) to aid in the development and promotion of performance measurement as a means to improve oral health. The Dental Quality Alliance was convened in 2010 and endorsed a first measurement set 2013. This measurement set has had extensive scrutiny by academic research partners. DSAC recommended these measures for use in MHCP.

quality of care and cost measures. Quality measures focus on utilization (e.g., whether a child received certain treatments and examinations.)

Table 3 identifies some examples of access measures that could be used, likely in combination, as a proxy for access to dental care.

Table 3: Examples of Access Measures

Focus	Examples
Service utilization	• The rate of MHCP-enrolled children who receive *any* preventive dental service; number age six to nine who have a sealant on a permanent molar (two measures by which CMS is monitoring states' dental services) • Percent of people who receive any dental services or obtain atraumatic care in an ER • The percentage of enrolled children who received an oral evaluation, sealants and fluoride treatments in a year*[42]
Geographic access	• The number and percent of dental providers in a geographic area, including current and new MHCP cases, providers who do not (or who no longer) accept MHCP patients and utilization and outcomes by rural/urban status.
Ability to obtain appropriate care	• Number of providers contacted until a participant finds a participating provider; quality of care; cultural measures
Disease and adverse events	• The prevalence of oral health disease and related factors, such as dental carries, periodontal disease, oral cancers, lost teeth and extracted teeth
30 minute/mile availability	• The availability of providers with within 30 minutes or 30 miles (this measure is often used by managed care organizations)
Health equity	• Access, disease and utilization measures by age, race, ethnicity, FFS/managed care, education status, disability, language used and others
Health Provider Service Area (HPSA) designations	• HPSA designations are based on factors such as geographic area, population groups and facilities. For instance, FTE dentist ratio to population, whether the population is a member of certain groups (e.g., Native American tribes) and whether the facility provides dental care services to an area or population group designed as having a dental HPSA.[43]

* These examples are from the DQA's "Measure Set 1"

Patient satisfaction or complaints	The number of MHCP participant and advocacy complaints made to ombudsman offices, MCOs and other monitoring organizations.
Other dental measures	Whether the person has a usual source of care or continuity of care; per member per month costs; operating costs

As noted in the table above, CMS, as part of the Oral Health Initiative, has set a goal for all Medicaid programs to increase two utilization measures for children enrolled continuously for at least 90 days. Within the next four years, states should increase, by 10 percent each,

- the rate of children who receive at least one preventive dental service (by or under the supervision of a dentist) and
- the rate of children ages six to nine who have a sealant on at least one permanent molar.

As noted in Section 1 of this report, Minnesota has been losing ground on these measures over the past three years. Recommendations about changes to the MHCP dental program should take into consideration how such changes will improve these measures.

As DSAC and others have concluded, dentistry lags behind other medical fields in establishing quality measures and standards of care. Factors contributing to this are the sole practitioner business model, lack of diagnostic codes and lack of an electronic dental record.[44]

- The American Dental Association (ADA) has standards for informatics and dental products; however, standards of care, equivalent to those for other medical conditions, do not exist.
- In legal situations, a "standard of care" generally refers to the degree of care that a reasonable and prudent provider would exercise under the same or similar circumstances. This seems to apply to the dental industry's state of the art.
- In other medical fields, standards of care typically include quality statements and measures, objective clinical criteria and processes for managing the condition and providing care.

Integration of Oral and Other Health Care Services

One characteristic of the current system is that most dental care is provided in settings separate from medical care, without coordination between settings. Care is offered in traditional dental offices, each with its own care management system, billing system and administrative and record-keeping systems. Even newer electronic dental records are separate from the electronic medical record. The separation of dental from other services can adversely affect care outcomes. As the Institute of Medicine reported:

> Evidence shows that decay and other oral health complications may be associated with adverse pregnancy outcomes, respiratory disease, cardiovascular disease and diabetes. While tooth decay is a highly preventable disease, individuals and many healthcare professionals remain unaware of the risk factors and preventive approaches for many oral diseases, and they do not fully appreciate how oral health affects overall health and well-being. The continued separation of oral health care from overall health care contributes to limited access to oral health care for many Americans.

The value of coordinating oral health care and overall health care is getting increased attention in Minnesota. For example, MDH's 2013 Oral Health Summit focused entirely on integrating oral health into broader health systems. Interviewees for this study indicated

- MHCP participants are seen at higher rates in medical settings than dental settings, which presents an opportunity for linking those visits to dental services. Care in integrated settings is more likely to include prevention and reduce oral disease. The system is likely to avoid the costs associated with treating preventable conditions.

- "One-stop" settings where MHCP recipients can receive multiple services, such as fluoride varnish and dental sealants during a well-child visit, increase access points and streamline the process of obtaining dental care for recipients.

- Delivering multiple services in one location can reduce administrative costs.

- Patients treated for chronic diseases, such as diabetes, are better served when oral health and medical health practitioners share information and complement each other's treatment protocols.

- Providing multiple entry points and referrals for dental care — at school, in the health clinic, at public health offices and in nursing homes— increases the likelihood that individuals will ultimately become patients of record in a full dental office.

Current approaches

As the value of coordination is more frequently realized, it is becoming more common. For instance, oral health screening is being offered to prenatal and diabetic patients; dental offices are providing blood pressure screenings and tobacco cessation referrals. Some medical providers, including FQHCs, have begun to co-locate dental offices in or alongside medical clinics, hospital emergency departments and public health clinics.

These settings

- can allow for non-dental staff to perform some procedures, such as applying fluoride varnish, with follow-up referral to a dentist for comprehensive care, or

- may include a full dental clinic on-site.

A few interviewees noted that children and seniors receiving MHCP are offered integrated care through Child and Teen Checkups and Minnesota Senior Health Options (MSHO), which specify

the need for early dental care, referral and anticipatory guidance, along with other health care services. The adult population between these age ranges does not have a comparable set of standard benefits integrating dental and health care.

Stakeholder recommendations for an improved system include

- **MCHP participants should have a regular source of dental care** rather than moving from dental clinic to dental clinic or using emergency rooms for non-emergency dental care. If access continues to be a challenge despite efforts to improve the system, DHS could consider expanding SOS dental clinics to serve a greater share of MHCP recipients.

- **Dental care should be integrated into new delivery systems,** particularly accountable care organizations (ACOs). ACOs have been developed to provide integrated care across many settings, but dental care is not included in their model.*

- **Facilities should be developed** that foster coordination of dental and medical care. For example, as some interviewees suggested, dental services could be expanded into local public health clinics and MCO-owned clinics. Communities could develop plans and partnerships to create new health centers with capacity to meet overall health care needs, including dental care.

- **The state's educational institutions** preparing the future medical and dental workforces should align their offerings with the state's need for professionals prepared to coordinate services across disciplines. With some exceptions, provider education is provided in separate medical and dental silos.

- **Rules and statutes should be changed to support the following:**

  - Use of oral health access and quality measures as standards for ACOs/health homes.

  - DHS/county referrals to help MHCP participants establish a regular source of care when participants contact public health and human services programs.

  - Interoperability or integration of the electronic health and dental records.

  - Establishment of quality and performance measures for coordinated care for practitioners to use in best practices for care coordination.

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* In 2010 the legislature mandated that DHS develop and implement a Health Care Delivery System (HCDS) demonstration, including ACOs. The goal of ACOs is to "ensure that every citizen of the state of Minnesota has the option to receive team-based, coordinated, patient-centered care that increases and facilitates access to medical care, behavioral health care, long term care, and other services. (MDH. Health Reform in Minnesota. Accessed December 13, 2013, http://mn.gov/health-reform/health-reform-in-Minnesota/).The model will expand the current ACO model and include 15 accountable communities for health. These communities will develop and test models for integrating care. Jointly administered by MDH and DHS, the model is expected to save $111 million over three years and involve more than three million Minnesotans

- Possible extra reimbursement for patients who have co-occurring dental and medical diseases requiring coordination.
- Required dental check-up for school entry (similar to requirement for immunizations).
- Establishment of best practices and workflow process (from intake to the most complex care) to guide development of community-based entry points that lead to regular dental care.

Prevention

In addition to a more coordinated system, there is also a need for a system focused on prevention.

- DSAC and others have noted the importance of prevention in assuring MHCP participant access to appropriate services and in improving care. For example, school-based sealant programs were developed as an important way to reach children "where they are" throughout the state, especially in areas that have the lowest utilization of dental services.
- Sealants programs are a high priority for public health officials nationwide and in Minnesota. Along with public water fluoridation, sealants programs are one of two evidence-based recommendations of the US Department of Health and Human Services Community Preventive Services Task Force. In 2012, 11 percent of six to nine year olds had a sealant on a permanent molar tooth; this represents a drop from 15 percent in 2011 and 17 percent in 2010.

Teledentistry

Teledentistry is another delivery mechanism gaining traction in service delivery. Teledentistry is the use of telecommunications to provide dental services at a remote site. As DSAC has concluded, teledentistry may serve several functions.

- First, teledentistry may be a means for general dentists to consult with specialists. This practice provides timely and efficient dental care in rural areas where specialists are underrepresented. For example, a general dentist could transmit intraoral photographs and radiographs to an oral surgeon to develop a plan of care. This practice aligns with the current coverage of telemedicine.
- Second, teledentistry can also be used to provide dental examinations in the absence of an onsite dentist. This can facilitate the entrance to dental treatment and accurately identify those with the most acute needs.

Research has shown that oral examinations via teledentistry are comparable to in-person examinations. Pilot studies in Arizona,[45] California[46] and the Department of Defense[47] have all supported the use of teledentistry to increase access to dental care for underserved patients. In this approach, teledentistry requires the use of numerous technologies:

- A computer and secure internet connection
- An electronic dental record that facilitates the collection of necessary data
- Digital radiographs that can be acquired on site and interpreted remotely
- Intraoral photograph that allows the remote dentist to view the teeth and soft tissues

Allied dental personnel gather dental data and transmit it to a dentist for review. The Minnesota Board of Dentistry determines the scope of practice of each allied dental personnel. Under the general supervision of a dentist, various team members can expose radiographs, complete preliminary charting of the hard and soft tissue, expose intraoral photographs and take vital signs. It is the responsibility of the collaborating dentist to determine if the information is complete and of adequate quality to completely assess the oral health of the patient and develop a plan of treatment. According to some Minnesota interviewees, there are benefits, risks and barriers to teledentistry:

> Teledentistry has the potential to increase access to dental care. In underserved areas, bringing services to the patient rather than the patient to the dental office has been an effective strategy. The availability of specialty consultation may increase the number of general dentist in rural area. Utilizing dental auxiliaries to gather patient data is an efficient use of resources.
>
> In terms of risk, Minnesota Board of Dentistry or the Minnesota legislature has not addressed regulatory concerns.* Standards are needed for informed consent, standards for secure information transfer, and standards for communicating the results of the examination to the patient, monitoring for patient abandonment, and monitoring of continuity of patient care. A barrier to teledentistry is that current state regulations prevent billing for it.[48]

Teledentistry allows patient examinations without the physical presence of the dentist. This is of little value unless the patient also receives the necessary dental care, states DSAC: teledentistry service must be coupled with a commitment by the consulting dentist to provide care.

* Other states, such as California, Alabama, Kentucky, Maine, Missouri and New Mexico, have addressed regulatory concerns.

Geographic Access

Another factor in providing oral health to MHCP enrollees is assuring access to services across all areas of the state. MHCP participants have uneven access to dental services, according to some interviewees and at least one measure of access, as identified in Table 4.

Table 4: Percent of MHCP recipients who received dental services for selected MSAs and non-MSA areas, 2012

Recipient MSA	
Minneapolis-St. Paul-Bloomington, MN-WI	40%
County not part of a metropolitan area	37%
Duluth, MN-WI	37%
St. Cloud, MN	39%
Rochester, MN	32%
Mankato-North Mankato, MN	39%
Fargo, ND-MN	37%
Grand Forks, ND-MN	38%
La Crosse-Onalaska, WI-MN	33%

Interviewees were most concerned about a lack of access in rural areas. As illustrated in Table 5, in nine percent of counties —all rural — only 24 to 29 percent of participants received any dental services. Across all counties, the percentage of participants who received services ranged from 24 percent to 49 percent.

Table 5: Percent of counties with lower, mid-range, and higher rates of MHCP dental services, 2012

County information	
Percent of counties with **24% to 29%** of MHCP enrollees receiving dental services	9%
Percent of counties with **30% to 39%** of MHCP enrollees receiving dental services	64%
Percent of counties with **40% to 49%** of MHCP enrollees receiving dental services	26%

- About two-thirds of the state's counties have been designated as a Health Professional Shortage Areas (HPSA) for dental care, most of them in rural areas. More than half of the dental HPSAs in Minnesota are low-income population designations.*[49]

- However, a higher proportion of rural dentists accept MHCP patients than do in other areas. In 2011, 77 percent of dentists in Greater Minnesota participated in MA, compared to 61 percent in urban and suburban areas.[50]

- MHCP participants overall report having a "big problem" finding dentists.† Factors contributing to access problems in rural areas include fewer dentists in rural areas and the need to travel further to reach dental care.[51]

Contributors to Access Problems

Changes in the Critical Access Dental (CAD) program over the years have had a greater impact on rural MA participants than on their urban counterparts, said a few stakeholders. Several interviewees said that Minnesota's low reimbursement rates have a disproportionate effect on rural residents because many dentists with rural practices operate in a small, sole practitioner business model; they cannot share administrative and other overhead costs as they do in larger offices. A few stakeholders said the following issues also contributed to geographic access barriers:

- There are fewer dentists in rural areas.

- Some rural participants had to travel relatively far to reach care.

- Some areas have a greater number of dentists and allied professionals providing services in community settings, such as schools, nursing homes and public health clinics.

- Frequent changes in payment rates are an obstacle to enrolling and maintaining providers throughout the state. Also, until 2013, for-profit dental clinics were not eligible for CAD, which many interviewees said acted as a disincentive to accept MA patients.

- There is a lack of providers willing to serve MHCP residents in urban areas. Some HPSA designations include parts of the Twin Cities, and, as noted, dentist MHCP participation is lower in urban and suburban areas than in rural areas.

Improving Access

The Minnesota dental community and others have worked for years to improve geographic access and have identified ways to continue improvements. The most commonly mentioned strategies are using teledentistry, simplifying dental therapist credentialing, providing specialized dental training, expanding use of allied oral health professionals and supporting school-based

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* Appendix E provides HPSA maps including low-income information.

† A 2009 DHS survey of FFS MA recipients found that more people had difficulty finding a dentist than they did finding a personal doctor or nurse, especially in the northern and central parts of the state. Compared to a statewide rate of just under a third of respondents who said it was a "big problem" to find a dentist, about two-thirds of respondents in the northeast, northwest and the central region reported this difficulty.

sealant programs (these issues are discussed in other sections of this report). In addition, stakeholders gave examples of current or suggested approaches to meeting geographic needs including

- **Continue and expand coverage of volunteer dentistry services**
  - Minnesota dental providers and other agencies have collaborated to provide dental services to people experiencing barriers to access in different areas of the state. For example, community clinics, specialty clinics and programs, individual providers, some managed care plans and dental administrators provide or facilitate services to particularly underserved populations.
  - Other collaborations involve charitable organizations and volunteer dental providers, such as the dental program at the Salvation Army's Good Samaritan Health Clinic (Olmstead County), the Mission of Mercy in Bemidji and many other programs.[52]
  - Many of these organizations indicate that their organizations provide dentists, who may otherwise not wish to enroll as a MHCP provider, with opportunities to provide dental services to low-income individuals within their areas.

- **Restructure payment rates**
  - A few stakeholders recommended revising payment rates to support geographic access (e.g., replacing CAD with a rural/urban rate structure and allowing providers to perform as many needed procedures as may reasonably and safely be performed at one visit (to minimize return trips for patients who must travel long distances).
  - Many stakeholders suggest a base rate increase would persuade rural providers to participate in MHCP.
  - Another suggestion was for the state to find ways to make it feasible for small rural practitioners to participate in MHCP via a larger pool of providers, such as through county-based purchasing and multi-disciplinary health clinics (i.e., developing centers where various disciplines would gather to provide services in a common location on a regular basis, rather than trying to bring the patients to each individual practitioner.)

Workforce Issues

Behind all the issues and innovations stands the dental services workforce, including dentist and allied health professionals. State policymakers, educators, administrators, providers and others have led changes to improve the workforce and related client access.

- **Training and support**
  - One major approach to improvement is to provide training and other support to attract dentists to work with rural residents, people in other underserved areas or people with special needs. Specifically, dental providers can be encouraged through loan forgiveness programs, other funding supports, internships and enhanced training. Many stakeholders advocated this approach, noting the high cost of dental school and

the imminent retirement of dentists, especially in rural areas (an estimated 60 percent of Minnesota dentists may retire in the next 15 to 20 years).[53]

- MDH administers the competitive Dentist Loan Forgiveness Program using legislatively appropriated funds.*[54] These competitive programs do not have adequate funding, and payments are taxed, which reduces their impact, said a few respondents.

- Stakeholders also noted that program restrictions limit participation, such as a requirement that dentists apply for the loan before setting up a practice. Stakeholders also recommended specialized training and internships, such as those at the University of Minnesota.

Other stakeholders suggested dentists and allied health professionals in training obtain experience working in rural areas or other underserved areas and with people with disabilities. Students must obtain community outreach experience as a condition of graduation from dental, dental therapy and dental hygiene programs.

- **Allied oral health professionals**
  In addition to encouraging more dentists to work with underserved populations, many people and organizations are working to expand the use of allied oral health professionals, including dental assistants, hygienists, dental therapists (DTs) and advanced DTs.

  - DTs positions and licensure requirements were created in 2010 and are increasingly viewed as helpful because of their capacity to expand access to underserved populations throughout the state, said several stakeholders. Statute requires DTs to practice in settings that serve low-income, uninsured and underserved patients or are located in dental HPSAs.[55]

  - Hygienists' scope of practice allows them to perform certain preventive and restorative procedures in settings outside a dental office, such as schools, group homes, community clinics and nursing homes.† Hygienists establish a collaborative agreement with a licensed dentist and work under her or his supervision. The dentist is not required to be present when the hygienist provides services, but must have prior knowledge of services being performed and give consent.

  - The 2012 Minnesota Oral Health Plan and many other sources support expanding use of allied health professionals as a way to both improve oral health in rural and underserved areas and to help accomplish other goals such as the integration of dental

* The program provides funds for repayment of qualified educational loans for dentists working with low-income patients. Candidates must plan to practice for at least 30 hours per week for most of the year for a minimum of three years; a quarter of their annual patient encounters must include patients enrolled in state public programs; or the dentist must agree to receive a sliding fee.

† Since 2001, dental hygienists who establish a collaborative agreement with a licensed dentist have been allowed to perform certain preventive services in community settings under general supervision (Minnesota Statute § 150A.10, Subd. 1a).

services with other health care services and the delivery of cost-effective care:[56]

> By playing a role similar to nurse practitioners in the medical field, additional types of dental providers can expand the dental team's reach and help bring care to millions of people who live where dentists are scarce. Midlevel dental professionals also can make it financially feasible — and in some cases profitable — for private-practice dentists to serve more low-income patients. Because their salaries are significantly lower than dentists' salaries, alternative providers — who operate under the supervision of a dentist — also offer states a cost-effective approach to address the unmet need for care.[57]

- Under the current DHS FFS rates, allied professionals are reimbursed for a service at the same level as the dentist. This is different from medical settings where physician assistants' and nurse practitioners' rates are 10 percent less than the rate paid to a physician for the same service; physician extenders' rates are 35 percent less. Allied dental professionals can be cost effective for dental clinics and may encourage dental clinics to incorporate these professionals into their practices. Tension still exists, however, between the goal of increasing access by allowing allied professionals to be a first point of contact for underserved populations in the community and the goal of ensuring that only a qualified dentist diagnoses.

Recommendation and Strategies

Recommendation 2: DHS should continue to collaborate with other entities to support an evidence-based, integrated service delivery system that uses preventive services, portable delivery systems, teledentistry, a comprehensive adult benefit set and an expanded workforce to increase access and enhance cost-effectiveness.

A comprehensive approach to improving service delivery is needed. The more that state agencies and stakeholders can agree to setting overall goals for system development and work together toward them, the sooner MHCP participants and other Minnesotans will have expanded access and improved health outcomes. Strategies in each of the major areas are highlighted below. The findings of this study serve to emphasize the need for a system in which services

- are based on research regarding their effectiveness and integrated (or coordinated) across services settings;
- focus on prevention to avoid worse cost and care outcomes down the road;
- include innovative practices for assuring access and quality care (particularly portable delivery systems and teledentistry); and
- are provided by an expanded workforce able to meet the needs of MHCP participants.

Strategies to improve measurement and standard of care
The Institute of Medicine has stated "The only way to know whether the quality of care is improving is to measure performance." As Minnesota strives to improve the quality of its MHCP dental program, the state should begin with determining validated quality metrics. In the future, the dental community can work toward developing or adopting validated standards of care such as those found for among other health care providers.

It is difficult for the state to identify and fund those services that are most important in improving access and quality when there is no evidence-based benefit set or care standards. Standards have not yet been created for several reasons, including the state-of-the-art of dental measurement activities, a lack of agreement among stakeholders and stakeholder focus on rates or maintaining adult benefits. These barriers should not prevent stakeholders from moving ahead.

DHS, in consultation with DSAC, should work with the legislature to implement a revised benefit set for non-pregnant adults. Related standards of care should give policy makers, researchers, providers and MHCP enrollees a critical tool for monitoring and improving cost effectiveness and care effectiveness of services.

- **DHS should evaluate whether changes in the dental program contribute to improvement in the Dental Quality Alliance (DQA) Measure Set 1.** This helps ensure that changes made to the dental program are focused on improving outcomes for MHCP recipients.

- **DHS should continue to use DSAC expertise to assist DHS in developing access, outcome and performance measures.** DSAC's stated purpose is to support evidence-based coverage policy; DSAC focus on this area can offer vital assistance in continuous improvement in quality and standard development.

- **The dental benefit set for adults should be amended to include all medically necessary care.** DHS should have the authority to determine the benefit set with legislative restrictions appropriate to limit non-medically necessary care. DHS should collaborate with others in discussions of which services are most important and prioritize them in terms of their expected impact on access.

In the future:

- **DHS should continue to assess and adopt quality and performance measures and work through DSAC to develop an evidence-based benefit set and standards of care.** DSAC and others endorse use of the DQA's current measure set, a strong place to start. However, increasingly refined measures are necessary. The DQA's set relates only to children's services and does not include care and health outcome measures, patient satisfaction or other person-centered indicators. Advanced measures would also provide insight regarding how many people tried to access services (but could not) and did not see a need for services.

- **DHS is replete with quality initiatives across health care settings and has working relationships with the dental community**: there is no need to reinvent the wheel

advancing the development of refined measures. Stakeholders can help to prioritize measures and assure that Minnesota efforts are aligned with best practices in measurement and care delivery (e.g., include measures for coordinated care).

Strategies to support integrated models of care

DHS supports integration of dental health with other health services. Oral health is a part of physical health. In Medicaid and the Affordable Care Act, oral health is defined as essential for children. Oral health is also an essential benefit for adults. Ways that DHS can foster integration, in coordination or collaboration with others, include the following:

- **DHS should support the integration of oral health for all MHCP enrollees, for example ACO models that include dental care in the total cost of care.**
  - The ACO would be responsible for the delivery of physical, dental and behavioral health. ACOs and the Minnesota Health Care Delivery System (HCDS) reforms are changing the shape of Minnesota's health care system and integrating care across other systems with potential impacts on care and costs. These arrangements should include oral health care.
  - Quality metrics, including access, structural, process and outcome measures, should be used for cost sharing within these integrated dental delivery systems.
  - Alternatively, dental provider payments could be tied to outcomes and incorporate alternative payment methodologies for providers.
  - Pilot programs have been proposed and may demonstrate the efficacy of these payment models. Further support for such pilots may be warranted.
  - As ACO models mature and expand, determine viable methods to include dental services in the total cost of care and include dental care cost and quality outcomes under the ACO contracts.
  -
- **DHS should assist in the development or dissemination of best practices and consider other changes to policies and processes to support integration.**
  - DHS should
    - provide MHCP participants with referrals when they contact DHS/counties to help them establish a continual source of care;
    - support efforts to develop interoperability or integration of the electronic health record and electronic dental record; and
    - consider paying additional reimbursement for patients with co-occurring dental and medical diseases requiring coordination.

- To the degree that it is in DHS's scope, DHS should also collaborate with others to help ensure that provider education includes more interdisciplinary curricula and residential opportunities.

- Other changes for possible future consideration include requiring a dental check-up for school entry (similar to requirement for immunizations) and establishing best practices for process flow from intake to the most complex care. Process flows could guide development of community-based entry points and lead to regular dental care.

Strategies related to prevention, portable systems of care and teledentistry
The expansion of teledentistry and portable delivery systems can promote fuller access to services for MHCP enrollees. Among other benefits, teledentistry and mobile clinics can meet people where they are, such as nursing homes, group homes and schools. DHS can support prevention programs by endorsing comprehensive, evidence-based programs like sealants and fluoride. In addition, pilot projects and legislative initiatives can advance the use of teledentistry as a vehicle for cost-effective, care-effective services.

- **DHS should coordinate with stakeholders in promoting a comprehensive prevention program for MHCP recipients comprising evidence-based strategies like sealants and fluoride.** Particularly important approaches that DHS could generally support when collaborating with other partners on system improvements include the following:

  - **Dental sealants** have been shown to prevent dental caries and reduce costs for dental care. School based sealant programs are endorsed by the Center for Disease Control, the American Dental Association and the Association of State and Territorial Dental Directors as effective public health interventions. The MDH promotes and provides consultative support for school based sealant programs. These programs are funded through various grants. School based sealant programs in every school with high risk children should be assured funding by the state.

  - **Fluoride varnish** is a proven preventive measure. This practice should be encouraged at well child visits with primary care medical providers to reduce early childhood caries. Efforts to promote the first dental visit by age 1, within 6 months of the eruption of the first tooth, can lead to increased prevention and reduced early childhood caries.

  - **School-based dental clinics** can improve timely service for children. Providing preventive and restorative treatment in schools allows for better care. Parents can consent to treatment, but avoid the barrier of travel and missed work to obtain dental care for their child. The use of midlevel providers may reduce cost and increase access.

  - **Dental Checkups** could be required for children enrolling in public and private schools. DHS, as a member of the Governor's Children's Cabinet should bring this concept forward for consideration by the Cabinet so that it can be analyzed collaboratively by the Departments of Human Services, Health, and Education.

- **DHS should endorse the use of portable delivery systems and teledentistry, understanding they must meet regulatory and quality assurance requirements, to improve access for care to MHCP participants.**
    - For example, DHS should support a two-year pilot of teledentistry and have a teledentistry policy that is not more restrictive than scope of practice laws and rules.
    - The use of mobile dental equipment is a strategy to increase access to underserved populations. All dental equipment can be contained in a van or brought into a site. These mobile dental clinics require onsite electrical and internet services. Portable dental equipment is transported and assembled on site.
    - Mobile systems bring the dental service to the patient, increase access and reduce the burden of transportation for the patient and caregiver. This practice facilitates timely treatment for children when parents cannot afford time from work to arrange dental care.
    - A risk to this approach is that the convenience of the mobile dentistry has a heightened potential for abuse when compared to fixed based operators. There are also concerns around continuity of care, provision of emergency care and informed consent. Many states such as California, Arizona, Massachusetts and Virginia have responded to this risk with increased oversight. These states require registration of mobile dental units with the Board of Dentistry, including plans to ensure quality of care. Minnesota should pursue similar regulations.
- **DHS should have a teledentistry policy that is not more restrictive than scope of practice laws and rules.** Further, DSAC recommends that a payment code or modifier be developed to allow for tracking of teledentistry examinations. These codes should be able to track the transmitting dental auxiliary provider as well as the examining dentist. Quality measures should be evaluated to assure that that teledentistry is effective in improving access to dental preventive or treatment services for the underserved.
- **DHS should allow a two-year pilot project in teledentistry. Payment for examinations conducted by teledentistry, once regulatory requirements are established, should be permitted.** Important questions that the Board of Dentistry can continue to address to facilitate such a pilot include
    - Who is accountable?
    - Who provides the care and who makes the recommendations?
    - Can the person making the recommendations be licensed in another state?
    - What are the standards of care?

Strategies related to workforce development

As it is within DHS's scope, DHS should collaborate with agencies and organizations, as appropriate, to help build a dental services workforce that improves access to services. Effective system-wide collaborations between DHS and others will help ensure statewide progress toward the common goal of enhanced access. Most of the strategies for enhancing the workforce contained in this section are largely or totally outside of DHS's purview (e.g., loan forgiveness programs, allied professionals scope of practice).* However, DHS can generally support dentists and allied health professionals by collaborating with other entities as appropriate in examining and developing workforce issues and strategies. Ongoing efforts where DHS may have varying degrees of influence include

- MDH and legislative strategies related to loan forgiveness and repayment programs (e.g., allowing applicants to retroactively apply for a loan once they have set up practice and providing matching grants to local communities for facilities and practices).
- Educational institution efforts to inform and encourage prospective and practicing dental providers to serve in underserved areas (e.g., new curricula and internship opportunities).
- Multiple partner strategies (e.g., MDH, education institutions, Board of Dentistry, Legislature, MDA, Minnesota Dental Hygiene Association) to support an allied workforce (e.g., education, financial incentives and supports, MDH sealant program and developing new arrangements under collaborative agreements (hygienists) and collaborative management agreements (DTs) with dentists).†
- Legislative efforts to
    - clarify or adjust the scopes of practice of allied professionals so they have clear authority to provide services in the community and refer patients to full dental practices for comprehensive exam and continuity of care and
    - bring dentists to non-office settings to partner with mid-level practitioners.
- Dental community efforts to develop standards of care to guide more uniform use of best practices across providers.

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* See also the administrative practices section for discussion of credentialing issues for allied health professionals.

† This may include addressing frequently asked questions such as: What services can be done in community settings (with variations for different settings and types of patients)? What is the optimal level of care that can be delivered in these settings? What supports need to be in place to ease time-of-service communications between mid-level providers and dentists working in a collaborative agreement model? How can referrals to comprehensive care be facilitated to move patients from entry points in the community into regular dental care? What record-keeping and communication technologies are needed to support the flow of information from setting to setting?

VII. Section 3: Administrative Structure and Processes

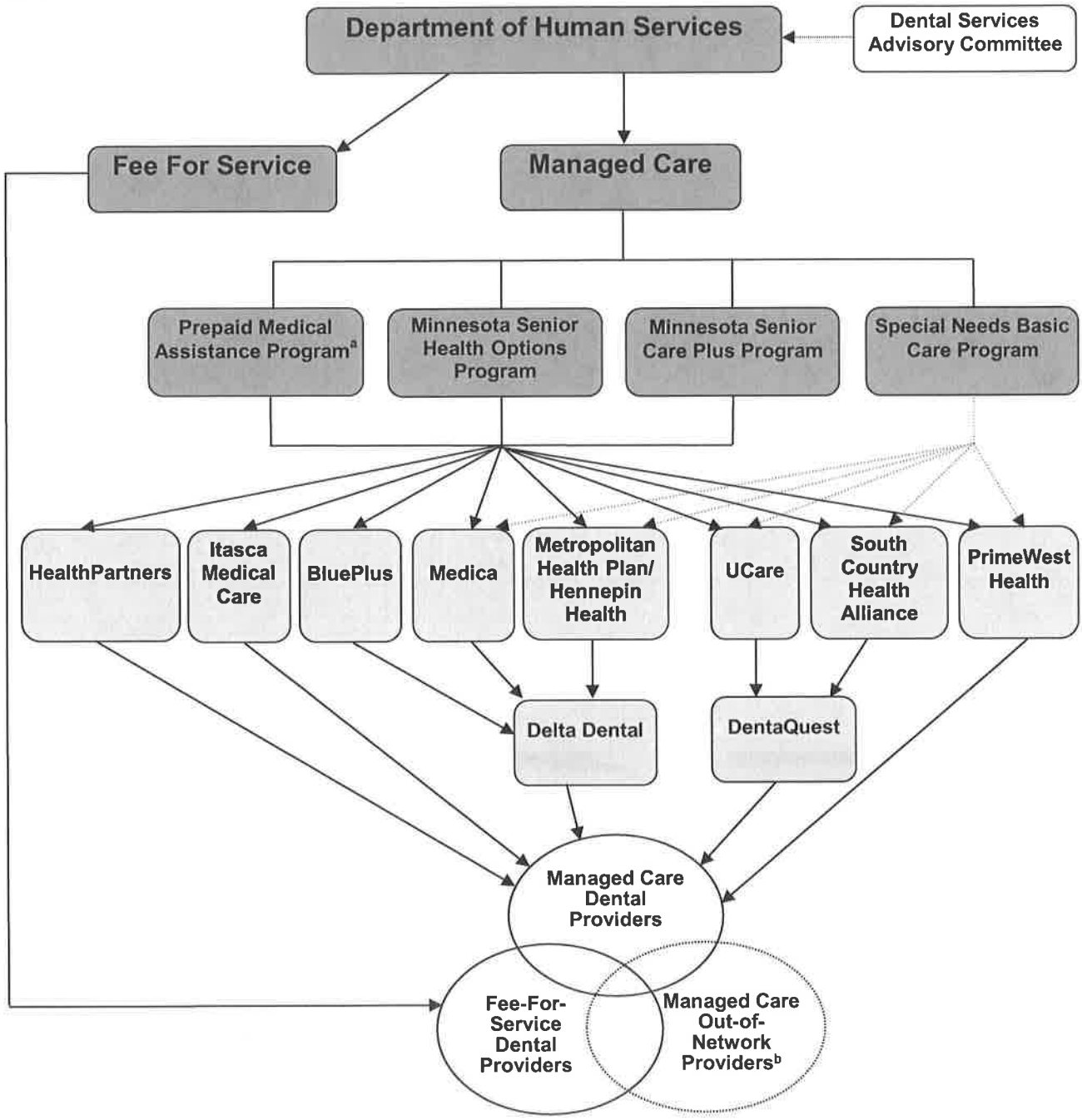
Background and Findings
This section describes the administrative complexity of the current system, outlines DHS administrative functions and discusses issues related to the option of implementing a single administrator model. It also considers ways to improve processes regardless of structural changes and provide strategies for preventing fraud and abuse.

Administrative Complexity
Dental services under MHCP are currently administered under a variety of methods (Figure 2). One major factor is whether the recipient is enrolled in the fee-for service (FFS) program or enrolled in managed care.

- DHS administers benefits for MHCP participants.
- Dental benefits for recipients enrolled in one of the managed care organizations (MCO) contracting with DHS generally are administered by a dental administrator subcontracted with the MCO.
- There are three dental administrators each subcontracting with one or more MCOs that administer the dental benefit for the majority of managed care recipients.

The result, when including DHS as the FFS dental administrator, is essentially four to six methods under which dental benefits may be administered. The various administrators differ in how the functions and activities outlined above are carried out, generating a range of administrative accommodations that providers must support. In turn, recipients must also navigate the changes from one administrator to another if their enrollment changes.

Figure 2: Minnesota's Administrative Structure for Medical Assistance Dental Services, 2012 *[58]



* (a) These programs also include a Preferred Integrated Network component that is implemented in only select counties. (b) An "out-of-network" provider does not have a contract with a managed care organization or its dental administrator to provide Medical Assistance dental services, but can agree to provide services to Medical Assistance patients on an ad hoc basis.

Administrative Functions
With the overall administrative structure, DHS's administration of dental benefits involves operating several functions (Table 6). Functions include: benefit policy, provider management, payment rates, claims processing, authorization/utilization management, provider and recipient relations, program evaluation and program integrity activities.

Table 6: DHS Administration of Dental Benefits

Function	Components Include:
Benefit Policy	• Identify services covered by the benefit, including program differences and eligibility type differences (e.g. children, pregnant women, non-pregnant adults) • Establish parameters for coverage that may apply to services, such as providers, places of service, medical necessity determinations and cost-sharing (if applicable) • Maintain system policies, including billing codes and standards and utilization management criteria (e.g. annual limits, authorization requirements, etc.)
Provider Management	• Manage provider enrollment process: verify qualifications of providers and manage contracts/agreements with enrolled providers • Maintain provider system data
Payment Rates	• Manage fee schedule for dental services • Maintain rates system data
Claims Processing	• Maintain system that adjudicates claims; manage adjudication process • Implement coordination of benefits with other payers as appropriate • Implement recovery of overpayments
Authorization /Utilization management	• Manage authorization/utilization management processes • Apply clinical criteria to individual cases to verify medical necessity prior to payment or as part of post-payment review
Provider and Recipient Relations	• Maintain resources for recipients/members o Recipient/member call center o Written and electronic material related to benefits, network, cost-sharing, etc. • Maintain resource material for providers o Provider call center o Written and electronic material related to enrollment, coverage criteria, claims processing, etc.
Program Evaluation	• Analyze various program aspects such as: access to services, utilization trends, cost trends, patient satisfaction and quality of care metrics

Function	Components Include:
Program Integrity Activities	• Investigate complaints of fraud and abuse; establish proactive methods to identify potential fraud and abuse • Maintain methods to identify inappropriate service utilization • Coordinate with other DHS/state activities

Major Issues

There are major issues associated with both the *overall administrative structure* for providing dental services and for *individual system processes and components*. The discussion below first focuses on the burdens of the administrative structure and the option of a single administrative model. This is followed by an examination of administrative processes that could be improved regardless of whether a single administrative model is used.

Administrative Structure

- **Burdens of the Current Structure**
  - Nearly all providers expressed frustration with the administrative burden created by the current structure of dental benefits administration. Since many dental clinics are small businesses, they may lack the resources necessary to support the varying processes and requirements. Managing multiple processes around provider credentialing, billing, authorization and utilization management are quite costly, particularly to a small dental practice. The OLA reported that 75 percent of dentists practiced exclusively in small private practices in 2012 and 90 percent practiced primarily in this setting.[59]
  - Most providers interviewed support a transition to a single dental administrator. Under such a model, all providers and recipients would be under a single set of administrative requirements and processes. For providers, this eliminates the need to support multiple enrollment, billing, authorization, payment and utilization management methods. In addition, recipients would no longer experience changes in availability of providers or services based on administrative differences.
  - DHS also experiences difficulties related to the distributed administration of dental benefits. One example is the administration of the CAD program. Providers apply to DHS for designation.
    - The add-on payments made to providers designated under the CAD program are administered entirely by DHS; however, the add-on payment is paid immediately with the FFS claim.
    - For a managed care claim paid by a MCO (usually through their contracted dental administrator), the CAD add-on payment is received by the provider in the subsequent quarter. DHS makes payment to each MCO for the total value of the CAD add-on payments based on quarterly reports submitted by the MCOs of all

claims paid to CAD providers by them or by their dental administrator. The separation of the add-on payment from the claims adjudication creates a complex method of verifying eligible claims, making adjustments from quarter to quarter to payments based on reversed or modified claims reported by MCOs.

Once made, the payments are difficult for many clinics to reconcile back to the individual patient because the payment is received separately from the original claim. Thus, it is difficult for providers to determine whether they have been accurately paid. The process also requires the MCOs and their dental administrators to support a separate quarterly report and process separate quarterly payments. A few stakeholders reported that the CAD process was administratively burdensome, while a few others said it was no more burdensome that the processes involved with other insurers, indicating that large systems had the infrastructure to manage it.

- **Administrative structure best practices**
  In examining best practices and opportunities for improvement in service delivery, DHS, through consultation with the Center for Healthcare Strategies (the organization contracted to provide technical assistance to states participating in the Medicaid Oral Health Learning Collaborative), contacted states that have focused on practices and program innovations and successfully increased dental utilization in their states. DHS reviewed policies in Virginia, Tennessee, and Connecticut, and had telephone discussions with representatives from the state who were involved in management of the dental program in that state.

  - All of these states have a utilization rate above the national average, and they attribute this in great part to consolidating their dental benefit under one Dental Benefit Administrator (DBA). The DBA's role for the states discussed below is through an Administrative Services Only (ASO) contract for all their Medicaid recipients.

  - These states also faced lack of dental access especially critical among low-income children served by the Medicaid programs. Representatives from all three states indicated that the method of service delivery was central to the issue of poor access.

  - Most of these states moved their clients to MCOs as far back as 1994, and this move had resulted in some increased access to dental services. However, they continued to receive complaints from the dental provider community about the administrative burden associated with supporting varying administrative requirements among the contracted MCOs and from Medicaid enrollees who were having difficulty locating a dentist.

  - The dental communities within those states indicated that multiple payer contracts (i.e., multiple MCOs and the FFS program similar to Minnesota's current system) combined with the issue of low provider reimbursement deterred their participation in the state Medicaid program.

- Collaborative discussions between the Medicaid program and dental stakeholders of these states led to the recommendation that the Medicaid program carve dental services out of MCO contracts and consolidate dental services under a unified dental administrative arrangement. Each of the Medicaid programs embraced the idea of a single dental administrator system and began working with the DBA. The DBA's role and responsibilities includes expanding the Medicaid program's dental provider network, including recruiting; handling prior authorization requests; processing claims and submitting encounter data; promoting the new dental program; conducting provider and enrollee outreach activities; handling enrollee and provider services issues with the goal to increase access to and utilization of high quality dental care services through an expanded and adequate network of dental providers.

- Prior to implementing the DBA, all three states faced barriers accessing dental care across the states and had already identified causes of dentists' reluctance to participate in public programs. Barriers included: low Medicaid reimbursement rates that are often less than what it costs dentists to provide care, excessive paperwork and other billing and administrative complexities, high rates of broken appointments, movement of patients between MCOs or between MC and FFS, poor oral health literacy and awareness about the importance of oral health, and the uneven distribution or location of dentists within some states and local communities. The experiences of these states indicate that contracting with DBA helps reduce administrative costs, simplify the administrative process, and reduce the burden on providers. For example:

Virginia
Virginia moved to a single dental administrator in 2005 as part of a statewide focus on oral health for children.

- Prior to 2005, Virginia had only 660 dentists' statewide seeing Medicaid patients and only half of those were accepting new patients.

- In addition, providers had not had a fee schedule increase in approximately 20 years (fees were based on 1980 rates) and had to manage policies under five MCOs and a FFS program.

- Providers in the state wanted administrative costs and complexity reduced and reimbursement increased.

- The move to a single administrator was accompanied by an approximately 30 percent increase in rates (28 percent across all services and another two percent to preventive dental services for children).

- Within 1½ years of making these changes, Virginia's Medicaid program had doubled its provider network and today has 1,819 dental providers participating in their program. More importantly, the rate of children enrolled in Medicaid who received preventive dental services in a year increased from 29 percent in 2004 to over 60 percent today. Coupled with the improved access, state officials noted a significant decrease in

emergency department visits for dental pain.

- Virginia dental program representatives interviewed attribute at least half of their improvement to the movement to a single administrator.

- Through the administrator, the state is able to centralize a focus on oral health goals, to monitor providers better and to be more responsive to provider's needs. For instance, Virginia significantly reduced prior authorization complexity by simply moving from multiple methods to a single method.

- In addition, the administrator is helping providers reach out to those who miss their dental appointments, ensuring coordination with transportation to help reduce future missed appointments.

- These steps were viewed favorably by dental providers as reducing the burden on their office staff when working with Medicaid patients and improving their willingness to serve Medicaid patients.

- The state transferred all responsibilities for beneficiary outreach, patient education, provider outreach and enrollment and claims processing to the dental benefits administrator.

- Dentists were very receptive to the uniformity in process and felt that the single administrator de-stigmatized participation in Medicaid, helping providers in the network realize that seeing Medicaid patients would not necessarily be a negative experience.

- Virginia officials also estimate that the state's cost for administering the dental services have also decreased by approximately one-third.

Tennessee

- The Tennessee Medicaid program shifted to a single dental benefits administrator contract in 2002. Dental services prior to that were administered by 12 MCOs, all with different contracts and different provider manuals and requirements and all with low rates paid to providers.
- Those interviewed in Tennessee noted that although the fee schedule was increased for dental services in 2002 (and includes no differentiation for urban vs. rural providers), no further increases have occurred except a small adjustment for select procedures.
- Despite this, they continue to have more dentists willing to participate than they need to serve their Medicaid population. They credit the single administrator structure with easing the administrative burden and costs, making participating easier and less costly for providers
- They note that many dental providers want to treat members of their community and don't expect to make money off of Medicaid patients, but the administrative burden in the past was simply too great. Having to manage only one provider contract and one set of administrative rules have made the difference for providers.
- Under the Tennessee ASO contract, the state covers expenditures for benefit claims and

the DBA is paid an administrative fee for managing dental benefits. The DBA is responsible for recruiting and maintaining a network of qualified dental providers adequate to make dental services available and accessible to beneficiaries. Providers are measured against several quality and performance benchmarks. According to the Tennessee officials, Medicaid dental providers are considered to be the best providers in the state and providers are seeking to be included in the state's dental network. In addition to conducting enrollee outreach and education activities, the DBA must also conduct statewide provider training programs annually. The DBA also manages data, provides mandatory reports, and conducts quality improvement programs and utilization review and management, as well as achieves specific performance requirements. As a result of the program changes, provider participation grew by more than 120 percent, and utilization of dental services by recipients' age three through 20 also increased from 36 percent to 51 percent annually.

- In 2013, Tennessee instituted its first risk-based contract with their dental benefits administrator. Under this arrangement, targets for utilization and costs are set and savings or costs will be shared between the state and the DBA depending on what targets are met or missed.

Connecticut:
The Connecticut model is similar to the DBA models in Virginia and Tennessee.

- Prior to 2006, their dental benefit administration was similar to Minnesota's current structure — FFS and 12 MCOs.

- In 2007, the state moved to a single dental administrator and reimbursement rates were increased to a rate equivalent to 90 percent of the 2007 commercial rate.

    - The single benefit administrator structure encouraged many more private practice dentists to treat children insured under Medicaid programs.

    - Utilization rates of preventive dental services for children continuously enrolled in Medicaid increased from around 35 percent to nearly 63 percent in 2011.

    - According to state officials, they went from one of the lowest performing states to second in the nation within two years of increasing rates and contracting with a single administrator.

    - Administrative requirements for providers have been eased, using more automated processes and a mixture of prior authorization, pre-payment, and post-procedure review to help identify quality issues and educate providers.

    - Officials note that with greater insight into provider performance, they have eased prior authorization requirements for providers who have long histories of high-quality services and few issues.

    - The DBA receives lists from the state of "non-utilizers" and reaches out to connect

them with dental services and also works with providers on methods to help ensure attendance of Medicaid enrollees who have missed dental appointments in the past.

- In addition to the increased rates and decreased administrative burden, providers in Connecticut were pleased with the uniform fee structure.

- Nearly all of Connecticut's cities and towns, including areas with the greatest concentration of children, experienced significant increase in utilization rates. Increased private practice dentist participation in the Medicaid program directly contributed to greater access to oral health services among low-income children. Today, Medicaid enrollees in the rural corners of the state have access to two dental providers and in urban areas of the state a provider is available within two miles of each enrollee.

- State officials in Connecticut indicated that their MCOs were "happy to get rid of" administering dental services. They noted that the MCOs were all subcontracting dental services anyway, so moving to a single dental administrator provided the state increased influence over the administration of dental services and the quality of services enrollees receive. State officials have been so pleased with the single administrative approach that they now contract with single administrators for all services, including health care since 2010.

While each state is pleased with their results, a single administrator alone, while important to reducing administrative costs for providers, is often not the only step necessary to increasing provider participation. Rate increases in at least two of the states were also an important step.

Minnesota, unlike many state Medicaid programs, provides at least a limited adult dental benefit. Of the three states interviewed, only Connecticut provides coverage of limited dental services to adults. The other two states provide comprehensive services to children as required under federal law, but have not chosen to exercise the option of providing more than emergency dental services to adults. However, it is reasonable to assume that with similar measures taken, similar improvements could certainly be achieved in Minnesota for children, and it would be likely that improvements would also be seen for adults.

Stakeholder comments regarding a single administrative structure
Several people and groups in this study suggested that the state simplify administrative issues and reduce costs by moving to a system where there is a single administrator of MHCP dental benefits instead of the multiple administrators currently in the system.

- A single administrator, several stakeholders said, would mean one benefit set and one set of processes, instead of the many processes now in effect. Stakeholders who said they wanted a single administrator did not necessarily agree who that should be. Some people wanted DHS to be the administrator, some wanted a current administrator and some wanted to open the selection process to other non-profits.

- Stakeholders suggested or acknowledged that if a single administrator were selected, it would be selected through a RFP process with carefully chosen criteria. Some interviewees advised that stakeholders be involved in setting the criteria.

- A few stakeholders objected or were cautious about a possible move to a single administrator or dental carve out. They opined that this could undermine the goal of oral/other health integration (e.g., as is being done at HealthPartners). They also felt that single administrator proponents overestimate the administrative costs associated with billing multiple MCOs. They also preferred having options for administrative services, stating that competition lead to better administrator performance.

Administrative Processes and Components
For administrative processes in general, providers noted the most problems surrounding these functions:

- Enroll as an MHCP dental provider: This includes obtaining credentialing for self and, as applicable, allied dental health professional (dentists are the conduits for credentialing other providers)

- Verify the patients as MHCP enrollees and verify the scope of benefits covered for the individual: For many providers, this includes working with different verification processes established through DHS FFS and each MCO.

- Obtain prior authorization from the DHS-contracted medical review agency or MCO(s) for certain procedures, including the submission of patient histories, x-rays and related information.

- Submit claim forms to DHS and/or MCOs and receive payments. Claim forms and codes are not standardized across DHS and MCO dental insurance programs.

- Manage missed appointments which are reportedly more common among MHCP and Medicaid than other patients.

- Arrange for interpreters and pay for interpreters when there are missed appointments. MCHP pays for interpreters but providers must arrange for them.

- Address data privacy (HIPPA) and fraud and abuse regulations.

Several stakeholders emphasized the importance of improved processes. A study of eight states similarly found that "states and providers say these simplifications are extremely important to maintain and increasing provider participation."[60]

Previous Minnesota research shows mixed results. In a 2012 survey of providers, about 23 percent of dentists said administrative work was a reason for not treating MHCP patients or not accepting more; low fees, limited scope of benefits and missed appointments were deemed more important.[61] Earlier research similarly shows that low fees were the most important problem with MHCP, followed by broken or cancelled appointments and denial of payments.

Stakeholder recommended improvements
Stakeholder recommendations fell into five major areas, as discussed below, many of which were identified by stakeholders to be exacerbated by the administrative structure that currently exists.

1. **Develop a common benefit structure**
   Several interviewees said the existence of multiple benefit sets increases administrative costs. There are several variations on the statutory benefit set and several stakeholders stated that although the adult standard benefit set is listed in detail in statute, it remains open to interpretation. In addition, benefits frequently change over time. For example, adult benefits contracted in 2010 and expanded slightly in 2013. Several stakeholders suggested that the current benefit set is a product of budgetary discussions rather than clinical-based discussion or guidelines.

2. **Simplify credentialing, MHCP enrollment and benefit verification processes**
   Some states have developed a single set of rules and one provider agreement for credentialed providers. Other states have streamlined provider enrollment by publishing enrollment forms online and allowing dentists to enroll or update information online, while others have simplified their system by moving from multiple claims forms to a universal form.[62] Minnesota's efforts to do this seem to have stalled. Another suggestion from stakeholders was to use electronic fund transfers for payments. Apparently, despite electronic fund transfer requirements, some providers still submit paper claims or use dial-up internet. Several interviewees also said it was difficult to look up patient histories to determine if an individual was eligible for coverage. Some states have systems of automated beneficiary eligibility verification, which allows Medicaid dental providers to access eligibility information from beneficiary membership cards, automated voice response systems and computer software.[63] The OLA suggested that DHS make IT changes to better support providers' ability to look up inquiries of patient eligibility and state restrictions or benefits.

3. **Streamline preauthorization (PA) processes**
   Another suggestion made by several stakeholders in Minnesota and other states is for the state (and MCOs) to examine the necessity of all existing prior authorizations.[64] Options include reducing or eliminating prior authorizations except for the most costly services and streamlining the process "by ensuring that the requirements are publicized in a format that is easy to both access and comprehend."[65] Others have suggested the use of an electronic clearing house to submit x-rays, reducing the amount of information that providers must submit and simplifying the means of delivery (e.g., electronic submission).

4. **Address appointment "no shows"**
   Another administrative issue of access to some providers is missed appointments. A 2001 DHS report stated that "reducing appointment failures would address one of the dentists' most frequently expressed reasons" for refusing to see MHCP participants.[66] This rings true today for some providers, although there was also a comment that missed appointments should be seen as an opportunity; missed appointments free-up time for serving walk-ins or taking same-day appointments. Several interviewees reported

strategies they have effectively used to reduce the number of people with missed appointments. Their efforts include education to members and county case mangers regarding the importance of going to dental appointments and discussing transportation and child care issues. Increased participant health care literacy was also mentioned by some stakeholders as a way to reduce missed appointments and in incent providers to serve more MHCP participants.

5. **Other stakeholder advice**
   A few people gave advice for improving administrative processes that included:

   - Allow DHS to directly reimburse dental hygienists or pay under the dental therapist (DT) provider number (DTs are reimbursed under the dental provider number and dentists go through a separate credentialing process when hiring DTs).
   - Develop evidence-based standards of care for the benefit set (per section 2).
   - Improve contracts between dentists and MCOs (small dental offices do not have much leverage, said one person).
   - Improve the CAD process, because it is burdensome and lengthy.
   - Use the existing Administrative Uniformity Committee process to simply practices of the health plans and state public programs.

Processes for Preventing Fraud, Abuse and Overtreatment
As directed by the legislature, DHS's recommendations for improving administrative structure and processes include strategies for preventing fraud, abuse and overtreatment. Overtreatment, fraud and abuse fall under the broad category of "improper payments." Improper payments include inadvertent errors, such as duplicate payments and miscalculations; payments for unsupported or inadequately supported claims; payments for services not rendered; payments to ineligible beneficiaries; and payments resulting from outright fraud and abuse by program participant and/or program employees.[67]

Corrective Strategies
Improper payments can occur for many reasons, and preventing them requires a multi-pronged approach that includes prospective and reactive methodologies and multiple stakeholders. The risk of improper payments increases in programs that have complex criteria for computing payments, experience a significant volume of transactions or place an emphasis on expediting payments. Strategies to address improper payments can be classified as either *proactive* (those that identify overtreatment, fraud and abuse before payments are made) or *reactive* (those that identify the improper activity after it has occurred). Strategies generally fall into one or more of the following categories:

- **Risk assessment**—performing reviews and analyses of program operations to determine if risks exist and the nature and extent of those risks.
- **Control activities**—taking actions to address identified risk areas and ensure that management's decisions and plans are carried out and program objectives are met. These

actions can include data sharing, data mining and recovery auditing.

- **Information and communications**—using and sharing relevant, reliable and timely financial and nonfinancial information in managing improper payment-related activities.

- **Monitoring**—tracking improvement initiatives, over time and identifying additional actions needed to further improve program efficiency and effectiveness.[68]

DHS implements strategies for preventing improper payments through the Surveillance and Integrity Review (SIRS) unit and Purchasing and Service Delivery division. In addition, the Minnesota Board of Dentistry, the State Medicaid Fraud Control Unit (MFCU), and MCOS conduct their own activities.

- **DHS OIG SIRS Unit**
  Data from the DHS Office of Inspector General's (OIG) SIRS unit shows that between 2003 and 2012, SIRS conducted between 2 and 33 investigations each year, with total annual recoveries ranging from $0 to about $92,000. There was an average of 12 cases per year and an average of $1983 in recoveries per case.* Investigations were conducted largely as a result of complaints the DHS OIG received through the OIG complaint hotline or as the result of data mining activities they conducted using DHS and other claims data. The SIRS unit has limited resources to actively perform risk assessments and monitor MHCP dental program activity, with only part-time staff dedicated to this. The unit is in the process of hiring additional staff to devote additional time to responding to hotline complaints, bolstering data mining analytics and coordinating with stakeholders in follow up activities.

- **DHS Purchasing and Service Delivery (PSD) Division**
  In addition to conducting data mining work and responding to complaints of provider fraudulent or improper billing, the DHS OIG SIRS unit coordinates with the DHS Purchasing and Service Delivery division to identify improper billing practices and recommend potential prospective edit checks in the DHS billing system. These edit checks are a front-line, prospective approach to identifying and preventing reimbursement for fraudulent billing practices. The PSD division coordinates with its IT staff to implement the edit checks.

- **Minnesota Board of Dentistry and the State Medicaid Fraud Control Unit (MFCU)**
  The Minnesota Board of Dentistry also investigates complaints alleging fraudulent or improper billing activities. Over the past five years, the Board has investigated 67 complaints with fraudulent or improper billing as the primary allegation, resulting in ten disciplinary and two corrective actions that ranged from fines to license revocation. The State Attorney General's Office also has a Medicaid Fraud Control Unit (MFCU) MFCU coordinates with various entities (e.g., DHS OIG and the Minnesota Board of Dentistry) to investigate and prosecute fraud allegations. These actions are reactive and focused on confirming and prosecuting illegal activity.

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* See Appendix H for the number of cases and recoveries per year.

- **MCOs**
  MCOs use claims software that tracks utilization and coding patterns to proactively identify improper payments for dental and other services, MCOs use their own internal investigation units or contract with external organizations to conduct post-payment investigations. MCOs are required to report to MFCU and the SIRS unit the results of their internal investigations but not the results of the subcontractor and contractor investigations conducted by external organizations. However, beginning in January 2014, the DHS SIRS unit will require MCOs to send the monthly results of all improper payment investigations, including the subcontractor and contractor investigations.

Major Issues
Stakeholder comments reveal some of the underlying reasons, or root causes, behind fraudulent and abusive dental practices, including overtreatment.

- **Lack of treatment standards**
  One reported reason for potential improper payments was the dental community's lack of best practices and treatment standards. Providers have an inconsistent understanding of what constitutes appropriate treatment for patients. Several interviewees spoke about how multiple dentists could develop widely varied treatment plans for the same patient; this plan could be seen as excessive by one dentist, sufficient by another and inadequate by a third. The lack of industry standards leads to confusion and irregularity across the industry and makes it difficult for investigators to determine the extent of over or under treatment. If treatment standards were developed even for the most common procedures, this would reduce some confusion and give providers and investigators a more informed context for treatment decisions. Peer review by outside oral health professionals is one approach dental practices have taken to develop consensus on standards of care. A few interviewees suggested that the state develop incentives for practices that are regularly reviewed by peers or conduct reviews for others. Incentives could be funded out of the provider tax and be tied to any performance standards or measures that are adopted by DHS or other entities.

- **Need for a coordinated and multi-faceted monitoring approach**

  - Along with provider-based fraud and abuse concerns, another factor affecting fraudulent and abusive factors is the degree of coordination among the various entities monitoring this issue. Monitoring strategies include implementing edit checks in the DHS billing system, limited data mining activities conducted by the SIRs unit, more robust data mining activities conducted by the MCOs, and peer review processes adopted by some dental practices. Investigations into improper billing practices are also made by MCOs, the SIRS unit, the Attorney General's MFCU and the Board of Dentistry. While these approaches follow industry best practices, they are not coordinated and, in some cases, not applied on a consistent or robust basis. In addition, recipients seeking to receive services for which state regulations or policies limit the frequency with which a service can be provided, have moved between FFS and managed care or from one MCO to another to get around such limitations. Because information is not shared between the various administrators, MCOs and FFS, such activity is very difficult to detect and prevent.

- Coordinated activities can be combined with more multi-faceted approaches. For instance, more extensive data mining can be used to analyze data for relationships and target fraud and abuse investigations. The SIRS unit has previously conducted some analytics to identify fraudulent activity among dental providers, including those who submitted dental claims for services performed during extreme blizzard conditions. These efforts resulted in criminal prosecution and recoveries for fraudulent billing. Neural networking is another approach. A neural networking system analyzes associations and patterns among data elements, allowing it to find relationships that can result in new queries. Texas' Medicaid Fraud and Abuse Detection System used this system to identify fraudulent patterns from large volumes of medical claims and patient and provider data. Texas has developed models for physician and dental providers and has used data mining activities and neural networking reports to recover millions of dollars annually.[69] In addition, a single administrator may also improve the collection and coordination of information to identify patterns of utilization by recipients who may be engaging in inappropriate activity.

Recommendation and strategies

Recommendation 3: To improve administrative structures and processes, the state should adopt elements of the single administrator model that have been successful in other states – streamlining administrative processes and strengthening efforts to prevent fraud and abuse.

Strategies related to improving administrative structure and processes

- **Minnesota should adopt elements of the single administrator model that have been successful in other states.** A single point of contact for providers and their office staff reduces paperwork, creates consistency, and may improve the timeliness of reimbursement. States interviewed for this study say that these simplifications are extremely important to maintaining and increasing provider participation. There is no "one size fits all" solution to increasing dental access for Medicaid eligible recipients. However, there are certain elements of what other states have done and that are innovative and can be replicated here in Minnesota. While the issue of reimbursement remains a central issue, improved collaborations between state, stakeholders, and dental providers will help address the issues.

  While there are no simple answers to addressing the issue of improving access to dental care for Medicaid eligible recipients, these states have demonstrated innovative service delivery. Minnesota has continued to lose ground on important children's dental measures, and new efforts must be implemented in order to make the changes necessary to meet the requirements established by CMS. The shift to single administration in

conjunction with base rate increases certainly helped increase access in the states interviewed. Such a transition should take into consideration ideas to preserve the relationships and integration between medical and dental services that have been established within some programs, including whether limited carve-outs could be supported, provided they are able to achieve the administrative simplification without increasing administrative costs. Progress can be made by combining innovative ideas with support from providers, stakeholders and the state legislature.

- **DHS should improve administrative processes by enhancing communication regarding what benefits are covered, training and technical assistance to dental providers and by incorporating, wherever possible, best practices.** Benefits are specifically listed in statute and DHS has a provider manual and other communications. MCOs also have provider resources identifying clinical criteria for coverage of services. However, providers still report frustrations in understanding what is covered and how statutory language is interpreted. DHS could analyze prior authorization issues to ascertain which areas are of greatest confusion and which modes of information sharing are most effective. Communication vehicles could include webinars, formal training sessions, improved web sites and the use of social media. DHS could also review call center procedures to assure that dentists have quick access to someone with dental services expertise when needed.

Strategies related to strengthening efforts to prevent fraud and abuse

- **DHS should expand use of analytics, risk assessments and data mining to proactively and strategically identify and address fraud and abuse issues. Expand use of analytics, risk assessments and data mining to proactively and strategically identify and address fraud and abuse issues.**
    - The state needs to expand proactive approaches to systematically identify improper practices and over payments. DHS SIRS and others are planning to hire new staff and make greater use of risk assessments and data mining analytics to identify questionable patterns of coding, utilization, or other practices. Additional staff would allow SIRS to conduct a broader range of analytics and refine edit checks in the billing system. If SIRS resources do not allow for increased levels of chart reviews, they should consider contracting with appropriate organizations. Chart reviews can be an effective approach to detect improper billing—analytics provide a tool for doing them more strategically. DHS should consider including the MHCP dental program in its recovery audit contracting efforts, as this could provide another opportunity to identify potentially fraudulent post-payment claims. If feasible, the SIRS unit should also consider collaborating with the PSD and DHS IT divisions and other key parties to develop and implement neural networking, an advanced means of extracting and analyzing data. This tool could be used not just within the MHCP dental program, but in other areas as well.
    - **Leverage existing relationships to encourage best practices sharing, monitor the dental program, and allocate resources accordingly.** Much is already being done

to prevent improper payments by DHS Purchasing and Service Delivery, the Board of Dentistry, the State MFCU, the SIRS unit and MCOs. Prospective activities include DHS billing edit checks and MCO-developed analytics to identify utilization and coding patterns. Post-review actions such as investigations are conducted by the SIRS unit, the Board of Dentistry and the MFCUs in reaction to consumer complaints. While the SIRs unit may refer complaints to the Board of Dentistry or the MFCU (and vice-versa), many of these activities occur in isolation and best practices are not shared across organizations. Minimizing improper activity and improper payments often requires the exchange of relevant, reliable and timely information, not only between individuals and units within an organization, but also with external entities, particularly those with oversight and monitoring responsibilities.

VIII. Conclusion

A 2002 DHS report described many of the same issues contained in the current study and noted that these changes would require a substantial infusion of funds, structural change and educational efforts. It also concluded, "given that none of these is likely to occur, the crisis is apt to continue and Minnesota's attack on disparities in health is apt to fail, at least regarding dental health.

As the Surgeon General makes clear, dental health profoundly affects all aspects of health."[70] A few stakeholders opined that the issues talked about in 2002 are still the ones challenging the state today, such as the need to improve access, increase rates and extend the use of allied health professionals.

At present the state is in an excellent position to make progress in improving the dental services system. This report provides a basis for DHS to implement additional improvements in the system, in discussion and collaboration with other stakeholders. In summary, the major themes and recommendations of this report include the following:

Table 7: Summary of Recommendations and Strategies

Recommendation 1.The legislature should increase base payment rates for dental services and refine the payment structure to encourage provider participation in Minnesota's Health Care Programs.
• The legislature should give DHS the flexibility to tie rate increases to access or quality outcomes. • The legislature should simplify and refine the payment system by incorporating critical access payments into the overall rate structure • **DHS or others should discuss ways in which the state could create a similar payment method for paying both physicians and dentists** • **DHS, MDH and others should collaborate to assure that oral health disparity information is efficiently and effectively gathered**
Recommendation 2: DHS should continue to collaborate with other entities to support an evidence-based, integrated service delivery system that uses preventive services, portable delivery systems, teledentistry, a comprehensive adult benefit set and an expanded workforce to increase access and enhance cost-effectiveness.
Measurement and Standards of Care • DHS should evaluate whether changes in the dental program contribute to improvement in the DQA Measure Set #1. • DHS should continue to use DSAC expertise in assisting DHS in developing access, outcome and performance measures. • DHS should continue to assess and adopt quality and performance measures and provide a forum for creating an evidence-based benefit set and standards

of care.
Integration of oral health with other health services • DHS should support the integration of oral health for all MHCP enrollees into ACO models, including dental care in the total cost of care. • DHS should assist in the development or dissemination of best practices and consider other changes to policies and processes to support integration
Prevention, portable systems of care and teledentistry • DHS should coordinate with stakeholder in promoting a comprehensive prevention program for MHCP recipients comprising evidence-based strategies like sealants and fluoride • DHS should endorse the use of portable delivery systems and teledentistry to improve access for care to MHCP recipients; for example, DHS should support a two-year teledentistry and have a teledentistry policy that is not more restrictive than scope of practice laws and rules
Dental Workforce • As it is within DHS' scope, DHS should collaborate with agencies and organizations, as appropriate, to help build a dental services workforce that improves access to services.
Recommendation 3: **To improve administrative structures and processes, the state should adopt elements of the single administrator model that have been successful in other states – streamlining administrative processes and strengthening efforts to prevent fraud and abuse.**
• Minnesota should adopt elements of the single administrator model that have been successful other states • DHS should streamline, simplify administrative processes by improving communication with providers and disseminating best practices. • DHS should expand data analytics, and leverage relationships to prevent fraud and abuse.

As DHS, the dental community and the legislature turn their attention to further improvements to the dental services system, they have strong assets upon which to build.

- Many hundreds of dentists, clinics, dental therapists, hygienists, managed care organizations, dental administrators and others provide excellent care to MHCP enrollees, conduct outreach activities to improve access, and target subpopulations of children, frail elders, people with disabilities, minorities and people in rural and urban areas who are homeless or have special problems accessing care.

- Stakeholders across many disciplines have years of experience in developing and improving policies to better address individual and systemic oral health needs.

- The legislature has maintained some level of dental services for adults and recently raised rates. It is critical to build upon this foundation to refine the payment, administrative, and service systems.

These refinements will help the state maintain a system that is both cost-effective and improves oral and overall health outcomes.

Appendixes

Appendix A: List of Stakeholder Interviewees

MAD staff interviewed 57 individual stakeholders either individually or as part of a group. They represented a range of perspectives, from providers to health plans to state agencies, and included:

- Eight managed care organizations (Blue Plus, HealthPartners, IMCare, MHP/HH, Medica, PrimeWest, South Country and UCare)
- Three dental administrators (DentaQuest, Delta Dental, HealthPartners)
- DHS State Operated Services
- Minnesota Dental Association
- Minnesota Dental Hygienists' Association
- Minnesota Board of Dentistry
- Apple Tree Dental
- Dental Services Advisory Committee
- Safety Net Coalition
- Minnesota Department of Health Oral Health Program
- Minnesota Department of Health Office of Rural Health and Primary Care
- Head Start
- Dental Associates
- University of Minnesota Dental School
- MnSCU-Metro State University
- Greater MN dental practices (three dentists)
- DHS Office of the Inspector General

Appendix B: Minnesota's non-pregnant adult dental services

Subd. 9. Dental services.

(a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for non-pregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planning once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

Appendix C: Selected DHS and MDH Initiatives

Initiative	Focus	DHS/MDH involvement
Accountable Health Model	Test new ways of delivering and paying for health care using the Minnesota Accountable Health Model (MAHM) framework. This model "expands patient-centered, team-based care through service delivery and payment models that support integration of medical care, behavioral health, long-term care and community prevention services."[71]	DHS MDH
Health Care Homes[72]	HCHs are an approach to primary care to improve individual and population health and contain costs. Design principles "focus broadly on the continuum of 'health' and incorporate expectations for engagement of the patient, family and community." The model includes behavioral health homes and includes a focus on patient- and family-centered care.[73]	DHS MDH
Reform 2020[74]	Reform 2020 refers DHS efforts to reform Medical Assistance (MA) to increase people's independence and health, reduce reliance on institutional care and meet other goals. It includes: • Community First Services and Supports (CFSS), to replace the Personal Care Assistant benefit with expanded self-directed options. • Anoka Metro RTC Demonstration, to facilitate transition between community and inpatient settings. • Money Follows the Person (continued) to individualize care and/or reduce institutional care.	DHS
The MN Health Care Reform Task Force	This group was created to provide the state with advice on federal and state health reform implementation, the task force recommended new pay-for-value financial models and care models based on patient-centered care and evidence-based programs.[75]	MDH DHS
Advancing Health Equities activities and report	The Minnesota Legislature in 2013 directed MDH and its partners to complete a report about advancing health equity in Minnesota. The report will assess Minnesota's health disparities and recommend best practices, policies, processes, data strategies and other steps. The project launched October 22, 2013. The report is due to the Legislature February 1, 2014.[76]	MDH
Eliminating Health Disparities Initiative (EHDI)	EHDI works "to eliminate disparities by partnering with populations of color and American Indians to create their own healthy futures." MDH's work includes a focus on helping adults prevent and manage chronic conditions (e.g., diabetes and cancer).[77]	MDH

Initiative	Focus	DHS/MDH involvement
Olmstead State Plan	Two lawsuit outcomes (the federal Olmstead Ruling and the Minnesota Jensen Settlement) have resulted in the state's Olmstead Plan. An Olmstead Plan is a way for a government entity to document its plans to provide services to individuals with disabilities in the most integrated setting appropriate to the individual. The Governor's subcabinet developed the Olmstead plan in 2013.[78]	

Appendix D: Rate Increase Studies

Numerous studies have examined the role of increased rates on access. Although results are somewhat mixed, research suggests that where states have moved to increase Medicaid reimbursement levels to be more consistent with market rates, dentists participation in Medicaid increased. For example, in a study of the impact of increased rates in six states, provider participation increased by at least one-third and sometimes more than doubled in the first two years. There was also an increase in the number of patients treated. In fact, patients' access to care not only increased after new rates were implemented, enrollees in all six states encountered less difficulty finding care. The increased rates were usually directed at the procedure codes used most by the pediatric population. Importantly, the provider rate increases were implemented in conjunction with other changes such as simplified administrative procedures, partnerships with stakeholders and dental schools, and educating families.[79]

When Connecticut recently raised rates and simplified administrative procedures, researchers concluded that despite some experts who argued that rates competitive with those of private insurance wouldn't be enough to entice private dentists to participate in Medicaid, and despite others who suggested that families on Medicaid may not seek dental care due to non-economic barriers—such as education, language, culture and transportation, Connecticut's experience showed that "these assumptions are not true." In response to a lawsuit regarding impaired access to basic dental services, Connecticut:

- Increased dental reimbursement rates to the 70th percentile of 2005 private insurance fees.
- Simplified Medicaid dental program administration (services are now managed by a single administrative services organization that has no financial risk).
- Initiated an outreach effort to increase dental program participation of both patients and providers. A representative guides new providers through streamlined processes.[80]

Increases in rates, not surprisingly, results in higher state costs for Medicaid claims. In some cases, the increases were substantial. For instance, research of children's dental access found modest positive relationships between increased rates and utilization and number of providers who accept Medicaid. The researcher concludes that "increasing Medicaid payments to the level of private market fees would increase access to care, but the incremental cost of the additional visits induced would be very high."[81]

Appendix E: HPSA Maps

Figure 3: Statewide map of Health Professional Shortage Areas[82]

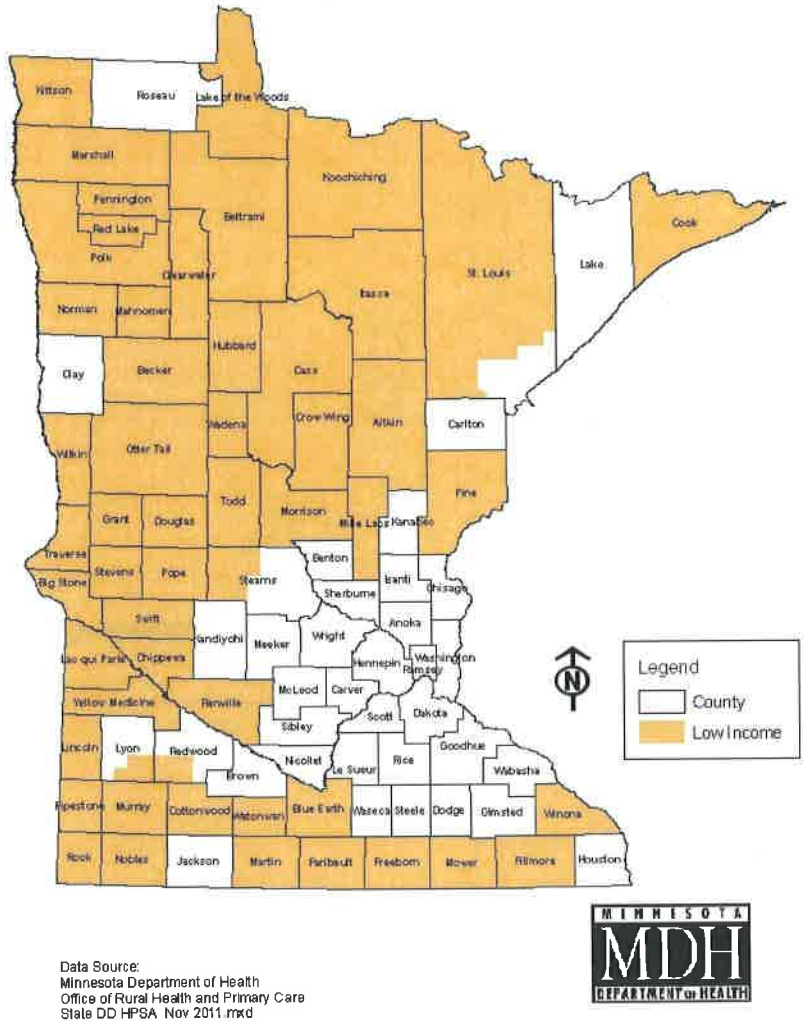
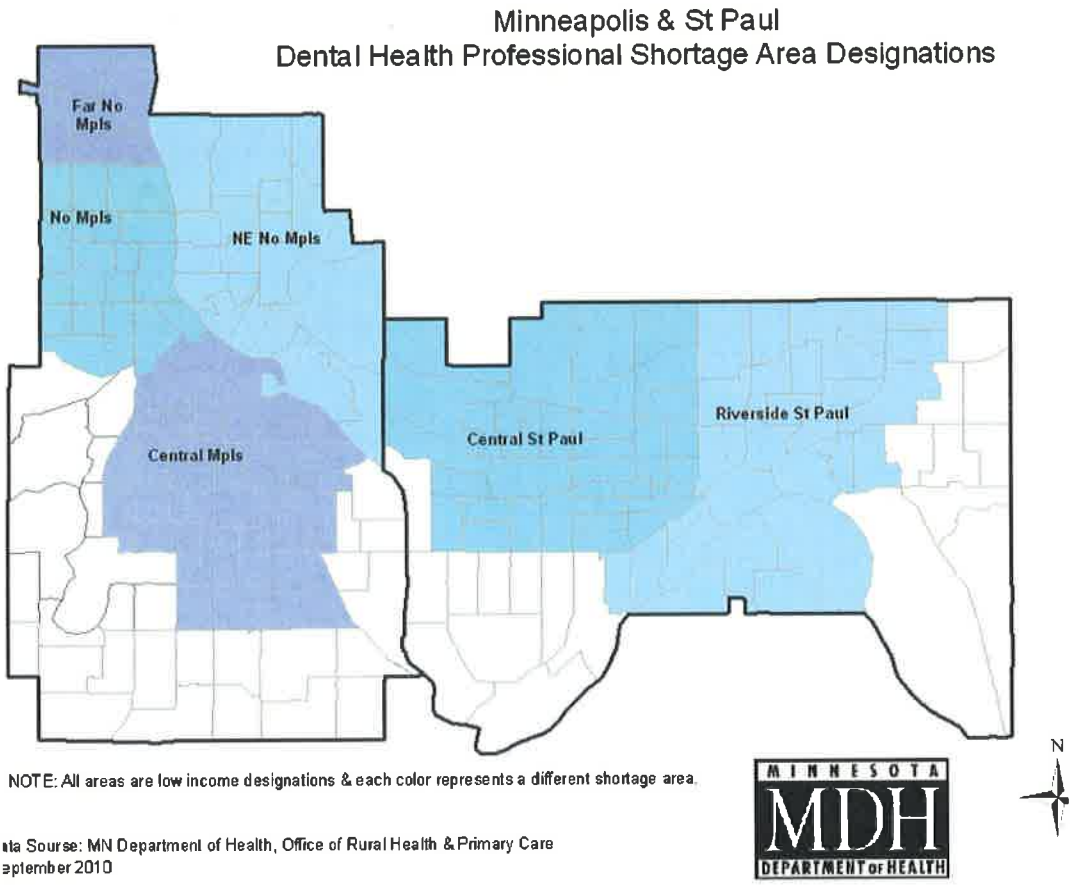


Figure 4: Health Professional Shortage Areas in Minneapolis and St. Paul[83]



Note: Variances in blue designate neighborhood boundaries; all blue shaded areas are HPSAs.

Appendix F: DHS OIG Dental Provider Recoveries 2004–2012

Year	# of Cases	$ Recoveries
2003	3	0
2004	2	240
2005	5	5,000
2006	2	8,641
2007	33	9,705
2008	32	91,604
2009	29	39,039
2010	5	13,946
2011	5	61,322
2012	4	8,417
TOTAL	**120**	**$237,914**

Appendix G: Endnotes

[1] Laws of Minnesota 2013, chapter 108, article 6, section 35
[2] Minnesota Department of Human Services. "Dental Services Overview," MCHP Provider Manual. Accessed October 31, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008953.
[3] For example: National Academy of Sciences, Institute of Medicine. "Advancing Oral Health in America." 2013.
[4] MDH, Oral Health Status
[5] Norris, Laurie. CMS Oral Health Initiative: Goals, Prospects and Progress. Presentation to Medicaid Oral Health Learning Collaborative. May 20, 2013.
[6] Burns & Associates, *Final Report to the Legislature: Compilation of Findings on Provider Rate Evaluations and Availability of Services in the Medicaid Fee-for-Service Program,* 2009. Accessed November 13, 2013, http://www.leg.state.mn.us/docs/2010/other/100321.pdf.
[7] 2012 from CMS-416, FFY 2012 C&TC Report, DHS, accessed December 12, 2013 at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6793-ENG
[8] DHS (McRae, James and Thomas Fields). Perspectives of Dentists and Enrollees on Dental Care under MHCP." May 2002. Accessed October 31, 2014,
[9] Borchgrevink, Alison; Snyder, Andrew and Shelly Gehshan. National Academy for State Health Policy. Effects of Medicaid Reimbursement Rates on Access to Dental Care, March 2008; OLA, 2013; DHS, "Perspectives of Dentists and Enrollees on Dental Care under MHCP." May 2002. Accessed October 31, 2014, http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_008302~1.pdf. CMS. Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight state Report. January 2011. Accessed November 8, 2013 at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/8statedentalreview.pdf
[10] Koppe, Sara. DHS. Disparities and Barriers to Utilization Among Minnesota Health Care Program Enrollees, June 2009.
[11] Koppe, Sara. Disparities and Barriers to Utilization Among Minnesota Health Care Program Enrollees. June 2009. ADA "Access to Dental Care/Oral Health Care" accessed October 8, 2013 at http://www.ada.org/2574.aspx; stakeholder interview results.
[12] Email with Minnesota Department of Human Services employees, October 15, 2013.
[13] Chun, Randall. "Medical Assistance." Minnesota House of Representatives Information Brief. October 2010. http://www.house.leg.state.mn.us/hrd/pubs/medastib.pdf.
[14] Minnesota Office of the Legislative Auditor (OLA), Program Evaluation Division. "Medical Assistance Payment Rates for Dental Services." St. Paul, 2013. *and* Department of Health and Human Services. 2010 Annual Report on the Quality of Care for Children in Medicaid and CHIP. December 2012. Accessed December 12, 2013, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2012-Ann-Sec-Rept.pdf.
[15] Borchgrevink, Alison; Snyder, Andrew and Shelly Gehshan. "Effects of Medicaid Reimbursement Rates on Access to Dental Care." National Academy for State Health Policy. March 2008. http://www.nashp.org/publication/effects-medicaid-reimbursement-rates-access-dental-care.
[16] Minnesota Statutes 2010 § 256B.0625, Subd. 9.
[17] OLA, "Payment Rates for Dental Services."
[18] Minnesota Department of Human Services. "2013 Dental Legislative Changes." Accessed November 4, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=165169.
[19] Minnesota Statutes 2010 § 256B.0625, subd. 9. and McGinn-Shapiro, Mary. Medicaid Coverage of Adult Dental Services, NASHP. Accessed October 27, 2013, http://www.nashp.org/sites/default/files/Adult%20Dental%20Monitor.pdf.
[20] A dentist may limit acceptance of new MHCP recipients if the MHCP recipient caseload is at least 10 percent of the provider's annual active caseload annual active caseload or the dental provider accepts new MHCP patients who are children (up to age 18) with special health care needs. "Active caseload" is the total number of patient encounters that result in a billing during the provider's most recent fiscal year. Minnesota Department of Human Services. "Limiting MHCP Caseload (Rule 101) Provider Assurance Statement." Accessed October 17, 2013,

https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5078-ENG; Minnesota Department of Human Services. "Provider Participation Requirements: Rule 101." Accessed October 18, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=144309.

[21] Minnesota Department of Health. "Minnesota Names to Medicaid Oral Health Learning Collaborative." Accessed October 17, 2013, http://www.health.state.mn.us/oralhealth/newsletter.html.

[22] Minnesota Statutes 2012, 16A.724.

[23] OLA, "Payment Rates for Dental Services."

[24] 42 U.S. Code, sec. 447.200 (2012).

[25] OLA, "Payment Rates for Dental Services."

[26] Laws of Minnesota 1989, chapter 327, sec. 5, subd. 2(b).

[27] Minnesota Department of Health. "Community Clinic Grant Program." Accessed November 21, 2013, http://www.health.state.mn.us/divs/orhpc/pubs/funding/comclinic.pdf.

[28] Minnesota Department of Human Services. "Critical Access Dental Program—Results and Recommendations." May 2008. http://www.health.state.mn.us/healthreform/oralhealth/dhsreportmay08.pdf.

[29] OLA, "Payment Rates for Dental Services."

[30] OLA, "Payment Rates for Dental Services."

[31] Borchgrevink, et al. "Effects of Medicaid Reimbursement Rates."; CMS, "Innovative State Practices."

[32] Buchmueller, Thomas C., Sean Orzol and Lara D. Shore-Sheppard. "The Effect of Medicaid Payment Rates on Access to Dental Care Among Children." Last updated July 2013, http://www.nber.org/papers/w19218.

[33] DHS. "Critical Access Dental Program."

[34] ADA. "Practice and Thrive: Free 2011 Survey of Dental Fees Now Available." February 2013. Accessed November 25, 2013 at: http://www.ada.org/EPUBS/practice/2012/january/page.shtml.

[35] American Academy of Pediatrics. "2013 RBRVS: What is It and How Does It Affect Pediatrics." http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/RBRVS-What-Is-It-and-How-Does-It-Affect-Pediatrics.aspx.

[36] National Alliance on Mental Illness. "NAMI Hearts & Minds: Dental Care." Accessed November 21, 2013, https://www.nami.org/Content/NavigationMenu/Hearts_and_Minds/Medical_Self_Advocacy/Dental_Care.htm. Minnesota Department of Health. "The Status of Oral Health in Minnesota." September 2013. Accessed October 2, 2013, http://www.health.state.mn.us/oralhealth/data.html. National Core Indicators, "NCI Charts: Last Dentist Visit" Accessed October 27, 2013, http://www.nationalcoreindicators.org/charts/?i=30. Centers for Disease Control and Prevention. "Healthy People 2010 Final Review." Accessed October 2, 2013, http://www.cdc.gov/nchs/healthy_people/hp2010/hp2010_final_review.htm.

[37] Snyder, Andrew. "Increasing Access to Dental Care in Medicaid: Targeted Programs for Four Populations." National Academy for state Health Policy. March 2009. http://nashp.org/publication/increasing-access-dental-care-medicaid-targeted-programs-four-populations.

[38] Borchgrevink, et al. "Effects of Medicaid Reimbursement Rates."

[39] OLA, "Payment Rates for Dental Services."

[40] American Academy of Pediatrics. "2013 RBRVS."

[41] OLA, "Payment Rates for Dental Services."

[42] ADA, Measure Sets. Accessed December 11, 2013 at: http://www.ada.org/8472.aspx.

[43] U.S. Department of Health and Human Services. "Dental HPSA Designation Overview." http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/dentalhpsaoverview.html.

[44] DSAC, draft recommendations for this study. December 2013. This is the source of other findings attributed to DSAC as well.

[45] http://www.azdhs.gov/phs/owch/oral-health/documents/reports/teledentistry-arizona.pdf

[46] http://dental.pacific.edu/Documents/community/special_care/acrobat/03_Glassman_UsingTelehealthToImproveOralHealth_July2012.pdf

[47] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2232632/pdf/procamiasymp00004-0958.pdf

[48] Minn. R. 9505.0220 Item F)

[49] MDH, Oral Health Plan, See HPSA maps in Appendix E. HPSAs have limitations as an access measure, but it may provide a gross indication of where dentists are in short supply and less accessible to MHCP participants HPSAs are defined by federal guidelines as lacking adequate service coverage based on geography, facilities, and

characteristics such as the population having "access barriers that prevent the population group from use of the area's dental providers." The state uses HPSA designations in researching needs and determining incentives to providers intended to increase access. The maps reflect DHS data on the distribution of dentists that accept at least one MA patient/year. See http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/dentalhpsaoverview.html for dental HPSA overview. For an example of perspectives on HPSA's limitations as access measure were, the president of the North Dakota Dental Association opined that: "The HPSA shortage area methodology should not be used as a measure of access to dental care for several reasons. *Conceptually,* provider to population ratios are too simplistic. They do not capture rational service areas and instead rely on county or other political boundaries. They do not capture effective demand for services…., *Empirically,* there is absolutely no relationship between the percent of the population living in unserved areas and access to dental care for Medicaid children…. Underscoring the potentially misleading conclusions from the HPSA methodology, states that decreased their dental shortages had no better outcomes than those that did not. See: Dr. Murray Greer, testimony at a October 20, 1013 North Dakota Health Services Committee meeting. Accessed December 13, 2013 at: http://www.legis.nd.gov/files/committees/63-2013nma/appendices/15_5038_02000appendixc.pdf?20131213080819

[50] OLA, "Payment Rates for Dental Services."

[51] Institute of Medicine. "Advancing Oral Health in America, 2011." Last updated April 8, 2011, http://www.iom.edu/Reports/2011/Advancing-Oral-Health-in-America.aspx. Burns & Associates. *Final Report.*

[52] Salvation Army. Good Samaritan Clinic. Accessed December 13, 2013 at: http://salvationarmynorth.org/community-pages/good-samaritan-clinic/. Minnesota Dental Foundation. Mission of Mercy. Accessed December 13, 2013 at: https://www.mndental.org/dentist_home/about_mdaprograms/mission_of_mercy/volunteers/.

[53] Fogarty, Christ. Testimony before the US Senate Health, Education, Labor and Pensions Subcommittee on Primary Health and Aging. February 29, 2012. Accessed December 12 at: http://www.help.senate.gov/imo/media/doc/Fogarty1.pdf.

[54] MDH, Guidelines for the Minnesota Dentist Loan Forgiveness Program. Accessed December 12, 2013 at: http://www.health.state.mn.us/divs/orhpc/funding/loans/dentloan.html .

[55] Minnesota Statute § 150.05 section 3, subdivision 1b.

[56] MDH, Oral Health Plan. National Academy for State Health Policy and the Pew Center on the States. Help Wanted: A Policy Maker's Guide to New Dental Providers. Accessed December 12 at: http://www.pewstates.org/uploadedFiles/PCS_Assets/2009/Dental_Report_Help_Wanted.pdf

[57] Pew Charitable Trusts. "In Search of Dental Care: June 2013." Accessed November 13, 2013, http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/In_search_of_dental_care.pdf.; National Rural Health Association, "Meeting Oral Health Care Needs in Rural America." April 2005, NRHA Policy Brief. Accessed November 13, 2013, www.ruralhealthweb.org.

[58] Minnesota Office of the Legislative Auditor (OLA), Program Evaluation Division, "Medical Assistance Payment Rates for Dental Services." (St. Paul, 2013), 5.

[59] OLA, "Payment Rates for Dental Services."

[60] CMS, "Innovative State Practices."; CMS, "Keep Kids Smiling."

[61] OLA, "Payment Rates for Dental Services."; DHS, "Perspectives of Dentists and Enrollees."

[62] American Dental Association (ADA). "Medicaid Program Administration." Accessed November 4, 2013, www.ada.org/sections/professionalResources/pdfs/medicaid_administration.pdf. CMS, "Innovative State Practices."

[63] ADA. "Medicaid Program Administration."

[64] CMS, "Innovative State Practices."

[65] CMS, "Keep Kids Smiling."

[66] Minnesota Department of Human Services. *Dental Access for Minnesota Health Care Programs Beneficiaries: Supplemental Report to the 2001 Minnesota Legislature on the Evaluation of the Effects of the 1999 Dental Initiatives.* January 2001.

[67] United States Government Accountability Office, *Executive Guide: Strategies to Manage Improper Payments—Learning From Public and Private Sector Organizations*, GAO-02-69G, October 2001.

[68] Ibid.

[69] Ibid.

[70] Minnesota Department of Human Services. "Perspectives of Dentists and Enrollees."

[71] Health Reform Minnesota. "State Innovation Model Grant: Minnesota Accountable Health Model." Accessed October 25, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home.
[72] Health Reform Minnesota. "About Minnesota's Health Care Homes (aka Medical Homes)." Accessed June 6, 2013, http://www.health.state.mn.us/healthreform/homes/about/.
[73] Minnesota Department of Human Services. "Adult mental health reform 2020 steering committee and workgroups." Accessed June 6, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_171741#P40_3299.
[74] Minnesota Department of Human Services. "Reform 2020 Section 1115 Waiver Proposal" and "Reform 2020: Pathways to Independence waiver proposal-November 2012." Accessed June 6, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_169839#.
[75] Minnesota Health Care Reform Task Force, "Health Care Reform Task Force." Accessed June 21, 2013, http://mn.gov/health-reform/health-reform-in-Minnesota/health-care-reform-task-force/.
[76] Minnesota Department of Health. "Advancing Health Equity." Accessed October 27, 2013, http://www.health.state.mn.us/divs/chs/healthequity/index.htm.
[77] Minnesota Department of Health, "Eliminating Health Disparities Initiative (EHDI) Community Grants Program." Accessed June 22, 2013, http://www.health.state.mn.us/ommh/funding/rfp120227/rfp120227.pdf
[78] Minnesota Department of Human Services. "Putting Olmstead's Promise into Practices: Minnesota's 2013 Olmstead Plan." Accessed on October 27, 2013, http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_179788.pdf.
[79] Borchgrevink, et al. "Effects of Medicaid Reimbursement Rates." 15–16.
[80] Connecticut Health Foundation. "Impact of Increased Dental Reimbursement rates on Husky A-insured children: 2006-2011." February 2013. http://www.cthealth.org/wp-content/uploads/2013/02/impact-of-increased-dental-reimbursement-rates.pdf.
[81] Buchmueller. "The Effect of Medicaid Payment Rates."
[82] http://www.health.state.mn.us/oralhealth/pdfs/StatePlan2013.pdf, p. 44.
[83] Ibid.

Report on Program Waiting Lists

Minnesota Department of Human Services

December 2014

For more information contact:

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Disability Services Division
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Legislative Report

Minnesota Department of **Human Services**

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Minnesota Department of Human Services
December 2014

Table of Contents

I. Executive summary

During the 2014 session of the Minnesota Legislature, lawmakers required (Laws of Minnesota 2014, Chapter 312, Article 29, Section 12) the Commissioner of the Department of Human Services (DHS) to:

- Prepare a listing of all the waiting lists for services that the department oversees and directs;
- Identify the number of people on those waiting lists as of October 1, 2014;
- Estimate the cost of serving them based on current average costs; and
- Report that information to the Governor, chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, and the Legislative Reference Library in electronic form by December 1, 2014.

Only two Department of Human Services Administrations currently have waiting lists for their programs: the Basic Sliding Fee Waiting List in Children and Family Services; and the Developmental Disabilities Waiver and the Community Alternatives for Disabled Individuals Waiver Waiting Lists in the Continuing Care Administration.

II. Legislation

Laws of Minnesota 2014, Chapter 312, Article 29, Section 12:

Sec. 12. **DIRECTION TO COMMISSIONER; REPORT ON PROGRAM WAITING LISTS.**

In preparing background materials for the 2016-2017 biennium, the commissioner of human services shall prepare a listing of all of the waiting lists for services that the department oversees and directs. The listing shall identify the number of persons on those waiting lists as of October 1, 2014, and an estimate of the cost of serving them based on current average costs. The commissioner is encouraged to engage postsecondary students in the assembly, analysis, and reporting of this information. The information shall be provided to the governor, the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, and the Legislative Reference Library in electronic form by December 1, 2014.

III. Basic Sliding Fee Waiting List

Currently, the only waiting list in the Children and Families Administration is for the Child Care Assistance Basic Sliding Fee (BSF) program.

As of September 30, 2014, the number of families on the Basic Sliding Fee waiting list, broken out by county, is listed below:

Number of Families on Basic Sliding Fee waiting list – September 2014	First Priority Students	Second Priority comp TY	Third Priority port pool	Fourth Priority Veterans	Fifth Priority Other	Total Waiting List		First Priority Students	Second Priority comp TY	Third Priority port pool	Fourth Priority Veterans	Fifth Priority Other	Total Waiting List
Aitkin	0	0	0	0	0	0	Martin-Faribault	0	0	0	0	0	0
Anoka	11	29	7	3	507	557	Meeker	0	0	0	0	0	0
Becker	0	0	0	0	0	0	Mille Lacs	0	0	0	0	0	0
Beltrami	0	0	0	0	0	0	Morrison	0	0	0	0	0	0
Benton	0	5	2	1	53	61	Mower	0	0	0	0	0	0
Big Stone	0	0	0	0	0	0	Nicollet	0	0	0	0	4	4
Blue Earth	0	0	0	0	0	0	Nobles	0	0	0	0	0	0
Brown	0	0	0	0	0	0	Norman	0	0	0	0	0	0
Carlton	0	0	0	0	0	0	Olmsted	0	0	0	0	26	26
Carver	2	4	1	0	97	104	Otter Tail	0	0	0	0	0	0
Cass	0	0	0	0	0	0	Pennington	0	0	0	0	0	0
Chippewa	0	0	0	0	0	0	Pine	0	0	0	0	0	0
Chisago	0	3	3	3	37	46	Polk	0	0	0	0	0	0
Clay	0	0	0	0	0	0	Pope	0	0	0	0	0	0
Clearwater	0	0	0	0	0	0	Ramsey	0	0	0	0	427	427
Cook	0	0	0	0	3	3	Red Lake	0	0	0	0	0	0
Crow Wing	0	0	0	0	0	0	Renville	0	0	0	0	0	0
Dakota	0	27	1	1	671	700	Rice	0	0	0	0	0	0
Des Moines Valley HHS*	0	0	0	0	0	0	Roseau	0	0	0	0	0	0
Dodge	0	0	0	0	0	0	St. Louis	0	0	0	0	0	0
Douglas	0	0	0	0	0	0	Scott	1	4	0	0	116	121
Fillmore	0	0	0	0	0	0	Sherburne	0	0	0	0	0	0
Freeborn	0	0	0	0	0	0	Sibley	0	0	0	0	0	0
Goodhue	0	0	0	0	13	13	Stearns	0	0	0	0	80	80
Grant	0	0	0	0	0	0	Steele	0	0	0	0	0	0
Hennepin	0	138	8	0	4,365	4,511	Stevens	0	0	0	0	0	0
Houston	0	0	0	0	0	0	Swift	0	0	0	0	0	0
Hubbard	0	0	0	0	32	32	Todd	0	0	0	0	0	0
Isanti	0	2	0	0	32	34	Traverse	0	0	0	0	0	0
Itasca	0	0	0	0	0	0	Wabasha	0	0	0	0	23	23
Kanabec	0	0	0	0	0	0	Wadena	0	0	0	0	0	0
Kandiyohi	0	0	0	0	0	0	Waseca	0	0	0	0	0	0
Kittson	0	0	0	0	0	0	Washington	0	0	0	0	98	98

Report on Program Waiting Lists

Koochiching	0	0	0	0	0	0	Watonwan	0	0	0	0	0	0
Lac Qui Parle	0	0	0	0	0	0	White Earth	0	0	0	0	0	0
Lake	0	0	0	0	0	0	Wilkin	0	0	0	0	0	0
Lake of the Woods	0	0	0	0	0	0	Winona	0	0	0	0	0	0
Le Sueur	0	0	0	0	99	99	Wright	0	0	0	0	0	0
Southwest HHS**	0	0	0	0	0	0	Yellow Medicine	0	0	0	0	0	0
McLeod	0	0	0	0	0	0							
Mahnomen	0	0	0	0	0	0							
Marshall	0	0	0	0	0	0	Statewide Totals	14	212	22	8	6,683	6,939

*Des Moines Valley Health and Human Services includes Cottonwood County Family Services, Jackson County Human Services and Cottonwood-Jackson Community Health.

**Southwest Health and Human Services includes the following counties: Lincoln, Lyon, Murray, Pipestone, Rock and Redwood.

Cost: The Basic Sliding Fee waiting list had 6,939 families in September 2014. The cost of serving 6,939 families for 12 months at the projected FY2016 average statewide cost of $945 per month per family is $79.3 million. This includes county administrative costs and some offsetting Child Care Assistance Program Transition Year Extension savings.

If Basic Sliding Fee were made available to all of these families in a given month, not all families would participate in the program as they might not be eligible in that month, or might not desire child care assistance in that month. If it is assumed that 50 percent (3,470) of the families on the waiting list are eligible for and want child care assistance, the cost of serving these families for 12 months at the FY2016 projected average statewide cost of $945 per month per family would be $39.7 million.

The costs of fully-funding Basic Sliding Fee may be higher than these estimates as we expect more families would apply due to the higher probability of receiving assistance upon application.

Basic Sliding Fee Child Care (BSF)	**FY2016**
Average monthly families to be served	6,939
BSF avg monthly payment	$945
Months	12
Direct service cost	$78,686,355
Administrative allowance	$3,934,318
Increased appropriation required	$82,620,673

Minnesota Family Investment Program/Transition Year Child Care (MFIP/TY)	**FY2016**
Increased BSF appropriation	$82,620,673
Percent which would fund TYE cases	4%
TYE cost	($3,304,827)

	FY2016 (in thousands)
Total MFIP/TY cost	($3,305)
Total BSF cost	$82,621
Total cost	$79,316

IV. Developmental Disabilities Waiver and Community Alternatives for Disabled Individuals Waiver Waiting Lists

Currently, the only waiting lists in the Continuing Care Administration are for the Developmental Disabilities (DD) waiver and Community Alternatives for Disabled Individuals (CADI) waiver.

As of October 1, 2014, there are 3,501 people on the DD waiver waiting list. Below are those figures broken out by county:

Lead Agency			Lead Agency			Lead Agency	
Aitkin	< 5		Lac Qui Parle	N/A		St. Louis	65
Anoka	541		Lake	N/A		Stearns	31
Becker	0		Lk of the Woods	0		Steele	6
Beltrami	8		LeSueur	6		Stevens	0
Benton	19		Lincoln	< 5		Swift	< 5
Big Stone	0		Lyon	7		Todd	5
Blue Earth	17		Mahnomen	0		Traverse	0
Brown	0		Marshall	< 5		Wabasha	< 5
Carlton	14		Martin	7		Wadena	< 5
Carver	28		McLeod	27		Waseca	< 5
Cass	8		Meeker	6		Washington	316
Chippewa	0		Mille Lacs	6		Watonwan	0
Chisago	23		Morrison	14		Wilkin	< 5
Clay	< 5		Mower	9		Winona	< 5
Clearwater	0		Murray	< 5		Wright	31
Cook	0		Nicollet	< 5		Yellow Medicine	0
Cottonwood	14		Nobles	< 5		**Statewide**	**3,501**
Crow Wing	8		Norman	0			
Dakota	271		Olmsted	171			
Dodge	6		Ottertail	11			
Douglas	5		Pennington	0			
Faribault	6		Pine	7			
Fillmore	< 5		Pipestone	0			
Freeborn	6		Polk	37			
Goodhue	18		Pope	0			
Grant	0		Ramsey	305			
Hennepin	1017		Red Lake	< 5			
Houston	< 5		Redwood	0			

Hubbard	< 5		Renville	< 5			
Isanti	14		Rice	32			
Itasca	8		Rock	0			
Jackson	< 5		Roseau	< 5			
Kanabec	5		Scott	204			
Kandiyohi	< 5		Sherburne	108			
Kittson	0		Sibley	< 5			
Koochiching	0						

Note: Those counties with less than 5 people on the waiting list are reported as <5 to avoid being able to identify specific individuals.

As of October 1, 2014, there are 1,447 people on the CADI waiver waiting list. Below are those figures broken out by county:

Lead Agency			**Lead Agency**			**Lead Agency**	
Aitkin	0		Lac Qui Parle	N/A		St. Louis	< 5
Anoka	136		Lake	0		Stearns	73
Becker	< 5		Lk of the Woods	0		Steele	< 5
Beltrami	0		LeSueur	< 5		Stevens	< 5
Benton	< 5		Lincoln	< 5		Swift	< 5
Big Stone	0		Lyon	< 5		Todd	8
Blue Earth	< 5		Mahnomen	0		Traverse	0
Brown	0		Marshall	0		Wabasha	0
Carlton	0		Martin	< 5		Wadena	< 5
Carver	< 5		McLeod	N/A		Waseca	0
Cass	< 5		Meeker	8		Washington	0
Chippewa	< 5		Mille Lacs	8		Watonwan	0
Chisago	9		Morrison	< 5		Wilkin	< 5
Clay	0		Mower	6		Winona	0
Clearwater	0		Murray	0		Wright	0
Cook	0		Nicollet	< 5		Yellow Medicine	N/A
Cottonwood	0		Nobles	< 5		**Statewide**	**1,447**
Crow Wing	< 5		Norman	0			
Dakota	48		Olmsted	5			
Dodge	< 5		Ottertail	29			
Douglas	< 5		Pennington	0			
Faribault	0		Pine	17			
Fillmore	0		Pipestone	0			

Freeborn	12		Polk	< 5			
Goodhue	0		Pope	0			
Grant	< 5		Ramsey	765			
Hennepin	200		Red Lake	0			
Houston	0		Redwood	< 5			
Hubbard	0		Renville	0			
Isanti	8		Rice	29			
Itasca	0		Rock	< 5			
Jackson	< 5		Roseau	0			
Kanabec	< 5		Scott	22			
Kandiyohi	0		Sherburne	12			
Kittson	0		Sibley	< 5			
Koochiching	0						

Note: Those counties with less than 5 people on the waiting list are reported as <5 to avoid being able to identify specific individuals.

Cost: This analysis represents the cost of eliminating the current waiting list for disability waivers by implementing open enrollment for the programs beginning July 1, 2015. There are waiting lists for two waivers: Community Alternatives for Disabled Individuals (CADI) and the Developmental Disabilities (DD) waivers.

Beginning July 1, 2015 there are no enrollment limits for the CADI waiver, so the cost of serving people on this waiting list are already included in the Medical Assistance forecast. As a result, there are no additional costs for eliminating this waiting list for this program.

The DD waiver program has had almost continuous enrollment limits in place, with one exception in 2001, which creates pent up demand for the program. Currently, the DD waiver is limited to 180 new waiver allocations per year. In FY 2016, the forecast assumes 300 new waiver allocations per year. It is anticipated that opening enrollment for this program will add people beyond those currently on the waiting list. Based on the program growth during the 90-day open enrollment period in 2001, it is estimated that during the first year of open enrollment the number of waiver recipients would increase by 178% beyond the current waiting list. It is estimated that an additional 1,000 people will be added the second year and 600 per year after that.

The current DD waiver enrollment process allocates enrollment priority based on statutory priorities, including urgency of need, so on average the current waiver recipients require higher intensity services than the additional people who will be added to the program due to open enrollment. This analysis projects that the average monthly cost of the additional recipients will be 80% of the current forecasted average service cost.

Many of the people on the waiting list for the DD waiver currently receive other Medical Assistance services, such as Intermediate Care Facilities for persons with Developmental

Disabilities (ICF/DD), other disability waivers, and personal care. The cost of these services has been subtracted from the projected additional DD waiver costs. The average cost of these services is based on the average monthly service use of DD waiting list recipients from Oct. 2013 through March 2014.

	Additional Recipients	Net MA Costs	State Costs
SFY 2016	4,078	$146.2 million	$74.9 million
SFY 2017	6,897	$291.8 million	$148.9 million
SFY 2018	7,680	$332.1 million	$169.4 million
SFY 2019	8,280	$363.9 million	$185.5 million

Appendix A: Basic Sliding Fee Waiting List Priorities.

Minnesota Statute 119B.03, subdivision 4 establishes the priorities for individuals on the waiting list for Basic Sliding Fee Child Care Assistance. Those families who are not included in the first through fourth priorities are included in the fifth priority:

Subd. 4. **Funding priority.** (a) First priority for child care assistance under the basic sliding fee program must be given to eligible non-MFIP families who do not have a high school or general equivalency diploma or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. This includes student parents as defined under section 119B.011, subdivision 19b. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(b) Second priority must be given to parents who have completed their MFIP or DWP transition year, or parents who are no longer receiving or eligible for diversionary work program supports.

(c) Third priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(d) Fourth priority must be given to families in which at least one parent is a veteran as defined under section 197.447.

(e) Families under paragraph (b) must be added to the basic sliding fee waiting list on the date they begin the transition year under section 119B.011, subdivision 20, and must be moved into the basic sliding fee program as soon as possible after they complete their transition year.

Appendix B: Development Disability Waiver Waiting List Criteria.

Minnesota Statute 256B.092, Sub. 12 establishes the priorities for individuals on the waiting list for development disabilities (DD) waiver services as on January 1, 2010. Those statewide priorities include:

Subd. 12.**Waivered services statewide priorities.**

(a) The commissioner shall establish statewide priorities for individuals on the waiting list for developmental disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) no longer require the intensity of services provided where they are currently living; or

(2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(c) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options. The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.

Appendix C: Community Alternatives for Disabled Individuals Wavier Waiting List Criteria.

Minnesota Statutes 256B.49, Subd. 11a establishes the statewide priorities for individuals on the waiting list for community alternative care, community alternatives for disabled individuals, and brain injury waiver services, as of January 1, 2010.

Subd. 11a. **Waivered services statewide priorities.**

(a) The commissioner shall establish statewide priorities for individuals on the waiting list for community alternative care, community alternatives for disabled individuals, and brain injury waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) no longer require the intensity of services provided where they are currently living; or

(2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(c) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options. The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.

Minnesota Departments of Human Services and Education

Minnesota's State-wide Plan

Building Effective Systems for Implementing Positive Practices and Supports

Department of Human Services
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State of Minnesota

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Table of Contents

Executive Summary

This report was completed by state leaders from the Minnesota Departments of Human Services and Education (e.g. DHS and MDE respectively) in collaboration with the Institute on Community Integration at the University of Minnesota. The purpose of this report is to summarize progress made on assigned objectives that are associated with Minnesota's Olmstead Plan. All of the efforts reflected in this report are driven by a vision to improve the lives of all people living in Minnesota. This report provides a framework for organizing policies, technical assistance, and resources to ensure people receiving services, are treated with respect, and receive the support they need to live independent, self-determined and meaningful lives in their home communities. Real change occurs when one's vision for a better life is not merely a set of words that are referred to in written form. *When a vision that is articulated by a group of people is made a part of everyday actions taken within an organization, county, region, and state-wide, significant and meaningful work can be achieved* (Fullan, 2005).

The state plan described in this report will be successful by a) designing and implementing a technical assistance plan that involves teaching organizations to embed the values and vision outlined in the Minnesota Olmstead plan into the everyday actions taken by individuals providing services, and b) working collaboratively to implement the plan with stakeholders who represent people receiving services across the lifespan, family members, caregivers, advocates, practitioners and community members. For this reason, the report represents a first step in the state-wide planning process. Four major activities that are being used to make the vision outlined in the Olmstead Plan a reality are included in this report. These activities are described in this summary and with a locator table (see Table 1) to align the work being completed with the objectives listed in Action 3 of the Olmstead Plan.

Inventory of Minnesota Policies and Best Practices. DHS and MDE initiated a system for the inventory and analysis of both restrictive procedures and positive practices currently used across agencies. The results from the first dissemination of an online survey is available in Appendix A. Responses from the survey and earlier work from various team members was used to gather the initial identification of policies and practices from 25 different statutory citations. Once inventory data for DHS and MDE are finalized, the inventory review process will be expanded to other agencies. A subset of staff members from a state-wide planning team are continuing to meet regularly to complete the DHS and MDE inventory by January, 2015.

Unified Cross-agency Definition of Key Terms. The first step in aligning definitions across agencies is to evaluate the extent to which these terms currently vary starting with DHS and MDE. Key terms were identified for common reporting purposes. The inventory survey included questions used to gather more information about terms used within each agency. A grid compiling the definitions for any terms that were submitted as part of the survey is being compiled but has not yet been finalized due to the need for further information (see Appendix B). The same workgroup assigned to finalizing the inventory will continue working on the definitions first identified in this activity.

Best Practice in Positive Supports. The state recommends that teams use a collaborative data-based decision making framework to support people and adopts the

broader term *positive supports* to reflect practices that are person-centered, encourage self-determined behavior, build on social and emotional skills, and take a person's physical, social, and mental health into consideration. Positive behavior support provides a larger framework for implementing systems change. This implementation framework will be used to guide technical assistance efforts with the assumption that technical assistance efforts reflected in this state-wide plan will include a number of positive practices for preventing problem behavior. However, person-centered planning and positive behavior support are recommended whenever a person would clearly benefit from these practices and/or when other positive supports have not been effective.

Minnesota's State-wide Plan for Implementing Positive Supports. The state-wide team recommends using research findings summarized by Fixsen and his colleagues (2005) to create a state-wide communication and technical assistance framework for coordinating efforts to decrease the use of restrictive procedures and increase implementation of positive supports across agencies. This infrastructure will be used to ensure the following six implementation goals are implemented: 1) establishing a technical assistance infrastructure across agencies, 2) designing and implementing strategies for data-based decision making and evaluation, 3) creating a marketing plan for increasing awareness of positive supports across the state, 4) expanding preservice and aligning inservice training systems state-wide, 5) developing and maintaining an inventory of policies related to restrictive practices and positive supports, and 6) expanding interagency crisis prevention planning. A logic model was developed by the team to summarize the expected outcomes related to positive support implementation (see Figure 3 and the Appendix D for more details). The first steps taken by the state-wide team is to recruit workgroup chairs and initial team members for each of six major implementation tasks. Initial meetings (one or more) within each workgroup will occur on or before January, 15, 2015. Quarterly state-wide team meetings will be scheduled for November, 2014 January, 2015 April, 2015, and July, 2015.

Table 1. Locator Table with Page Numbers Related to Action 3 of the Olmstead Plan.

Activities (Pages 65-67)	*** Olmstead Activities from Action 3**	**Timeline**	**Page Numbers**
Action 1 [SS 3A]	The state will implement the new Minnesota Statute §245D standards.	1-1-14	
Action 2 [SS 3B]	A Rule with operational details that replaces Minnesota Rules, parts 9525.2700 to 9525.2810 (also known as Rule 40) will be promulgated. [SS 3B]	7-1-15	
Action 3 [SS 3C]	The state will create an inventory and analysis of policies and best practices across state agencies related to positive practices and use of restraint, seclusion or other practices which may cause physical, emotional, or psychological pain or distress.	7-1-14	5-6 10-12 26, 27 Appendix A
Action 4 [SS 3D]	A report outlining recommendations for a state-wide plan to increase positive practices and eliminate use of restraint or seclusion will be delivered to the Olmstead Subcabinet or their designee by an assigned team of representatives from Olmstead Subcabinet agencies.	7-1-14	5-6 15-30 Appendix D
Activity 5 [SS 3E]	The state will develop, across state agencies, a common definition of incidents, including emergency use of manual restraint, that are to be reported, and create common data collection and incident reporting processes.	8-1-14	5-6 12-13 22-24 Appendix B
Action 6 [SS 3F]	State-wide implementation of common incident reporting will begin.	7-1-15	22-23 26-27 Appendix D
Action 7 [SS3G.1-3G.4]	Quarterly summaries of incidents of emergency use of manual restraint or other types of restraint, seclusion or other practices that may cause physical, emotional, or psychological pain or distress will be reported to an assigned team of representatives from each state agency for review and to inform recommendations to reduce the incidents.	10-1-15	15-24 25 Appendix D
Action 8 [SS H.1, 3H.2]	Annually thereafter, the team will provide recommendations to the Olmstead Subcabinet to reduce emergency use of restraints, or other practices that may cause physical, emotional, or psychological pain or distress, and to increase positive practices.	7-1-15	26 Appendix D
Action 10	A coordinated triage and "hand-off" process for crisis	8-1-14	26-27

[SS 3I]	intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation. Report will be delivered to the Olmstead Subcabinet.		Appendix D
Action 11 [SS 3J]	An assigned team of representatives from state agencies, community organizations, community corrections and people with disabilities who have used the crisis system will: identify best practices, including use of technology; set service standards; and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions (e.g. person-centered planning, positive practices, available resources). Progress toward goal will be reported to the Olmstead Subcabinet or their designee.	12-1-14	26-27 Appendix D
Action 12 [SS 3J.1]	DHS will have completed the necessary analysis and planning to expand crisis services, diversion, and early intervention services to persons at risk of experiencing a crisis situation. The expansion plan will include projected start dates for implementation of the services.	1-15-15	22-23 25,27 Appendix D
Action 13 [SS 3J.1]	Crisis services, including diversion and early intervention services, will be made available to any person in need of these supports and at risk of experiencing a crisis situation. The purposes of this intervention include stabilizing the person's situation or avoiding the use of civil commitment.	7-1-15	26-27 Appendix D
Action 14 [SS 3K]	Develop measurements to better understand and track crisis episodes across service systems; create a data collection plan and mechanisms; establish baseline data and set targets (e.g., number of crisis calls made, reason for the call, response given, follow-up information.) Baseline data and targets will be delivered to the Olmstead Subcabinet or their designee.	7-1-15	26, 27 Appendix D

* *While not the Direct Focus of the Report, the Actions Indicated in Light Grey are Addressed as Part of State-wide Planning and Future Targeted Timelines*

Minnesota's State-wide Plan: Building Effective Systems for Implementing Positive Practices and Supports

Purpose and Introduction

This report was completed by state leaders from the Minnesota Departments of Human Services and Education (e.g. DHS and MDE respectively) in collaboration with the Institute on Community Integration at the University of Minnesota. The purpose of this report is to summarize progress made on objectives that are associated with Minnesota's Olmstead Plan including the actions related to an inventory of policies, creating common definitions for reporting purposes, best practice technical assistance in the implementation of positive supports, and state-wide planning. All of the efforts reflected in this report are driven by the vision that seeks to improve the lives of all people living in Minnesota as outlined in the Olmstead Plan report (pages ten and eleven). The actions taken by the state-wide team will help to articulate how services will be delivered in a manner that will ensure all people are treated with respect and receive the support they need to live independent, self-determined and meaningful lives in their home communities.

Research in systems change indicates that it is not sufficient to create a vision and mission statement that is referenced in written reports or placed on posters that are hung on the wall. Significant and meaningful change occurs when one's vision for a better life is not merely a set of words that are referred to in a passive manner; a vision and mission must be made a part of the actions taken within an organization and that drive decisions on an every day basis (Fullan, 2005). The goal of implementing positive and proactive interventions and decreasing the use of restrictive procedures across the state of Minnesota will become a reality when the vision that has been articulated in the Olmstead Plan has been embedded within the state system and within organizations providing services across the state. To make this vision a reality, it is important to align and improve policies at state and organizational levels, disseminate ongoing and coordinated training and technical assistance, and recognize, reward, and empower leaders who demonstrate to others how people across the lifespan can be empowered and supported using person-centered services and supports.

Furthermore, the state planning described in this report will only be successful if all of the stakeholders across the state of Minnesota are actively involved in making decisions and guiding all implementation efforts. Team-based collaboration is necessary to achieve these changes with participants representing people receiving services across the lifespan, family members, caregivers, advocates, practitioners, and community members. For this reason, the state-wide plan described in this report is considered a first draft that will be expanded and modified based on feedback from stakeholders who are assisting the state in these systems change efforts. This planning process presumes that the changes that are implemented will occur across and within state systems including Direct Care and Treatment and services provided under Disability Services Division (DSD) as well other divisions (mental health, aging education, etc.).

The report will describe four major activities that will assist the state in making the vision outlined in the Olmstead Plan a reality. These tasks include:

- Creating an inventory of policies that refer to limiting the use of restraint,

seclusion or other practices and establishing best practices across state agencies related to positive support practices;
- Developing a common definition of incidents that will lead to (including emergency use of manual restraint), common data collection and incident reporting processes;
- Identifying best practices, setting service standards, and developing and delivering training and technical assistance in order to respond to a request for assistance with least intrusive service/actions; and
- Outlining recommendations for a state-wide plan to increase positive practices and eliminate use of restraint or seclusion.

The locator table (see Table 1) provides information regarding how the report addresses objectives listed in Action 3 of the Olmstead Plan. Timelines for actions in the report are aligned with the objectives listed on pages 65-67 of the Olmstead Plan report. Each section of this report describes important elements related to the four objectives including: a) the process used to establish an inventory of policies related to restrictive practices and positive strategies for increasing person-centered prevention-based interventions, b) steps taken to define key terms associated with incidents of problem behavior and positive strategies for supporting people, c) best practices in positive behavior support for large-scale technical assistance, d) a first draft of a state-wide plan to decrease the use of restrictive practices and increase person-centered prevention-based supports, e) an evaluation plan for measuring the impact of the state's implementation efforts, and f) next steps for moving forward.

Inventory of Policies and Practices

The Minnesota Department of Human Services initiated a process for creating an inventory and analysis of both restrictive procedures and positive practices across state agencies. To accomplish this task, a plan was developed to complete the inventory and analysis with input from state leads. The Minnesota Department of Human Services (DHS) (including Disability Services Division, Adult Mental Health, Aging, Alcohol and Drug Abuse Division, Children's Mental Health etc.), and the Department of Education (MDE) were identified as the first two state agencies to complete the inventory survey. The following state agencies are identified for next phase of inventory include the Department of Health (MDH), Department of Employment and Economic Development (DEED), Department of Corrections, Department of Human Rights and other state agencies identified during the inventory process. Key deliverables of the plan included:

- Identifying inventory categories,
- Creating an online inventory survey using a format accessible to state agency staff,
- Recruiting key staff to complete inventory survey,
- Launching the online survey,
- Reviewing and analyzing inventory results, and
- Identifying next steps for finalizing what will become an annual inventory assessment process.

An online inventory survey was created by the University of Minnesota ICI using Qualtrics Survey platform to collect information about current policies and practices across state agencies. Key DHS and MDE staff with policy-related expertise were recruited to assist in designing the cross-agency inventory. Staff members from DHS representing Disability Services Division, Adult Mental Health, Alcohol and Drug Abuse Division, Children's Mental Health were then recruited to participate in completing the initial survey inventory. Lead staff members from MDE were also sent a request to complete the inventory. MDE representation included key staff from Compliance and Assistance Division.

A draft of a survey that would be used to gather information for the inventory was reviewed on Oct. 3, 2014 and revisions were made to this survey on Oct 8, 2014. The inventory survey was activated on Oct. 10, 2014 and sent to identified staff who were asked to complete the survey on or before October 15, 2014. The online survey, available in Appendix A of this report, asked respondents to identify: a) policies and practices that restrict, limit, define the use of non-positive supports including approaches that are prohibited; and /or b) best practices/promising practices that support prevention of problem behavior through positive, self-directed support to people at risk. Survey details to be completed by respondents included:

- State agency and division,
- Identification of policies related to restrictive practices and promote positive, proactive strategies for preventing problem behavior,
- Identification of best practices/evidence-based practices used to address restrictive/restricted or prohibited practice and promote positive, proactive strategies for preventing problem behavior,
- Source of document including hyperlink, when applicable;
- Publication date of document and whether it's in process of being revised or updated including status;
- Identification of type of document (policy, procedure, statute/law, rule/regulation, practices manual etc.);
- Citation of state or federal regulation, statute, rule or policy, if applicable;
- Names of related documents and numbers, where applicable;
- Application of policy or practice for personnel requirements related to practices or programs;
- Definition of incidents requiring reporting and documentation;
- Information about data collection systems (how information is recorded and summarized);
- Identification of who is intended audience for policy or practice; and
- Contact information for the staff completing the inventory survey.

The result of the first dissemination of the survey is available in the Appendix A Responses from the survey and earlier work from various team members produced the initial identification of policies and practices from 25 different statutory citations; 13 rule citations; five (5) trainings and six (6) policy and practice citations. Those policies and practices identified through the inventory survey include five (5) responses identifying the policy as best practice/evidence based practice for positive supports, ten (10)

responses identifying that the policy restricts, limits, defines the use of non-positive supports such as restrictive procedures, seclusion, restraint, prohibited procedures etc. Additionally, eight (8) of the survey responses indicated that the policy or practice contained a definition of incidents that must be reported. The next step in gathering inventory information will be to reach out to state staff who can provide information about the areas of the inventory that are not completed. After the complete inventory process is finalized across DHS and MDE, the process will be expanded to other agencies.

A subset of staff members from the state-wide planning team are continuing to meet regularly to complete the inventory of DHS and MDE policies and to analyze the final results. The inventory of policies for DHS and MDE will be completed by January, 2015 and timelines for expanding the inventory to other agencies will also be reported at that time. The subset of staff working on this task will be reaching out to stakeholders to share the inventory results and the finalized inventory of policies will available online for public use. The inventory survey included questions about the definitions that are used by DHS and MDE to record significant problem behaviors. Of particular interest is how incident reports and office discipline-related terms are used to document problem behavior occurring in educational contexts, and within residential and community settings.

Unified Cross-agency Definition of Key Terms

The state team identified a list of common terms that are used across DHS and MDE in common reporting systems while the inventory survey was being completed. Clear and consistent definitions are important for establishing the data collection systems that will be used by the state but are also essential for creating a common language of prevention across the state. The following were identified by the team as examples of terms that need to be formally defined:

- reportable incidents,
- restrictive procedures/restricted procedures,
- crisis,
- emergency,
- positive supports,
- positive behavior support,
- person-centered planning,
- evidence-base practices, and
- best practices.

The first step in aligning definitions across agencies is to evaluate the extent to which these terms currently vary across DHS and MDE contexts. A grid outlining the definitions of key terms that were submitted as part of the online survey cannot be summarized until the inventory of policies are completed. However, Appendix B provides the initial organizational structure that will be used to complete this task. The same workgroup assigned to complete the inventory will continue working on the definitions in collaboration with state information technology (IT) staff and state personnel involved in incident report data collection systems. Lead staff across each

agency and representatives of stakeholder groups will be asked to provide feedback and gain consensus on the definitions as a part of a consensus-building process. Since the definitions in question will be used for evaluation and data-based decision making at the local, regional, agency-wide, and state-wide levels, the state is proceeding systematically to ensure the data collected will align with technical assistance efforts. Part of the technical assistance efforts that are implemented related to positive supports will include teaching organization-wide teams to use data to implement interventions, engage in progress monitoring, and to report decreases in incidents, crises, use of restraints and other responses associated with problem behavior. A number of important terms that will help make the vision and mission of the Olmstead plan a reality are addressed in the next section of this report including: evidence-based practices, positive behavior support, and positive support strategies, a broader term that describes a broader array of value and prevention-based practices.

Evidence-based Practices

The term, evidence-based practice, is now widely used at the federal and state levels and across many fields of study. Most of these definitions share similar features across different fields (for example, please see Table 2 and http://nrepp.samhsa.gov/AboutNREPP.aspx).

Table 2. Definitions of Evidence-based Practice Across Different Fields.

American Psychological Society	"Evidence-based practice in positive behavior support is defined as the integration of rigorous science-based knowledge with applied expertise driven by stakeholder preferences, values, and goals within natural communities of support."
Institute for Medicine	"...the integration of best research evidence with clinical expertise and patient values".
Association for Positive Behavior Support	"Evidence-based practice in positive behavior support is defined as the integration of rigorous science-based knowledge with applied expertise driven by stakeholder preferences, values, and goals within natural communities of support."

Not all current practices have fully completed the rigorous large-scale research studies necessary to be considered an evidence-based practice. Practices that are evidence-based must establish the efficacy of the approach and its applicability across the diversity of today's settings, people, and contexts. Many practices across different fields of study are still in the process of acquiring this evidence and are not yet recognized as a formally approved evidence-based practice. For this reason, the need for individual data-based decision making is essential for people and their teams to ensure that each person's services are evaluated closely.

Positive Supports as a Broader State Term for Prevention

During early discussions with state team members and other stakeholders, the importance of honoring all positive prevention-based practices used across agencies was described as an essential consideration. Person-centered planning, dialectical behavior therapy, cognitive behavior therapy, positive behavior support, trauma informed therapy, and many other practices were identified as strategies for preventing problem behavior. This conversation led to the identification of a broader term, *positive supports. The state-wide team recommends the use of positive supports as a more inclusive term referring to all practices that include the following characteristics: 1) person-centered interventions, 2) prevention of problem behavior, 3) skill-building, independence, and self-determination, and 4) interventions that focus on changing the social, emotional, and physical environment around a person (sensitivity training for staff members, increasing predictability, stability, etc.).*

Team-based action planning requires interagency teams to work together to empower an individual and his/her family in identifying the practices that will help the person achieve self-determination, independence and a high quality of life. Interventions and practices are selected to fit the unique skills, communication preferences, mental health status, and physiological and health needs of each person receiving support. The state recommends that teams evaluate practices and use data-based decision making to improve outcomes for people receiving services. One approach that naturally encourages interagency collaboration within a team-based data-based decision-making framework is positive behavior support.

National experts define positive behavior support as a set of tools and strategies incorporating: 1) valued outcomes (plans must improve the quality of a person's life and fit cultural views, skills, and resources of people implementing the plan), 2) research based on the principals of behavior, mental health and biomedical sciences, 3) validated procedures that are proven to be effective, and 4) systems change strategies to ensure supports are both effective and sustainable over time. Positive behavior support includes an assessment process that is used to identify the reason, or function, maintaining problem behavior. Once the function of the problem behavior is identified, interventions for teaching new social, emotional, and communication skills are used to prevent problem behavior. Changes in the social and physical environment are made, mental health and wellness strategies implemented, and biomedical and physiologically-base interventions are put in place to improve quality of life and decrease problem behavior.

Positive behavior support is an approach that places great importance on interagency collaboration as an essential feature necessary for effective planning and supports. Each positive behavior support plan is based on a trans-disciplinary team including the people receiving services, family members and caregivers, community representation, and professionals representing key areas of expertise who provide services across wide variety and type of services including but not limited to disabilities, mental health, education, juvenile justice, foster care and family preservation, and aging. Each professional involved in assisting a person in need of support brings a wealth of knowledge about important prevention-based practices that are complementary in nature with positive behavior support. The goal is to empower the individual and his/her family in identifying the unique supports and services needed to improve quality of life, ensure self-determination, and assist people in living meaningful lives in their own communities.

However, positive behavior support is not always necessary in all situations and settings. For instance, person-centered planning can result in significant decreases in problem behavior making a positive behavior support plan unnecessary. A person and his/her team will select the practices that are the best fit while providing evaluation data showing evidence that these practices are successful. For this reason, the state recommends that person-centered planning be implemented prior to positive behavior support. Furthermore, both person-centered planning and positive behavior support are recommended in situations where people who engage in problem behavior would benefit from applied behavior analysis, physiological and biomedical interventions, data-based evaluation, and evidence of improved quality of life outcomes. If other positive support strategies that have been implemented do not prove to be successful as a stand-alone intervention, positive behavior support should be added to a person's planning process.

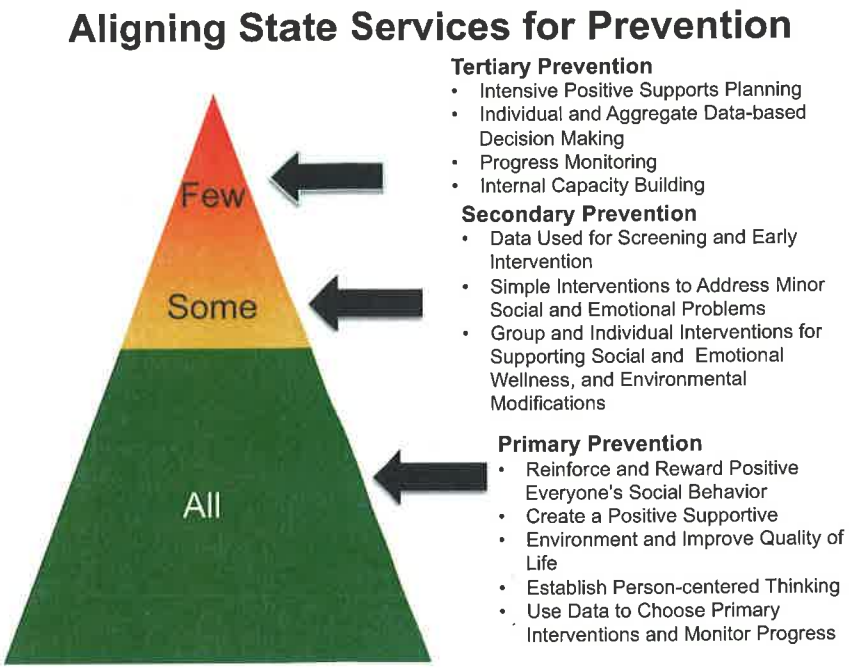
Creating a Framework for Large-scale Implementation

A unique feature of positive behavior support is its emphasis on systems change and strategies for larger scaling up implementation efforts. An interagency synthesis of research on systems change conducted by Dean Fixsen and his colleagues 2005) provides a framework for implementing large-scale technical assistance and training. Positive behavior support efforts are underway across the nation and in a growing number of countries using the information outlined by Fixsen and his colleagues. Large-scale, state-wide implementation of positive behavior support using a three-tiered prevention model is now implemented in the disability field, juvenile justice, early childhood, education, and mental health. A growing number of states are working on strategies for improving interagency communication at the state-wide level as different agencies move forward implementing technical assistance in positive behavior support.

Three-tiered Prevention of Problem Behavior. Key elements of these systems-change efforts include establishing a framework or infrastructure that will assist state teams in training, supporting, and monitoring schools and organizations involved in the implementation of three different levels of systems change (See Figure 1). The three tiered model described in this section was adopted by the World Health Organization (2004) and adapted to address the prevention of problem behavior (Gordon, 1983). The three prevention levels are described as universal or *primary prevention interventions* including practices for promoting person-centered environments and encouraging positive social communication among staff members and people receiving services. At the primary prevention level, teams use data to guide decision making and monitor progress. S*econdary prevention strategies* involve the use of data for early identification and intervention to support people who are at risk for engaging in more serious problem behavior. *Tertiary prevention systems* provide intensive and individualized person-centered planning, positive behavior support, and other practices that will assist people who do not respond to primary and secondary interventions. An important element of positive behavior support at each prevention level is the use of data for decision making. Trainers using a three-tiered model for preventing problem behavior teach organization-wide teams to use data on a regular basis to change inservice and preservice training, improve management, increase or modify supervision, and tailor services and supports for people receiving services. *The state-wide team recommends the use of the implementation framework used to implement positive behavior support but will broaden*

the goals of this infrastructure by using it as a vehicle for implementing the broader array of positive support practices that are identified within state-wide planning processes.

Figure 1. Aligning State Services with a Three-tiered Prevention Model.



Organization-wide Team-based Planning. The goal of positive behavior support at an organizational level is to teach people receiving services, staff members, administrators, and family and community members to work together to solve problems (for example, how do we improve staff training, increase positive reinforcement, become more sensitive to past trauma, accommodate mental health issues, etc.). Consensus building and buy-in increases when all individuals within a setting contribute to important decisions that are made. This empowering message combined with data for progress monitoring, commitment to continuous improvement, troubleshooting, and celebration of success provides a powerful model for building community. Organization-wide teams choose to participate in positive behavior support knowing it requires a long-term commitment. Administrator leadership and direct participation is essential to the change process. Buy–in and consensus-building processes using a team approach and all individuals (people receiving services, staff, management, family members, etc.) within a particular setting increases the likelihood of effective implementation. Regular team meeting processes employ the use of data to drive action planning over time. Positive reinforcement systems are used to acknowledge and recognize staff members' efforts in improving a person's quality of life, encouraging independence, and facilitating meaningful friendships with others. In some organizations, people receiving services actively reinforce staff members they observe engaging in positive person-centered actions.

Agency-wide Coordination. Figure 2 shows how state-wide agency teams are organized to produce large-scale coordination of positive behavior support. The purpose of the agency-wide team is to provide oversight and coordination of technical assistance to organizations learning to make fact-based, data-based decisions for improving outcomes for the people they serve. The data collected by these organizations are summarized at the agency-wide team with an emphasis on using these data in a manner that is dedicated to the ethical principles associated with continuous services and personal improvement. State-wide leadership teams coordinating the implementation of positive behavior support within one service area (e.g. education, mental health, etc.) ensure open communication and transparent processes are established by recruiting people who represent important stakeholders. Examples of stakeholders include people receiving services, family members, administrators, managers, professionals, community members, higher education, and anyone else who represents an important stakeholder associated with services within a particular agency context. Figure 2 describes the important roles of the leadership team. Teams meet on a regular basis to ensure funding is available for technical assistance efforts, there is visibility and awareness of the positive behavior support efforts taking place (website, newsletters, board presentations, community outreach), technical assistance content is in place, and policies are aligned with best practices. Interagency systems are established to improve coordination of services and communication.

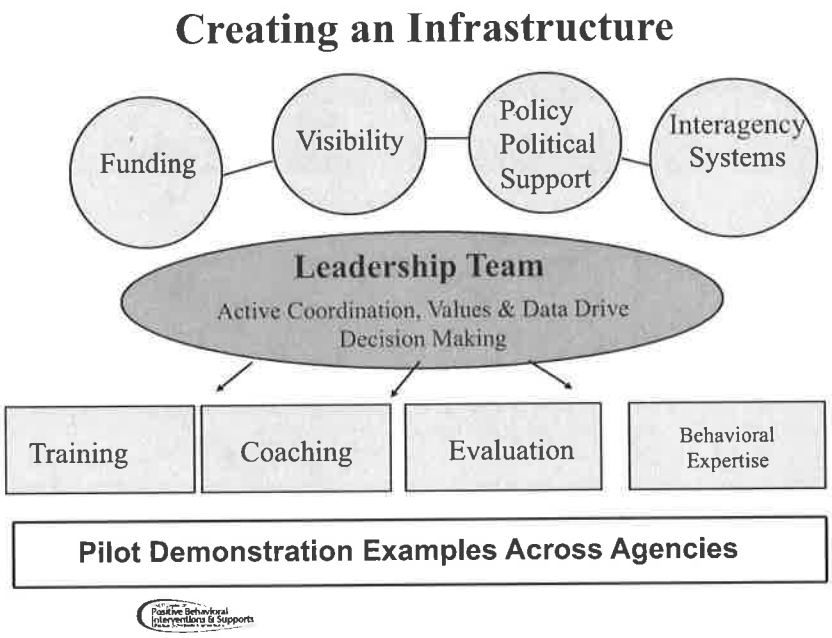
The leadership team establishes the curriculum needed for technical assistance with an agency-wide coordinator taking on the role of ensuring training events are organized, handling logistics related to state-wide meetings, and prompting organizations to collect and submit data for reporting purposes. The coordinator supports and monitors coaches who work within each organization to ensure that organization-wide teams are meeting, action plans are moving forward, and data are being collected and submitted. The evaluation process is monitored through the agency-wide team with the coordinator working with coaches to collect data regularly and to assist in problem solving when issues arise.

An immediate consideration for most organizations is the need to train professionals who will facilitate positive behavior support plans as well as other positive support strategies and who will, over time, take on the role of inservice and preservice preparation within the organization. It takes time for people to become confident facilitating positive behavior support. For this reason, organizations are encouraged to start training professionals to facilitate positive behavior support immediately, plan for unexpected staff attrition, and provide staff incentives for participating in intensive positive behavior support facilitator training.

Internal Organizational Capacity for Positive Support. The state team recommends that an investment of intensive positive support facilitator training should occur with evaluation methods put in place and monitored over time to provide evidence that outcomes are improving for people receiving services. The team is now discussing intensive training needs for a number of positive supports and identifying the types of instruction that will be needed to build capacity across the state. Positive behavior support and person-centered planning facilitator training will be selected as practices that will be used to pilot the first implementation efforts. Evidence provided by person-centered positive behavior support facilitators include: direct observation data collected

across baseline, intervention, and follow-up phases for problem behavior as well as for social behavior intended to help an individual achieve a self-determined lifestyle, evidence of improved quality of life, and survey data that show that the plan meets the needs of family members, caregivers, and other people who implement the positive behavior support plan.

Figure 2. Establishing Technical Assistance Systems to Ensure Effective Sustainable Implementation.



Adapted From: Sugai, G., Horner, R., Sailor, W., Dunlap, G., Eber, L., Lewis, T., Kincaid, D., Scott, T., Barrett, S., Algozzine, B., Putnam, B., Massanari, C., & Nelson, M. (2005). *School-wide positive behavior support: Implementers' blueprint and self-assessment.* T echnical Assistance Center on P ositive Beha v-ioral Interventions and Supports.

Reinforcement and Recognition. An important role of the agency-wide team is to consider strategies for reinforcing organization-wide efforts that are successful implementing positive behavior support and can show evidence that incident reports and the use of restrictive procedures are decreasing while positive support strategies are increasing over time. Currently, many individuals associate sharing of data with punishment. This can occur when systems focus more on remediation rather than on encouraging the use of positive supports by the organization. Teaching organizations to use data to monitor and celebrate progress can increase the perceived value of data. Nationally, agency-wide teams have established benchmarks for organizations to reach by providing data summaries with incentives tied to key accomplishments. In some states, organizations receiving these "bronze, silver, and gold" awards create friendly competition with other organizations and are a cause for celebration. Creating opportunities for organizations to meet annually to report successes, celebrate progress, problem solve together, and share resources provides another type of reinforcement that can bolster implementation efforts. Annual conferences or meetings that allow organization-wide teams, coaches, and mentors to come together in this manner is an

important way in which to establish a positive culture of innovation and changes the way in which people perceive the use of data. Sending champions, mentors, and coaches to annual positive support-related conferences for ongoing learning is yet another example of how some states have considered reinforcement systems at a state-wide level. While punishment for organizational misbehavior is necessary at times, the use of reinforcement and recognition for positive implementation efforts can increase motivation and morale.

State-wide Coordination. States with more than one agency implementing scaling up methods for positive behavior support often form an overall state-wide interagency team including coordinators representing state agencies that are implementing positive behavior support, state leaders, professionals representing major prevention efforts (e.g. positive supports), people receiving services, family members, higher education professionals, state policy professionals, non-profit community leaders, and any other representation that will further the team's action planning efforts. The goal of the interagency team is to establish a common language for prevention efforts, leverage limited state resources, align state-wide technical assistance, and summarize evaluation data for policy, funding, and state reporting issues. A number of states currently maintain interagency state-wide teams. However, since state systems are unique, these teams vary in vision, mission, and overall action planning efforts.

Minnesota's State-wide Implementation Plan

The best practice information described in this report was used to establish a state-wide action plan for implementing positive supports. *This report will refer to positive behavior support when discussing the infrastructure for establishing technical assistance systems and data collection processes but will consider the broader term positive supports when discussing all content and practices that will be disseminated via the technical assistance efforts that take place.* The information in this report sets the stage for future legislative requests that will drive technical assistance efforts. The state will re-allocate existing funds working smarter not harder to implement the action plan. The information in this report will be used to guide implementation efforts and to move forward using funds that are available. The scale, progress, timeline, and impact of these efforts across the state will determined by the ability of the state-wide team to acquire the funds necessary for moving forward.

An initial interagency team was formed to begin state-wide planning with the understanding that more individuals representing different stakeholder groups will be recruited once the October 22, 2014 report is complete. The team that met to create the initial state-wide report included state personnel at the Department of Human Services' Disability Services Division, the Adult Mental Health Division, the Alcohol and Drug Abuse Division and the Division of Direct Care and Treatment at the Department of Human Services as well as Positive Behavior Support professionals from the Minnesota Department of Education. The goal of this team was to report on the actions already taken by the state across the four main tasks outlined in the introduction (inventory, definitions, best practice, and state-wide report) and to design a communication infrastructure and implementation plan that would allow for systematic growth of positive supports across agencies in Minnesota.

Figure 2 shows a second part of the overall infrastructure. Regional, agency-wide, county-wide, and the interagency state-wide teams will use the leadership model

described in Figure 2 as a way to guide implementation efforts. At the bottom of Figure 2, pilot demonstration exemplars are considered a helpful feature for launching positive behavior support. The state's efforts to implement positive supports will be more successful when there are organization-wide teams sharing success stories and providing examples of exemplary implementation using data to evaluate progress. Agencies involved in the first implementation efforts, aging, disabilities, mental health, and education will begin action planning at county-wide and region-wide levels. Each agency will have a unique plan with targeted positive supports that will be implemented. The agency-wide teams will establish exemplary organization-wide demonstrations and create a plan for taking these efforts to scale across the state.

Development of Roles and Responsibilities. The state is already implementing technical assistance across a number of positive support practices. These technical assistance efforts use terms to describe the implementation process with clear roles and responsibilities and terms used for types of trainers. The term "coach" and "mentor," for instance, are used within the training person-centered planning. The state-wide team will work with already existing implementation efforts like person-centered planning to establish the overall technical assistance infrastructure and to define key terms within the overall infrastructure including:

- Organization-wide, county-wide, region-wide, and state-wide teams,
- Coordinators who guide meetings, provide oversight at regional, agency-wide, and state levels, and assist in gathering and summarizing data,
- Coaches who assist individuals within their organizations to implement positive supports, and
- Mentors who provide training to individuals within organizations.

Consistent use of terms such as coaches, mentors, etc. will improve consistency of communication across state training efforts and streamline communication at organization-wide, county-wide, region-wide, and state-wide levels.

Regional Teams and Facilitation. Regional teams are recommended as an addition to the Minnesota technical assistance system. This regional team model will encourage interagency collaboration and improve communication across agencies. The regional teams will include broader goals for improving service coordination and communication. Regional Coordinators will be added to the Minnesota state-wide infrastructure with the role of facilitating regional action plans, assisting in oversight of training systems, and gathering data for regional decision making. The number and types of organizations in each region will vary depending on the number and type of organizations that choose to participate each year.

Since Minnesota school-wide PBS is already in progress, implementation efforts in education will be tailored to meet the unique needs of each region. In some regions, exemplary school coaches and teams will be able to assist in regional training and supports. For example, in some states, new coaches from outside agencies will visit with school coaches spending time observing how similar tools and procedures are used in education. This helps coaches from the different agency learn more about the universal elements of the training and contributes to cross-agency awareness. Coaches then return to their own trainer/mentors and learn how to use similar types of tools in mental health

settings, nursing homes, residential settings or employment contexts. Taking advantage of the strengths of the current positive behavior support implementation in education is an opportunity unique to Minnesota's state-wide planning efforts. This strength-based approach to organization-wide training will help model the importance as it is applied to each field.

Establishing Communities of Practice. The state-wide team will use communities of practice across many levels of the infrastructure for Minnesota's technical assistance efforts. The goal of the large-scale technical assistance efforts will be to ensure that organization-wide teams can identify the unique needs within local and regional contexts. This information is used to initiate, organize and facilitate local communities of practice events. Examples of community of practice events include self-advocate led learning opportunities, meetings for families interested in learning more about positive supports, or interagency meetings held to share information about positive support resources available within the community. Each coaching level within the Minnesota technical assistance efforts (state agency coordinators, regional coaches, organization-wide coaches) will form a community of practice with events scheduled to encourage ongoing learning, troubleshoot together, and share ideas about implementation efforts. Individuals who learn to facilitate specific positive support strategies will form another type of community of practice. Individuals who participate in facilitator-level communities of practice continue learning about the new research strategies, systems change approaches, and other information that can be used to continuously improve services for people across the state.

Gradual Expansion of Agency-wide Coaching. State coordinators who will oversee implementation in mental health, DSD, and aging will be recruited as a first step in building an infrastructure for positive behavior support implementation. Training and supports will be provided to new state coordinators as initial implementation steps are taken within their agency. State-wide coordinators will learn to communicate regularly with regional coaches, facilitate agency-wide action planning to gradually expand the number of organizations participating, and assist in summarizing data for state-wide action planning purposes. Early training steps will include inviting the current state-wide school-wide positive behavior support coordinator to present to new agency coordinators. Training systems will be created in each agency starting positive support implementation. Each agency will have the opportunity to ensure that the tools and larger positive supports curriculum needed are organized for implementation. By August, 2015, action plans for implementation will be established for aging, mental health, and DSD and a tailored expansion plan will be in place for education as it continues its implementation efforts. Each organization recruited will be asked to prepare for training by identifying a coach, establishing a team, and completing a readiness assessment that includes clear administrator buy in and support for implementation of positive behavior support. Prior to August, 2015, the agency coordinators will work with the interagency state-wide team to recruit organizations within five regional teams as a first step in the implementation process.

Mentors and Local Champions. Mentors are also considered an important element within the Minnesota State-wide plan. Although similar, coaches and mentors have different roles within the implementation process. Coaches prompt organization-wide teams to schedule and record meetings, work with the team to collect and submit

data, and communicate with agency-wide team coordinators. Mentors provide training to coaches and organization-wide teams with guidance provided on an ongoing basis throughout the implementation process. Mentors will be identified and recruited over time through a variety of methods to ensure that ongoing technical assistance and training will continue in a sustainable manner at the local level. For instance, professionals who complete intensive positive behavior support facilitator training, coaches who show extraordinary skills supporting people who are learning new skills, regional professionals who might take on an autonomous role in facilitating regional team meetings are all examples of future mentors within the overall state-wide plan. The role of the state-wide team is to actively seek out and enroll individuals to champion state-wide efforts and to monitor the growing number of professionals who are assisting in overall state-wide efforts. *As mentioned earlier, the terms used to refer to individuals who provide training and mentoring in different contexts will be aligned with current terms that are used in technical assistance efforts.*

Data-based Decision Making. Data will be collected at the organizational level using the state's incident reporting system as a key mechanism for gathering and sharing data. Incident report data will include information about the events occurring including average incidents per day per month, types of problem behavior, time of problem behavior, the person for whom the incident was written, other people involved in incidents, and location of problem behavior. Other data will be included such as restraints used, police or legal contacts, and contextually relevant terms such as in and out of school suspension, acute care short-term stays, or emergency room visits. Organization-wide teams will also learn to collect other types of data to guide decision making including staff attrition, and climate surveys for staff members and people receiving services. A statistical measure that will assist the state in making comparisons will be identified. For instance, office referral data are often organized using "incident reports by 100 students". This allows for comparisons to be made across larger and smaller organizations across the state. The state-wide interagency team will work with IT staff to establish summaries of incident report data for teams at the organization-wide, regional, agency-wide, and state-wide levels. Table 3 describes the types of data that will be used by different teams for decision-making purposes. The next section of this report describes how the state-wide plan will be organized and evaluated using a logic model to describe the details related to implementation efforts.

Aligning State Services to a Three-tiered Prevention Model. In addition to establishing a system for implementing technical assistance in positive supports across agencies, the state-wide team will assess how funds, services, training and technical assistance, and other resources are used to address primary, secondary, and tertiary prevention systems. The team will complete the prevention triangle for each agency with assistance from representative stakeholders, identify gaps in the types of prevention-based services that exist, and closing them by changing policy.

Table 3. Types of Data Used by Teams for Decision Making.

Teams Implementing Action Plans	Types of Data Summarized
Organization-wide Teams (Examples Include Schools, Districts, Residential Support, Supported Employment, Mental Health Centers)	• Action Planning Evaluation (What the Organization Achieved) • Incident Reports • Restraints and Crisis Events • Injuries, Emergency Room Visits • Acute Care/ Restrictive Settings • Climate Data Related to People Receiving Services and Staff • Fidelity of Implementation • Individual Support Plans Evaluated and Aggregated Attrition, Workers Compensation
County Teams	• Action Planning Evaluation (What the County Teams Achieved) • Number and Type of Organizations within County • Growth Patterns for Organizations by County • Summary of Implementation Outcomes and Fidelity of Implementation *Across County Agencies* • Individual Support Plans Evaluated and Aggregated
Regional Teams (Interagency Regional Teams)	• Action Planning Evaluation (What the Regional Teams Achieved) • Number and Type of Organizations per Region • Growth Patterns for Organizations by Agency • Summary of Implementation Outcomes and Fidelity of Implementation *Across Agencies* • Individual Support Plans Evaluated and Aggregated
Agency-wide Teams (Mental Health, Aging, DSD, Education)	• Action Plan Evaluation (What the Agency Teams Achieved) • Number of Organizations implementing Within Each Agency • Growth Patterns for Organizations *by Region* • Summary of Implementation Outcomes and Fidelity of Implementation *Across Organizations and Regions* • Individual Support Plans Evaluated and Aggregated *by Organization and Region*
State-wide Interagency Team (Responsible for Oversight of Entire System)	• Action Plan Evaluation (What the State-wide Team Achieved) • Growth Patterns for Organizations *Across Agencies and Regions* • Summary of Implementation Outcomes and Fidelity of Implementation *Across Agencies* • State-wide Summary of Implementation Outcomes and Fidelity of Implementation • Individual Support Plans Evaluated and Aggregated *by Organization, Region, State*

The goal will be to assess whether additional waiver services, training systems, data collection and progress monitoring systems, or other resources are needed to ensure that each agency provides services addressing primary, secondary, and tertiary prevention. Actions will be taken to ensure that each agency has outlined a three-tiered prevention model with positive support practices addressing each prevention level.

The meetings that takes place to gather this information will provide state personnel with an opportunity to gather information from key stakeholders about: the overall state-wide plan, progress made on developing an inventory of policies, thoughts related to building common definitions for key terms, as well as the types of positive support practices that are unique to each particular agency. Strategies for continuing to disseminate information across each agency will be discussed as well. The information that is gathered will be brought back to the state-wide team and a plan for continuing to reach out via various marketing and awareness strategies will be established. In the next section of this report, the way in which the state-wide team will implement the overall state-wide planning goals and objectives are described.

Logic Model and Outcome Measures

The state-wide team met during the month of October, 2014 to outline the draft of a state-wide plan. Special attention was given to how this state-wide plan would be organized and linked to the infrastructure for technical assistance and to the alignment of services across a three-tiered prevention model. The first step taken was to create a logic model to summarize the major elements associated with implementation and evaluation of the state-wide plan.

Description of Logic Model. A logic model provides a helpful framework for implementing positive supports (see Figure 3). This particular logic model in Figure 3 summarizes the major details while Appendix D contains a more detailed description of state-wide planning. The word "Context" is written in a vertical band on the left hand side of this visual. Due to page/figure size constraints, details related to important contextual elements of Minnesota's state-wide planning are summarized in this report. In program development and evaluation terms, "Context" refers to the political, fiscal, social, and organizational settings and situations that, collectively, constitute the broader cultural environments ("Contexts") in which programs operate (i.e., the historical, contemporary and future influences that are expected to support or hinder the anticipated inputs, implementation, reach, and/or outcomes for Minnesota's state-wide plan). The first main column of the logic model starting on the far left hand side of Figure 3 describes how and to what extent a state-wide team uses and/or allocates its resources, described as "Inputs" in the first main column. The goals that will be put into place are listed in the second column called "Implementation". The third column describes the people the state-wide plan intends to impact, referred to as "Reach". The "immediate", "intermediate", and "longer-term" outcomes are then listed as they relate to the implementation goals listed in column two.

"Impacts," refer to the broader changes that occur due to implementation of a project. Contextual features can influence these potentially larger-scale "Impacts" of a program in ways which can affect larger-scale quality well beyond that of program participants. In order to draw meaningful conclusions or make judgments about the efficiency, fidelity of implementation, and/or effectiveness of Minnesota's state-wide

planning efforts, it is first necessary to understand the contextual features that have influenced its conception, development, implementation, and outcomes. The next section of the report provides a summary of each of the elements of the logic model starting with context.

Context. The Olmstead plan and efforts to decrease the use of restrictive procedures is an important contextual feature influencing the state-wide plan for implementing positive supports. The pressure to implement key action-planning goals by specific timelines already guide the state's efforts to decrease restrictive practices and increase proactive and prevention-based efforts. The emphasis on the development interagency and common policy and procedures is an important contextual feature to state-wide planning and works well with what is known about improving outcomes for people in need of positive supports. Focusing on interagency systems and a common language for prevention can be seen as a contextual strength for implementation. Currently, there are not enough professionals who have experience facilitating positive supports such as person-centered planning, trauma informed thinking, positive behavior support, and other important practices. This contextual feature must be considered within the planning process. The other issue discussed by some state-wide team members was that it would be important to ensure that within agency contextual issues would be addressed to ensure that communication and collaboration would occur *within* agencies as well as *across* the different state agencies.

Inputs. The Minnesota state-wide team benefits from a number of resources that can be used within the action planning process. There are a number of stakeholders who can participate in and contribute to the planning process. These stakeholders represent people across the lifespan who receive one or more services from the state. Family and community members, state professionals across agencies, university and college professionals, practitioners and providers, and individuals with a background in positive supports. A variety of funds can be leveraged or added to state-wide planning efforts. For instance, the State-wide School-wide Positive Behavior Support team has funding for current implementation efforts and provides a helpful model for other agencies moving forward. State-wide FTE dedicated to issues related to behavioral support can be helpful when thinking how to "work smarter, not harder" with existing funds. There are also state-wide and national resources that can be used to assist in the implementation of positive supports. Several universities are moving forward with training and technical assistance related to positive supports and online resources are available to providers across the state. The International Association for Positive Behavior Support encourages members to share ideas, tools, and resources with individual networks often collaborating in different ways on state-wide planning related tasks.

Implementation. Six implementation goals were identified and outlined in Figure 3. These goals include:

1) Establishing Technical Assistance Infrastructure Across Agencies,
2) Designing and Implementing Strategies for Data-based Decision Making and Evaluation,
3) Creating a Marketing Plan for Increasing Awareness of Positive Supports Across the State,

4) Expanding Preservice and Align Inservice Training Systems State-wide,

5) Developing and Maintaining an Inventory of Policies Related to Restrictive Practices and Positive Supports, and

6) Expanding Interagency Crisis Prevention Planning.

Each implementation goal is broken down into further objectives with strands of immediate, intermediate, and long-term goals documented to show how the timeline and impact of action planning over a five year period of time. Appendix D provides more detailed information about outcomes that are targeted for implementation based on funding allocated for these tasks.

Reach. The individuals and organizations that the state-wide team will reach out to are listed in the third column of Figure 3. A number of agencies will start the implementation and planning process first. These agencies include: aging, education, disabilities, and mental health. Once the framework for implementing positive supports technical assistance is established and large-scale implementation is initiated, additional agencies will be added to the technical assistance efforts. The agencies that will follow the "First Step" agencies as part of the "Expansion of Reach" includes: Department of Corrections, DEED, Department of Health, Human Rights, the Courts, and ombudsman. The variety of stakeholders that will be involved in the planning process includes people receiving services across the lifespan, family and members, practitioners across services, legal professionals (judges, police, attorneys, etc.), and higher education.

Immediate Intermediate, and Long-term Outcomes. Figure 3 is also organized so that the immediate, intermediate, and long-term outcomes are considered across pathways associated with the main implementation goals. For instance, the technical assistance planning occurring with the first step agencies (aging, disabilities, education, and mental health) is in place within the first six months. By the first few years, pilot demonstrations that provide evidence of the effectiveness of the state's efforts are provided at the organizational level and with individual positive behavior support plans within those organizations. This means that the people receiving services (living, working, and learning) within those settings are reporting that they are happier, that they have more opportunities for making choices, engaging in self-determined actions that are meaningful to them, and that their quality of life has been impacted due to the implementation efforts taking place. Individual PBS plan summaries would provide evidence that restrictive procedures are decreasing and that the lives of people who have experienced challenges within their settings are improving over time.

The state-wide team will form workgroups to ensure that the implementation details outlining immediate, intermediate, and long-term goals and objectives (see the Appendix D for more information) for all six of the main implementation efforts are achieved. Workgroups will be assigned a state staff person to take on the role of Chairperson although Co-chairs also may represent other stakeholder groups. Teams will include representation across diverse stakeholder groups and anyone who learns about the planning process and is interested in joining a workgroup will be encouraged to contact the state-wide team coordinator. The coordinator will make sure that each workgroup has an adequate number of team members.

Figure 3. Minnesota's State-wide Planning Logic Model.

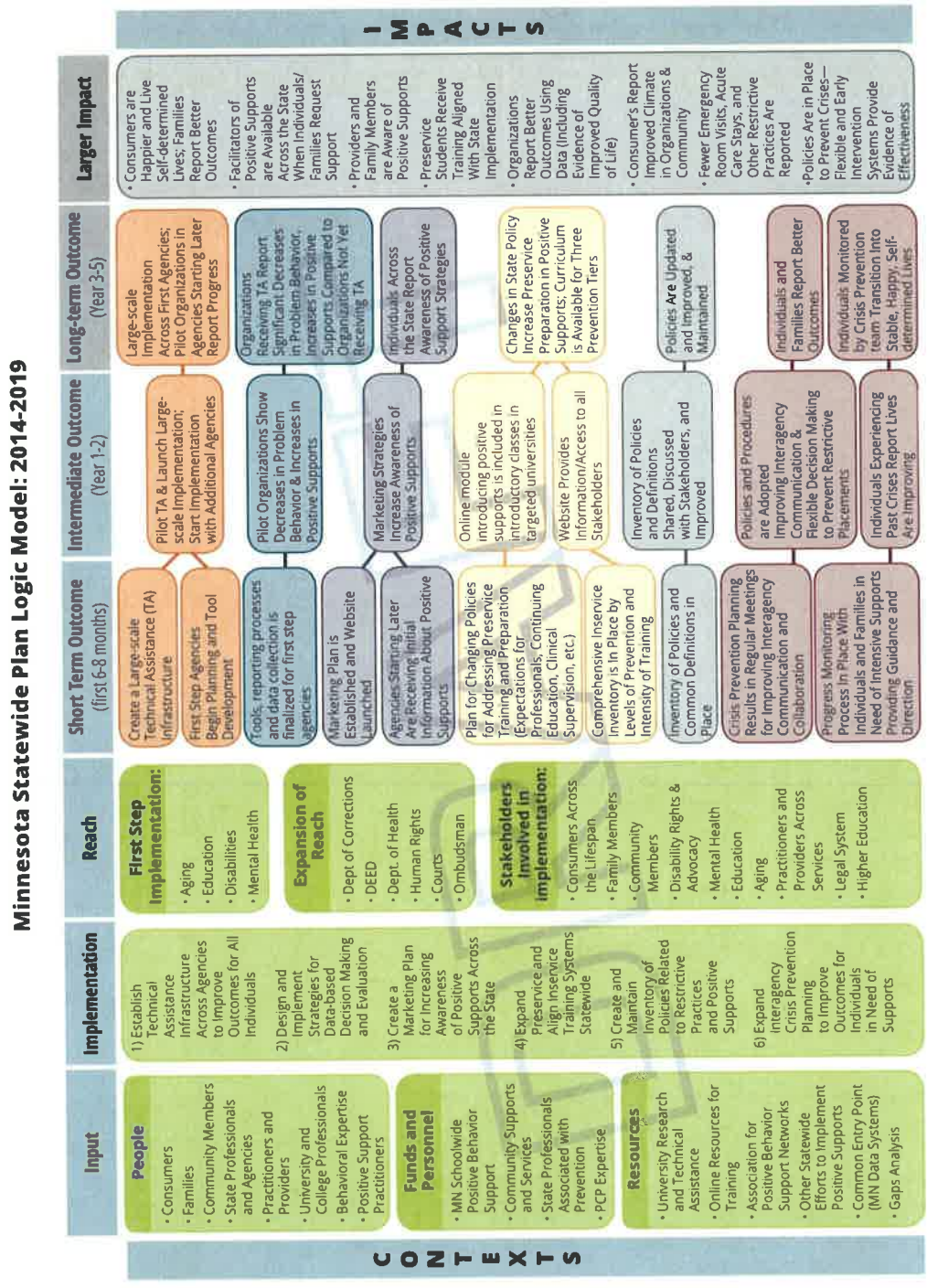
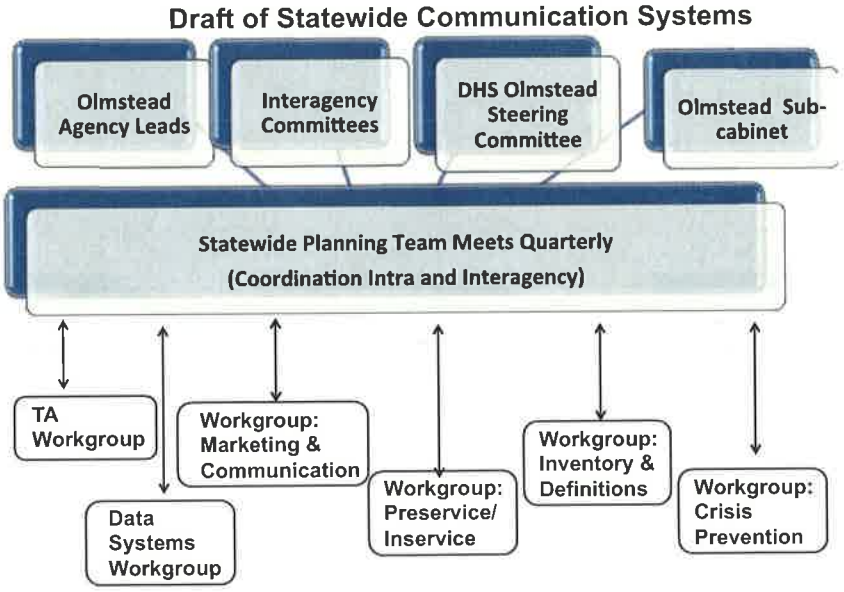


Figure 4 describes the communication infrastructure that will be used to monitor the state-wide plan and to ensure data are used for decision making. There are a four groups meeting at the state level related to implementing the Olmstead plan: DHS Olmstead Steering Committee, Olmstead Agency Leads, Interagency Committees (addressing topics including, for example, the Employment Interagency Leadership Panel), and Olmstead Sub-cabinet. Figure 3 demonstrates how the Interagency State-wide Team will form a hub of communication with information coming from each of the six workgroups and from the Minnesota Olmstead Planning teams. The state-wide team will meet quarterly with workgroups meeting schedules meeting more frequently in order to report progress on the action plan outlined in the Appendix D at the quarterly state-wide meetings. The coordinator of the state-wide meeting will share information with the three Olmstead committees and will ensure that information is shared with the state-wide team and each of the workgroups.

Figure 4. Communication and Feedback Systems for Interagency State-wide Positive Supports Planning



The workgroup associated with data collection systems will work closely with the technical assistance workgroup to ensure that the data entered into the state monitoring system can be summarized and shared at the organizational, regional, agency, and state-wide levels. In addition to quantitative data gathered using the state's data collection systems, qualitative information will gathered to ensure that people receiving services and their families or caregivers will be able to communicate their perspectives on an ongoing basis. The state has a number of surveys and quality of life measures that are already in the planning stage. The workgoup responsible for data collection will gather information about the various activities already planned and ensure that all elements of

the state-wide planning process will include opportunities to gather information from people receiving services and other stakeholders. This information will be used to ensure that the state-wide planning, technical assistance and training, marketing and communication, preservice training, crisis management systems will be guided by people receiving services across the state of Minnesota.

Impacts. This essential element of the logic model is referred to as "Impacts" and is visible in Figure 3 as a vertical band on the right hand side of the logic model. Impacts are the results of a project that goes well beyond long-term outcomes and reflect the larger shifts that may occur as a result of the implementation efforts. The impacts of programs can be positive, whether planned or unplanned, or impacts can be well intended, but ultimately counter- productive ("iatrogenic") in nature. The challenge of the state-wide team is to ensure that all elements of the implementation efforts described here encourage people to participate in the implementation of positive supports and seek strategies to decrease restrictive practices. As Fullan (1993) stated most eloquently, "You can't mandate what matters... the more complex a change effort is, the less likely you can force individuals to become involved in the process" (p. 21). For this reason, the state will work diligently to establish positive and proactive strategies for encouraging participation, collaboration, and consensus-building strategies throughout all elements of the implementation process. Systems change research highlights the need to establish champions at all levels within systems. This means that everyone is important and plays an essential role in systems change. The state will seek out champions of positive supports across the state of Minnesota and encourage these individuals to become leaders within their region of the state. Strategies for rewarding organizations and individuals who champion the positive supports efforts will be considered as an essential part of the state-wide planning process. Individuals who are recruited to participate in intensive person-centered planning or positive support training will be recognized and rewarded for participating in these certification processes and the state-wide team will seek out ways to ensure these trainings are considered essential requirements for organizations. In summary, the goal will be to model the behaviors that are expected by the same practices recommended in positive prevention-focused efforts with the people we expect to change their behaviors as part of the implementation process. Practitioners, administrators, and community members respond to the same respectful, positive and proactive approaches we demand are used with all people who receive services.

Next Steps

Many of the tasks reflected in this state-wide plan are already being implemented by professionals representing state, university, and other stakeholders. The goal of this state-wide plan is to create a communication infrastructure to ensure that information is shared systematically and action-planning efforts are streamlined. The first steps taken by the state-wide team is to recruit workgroup chairs and initial team members for each of the six major implementation tasks. Some of these workgroups are already operational even though a full workgroup with stakeholder representation has not yet been achieved. For instance, the group involved in policy inventory and definition of common terms have completed the initial assessment and are conducting further work to establish a system for refining and maintaining the inventory of polices. While some workgroups are already moving forward, the goal is to launch all workgroups and achieve one or more

meetings within each workgroup before January, 15, 2015. Quarterly state-wide team meetings will be scheduled for November, 2014 January, 2015 April, 2015, and July, 2015. The first full meeting with a more representative stakeholder group will occur by January, 2015. A plan for sharing information about this state-wide plan, the work mentioned earlier related to establishing common terms, and details about the policy inventory will also be in place by January, 2015

References

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Fullan, M. (2005). *Leadership and sustainability.* Thousand Oaks, CA: Corwin Press.

Gorden, R. S. (1983). An operational classification of disease prevention. *Public Health Reports, 98*, 107-109.

Sugai, G., Horner, R., Sailor, W., Dunlap, G., Eber, L., Lewis, T., Kincaid, D., Scott, T., Barrett, S., Algozzine, B., Putnam, B., Massanari, C., & Nelson, M. (2005). *School-wide positive behavior support: Implementers' blueprint and self-assessment.* T echnical Assistance Center on P ositive Beha v- ioral Interventions and Supports.

World Health Organization (2004). *Prevention of mental disorders: Effective interventions and policy options*. Gevena: WHO

Appendix A

Progress Defining Common Terms

The following statutes, rules, policy and practices was identified by DHS staff to be included in inventory survey.

Identified For Inventory

Statutes:

Minnesota Statute 245D Home and Community Based Services Standards
- Protection Standards 245D.06
- Emergency Use of Manual Restraint 245D.061
- Service Planning and Delivery; Intensive Supports 245D.071

Minnesota Statute 245.8261 Restrictive Procedures Planning and Reporting (Mental health services for children)
Minnesota Statute 125A.094 Standards for Restrictive Procedures (Schools)
Minnesota Statute 125A.0941 Standards for Restrictive Procedures (Definitions)
Minnesota Statute 125A.0942 Standards for Restrictive Procedures (Standards)
Minnesota Statute 121A Students Rights, Responsibilities and Behavior
- Exclusion and expulsion of pupils with a disability 121A.43
- Corporal Punishment - Banned 121A.58
- Student Discipline; Reasonable Force 121.582
- Discipline and Removal of Students from Class 121A.61
- Removal by Peace Officer – Specifically for Students with IEP's 121A.67

Minnesota Statute 245.461 Minnesota Comprehensive Adult Mental Health Act; Policy and Citation
Minnesota Statute 245.487 Minnesota Comprehensive Children's Mental Health Act Citation; Declaration of Policy; Mission
Minnesota Statute 245A.66 Requirements; maltreatment of minors
Minnesota Statute 252A.111 Powers and Duties of Public Guardian or Conservator
Minnesota Statute 253B Civil Commitment
Minnesota Statute 256B Medical Assistance for Needy Persons
Minnesota Statute 524.5-101 to 524.5-502 Uniform Guardianship and Protective Proceedings Act
Minnesota Statute 6090.255 False Imprisonment
Minnesota Statute 626.566 Reporting of Maltreatment of Minors
Minnesota Statute 626.557 Reporting of Maltreatment of Vulnerable Adults
- Definitions 626.5572

Rules:

Minn. R. 9525.2700 to 9525.2810 (formerly known as Rule 40)
Proposed Minn. R. 9544.000-9544.0160 (Positive Supports)
Minn. R. 3525.0850 (State Policy to encourage use of positive approaches in schools)
Minn. R. 3525.2810 (Behavioral Interventions and Supports in schools)
Minn. R. 9555 Social Services for Adults
Minn. R. 9502 Licensing of Day Care Facilities
Minn. R. 9520 Mental Health Services

Minn. R. 9503 Child Care Center Licensing
Minn. R. 2960 Licensure and Certification of Programs for Children

Policy & Practice:
Behavior Intervention Reporting Form – Form 5148
Positive Support Transition Plan – Form 6810
Positive Support Transition Plan Review – Form 6810A
Instructions for Completing Positive Support Transition Plan – Form 6810B
Sample Policies and Forms for Basic Supports and Services
Sample Policies and Forms for Intensive Supports and Services

Incidents
Emergency Use of Manual Restraint Policy
Behavior Intervention Reporting Form – Form 5148
Positive Support Transition Plan – Form 6810
Positive Support Transition Plan Review – Form 6810A
Instructions for Completing Positive Support Transition Plan – Form 6810B

Initial Report of Survey Results

Initial Report 10.19
Last Modified: 10/19/2014

1. Is this a policy or a practice? Check all that apply

#	Answer		Response	%
1	Policy		11	50%
2	Practice		0	0%
3	Other, please specify		11	50%

Other, please specify
State Statute
Statute
Statute
Rule and Variance
case law
Training
Training
Training
Training
Training
Training

Statistic	Value
Min Value	1
Max Value	3
Total Responses	22

2. Which best describes this policy or practice? Check all that apply

#	Answer		Response	%
1	A. This policy or practice is best practice/evidence based practice for positive supports		5	36%
2	B. This policy or practice restricts, limits, defines the use of non-positive supports such as restrictive procedures, seclusion, restraint, prohibited procedures etc.		10	71%
3	C This policy or practice is a prohibited practice		2	14%
4	Other, please specify		0	0%

Other, please specify Statistic	Value
Min Value	1
Max Value	3
Total Responses	14

3. Which of the following does this policy or practice that restricts, limits and or defines the use of non-positive supports influence or guide? Check all that apply

#	Answer		Response	%
1	Personnel requirements such as licensure, certification or professional development		9	75%
2	Practice		12	100%
3	Programs		12	100%

Statistic	Value
Min Value	1
Max Value	3
Total Responses	12

4. Does this policy or practice contain a definition of incidents that must be reported?

#	Answer		Response	%
1	Yes		8	67%
2	No		4	33%
	Total		12	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.33
Variance	0.24
Standard Deviation	0.49
Total Responses	12

5. If you responded yes to question above, what data must be collected for reportable incidents?

Text Response
Annual report stating number and types of restrictive procedures performed.
each use of protective procedure is documented in the client record;
use of restraint and seclusion
"Subdivision 1.Incident response and reporting. (a) The license holder must respond to incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person... h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b) within 24 hours of the occurrence. The license holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061."
Subd. 5.Reporting emergency use of manual restraint incident. (a) Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the designated coordinator the following information about the emergency use:

Statistic	Value
Total Responses	5

6. What happens to incident report data once collected?

Text Response
This has been an unfunded mandate that the department does not collect. there is a quarterly administrative review required by the rule administrative review

Statistic	Value
Total Responses	3

7. State Agency Select one

#	Answer	Response	%
1	Department of Human Services (DHS)	16	89%
2	Depart of Education (MDE)	2	11%
3	Department of Health (MDH)	0	0%
4	Department of Employment & Economic Development (DEED)	0	0%
5	Department of Corrections (DOC)	0	0%
6	Department of Human Rights	0	0%
7	Other, please specify	0	0%
	Total	18	100%

Other, please specify Statistic	Value
Min Value	1
Max Value	2
Mean	1.11
Variance	0.10
Standard Deviation	0.32
Total Responses	18

8. Division

Text Response
Children's Mental Health
Alcohol and drug abuse
Alcohol and Drug Abuse Division
Alcohol and Drug Abuse Division
Adult Mental Health
Disability Services
DSD
Compliance and Assistance
DSD
Compliance and Assistance
DSD

Statistic	Value
Total Responses	11

9. Document Name and Number, where applicable

Text Response
RESTRICTIVE PROCEDURES PLANNING AND REPORTING
Chemical Dependency Licensed Treatment Facilities (Rule 31): Behavioral Emergency Procedures
Detoxification Programs: Protective Procedures
Integrated Dual Diagnosis Treatment: Policies, Procedures, and protocols
Civil Commitment; temporary confinement; emergency admission; authority to detain and transport a missing patient
Chapter 2960 Licensure and certificatio of programs for children
Vulnerable Adult Act and Maltreatment of Minors Act
Civil Commitment Act
Rule 36 and the IRTS Variance to Rule 36
the Jarvis decision and the Price Sheppard decision
Home & Community Based Standards-Protection Standards
Emergency Use of Manual Restraint
Standards for Restrictive Procedures
Positive Behavior Support – SOS0000830
Intro-Positive Behavior Supports in Mental Health – SOS0001397
MN Positive Behavior Support Initiative – SOS0001488
Positive Behavior Supports on the Job – SOS0001558
CDS: PBS – Understanding Positive Approaches – SOS0001734
Intro to Function Based Positive Behavior Supports – SOS0001770
Service Planning and Delivery; Intensive Supports
Standards for Restrictive Procedures
Administrative Rule-Formerly known as Rule 40

Statistic	Value
Total Responses	22

10. Citation of State or Federal Regulation, Statute, Rule or Policy, if applicable

Text Response
Minnesota Statutes 245.8261.
Rule 9530.6475
Rule 9530.6535
9530.0050 Subp. 3 Behavioral emergency procedures
Chapter 253B; 253B.045; 253B.05; 253B.141
2960.0710
Minnesota Statutes 626.557 and 626.5572, 626.556
253b
Caselaw
Minn. Stat. 245D.06
Minn. Stat. 245D.061
Minn. Stat. 125A.094
Minn. Stat. 245D.071
Minn. Stat. 125A.0941
Minn. R. 9525.2700 to 9525.2810

Statistic	Value
Total Responses	15

11. Document SourceInclude hyperlink to on-line location when applicable

Text Response
https://www.revisor.mn.gov/statutes/?id=245.8261
https://www.revisor.leg.state.mn.us/rules/?id=9530.6475
https://www.revisor.leg.state.mn.us/rules/?id=9530.6535
https://www.revisor.leg.state.mn.us/rules/?id=9533.0050
https://www.revisor.leg.state.mn.us/statutes/?id=253B
https://www.revisor.leg.state.mn.us/rules/?id=2960.0710
https://www.revisor.leg.state.mn.us/statutes/?id=245D.06
https://www.revisor.leg.state.mn.us/statutes/?id=245D.061
https://www.revisor.leg.state.mn.us/statutes/?id=125A.094
https://www.revisor.leg.state.mn.us/statutes/?id=245D.071
https://www.revisor.leg.state.mn.us/statutes/?id=125A.0941
https://www.revisor.leg.state.mn.us/rules/?id=9525.2700

Statistic	Value
Total Responses	12

12. Publication Date of Document

Text Response
2011
10/15/2013
10/15/2013
11/12/2013
08/05/2008
Ongoing
Ongoing
Ongoing
Ongoing
2013- Amended in 2014
2013
2013
2013
October 16, 2013

Statistic	Value
Total Responses	14

13. Type of Document/Publication.Check all that apply.

#	Answer	Response	%
1	Policy	0	0%
2	Procedure	0	0%
3	Practices Manual	0	0%
4	Statute/Law	9	41%
5	Rule/Regulation	6	27%
6	Interpretative Guideline	0	0%
7	Bulletin	0	0%
8	Form	0	0%
9	Case Law	1	5%
10	Training (State funded)	6	27%
11	Technical Assistance Guide/Manual	0	0%
12	Other, please specify	1	5%

Other, please specify
Variance

Statistic	Value
Min Value	4
Max Value	12
Total Responses	22

14. Who is the intended audience for this policy or practice? Check all that apply

#	Answer	Response	%
1	Policymakers	13	81%
2	Organization Leaders	12	75%
3	Regulators/Licensors	12	75%
4	Lead agencies, counties, tribes	13	81%
5	Service Providers-Management	14	88%
6	Service Providers-Supervisory	12	75%
7	Service Providers-Direct Support Professionals	12	75%
8	Educators - K-12	3	19%
9	Educator - Post Secondary	1	6%
10	Clinicians	9	56%
11	Family members	6	38%
12	Self-advocates	5	31%
13	People being supported with services	10	63%
14	Guardians	6	38%
15	Other, please specify	0	0%

Other, please specify Statistic	Value
Min Value	1
Max Value	14
Total Responses	16

15. Is this policy or practice currently being revised or updated?

#	Answer	Response	%
1	Yes	2	18%
2	No	9	82%
	Total	11	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.82
Variance	0.16
Standard Deviation	0.40
Total Responses	11

16. If responded yes, what is status of the revision or update?
Text Response
draft proposals are being vetted with stakeholders; DHS commissioner working on a plan to include detoxifcation services as a medical assistance benefit

Statistic	Value
Total Responses	1

17. Name
Text Response
Jill Johnson
Brian Zirbes
Brian Zirbes
Brian Zirbes
Brian Zirbes
Brian Zirbes
Faye Bernstein
Faye Bernstein
faye bernstein
faye bernstein
ICI Staff
ICI Staff
Robyn Widley by ICI Staff
Stacy Danov
Stacy Danov
Stacy Danov
Stacy Danov
Stacy Danov
Stacy Danov
ICI Staff Entry
Robyn Widley
ICI Staff for Charles Young

Statistic	Value
Total Responses	22

18. Title
Text Response
Children's Mental Health Consultant
Planner Principal State
Planner Principal State
Planner Pricipal State
Planner Principal State
Planner Principal State
Mental Health Program Consultat
Program Consultant
mental health program consultant
mental health program consultant
ICI Staff
ICI Staff
Community Capacity Building Clinical Coordinator

Statistic	Value
Total Responses	13

19. Email
Text Response
jelaine.johnson@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
ICI Staff
ICI Staff
Stacy.e.danov@state.mn.us

Statistic	Value
Total Responses	13

Appendix B

Sample Crosswalk for Definition of Incident across state agencies:

State Agency	DHS	MDE	MDH	DOC	DEED
Definition					
Reporting Requirements					

Inventory Survey Results for Policies and Practices that include a definition of incidents that must be reported.

Incidents

Last Modified: 10/19/2014

Filter By: Report Subgroup

1. Is this a policy or a practice? Check all that apply

#	Answer	Response	%
1	Policy	5	63%
2	Practice	0	0%
3	Other, please specify	3	38%

Other, please specify
State Statute
statute
Rule and Variance

Statistic	Value
Min Value	1
Max Value	3
Total Responses	8

2. Which best describes this policy or practice? Check all that apply

#	Answer	Response	%
1	A. This policy or practice is best practice/evidence based practice for positive supports	1	14%
2	B. This policy or practice restricts, limits, defines the use of non-positive supports such as restrictive procedures, seclusion, restraint, prohibited procedures etc.	7	100%
3	C This policy or practice is a prohibited practice	1	14%
4	Other, please specify	0	0%

Other, please specify Statistic	Value
Min Value	1
Max Value	3
Total Responses	7

3. Which of the following does this policy or practice that restricts, limits and or defines the use of non-positive supports influence or guide? Check all that apply

#	Answer	Response	%
1	Personnel requirements such as licensure, certification or professional development	6	86%
2	Practice	7	100%
3	Programs	7	100%

Statistic	Value
Min Value	1
Max Value	3
Total Responses	7

4. Does this policy or practice contain a definition of incidents that must be reported?

#	Answer		Response	%
1	Yes		8	100%
2	No		0	0%
	Total		8	100%

Statistic	Value
Min Value	1
Max Value	1
Mean	1.00
Variance	0.00
Standard Deviation	0.00
Total Responses	8

5. If you responded yes to question above, what data must be collected for reportable incidents?

Text Response
Annual report stating number and types of restrictive procedures performed.
each use of protective procedure is documented in the client record;
use of restraint and seclusion
"Subdivision 1.Incident response and reporting. (a) The license holder must respond to incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person... h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b) within 24 hours of the occurrence. The license holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061."
Subd. 5.Reporting emergency use of manual restraint incident. (a) Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the designated coordinator the following information about the emergency use:

Statistic	Value
Total Responses	5

6. What happens to incident report data once collected?

Text Response
This has been an unfunded mandate that the department does not collect. there is a quarterly administrative review required by the rule administrative review

Statistic	Value
Total Responses	3

7. State Agency Select one

#	Answer		Response	%
1	Department of Human Services (DHS)		7	100%
2	Depart of Education (MDE)		0	0%
3	Department of Health (MDH)		0	0%
4	Department of Employment & Economic Development (DEED)		0	0%
5	Department of Corrections (DOC)		0	0%
6	Department of Human Rights		0	0%
7	Other, please specify		0	0%
	Total		7	100%

Other, please specify Statistic	Value
Min Value	1
Max Value	1
Mean	1.00
Variance	0.00
Standard Deviation	0.00
Total Responses	7

8. Division

Text Response
Children's Mental Health
Alcohol and Drug Abuse Division
Adult Mental Health
Disability Services
DSD
DSD

Statistic	Value
Total Responses	6

9. Document Name and Number, where applicable

Text Response
RESTRICTIVE PROCEDURES PLANNING AND REPORTING
Detoxification Programs: Protective Procedures
Chapter 2960 Licensure and certificatio of programs for children
Vulnerable Adult Act and Maltreatment of Minors Act
Rule 36 and the IRTS Variance to Rule 36
Home & Community Based Standards-Protection Standards
Emergency Use of Manual Restraint
Administrative Rule-Formerly known as Rule 40

Statistic	Value
Total Responses	8

10. Citation of State or Federal Regulation, Statute, Rule or Policy, if applicable

Text Response
Minnesota Statutes 245.8261.
Rule 9530.6535
2960.0710
Minnesota Statutes 626.557 and 626.5572, 626.556
Minn. Stat. 245D.06
Minn. Stat. 245D.061
Minn. R. 9525.2700 to 9525.2810

Statistic	Value
Total Responses	7

11. Document SourceInclude hyperlink to on-line location when applicable

Text Response
https://www.revisor.mn.gov/statutes/?id=245.8261
https://www.revisor.leg.state.mn.us/rules/?id=9530.6535
https://www.revisor.leg.state.mn.us/rules/?id=2960.0710
https://www.revisor.leg.state.mn.us/statutes/?id=245D.06
https://www.revisor.leg.state.mn.us/statutes/?id=245D.061
https://www.revisor.leg.state.mn.us/rules/?id=9525.2700

Statistic	Value
Total Responses	6

12. Publication Date of Document

Text Response
2011
10/15/2013
08/05/2008
Ongoing
Ongoing
2013- Amended in 2014
2013
October 16, 2013

Statistic	Value
Total Responses	8

13. Type of Document/Publication.Check all that apply.

#	Answer	Response	%
1	Policy	0	0%
2	Procedure	0	0%
3	Practices Manual	0	0%
4	Statute/Law	4	50%
5	Rule/Regulation	4	50%
6	Interpretative Guideline	0	0%
7	Bulletin	0	0%
8	Form	0	0%
9	Case Law	0	0%
10	Training (State funded)	0	0%
11	Technical Assistance Guide/Manual	0	0%
12	Other, please specify	1	13%

Other, please specify
Variance

Statistic	Value
Min Value	4
Max Value	12
Total Responses	8

14. Who is the intended audience for this policy or practice? Check all that apply

#	Answer	Response	%
1	Policymakers	7	88%
2	Organization Leaders	7	88%
3	Regulators/Licensors	8	100%
4	Lead agencies, counties, tribes	8	100%
5	Service Providers-Management	8	100%
6	Service Providers-Supervisory	7	88%
7	Service Providers-Direct Support Professionals	7	88%
8	Educators - K-12	1	13%
9	Educator - Post Secondary	1	13%
10	Clinicians	4	50%
11	Family members	3	38%
12	Self-advocates	2	25%
13	People being supported with services	5	63%
14	Guardians	3	38%
15	Other, please specify	0	0%

Other, please specify Statistic	Value
Min Value	1
Max Value	14
Total Responses	8

15. Is this policy or practice currently being revised or updated?

#	Answer	Response	%
1	Yes	2	33%
2	No	4	67%
	Total	6	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.67
Variance	0.27
Standard Deviation	0.52
Total Responses	6

16. If responded yes, what is status of the revision or update?
Text Response
draft proposals are being vetted with stakeholders; DHS commissioner working on a plan to include detoxification services as a medical assistance benefit

Statistic	Value
Total Responses	1

17. Name
Text Response
Jill Johnson
Brian Zirbes
Brian Zirbes
Faye Bernstein
faye Bernstein
ICI Staff
ICI Staff
ICI Staff for Charles Young

Statistic	Value
Total Responses	8

18. Title
Text Response
Children's Mental Health Consultant
Planner Principal State
Planner Principal State
Mental Health Program Consultat
mental health program consultant
ICI Staff
ICI Staff

Statistic	Value
Total Responses	7

19. Email
Text Response
jelaine.johnson@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
ICI Staff
ICI Staff

Statistic	Value
Total Responses	7

APPENDIX C

Vision and Goals of the Minnesota Olmstead Plan (Pages 10-11)

The Olmstead Subcabinet adopted a vision statement at one of its first meetings:

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;
- Readily available information about rights, options, and risks and benefits of these options, and the ability to revisit choices over time.

Olmstead Plan Goals

To move the state forward, towards greater integration and inclusion for people with disabilities, the state has set an overall goal. If Minnesota's Olmstead Plan is successful, Minnesota will be a place where:

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

To achieve this overall goal, Minnesota's Olmstead Plan addresses goals related to broad topic areas:

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

Housing: People with disabilities will choose where they live, with whom, and in what type of housing.

Transportation: 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.

Supports and Services: People with disabilities of all ages will experience meaningful, inclusive, and integrated lives in their communities, supported by an array of services and supports appropriate to their needs and that they choose.

Lifelong Learning and Education: 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.

Healthcare and Healthy Living: 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.

Community Engagement: 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.

Action Three: ***Build effective systems for use of positive practices, early intervention, crisis reduction and return to stability after a crisis*** **(pages 65-67)**

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. People will be able to move to and remain in integrated settings when plans and supports are in place to avoid crises and timely and appropriate crisis intervention is available. 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.

Timeline:

- By January 1, 2014 the state will implement the new Minnesota Statute §245D standards,[SS 3A], and by July 1, 2015 a Rule with operational details that replaces Minnesota Rules, parts 9525.2700 to 9525.2810 (also known as Rule 40) will be promulgated. [SS 3B]

Responsibility: The Commissioner of the Department of Human Services (DHS) will designate a responsible person.

- By July 1, 2014 the state will create an inventory and analysis of policies and best practices across state agencies related to positive practices and use of restraint, seclusion or other practices which may cause physical, emotional, or psychological pain or distress. [SS 3C]
- By July 1, 2014 a report outlining recommendations for a state-wide plan to increase positive practices and eliminate use of restraint or seclusion will be delivered to the Olmstead Subcabinet or their designee by an assigned team of representatives from Olmstead Subcabinet agencies. [SS 3D] **Responsibility:** The Olmstead Subcabinet will designate a responsible person.
- By August 1, 2014 the state will develop, across state agencies, a common definition of incidents, including emergency use of manual restraint, that are to be reported, and create common data collection and incident reporting processes. [SS 3E] By July 1, 2015, state-wide implementation of common incident reporting will begin. [SS 3F] Beginning October 1, 2015, quarterly summaries of incidents of emergency use of manual restraint or other types of restraint, seclusion or other practices that may cause physical, emotional, or psychological pain or distress will be reported to an assigned team of representatives from each state agency for review and to inform recommendations to reduce the incidents. [SS 3G.1 – 3G.4] By July 1, 2015 and annually thereafter, the team will provide recommendations to the Olmstead Subcabinet to reduce emergency use of restraints, or other practices that may cause physical, emotional, or psychological pain or distress, and to increase positive practices. [SS 3H.1, 3H.2] **Responsibility:** The Olmstead Subcabinet will designate a responsible person.
- By August 1, 2014 a coordinated triage and "hand-off" process for crisis intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation. Report will be delivered to the Olmstead Subcabinet. [SS 3I] **Responsibility:** The Commissioner of DHS will designate a responsible person.
- By December 1, 2014 an assigned team of representatives from state agencies, community organizations, community corrections and people with disabilities who have used the crisis system will: identify best practices, including use of technology; set service standards; and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions (e.g. person-centered planning, positive practices, available resources). Progress toward goal will be reported to the Olmstead Subcabinet or their designee. [SS 3J] **Responsibility:** The Olmstead Subcabinet will designate a responsible person.
- By January 15, 2015 DHS will have completed the necessary analysis and planning to expand crisis services, diversion, and early intervention services to persons at risk of experiencing a crisis situation. The expansion plan will include projected start dates for implementation of the services. **Responsibility:** The Commissioner of DHS will designate a responsible person.
- By July 1, 2015 crisis services, including diversion and early intervention

services, will be made available to any person in need of these supports and at risk of experiencing a crisis situation. The purposes of this intervention include stabilizing the person's situation or avoiding the use of civil commitment. [SS 3K] **Responsibility:** The Commissioner of DHS will designate a responsible person.

- By July 1, 2015 develop measurements to better understand and track crisis episodes across service systems; create a data collection plan and mechanisms; establish baseline data and set targets (e.g., number of crisis calls made, reason for the call, response given, follow-up information.) Baseline data and targets will be delivered to the Olmstead Subcabinet or their designee. [SS 3L] **Responsibility:** The Commissioner of DHS will designate a responsible person.

APPENDIX D

Minnesota's State-wide Plan

Work Group Name: Establishing Infrastructure for Technical Assistance and Data Systems

Date: _____ Committee/Work Group Members:_____

Implementation Goal #1: Establishing Infrastructure for Technical Assistance and Data Systems

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	How will the success of the immediate-term objective be evaluated?	What are steps to achieve the immediate-term objective?	How is this immediate-term objective relevant to the long-term objective?	What is the time frame for achieving the immediate-term objective?
Establish Interagency State-wide Organizational Chart to Show Communication System	Organizational Chart	• Establish Workgroup • Draft of Organizational Chart • Gather Feedback From All Relevant Stakeholders	Creates the Communication and Feedback Systems Necessary for Achieving Goal	To Be Finalized in First Six Months (April, 2015)
Identify Facilitator of the Interagency State-wide Team	FTE Assigned to Facilitator Meeting Minutes	• Recruit Individual • Provide Mentoring to New Coordinator	Assigns a Person Who Will Schedule Meetings, Reserve Rooms, Send Communication, Address Logistics, etc.	To Be Finalized in First Six Months (April 2015)
Workgroup creates plan to address training for each of the agencies in first step implementation with timeline for steps involved	A document showing the timeline for implementation of technical assistance with be established and progress will be documented within the state's annual interagency evaluation report	• Timeline for Implementation Established: Aging Disabilities Mental Heal *Education Ombudsman • Timeline for Agencies Implementing Later: DEED Dept. of Corrections Dept. of Health Human Rights Courts	A System for Implementing positive supports is necessary to ensure organizations receive effective technical assistance (TA)	Timeline for Implementation Available With First Six Months (April 2015)

What Actions Are Needed to Meet This Goal?	How will the success of the immediate-term objective be evaluated?	What are steps to achieve the immediate-term objective?	How is this immediate-term objective relevant to the long-term objective?	What is the time frame for achieving the immediate-term objective?
Curriculum is developed for each agency	Curriculum and TA Systems Described as Training Manual Online at Designated Time for Each Agency Implementing	Each Agency That Begins Implementation Will 1. Form an Agency Oversight Team 2. The Team Will Assign an Agency-wide Coordinator 3. Team will meet regularly to establish training and data collection systems 4. Agency will report to Interagency state-wide team quarterly and provide annual summary of progress	Agency representation must be involved in the creation of the content to establish buy in, ensure content meets the need of the agency, and that professionals will be prepared to participate in training when it is implemented	Timeline will be dictated by when agencies start implementing
State and regional coaching systems will be established for the TA system	State-wide Team will document assessment and action plan for using state FTE to organize efforts – annual report will document decisions made State Coordinators, Regional Coaches, and Organization-wide (local) coaches roster will be available Meetings scheduled regularly for training and to monitor implementation	State Coordinators will be recruited based on timelines for agencies to start process State coordinators recruited for agencies starting as part of the legislative ask proposal Regional Coordinators recruited as part of the legislative ask proposal Organization-wide coaches will be recruited from organizations participating in	Coordinators and coaches are "positive nags" who ensure dates for meetings are set, agendas are ready, meeting minutes are sent, and data are being completed at local, regional, and state-wide levels These individuals communicate via the interagency state-wide communication system when problems are encountered or	Identification of State-wide Coordinators starting the TA: (April 2015) Regional Coaches: prior to legislative ask implementation (August, 2015) Coaches will be identified once implementation is organized (September,-October, 2015)

		legislative ask proposal Curriculum and training for coordinators and coaches will be prepared prior to the legislative ask implementation timeline	assistance is needed	
Workgroup meets with IT to ensure training is set up for local and regional decision making and that data are available for decision making	Meeting minutes indicating IT and workgroup are meeting Curriculum for all providers describing new incident reporting system	Webinars, website information, and local awareness presentations give to providers. Documentation of organizations who have received training within each agency area shows expansion of training across the state State requires all providers to complete simple online training explaining how to complete incident report and IT are available to support and answer questions	The accuracy of data collection is important to ensure information is accurate Organizations receiving additional TA in positive supports will learn how to collect additional data for decision making The goal is to show that TA is an effective way in which to decrease problem behavior, crises, etc.	

* School-wide PBS is already being implemented; SWPBS goals address expansion plan

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Agencies participating in TA process later are involved in curriculum and tool development DEED Dept. of Corrections Dept. of Health Human Rights Courts	Meeting minutes from state-wide and agency wide teams Agency workgroups formed to work on tasks Tools and curriculum available	As per plan described in immediate steps, agencies targeted to move forward will: • Establish an agency coordinator • Develop curriculum and training system • Work with regional coaches to recruit organizations to participate in TA	Training systems for moving forward systematically with agencies will ensure organizations receive what they need to be successful	October, 2015-October 2016
Infrastructure for interagency state will move from initial implementation to full implementation of TA systems	Org chart will be finalized Annual report will describe changes made to improve feedback and communication systems, data collection, etc.	State-wide team will meet with regional coaches, local coaches, and other stakeholders to share how systems can be improved Team will review surveys of satisfaction from participants in TA for organizations and Cohort training	The implementation process requires modifications and improvements to ensure effectiveness and sustainability	August, 2015-October, 2016 Annual Reports for each year
Curriculum for agencies starting the process will move from initial implementation to full operation	Meeting minutes from agency-wide team Curriculum Annual report will describe changes made	Agency-wide teams will meet regularly to discuss what worked well, what needs to be modified Team will review surveys of satisfaction from	The implementation process requires modifications and improvements to ensure effectiveness and sustainability	August, 2015-October, 2016 Annual Reports for each year

		participants		
Annual report and quarterly report systems will be move from initial formats to a more formalized system	State-wide team's meeting minutes Annual reports at different levels will be simple but include key updates • Agency-wide summary • State-wide summary • Regional summary • Organization-wide summary	State-wide team will meet with key participants to review the initial reporting system and make improvements based on feedback	Data summaries at different levels of the system are important for communication systems	Annual Reports for each year
Champions will be identified across the state from coach roles, cohort training, leadership, people receiving services, etc. These individuals will be recruited to assist in state-wide efforts	Number of stakeholders participating in state-wide planning processes Diversity of stakeholders participating in process Annual report will document progress in this area	Encourage individuals to assist in state-wide planning efforts Identify and recruit individuals during trainings, awareness presentations, webinars, local events, etc. Create incentives for champions to ensure there are positive outcomes associated with participation	Buy in and consensus will increase when individuals from different stakeholder groups are advocating, teaching, and sharing successes	October 16 should show significant listing of "champions" participating in state-wide planning in different ways (providing awareness trainings, attending meetings, testimonials and quotes, case studies, etc.)

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	How will the success of the long-term objective be evaluated?	What are steps to achieve the long-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Agencies show that organizations receiving TA have higher levels of positive support implementation, lower problem behaviors, and fewer restrictive interventions	**Outcome data that include:** Organization-wide Data • Fidelity of implementation • Incident reports • Restrictive interventions • Emergency room visits • Acute care events • Staff attrition, injury • Workers comp **Individual Plan Data** • Fidelity of Implementation • Baseline intervention data showing decreases in problem behavior, increases in positive social behavior • Quality of life data • Goodness of fit (how plan fits family, caregivers) **Qualitative Data** • Focus Groups • Interviews • Surveys **Pre-post Conceptual Knowledge** • Staff in organizations participate in survey before and after TA is	• Implementation of training for TA in positive supports, • Training for all providers in collecting effective incident report form data • IT systems are in place to gather and report data at local, regional, agency, and state-wide levels	This long-term objective will show that the state's efforts to provide training and support has been effective	Annual report of progress August 15, 2015 (first organizations participating in TA) August 15, 2016 (evaluation data for organizations in first training efforts) August 15, 2017 (evaluation data for first organizations and organizations starting in next implementation year)

	provided • Regional teams ask all organizations in catchment area to complete survey (organizations not yet participating) with incentive			
State-wide infrastructure moves from full operation to innovation with examples of improvements and changes made based on mature implementation efforts	Qualitative review of meeting minutes, focus group and interviews with key participants, Review Annual report -- describe changes made to improve feedback and communication systems, data collection, etc.	Data workgroup summarizes results of qualitative efforts to evaluate effectiveness of infrastructure Data workgroup presents information via the interagency state-wide team for discussion Quantitative and qualitative data are used to create new and innovative changes to systems	Moving to innovation stages of implementation requires data-based decision making	Annually 2016, 2017, 2018
Expansion of leaders and champions in the system lead to larger impact level changes across the state	Qualitative and Quantitative data will show that the numbers of people receiving support is growing faster compared to previous years as measured by • Aggregate data on individual plans • Organizations reporting data • Champions available to assist the state • State-wide incident report and data overall	State-wide interagency team uses workgroups to • Evaluate progress over time • Create incentives for people interested in becoming champions • Establish a tracking system to monitor evidence of expansion	State will reach a "critical mass" when there the number of people who implement positive supports will market the implementation efforts beyond the state-wide team's efforts	Evidence is available within the 2018-2019 annual report

Work Group Name: Design Qualitative and Quantitative Systems for State-wide Data-based Decision Making

Date: _____ Committee/Work Group Members_____

Implementation Goal #2: Design Qualitative and Quantitative Systems for State-wide Data-based Decision Making

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	How will the success of the immediate-term objective be evaluated?	What are steps to achieve the immediate-term objective?	How is this immediate-term objective relevant to the long-term objective?	What is the time frame for achieving the immediate-term objective?
Incident report system collect key data used for local, regional, agency, and state decision making—List of key data included in recording will be clearly outlined	New system is beta tested with participants indicating successful data collection via simple survey and report	Create templates for incident report forms and plan for beta test implemented Feedback from beta test used for last edits Plans to analyze local, regional, and state-wide data are in draft including how regional and local coaches will access the data regularly	Data will be a key outcome for state-wide planning	
Data workgroup will work with the infrastructure workgroup to ensure that training systems are in place for providers who will use the incident reporting system	Meeting minutes Documented plan for training Curriculum	Infrastructure and data workgroups will meet to outline training curriculum and system	Accurate data collection will be essential for state-wide planning	
Tools for fidelity of implementation at the organization-wide and individual level are in draft for first participating agencies	Fidelity documents are available for first participating organizations	Representatives from first participating organizations learn how MN SW data are collected at state-wide meeting	It is important to show that positive supports are actually being implemented	June, 2015

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Workgroup will provide a list of data that will be collected via local, regional, agency, and state-wide levels for first step agencies	Document listing all data not included in incident report that will be part of the decision making process – this will be completed in collaboration with the infrastructure workgroup	Infrastructure and data workgroups will meet to outline the key data collection procedures	An important key to success will be the training systems for providers to ensure accurate data	
Plan for qualitative data collection is in place	Documented plan is available describing how data will be gathered, analyzed, and used	Workgroup identifies key professionals who will gather data State team identifies all qualitative data already being collected Plan is written describing how different sources of qualitative information will be used	Qualitative data will provide rich information about how the state-wide planning is impacting the lives of people receiving services and providers	August 2015

* School-wide PBS is already being implemented; SWPBS goals address expansion plan

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Tools for fidelity of implementation at the organization-wide and individual level are in draft for agencies expanding later in the timeline	Fidelity documents are available for participating organizations expanding later in timeline	Representatives from participating organizations learn how MN SWPBS data are collected at state-wide meeting Agency team meets regularly to establish data that will be used to evaluate organizational and individual planning progress Tool will be created in draft form and circulated to gather feedback	It is important to show that positive supports are actually being implemented	August, 2016
Summaries of incident report data are available for annual report purposes a the local, regional, agency, and state levels	Annual report will include data at each level	Infrastructure workgroup and data workgroup will ensure data are gathered and reported for report	Content and IT professionals are needed to create the most effective summaries of data	August 2016
Qualitative workgroup team analyzes first year of data and provides a summary for the annual report	Qualitative transcripts analyzed, themes established, and summary of results are included in annual report	From August 2015-April, 15, 2015 data collection occurs, transcribing completed, and themes identified April, 2015-August, 2016 Written summary organized and presented to state-wide team for report	Quotes and stories that can be used for marketing, awareness, etc will come from this type of evaluation Information about changes in quality of life for people receiving services and providers will be available in descriptive form	September, 2016

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Pre-post conceptual knowledge about positive supports will be conducted prior to organizations participating in TA and a plan for systematically surveying organizations not yet started will be in place	Survey data gathered August-September, 2015 and again during August-September, 2016 will be available for review	Workgroup will work with infrastructure workgroup to establish survey draft Survey will be shared with key content professionals across the state and nationally A system for gathering data from participating organizations and nonparticipating organizations will be approved by the state-wide team Data will be gathered and analyzed for annual report	Pre post data provides some evidence that the TA process is contributing to increased awareness and knowledge of key positive support terms	August-September, 2015 August-September, 2016 Annual Report for 2016-2017
State-wide team provides evidence that efforts to implement TA after first year of implementation outlining in detail successful pilot/exemplary implementation sites	Case studies of pilot/exemplary case examples of implementation based on TA support for marketing purposes	Data workgroup and marketing workgroup will use the case studies gathered for awareness trainings, newsletters, website, etc.	The goal is to show how data can be used to celebrate and reinforce people; Marketing by stakeholders to stakeholders is more effective than by state or university professionals alone	

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
State-wide team provides evidence that efforts to implement TA on a wide-scale basis is effective in decreasing problem behavior, incident reports, emergency room visits, acute care stays, restrictive procedures, etc.	Interagency Annual report data Interagency Annual Report for 2017-2018 Interagency Annual Report for 2018-2019	Data are gathered from infrastructure system at the local level; Regional coordinators summarize data and share with agency teams; Agency teams share progress across regions with state-wide team State-wide team will review the MN SWPBS annual report and discuss as a first step discussion for agency-level reporting Responsibility for gathering and summarizing data occurs at each level of the system: • Local Coach • Regional Coordinator • Agency Coordinator • State-wide Coordinator State-wide coordinator works with interagency team to design and finalize interagency report format	Creating a system for summarizing data allows for a distribution of work related to preparing the final report	First Draft of an Interagency Report occurs September, 2016 September 2017 September, 2018

What Actions Are Needed to Meet This Goal?	How will the success of the long-term objective be evaluated?	What are steps to achieve the long-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Qualitative evaluation data show that people receiving services, family members, and provider lives are improving over time	Annual report – section dedicated to qualitative analysis	Qualitative team provides summary of progress each year; Changes in themes are captured as implementation occurs over time across regions Team reports if any changes are occurring in organizations that have implemented positive supports over 2-3 years	Perspectives of stakeholders are an important consideration in state-wide evaluation	August 2017 Annual Report August 2018 Annual Report August 2019 Annual Report
Pre-post conceptual knowledge about positive supports will show that organizations not yet participating in intensive training is showing increases in key terms via simple awareness and marketing (comparison with outcomes from prior years with nonparticipating organizations---but also showing slightly lower scores compared to organizations participating in intensive training)	Survey data gathered August-September, 2017 and again during August-September, 2018 will be available for review for organizations in later expansion Survey data will continue to be gathered for agencies expanding number of organizations participating August-September, 2017 and again during August-September, 2018	Workgroup will work with infrastructure workgroup to establish survey draft for agencies in later expansion Survey will be shared with key content professionals across the state and nationally A system for gathering data from participating organizations and nonparticipating organizations will be approved by the state-wide team Data will be gathered and analyzed for annual report	Pre post data provides some evidence that the TA process is contributing to increased awareness and knowledge of key positive support terms	August-September, 2017 August-September, 2018 August – September, 2019 Annual Report for 2017-2018 Annual Report for 2018-2019

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Cost Benefit Analysis Evaluation is conducted to evaluate: Costs of TA, costs related to crises (state costs) Decreases in Costs related to Problem behavior at the organizational level (workers comp, staff attrition	Annual report for 201- 1019	Recruit professional who can consult with state on cost effectiveness/cost benefit related issues Create a plan to evaluate costs involved in training and gather data related to costs incurred by state and by organizations related to problem behavior	It is important to evaluate the costs involved in large-scale implementation efforts and to establish sustainable and affordable strategies while maintaining prevention-focused state-wide planning	August, 2018

Work Group Name: Establishing a Marketing Plan to Increase Awareness of Positive Supports

Date: _____ Committee/Work Group Members: _____

Implementation Goal #3: Establish a Marketing Plan to Increase Awareness of Positive Supports

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Create a plan for marketing positive supports strategies across the state	Document summarized for annual report documenting plan for expanding awareness	Create a list of stakeholders that will be targeted for marketing purposes Establish timeline for posting website; Identify a team representing the TA efforts, cohort training, IT, etc.	It is important to make sure people know how to access information and join training and TA efforts	May, 2015

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Share state-wide plan with representative stakeholders across the state via onsite meetings and webinars; use feedback to modify and improve plan for final formalized document	Feedback documentation; evidence of modifications made to plan	Meet with interagency team to present recommendations from the workgroup that includes: • Number of webinars • Placement of state-wide plan on public website for access • Number of presentations • Locations of onsite presentations	It is important to increase awareness of the state-wide plan, and to build buy in and consensus by the direct involvement of stakeholders; this process may help to identify possible champions and participants	To Be Finalized in First Six Months (April, 2015)
Create a website that will be used as an entry point for awareness, a place to learn more about data collection, and the site of all training materials including: • Awareness • Skill building materials • Cohort training in PBS, PC thinking/PCP, Trauma informed thinking/Therapy, positive psychology, etc.) • Trainer/Champion Level (How to become a trainer in positive supports)	Website Pages Launched Website Stats	Create a first draft of the website Identify an easy to remember URL Find a website stats program to monitor visitors, unique visitors, downloads, etc. Create a password system to allow for champion/leader communication systems Pilot website and gather feedback via online survey Launch fully functional website in time for TA from legislative		May, 2015

		ask		
What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Monitor Website Statistics, Awareness trainings, cohort trainings, etc. and provide annual summaries of progress	Quarterly and Annual Website Data Reports	Work with Data team to set up website statistics and set up quarterly access to data Review data in workgroup meetings and at interagency state-wide meeting once a year	Website statistics are used to increase awareness and usage over time	August 15, 2015-August 15, 2016 August 2016-August, 2017 August 2018-August 2019
Market awareness materials to agencies involved in later expansion	Presentation materials and dates of events Documentation of awareness materials	Establish plan and timeline Recruit individuals to participate in tool development with infrastructure and data workgroups	It is important to prepare stakeholders and increase awareness--- this helps with later recruitment and increases buy in	August, 2016
Create newsletters, brochures, and other materials for expanding awareness; Use case studies, quotes, and other information from TA efforts and qualitative evaluation	Presentation materials and dates of events Documentation of awareness materials	Establish actions dedicated to expanding awareness of positive supports to DEED Dept. of Corrections Dept. of Health Human Rights Courts	Increase awareness of positive supports and how to participate in training opportunities	First plan by April, 2015 Annually each year
The workgroup will use state-wide plan to submit petition to the Association for PBS to become a network; Five APBS members are needed in this first petition	Petition documentation Email confirmation from APBS	Obtain petition documentation Finalize state-wide planning document (logic model, annual report document, action plan tool example) Identify lead network person and submit petition	Becoming an APBS network provides the state with access to other state networks interested in sharing resources	January, 2015

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Create main sections of website to meet the needs of state-wide planning including: • Entry to training materials (Organization-wide positive supports, person-centered thinking, person-centered planning, trauma informed care, etc.) • Resources for stakeholder groups • Awareneness materials • Information about state-wide planning • Communication site for implementers • Place for Champions to access information • Reinforcement for • Evaluation data summaries	Online surveys evaluating site, feedback from agency-wide teams, feedback from professionals participating in training events, website statistics	Agency-wide planning teams work with the marketing workgroup to place content related to positive practices and to ensure pages address context	Information for marketing, easy to located training materials, and communication are key contributions of the website	**August 15, 2015**
Ensure events are scheduled that allow individuals to share implementation success and for the state to recognize exemplary practice (award ceremonies, certificates of completed trainings, etc.)	Conference evaluation surveys, number of individuals in attendance	Assess the events already scheduled that could be reorganized to address reinforcement, sharing of positive supports, etc.	Stakeholders will be more likely to implement new practices when their colleagues are recommending it; Buy in increases when leadership occurs from implementation levels	Annually starting in 2016 (Date to be identified in a manner that meets the needs of interagency stakeholders)

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Materials developed for marketing purposes become a part of every presentation, webinar, training, and event (e.g. postcards, business cards, newsletters, case study stories, etc.)	Materials available in marketing portfolio both in hard copy and online	Workgroup uses marketing plan to create timeline for creating materials for distribution and infrastructure workgroup assists by distributing within training and TA Evaluation of marketing materials occurs annually to ensure all agencies are represented starting with first step agencies Workgroup places all marketing materials in a portfolio that can be used by all state professionals Agency-wide teams review portfolio and makes recommendations to improve representation of all stakeholders	Representation of case studies and information must reach all stakeholders using context, language, and stories that fit unique people served	Portfolio created by April, 2016 Evaluation of portfolio annually starting in 2016

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Qualitative and Quantitative Data indicate that stakeholders know what positive supports are and how to receive assistances	Evidence: pre post conceptual knowledge, qualitative evaluation, number of people impacted via presentation, google search shows MN-PBS website in first 10 links, website stats show visitors from MN increase every year, etc.	Collaborates with state-wide team to make sure that evidence evaluating marketing plan is in place	The first step in systems change is awareness of a new practice	August, 2017 Annual Report August 2018 Annual Report
Awareness presentations are given across the state by MN Champions (individuals trained and recruited to assist in implementation)	Number of presentations, types of trainings, or other interactions with stakeholders implemented by individuals who are not part of initial training and TA	Work with state-wide team to ensure that a plan for tracking volunteer behavior is in place Incentive system is established to encourage individuals across the state to assist in marketing, presentations, and training Infrastructure workgroup trains champions to complete task they volunteer to complete	The implementation of positive supports will occur when stakeholders are advocating for its use	August, 2017 Annual Report August 2018 Annual Report
Website stats show that the state's website is known both within the state and nationally as an important interagency resource	Evidence of prominence includes visitors, unique visitors, downloads, visits from the state,	Promote website in all trainings and presentations (in and out of state)	It is important to create a site that is easy to find when people need assistance, that	August, 2017 Annual Report August 2018 Annual Report

	visits from other states/countries (indirect evidence of strong content), types of google search strings used, MN website shows up using regular search engines like google in first 10 links offered	Create brochures, flyers, etc. Recognize exemplary implementers in case studies Work with IT to ensure website can be found on search engines	offers problem solving ideas, assists MN providers in reaching out to others, and creates a place where individuals know they can access best practice training materials	

Work Group Name: Design Comprehensive Preservice and Inservice Training Systems for Three-tiered Positive Support

Date: _____ Committee/Work Group Members:_____

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Implementation Goal #4: Design Comprensive Preservice and Inservice Training Systems for Three-tiered Positive Support

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Evaluate the extent to which the state can influence policy and supervisory systems to encourage universities to include specific training resources for preservice purposes (legislative requirements for education, clinical supervision, continuing education, etc.	Annual report, 2016 and annually thereafter will include section that addresses the expansion of preservice training in positive supports	Make a list of the universities and colleges in MN already providing positive supports education at bachelors and masters level Prioritize types of departments that workgroup will start contacting Use list of state-level actions to begin communicating with universities and colleges in the prioritized list	Professionals need to be prepared to implement positive supports and need to be exposed to practicum and supervisory experiences that will prepare them for success	Initial discussion, assessment, and prioritization occurs by March, 2015 Annual report 2016 summarized first actions taken and evaluates effectiveness

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Workgroup assesses all training materials related to inservice training across agencies and creates a summary of content-plan for comprehensive cross-agency inservice training systems is established (e.g. SWPBS, trauma informed care, cognitive behavior therapy, person-centered planning, cohort PBS training, etc.)	Section of annual report includes details regarding training materials and systems related to positive supports and where this training can be accessed	State-wide team discusses how to move forward with assessment process (e.g. SWPBS team presents training and evaluation tools, mental health presents information on trauma informed care, etc.) Workgroup organizes inventory of training materials and provides a way that individuals can access these materials	It can be helpful for professionals involved in implementation to gain access to the training materials used by, for instance, SWPBS teams to make comparisons and learn more about systems used to monitor progress	August, 2015

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Changes in state expectations leads to examples of policies and supervisory systems that are adapted and evidence that universities and colleges have responded will be provided	Policy documentation Meeting minutes and documented conversations Number of universities impacted	Based on initial assessment, state professionals change policies related to preparing professionals in different service areas—starting with content related to prioritized departments Work with one or two universities to establish new clinical supervision systems Evaluate the effectiveness of these efforts	Preparing individuals to provide effective services is a proactive strategy for changing behavior	Annual report 2016
Create short online introduction to the state's implementation of positive supports that can be included in introductory classes	Online training documentation	Based on conversations with universities and colleges, create a simple online training that can be included as an activity in a class that introduces students to education, psychology, special education, etc.	Awareness of positive supports must start in different ways including with the university professional	Online module available by summer, 2017

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Map out curriculum needed for preservice and inservice related to positive supports across the three-tiered model with curriculum that addresses • Universal prevention (wellness, person-centered strategies, data based decision making) • Secondary prevention (group interventions for social skills, counseling, communication) • Tertiary prevention (individualized behavioral support, cognitive behavior therapy, etc.)	Annual report, 2016 includes an inventory of training systems and curriculum addressing three tiers and plans for adding curriculum that may not be available (for instance, secondary prevention group instruction in sexuality education, friendship building, etc.)	Work with agency leads to establish initial inventory of training systems and materials Present to state-wide team and discuss need for curriculum to be developed Create a plan for continuing to build on curriculum and to add into infrastructure training	The infrastructure workgroup needs assistance in developing resources that can be used by organizations implementing positive supports	Inventory included in Annual Report 2016
Map out curriculum need for preservice and inservice training related to levels of intensity needed in positive supports training including: Awareness Skill building in positive supports Facilitation of positive supports Trainer-level preparing facilitators	Annual report, 2016 includes an inventory of levels of training intensity in positive supports	Work with infrastructure and marketing workgroups and agency leads to establish initial inventory of training systems and materials Present to state-wide team and discuss need for curriculum to be developed Create a plan for continuing to build on curriculum and to add into infrastructure	Although awareness level training materials have been targeted within the marketing workgroup, a comprehensive assessment will be helpful outlining the types of training material by level of intensity across positive supports (for instance, trauma informed	Inventory included in Annual Report 2016

		training	therapy vs. trauma informed thinking)	

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
State positions include application and hiring procedures that require individuals to have experience in positive supports	Documentation of state application, hiring, and related documents	Agency-wide teams take the lead by creating policy and documentation indicating all state positions strongly prefer professionals who have received training in positive supports in preservice or inservice settings	State professionals who are already aware of positive supports are better able to support implementation	2017 Annual Report includes progress made in this area
Curriculum is in place across three prevention tiers and across levels of intensity for positive supports; website provides a way in which individuals can learn more about accessing these layers of curriculum	Annual report 2017 described final steps in initial curriculum development Website describes layers of curriculum to individuals interested; access to training materials is available via the website	State-wide team works through immediate and intermediate steps to finalize this goal Workgroups responsible continue to refine and innovate curriculum over time	Data are used to improve training systems each year and website provides transparent and easy access to training for systems change purposes	2018 Annual Report
Departments in prioritized list across universities are providing preservice training and working with state professionals to prepare individuals for implementing positive supports	Annual report 2018 provides list of accomplishments including universities and departments that responded to requests Policy describing changes in personnel preparation via bachelor's degree,	State-wide team works through immediate and intermediate steps to finalize this goal State finalized documentation necessary to support changes in policy	Policy level changes helps to ensure sustainable practice	2018 Annual Report 2019 Annual Report

	master's degree, continuing education, and clinical supervision and practicum experiences to align with need for training in positive supports			

Committee/Work Group Name: Create and Maintain an Inventory of Policies

Date: _____ Committee/Work Group Members: _____

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Implementation Goal #5: Create and Maintain an Inventory of Policies

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
An inventory of policies across agencies related to restrictive practices and positive supports is conducted	Documentation (inventory)	Create excel file Send out online survey to gather information	The state is reviewing consistency of policies across agencies to improve practices	October 22, 2014
Team analyzes inventory and identifies strengths and areas of need	Annual report 2014 including summary of strengths, needs, and actions taken	State-wide team members review inventory and creates a summary to be shared with state-wide team	The analysis assists the state in moving forward with consistency and best practice	October 22, 2014
Inventory is placed on Sharepoint internally within the state for initial sharing of information	Sharepoint contains information	DHS will take the lead in posting materials	Transparency and communication is important in the state-wide planning process	November, 2014
A list of common terms that will be evaluated to ensure information is consistent across agencies	Documentation for annual report, 2015	Team is listing common terms based on overall inventory	Communication and consistency is an important goal in state-wide planning	October, 22, 2014

What Actions Are Needed to Meet This Goal?	How will the success of the immediate-term objective be evaluated?	What are steps to achieve the immediate-term objective?	How is this immediate-term objective relevant to the long-term objective?	What is the time frame for achieving the immediate-term objective?
A grid with definitions occurring across agencies for the common terms will be established	For October 22, 2014 report	Terms are gathered across agencies along with the inventory of policies	First steps in establishing common definitions is to assess similarities	October, 22, 2014
Action plan for continuing to link definitions to incident reporting system for data-based decision making is in place	For October 22, 2014 report	Definitions to increase commonality across specific terms (e.g. restraint, crisis, etc.) will be presented across stakeholder groups, placed online for common via online survey, and modified based on definitions that fit across agencies	Communication and consistency is an important goal in state-wide planning	October, 22, 2014 through July, 2015 as incident report system is finalized

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Inventory of terms are placed on the MN PBS website for all stakeholders	Website Documentation	Work with marketing workgroup to establish website Place content in section that is easy to access Monitor access to inventory via downloads	Communication and consistency is an important goal in state-wide planning	August 2015

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Training materials and incident report form information is available on MN PBS website	Website Documentation	Work with marketing workgroup to establish website Place content in section that is easy to access Monitor access to inventory via downloads	Communication and consistency is an important goal in state-wide planning	August 2015
Once inventory is stable and definitions confirmed with stakeholders, the state-wide team will organize a webinar and invite APBS network members from other states to participate in discussion	Webinar materials for presentation	Establish lead presenter Set up logistics (date, platform for sharing materials, etc.) Invite individuals using the apbs.org members site to identify individuals who may be interested	Sharing information with others may provide new ideas and ways to proceed forward	October, 2015

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	How will the success of the long-term objective be evaluated?	What are steps to achieve the long-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Inventory is refined and maintained online over time reflecting evolution of MN Positive Supports	Meeting minutes Inventory documentation Annual reports	State-wide team adds inventory to agenda each year and reviews whether changes are necessary	State-wide planning will move from initial implementation to innovation over time	Updates to inventory reported in Annual Reports 2016-2019
Definitions are reviewed and modifications made to data systems	Meeting minutes Grid with definitions	State-wide team adds inventory to agenda each year and reviews whether changes are necessary	State-wide planning will move from initial implementation to innovation over time	Updates to inventory reported in Annual Reports 2016-2019

Committee/Work Group Name: Establish an Interagency Crisis Management Team to Monitor and Support Individuals Needing Intensive Plans

Date: _____ Committee/Work Group Members: _____

Implementation Goal #6: Establish an Interagency Crisis Management Team to Monitor and Support People Needing Intensive Plans

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Form an interagency crisis prevention team	Meeting minutes List of participants for public meeting List of sub team members to monitor people regularly	State-wide team makes a list of crisis systems teams, and state professionals; Other related stakeholders are invited (people receiving services, advocates, etc.) Part of meeting is public (2x a year for larger discussions) State sub team members will identify specific people who engage in serious problem behavior and have experienced multiple "crises"	Crisis prevention is part of Tier 3 services provided by the state	November, 2014
Identify an initial small number of people to follow and monitor progress Establish whether individualized plans are in place to support individual	Meeting minutes	Use information about a small group of people needing more intensive supports to: • Streamline communication across agencies • Improve flexibility of services for people • Establish	Providing a way to monitor people with a history of experiencing crisis can provide important information that is used to improve services	November, 2014

		strategies for improving positive supports • Brainstorm ways to increase behavioral expertise and supports		
Explore national crisis models and identify ways to improve outcomes and increase behavioral expertise for crises	Presentations by invited professionals	Invite presenters representing major crisis management systems	Learning about best practice in crisis management systems provides new information as new systems are reported over time	January, 2015 through July, 2015

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Outline lessons learned by crisis prevention team and create a report that outlines policies and procedures to improve crisis prevention	Annual report includes section on crisis prevention planning	Use information gathered from public discussions and private progress monitoring to make recommendations Workgroup shares recommendations with state-wide team Policies and procedural suggestions are made formally to state system	The crisis workgroup will provide details necessary to consider innovative strategies for prevention	Annual report 2015

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Create a plan to provide incentives to exemplary organizations who choose to work with people who have a history of challenging behavior since these systems are better able to prevent challenging behavior	Annual report provides this information based on workgroup recommendations	Crisis workgroup continues gathering information from public group and progress monitoring Recommendations are proposed to the state-wide team Information is shared via a proposal for new policy and supports	Use growing evidence and data from implementation to show why policies are needed	Annual report 2015 Policy documents 2016

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	How will the success of the long-term objective be evaluated?	What are steps to achieve the long-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
New policies and procedures are approved and legislative support in place to improve crisis prevention system	Policies and procedures approved Evidence of legislative proposals	Workgroup completes immediate and intermediate actions to accomplish this task	New ideas driven by workgroup experience improves interagency communication and service provision	Annual report 2016 and 2017 describes progress made
Data from state-wide planning show that organizations receiving TA have lower numbers of crises over time compared with organizations that have not yet started implementing	Data from local, regional, agency-wide and state-wide reports	Work with state-wide team to monitor data related to crises, injury, emergency room visits, acute care stays, etc. via the crisis management workgroup	Using data for decision making should occur at all levels of state-wide planning	Annual reports 2017, 2018, 2019 highlights evidence regarding long term implementation of positive supports
Incentives are in place for exemplary organizations to manage more	Policy documents finalized and approved	Plan for sharing information via organizations participating in	Transition planning occurs for people who are not well	Annual reports 2017, 2018

challenging cases since these systems are better able to support people with challenging behavior		TA Place information on the website Workgroup identifies people who would excel in certain conditions and assists in transition planning	suited for current living situations Organizations serving individuals choose to participate in TA training in order to improve services for individual the group is monitoring	

MINNESOTA MDH DEPARTMENT OF HEALTH Oral Health Program

The Status of Oral Health in Minnesota

September 2013

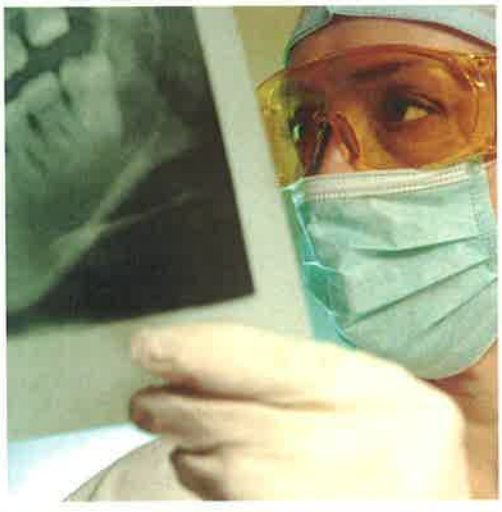

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Table of Contents

Executive Summary

Oral health is integral to overall health. The mouth not only reveals signs of poor nutrition and diseases such as infections, immune disorders, injuries, and certain cancers, but research has shown associations between chronic oral infections and heart and lung diseases, stroke, low-birth-weight, premature births, as well as diabetes. Among the top risk factors for oral disease are high-sugar beverages and foods, which also contribute to obesity, along with tobacco and alcohol. There are several ways in which people suffer from pain and discomfort because of poor oral health: tooth decay; oral and craniofacial diseases; gum disease; cleft lip and palate; oral and facial pain syndromes; traumatic injury; and oral and pharyngeal (mouth and throat) cancers. Tragically, untreated oral disease can also lead to death. Yet many of these conditions and diseases are preventable.

In 2000, Surgeon General David Satcher released Oral Health in America: A Report of the Surgeon General.[1] The report found a low awareness of oral health among the public, a significant disparity between racial and socioeconomic groups in regard to oral health, and ensuing overall health issues. Since then several steps have been taken to promote access to oral health care for all, especially the disadvantaged, minority and at risk children.

In April 2009, the Institute of Medicine (IOM) through their publication 'Advancing Oral Health in America: Publication of the Committee on an Oral Health Initiative[2] recognized that factors such as settings of care, workforce, financing, quality assessment, access, education and stakeholders in private and public sector, influence oral health and the entire health care system. To provide a foundation for sustainability and to set measureable goals and objectives for the initiative, benchmarks were set in the form of Healthy People 2020 indicators.

While Minnesotans in general enjoy a high level of oral health, there is room for improvement, especially among underserved populations who bear the brunt of oral diseases. Significant disparities exist for low-income children and adults, people of color, and the elderly, all of whom disproportionally suffer from oral diseases due to inadequate access to affordable dental care.

This report presents the updated information on oral disease morbidity and mortality (oral and pharyngeal cancer), identifies risk factors and high risk groups, reports on preventive strategies such as dental sealants and community water fluoridation, and offers insight into dental care access and workforce supply and distribution. Based on available data, state and national data are compared with the Healthy People 2020 objectives.

Even though dental caries (tooth decay) is nearly 100 percent preventable, it is the most common chronic childhood disease and is five times more common than asthma[1]. According to Minnesota Basic Screening Survey (BSS) 2010, 55% of third graders in Minnesota experienced dental decay compared to 53% of children 6 to 8 years in the nation (National Health and Nutrition Examination Survey (NHANES) 1999-2004). The survey also found 18% of third graders with untreated cavities compared to 29% in the nation (NHANES 1999-2004). Low-income and children of color bear the greatest burden of oral diseases and conditions when compared to

their more affluent and white peers. BSS showed that caries experience and untreated caries rise as income declines: the poorest children (schools with >75% of children on Free and Reduced Lunch) were almost twice as likely to experience tooth decay and almost three times more likely to have their tooth decay go untreated than students in more affluent schools. And, children of color were 12 percent more likely to experience caries and 7 percent more likely to have untreated caries when compared to white children.

Behavioral Risk Factor Surveillance System (BRFSS) data for 2010 shows that poorest Minnesota adults with income $15,000 or less per year, were three times less likely to visit a dentist in the past year than adults making $50,000 or more. Among the elderly, a person without a high school degree was 10 times more likely to have all their teeth extracted than someone with a college degree. Between 2004 and 2010, older Minnesotans who had any permanent teeth extracted declined slightly from 36 to 33 percent as national trends remained stagnant at 44 percent. While these downward trends are encouraging, with virtually no Medicare dental benefits for older adults in the state, it is less likely that this population will seek oral health care and will eventually compromise their quality of life and health.

According to Centers for Medicaid and Medicare Services (CMS), in 2009, the national dental services expenditure was $102.2 billion with 42 percent of that amount spent on out-of-pocket payments. The evidence also suggests that dental services offered through CMS are continuously underutilized by low-income children and their families. In Federal Fiscal Year (FFY) 2011, of the 453,502 eligible Early Periodic Screening Diagnostic and Treatment (EPSDT) children in Minnesota, majority (59 percent) did not receive dental services. On the flip side, a 6 percent increase in children 21 years and younger eligible for Medicaid from FFY2010 to FFY2011 was noted; it is anticipated that this number will increase once the Affordable Care Act is fully enacted by 2014.

Trends indicate that issues related to accessibility and affordability have led people to seek care in emergency departments and hospitals adding to the overall cost to health care. From 2008 to 2010, cost for hospital-treated "non-traumatic" conditions that could have been treated by a dentist, rose by 9 percent with the cost totaling $148 million. Four times more people sought treatment for non-traumatic oral emergencies at hospitals as compared to those seeking treatment for traumatic conditions. From 2007 to 2010, just over a third (37 percent) of patients visiting emergency departments with traumatic conditions were from rural areas. Significantly, people who sought treatment from a hospital for non-traumatic oral emergencies were four times more likely to be admitted to the hospital than those seeking treatment for oral trauma conditions. This may be attributable to dental conditions that could have been treated by a dentist early on having evolved into more complicated and costly ailments that needed hospitalization.

Highlights: Minnesota Oral Health

Children

- 55% of 3rd graders experienced dental decay (caries experience) (2010)
- 18% of 3rd graders have untreated cavities (2010)
- Children of color are 12% more likely to experience caries and 7% more likely to have untreated caries as compared to white children (2010)
- Minnesota's 64% school-based sealant rate far exceeds the national average of 32% (2010)
- 59% children with Medicaid coverage did not receive any dental services by or under the supervision of a dentist during FFY2011.
- 403 cases out of 361,109 births or 1 in 1,000 births had an oro-facial defect such as clefting (2005-2009)

Adults and the Elderly

- 79% of adults 18 years and older reported visiting a dentist or dental clinic within the past year (2010)
- The poorest adults (<$15K) were 3 times less likely than their most affluent peers ($50K+>) to visit a dentist in the past year (2010)

Adults and the Elderly

- Natural teeth extractions fell by 50% for older adults as compared to the national 36% drop in rate (1999-2010)
- An older person without a high school degree was 10 times (nationally and 7 times locally) more likely to have all their teeth extracted than one with a college degree (1999-2010)

Cancer of the Oral Cavity and Pharynx

- Minnesota incidence rate is 11.4/100,000 population for oral and pharyngeal cancers compared to 10.9/100,000 nationally (2005-2009)
- Minnesota mortality rate for oral and pharyngeal cancers is 2.0/100,000 population compared to 2.5/100,000 nationally (2004-2008)
- Oral and pharyngeal cancer is highest (23%) among Minnesota's American Indian men living on or near Indian reservations (2004 and 2008)

Community Water Fluoridation

- 78% of Minnesotans receive fluoridated water compared to 64% of people across the nation (2010)
- Almost all Minnesotans have access to fluoridated water through the public water system (2010)

Dental Workforce

- 47% of dentists are 55 years or older (2009-2010)
- Of the 3,908 dentists who renewed their Minnesota license, only 26% were practicing in rural areas (2010)
- Just over half (53%) of practicing dentists submitted at least one dental claim for patients on public programs to the Minnesota Department of Human Services (2010)
- In 2009, Minnesota signed into law two new types of "mid-level" dental providers: dental therapist and advanced dental therapist
- Only 7% of dentists and 6% of hygienists work with a "collaborative agreement" (2009-2010)
- Only 23% of dentists are female (2010)
- Only 6% of dentists are people of color (African American, Native American, Asian or multiracial); 2% are Hispanic (2010)
- As of March 2013, there are 25 licensed Dental Therapist in the state. Out of these 25, 16 are practicing and all of them have established at least one Collaborative Management Agreement

Chapter 1: Introduction and Background

According to the first Surgeon General's Report on Oral Health in 2000, the health of the mouth and surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being[3,4]. Over the past 50 years, significant improvement in the oral health of Americans is a public health success story. Most of the gains are a result of effective disease prevention and treatment efforts. Community water fluoridation is one of the major successes of the twentieth century and seven out of ten Americans enjoy the benefit of receiving fluoridated water through public water systems.

There are several ways in which oral health can be compromised. Oral and craniofacial diseases and conditions include dental caries (tooth decay), periodontal (gum) diseases, cleft lip and palate, oral and facial pain, traumatic lesions, and oral and pharyngeal (mouth and throat) cancers. In Minnesota, although a large portion of the population enjoys a high level of oral health, there are segments of the population that bear an uneven burden of oral disease. Studies show that access to adequate health care, and dental care in particular, is affected by education level, income, race, and ethnicity.

To address the pressing oral health issues in the state, the Minnesota Department of Health (MDH) received funding from the Centers for Disease Control and Prevention (CDC) and the Health Services and Resources Administration (HRSA) to develop capacity and infrastructure for oral health in the state. Since its inception in 2008, Oral Health Program (OHP) has made tremendous progress by developing the first State Oral Health Plan (OHP), a blueprint for reducing the prevalence of oral disease. The OHP also conducted the first open-mouth screening (Basic Screening Survey) of Minnesota third grade children, developed communications via the oral health website, increased activities with policy and compliance, and enhanced collaborations with programs and departments including Health Promotion and Chronic Disease Division (HPCD), Center for Health Promotion (CHP), Drinking Water Protection, Maternal and Child Health (MCH), tobacco control, Minnesota Obesity Project and Department of Education.

In 2009, to promote oral health and improve the dental care delivery system for underserved populations, then Minnesota Governor, Tim Pawlenty signed a bill into law creating new dental professionals called Dental Therapists (DT) and Advanced Dental Therapists (ADT). These new providers are now working under direct/indirect supervision of a dentist through a collaborative management agreement and are part of the dental teams. Minnesota is the first state after Alaska to work with this new type of dental workforce to reduce oral health disparities.

Purpose, Use and Target Audience of Burden of Oral Disease Document

The purpose of the 'Burden of Oral Disease' document is to raise awareness of the need to monitor burden of oral disease in populations, to guide efforts to prevent and treat oral diseases to enhance quality of life of Minnesotans. Data comparisons on national, state and

'Healthy People 2020' objectives are being made on several indicators depending on the availability of the information.

This document can be used to provide information for decision making, policy development and implementation of preventive strategies to address oral health needs of vulnerable populations in particular.

This document is written for oral disease prevention/oral health promotion stakeholders committed to recognizing oral health as integral to overall health, improving oral health, enhancing healthy behavior, preventing and reducing burden of oral disease and disparities.

Chapter 2: State Demographics

Overview of the State

Geographically, Minnesota is located in the north central United States. In the North, it borders Canadian provinces of Manitoba and Ontario, in the west, borders North Dakota and South Dakota, in the south borders Iowa, and in the east Wisconsin and Lake Superior.

Minnesota ranks 12th in the nation in land area. It is the fourth healthiest state after Vermont, New Hampshire and Massachusetts.[5] The residents have low rates of premature death, infant mortality, cardiovascular disease, and occupational fatalities, higher life expectancies, and a high rate of health insurance.

Overall Population, Growth and Diversity

The large majority of residents are white (Scandinavian and German descent). Ethnic diversity (African, Asian, and Latin American) has increased in recent years as shown in the following table.

Figure 1: Minnesota Population Change by County: 2000 - 2010

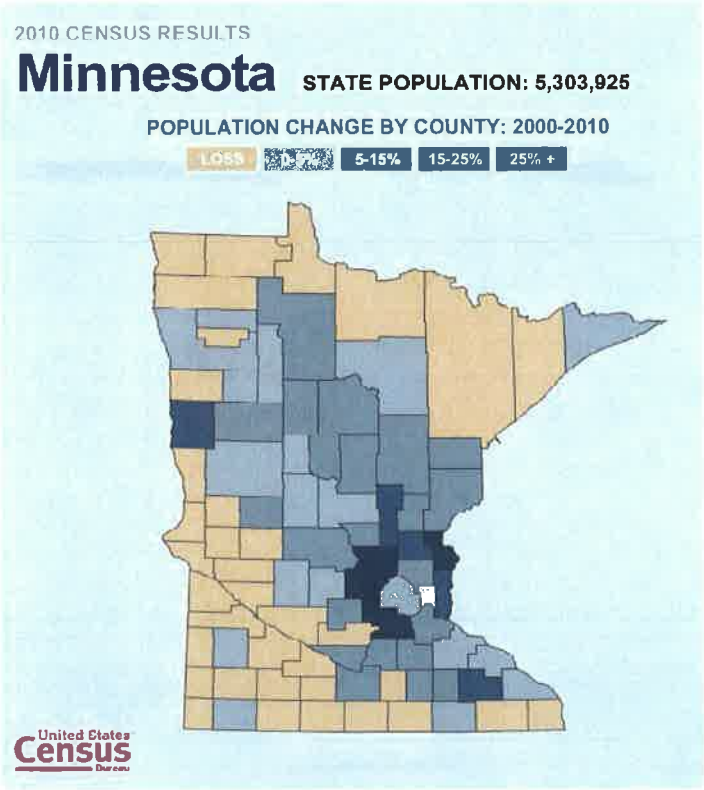


Table 1: Minnesota State Population by Race and Hispanic Ethnicity, 2010[6]

Racial/Ethnic groupings	2010 Census	% of population	Change 2000-2010
White	4,524,062	85.3	+ 2.8
Blacks, African American	274,412	5.2	+ 58.9
American Indian Alaskan Native	60,916	1.1	+ 10.8
Asian	214,234	4.0	+ 50.9
Native Hawaiian/Other Pacific Islander	2,156	0.04	+ 8.9
Other race	103,000	1.9	+ 56.5
Two or more races	125,145	2.4	+ 51.2
Ethnic Origin			
Hispanic or Latino origin (may be of any race)	250,258	4.7	+ 74.5
Non-Hispanic or Latino	5,053,667	95.3	+ 5.8
Total	5,303,925		+ 7.8

As stated above, during the 2010 census, Minnesota State Population was 5,303,925. However, 2012 population estimates have shown a growth of 1.4% (75,214) to 5,379,139[7].

Socio-economic Status

Public health professionals and policy makers have started to realize that complex, integrated and overlapping social structures and economic systems are responsible for health disparities. Several studies have shown that health outcomes improve as a result of improved socioeconomic status. According to the CDC, socioeconomic gradients in health can be measured through an individual's income, occupation or the highest level of education[8].

Research has also shown a strong correlation between health outcomes and education. According to U.S. Census data, 46 percent of Minnesota's population age 25 years and older attained an associate degree or higher[9] as compared to 38 percent of adults having an associate degree or higher nationally. During the same year, the high school graduation rate [10] in the state (88.2 percent) was higher than the national rate (78.2 percent).

According to the census bureau report issued in September 2012, official poverty rate did not change from 2010 to 2011 (15 percent or 46.2 million people both years)[11]. In Minnesota, 11.9 percent of the population live in poverty (about 612,970 people), which puts Minnesota 13th in the nation in number of those living below the poverty line ($11,344 for an individual or $22,113 household income for a family of four)[12]. In 2009, per capita income in the state ($55,621) was higher than the nation ($50, 221). According to the Bureau of Labor Statistics Current Population Survey, the unemployment rate for Minnesota in May 2013 was 5.2% compared to 7.6% nationwide[13]

Chapter 3: National and State Objectives for Oral Health

United States Surgeon General and the Institute of Medicine Reports

On May 25, 2000, Surgeon General David Satcher released Oral Health in America: A Report of the Surgeon General[1]. Since 2000, this report has framed the science on vital health issues in a way that has helped educate, motivate and mobilize the public to more effectively deal with oral health related issues. The report found a low awareness of oral health among the public, a significant disparity between racial and socioeconomic groups in regard to oral health, and ensuing overall health issues. Based upon these findings, the Surgeon General called for action to promote access to oral health care for all Americans, especially the disadvantaged and minority children found to be at greatest risk for severe medical complications resulting from minimal oral care and treatment.

In 2009, HRSA approached the Institute of Medicine (IOM) to provide recommendations for a potential oral health initiative. The committee, organized by IOM recognized that factors such as settings of care, workforce, financing, quality assessment, access, education and stakeholders in private and public sector influence oral health and its care system. The committee used oral health in its most comprehensive sense—as the responsibility of the entire health care system.

The recommendations on an oral health initiative for Health and Human Services (HHS) were published in April 2011 titled 'Advancing Oral Health in America: Publication of the Committee on an Oral Health Initiative[14] with the following organizing principles:

1. Establish high-level accountability.
2. Emphasize disease prevention and oral health promotion.
3. Improve oral health literacy and cultural competence.
4. Reduce oral health disparities.
5. Explore new models for payment and delivery of care.
6. Enhance the role of non-dental health care professionals.
7. Expand oral health research, and improve data collection.
8. Promote collaboration among private and public stakeholders.
9. Measure progress toward short-term and long-term goals and objectives.
10. Advance the goals and objectives of Healthy People 2020.

To give the initiative a foundation for sustainability and to set measureable goals and objectives for the initiative the committee advised HHS to use well-accepted set of benchmarks developed through strong collaboration of multiple partners in the form of Healthy People 2020.

In the fall of 2009, with support from HRSA and the California HealthCare Foundation, the National Research Council (NRC), IOM formed the Committee on oral health access to services to assess the current oral health care system and to focus on the delivery of oral health care to

vulnerable and underserved populations. After reviewing the evidence, overall conclusions of the committee were:

1. Improving access to oral health care is a critical and necessary first step to improving oral health outcomes and reducing disparities.
2. The continued separation of oral health care from overall health care contributes to limited access to oral health care for many Americans.
3. Sources of financing for oral health care for vulnerable and underserved populations are limited and tenuous.
4. Improving access to oral health care will necessarily require multiple solutions that use an array of providers in a variety of settings. [15]

Overview of Healthy People 2010/2020

Healthy People 2020 (HP2020) is a continuation of Healthy People 2010, a ten year evidence-based strategy to improve the nation's health through monitoring progress toward a set of benchmarks. The process guides health professionals to make informed health decisions, and measure impact of prevention activities by encouraging collaborations across sectors. A consortium of more than 2,000 organizations including public health and prevention experts, federal, state and local government officials and public have been involved in developing these objectives and indicators. The Leading Health Indicators (LHI) are composed of 26 indicators organized under 12 topics including access to health services, clinical preventitive services, environmental quality, injury and violence, maternal, infant, and child health, mental health, nutrition, physical activity, and obesity, oral health, reproductive and sexual health, social determinants, substance abuse, and tobacco. This is the first time that oral health has been included as one of the 26 LHI. The indicator is: persons aged 2 years and older who have used the oral health care system in the past 12 months (OH-7). There are 17 oral health HP2020 objectives covering children and adolescents, adults, preventive services, oral health interventions, monitoring and surveillance systems and public health infrastructure[16.]

Chapter 4: The Burden of Oral Disease

Generally, the term "Oral" refers to the mouth and associated structures which include not only the teeth and the gums (gingivae) and their supporting connective tissues, ligaments, and bone, but also hard and soft palate, soft mucosal tissue lining of the mouth and throat, tongue, lips, salivary glands, chewing muscles, and upper and lower jaws, which are connected to the skull by the temporomandibular joints. Equally important are the branches of the nervous, immune, and vascular systems that animate, protect, and nourish the oral tissues, as well as provide the connections to the brain and the rest of the body. The genetic development pattern in utero also reveals the relationship of oral tissues to brain development and to the tissues of head and face that surround the mouth.

Hence, when the term oral health is used, it means being free of chronic oral-facial pain conditions, oral and pharyngeal (throat) cancers, oral soft tissue lesions, birth defects such as cleft lip and palate, and scores of other diseases and disorders that affect the oral, dental, and craniofacial tissues, collectively called the craniofacial complex. These tissues allow us to speak, smile, smell, touch, taste, chew, swallow, cry out and make facial expressions.

Dental Caries Experience in Children

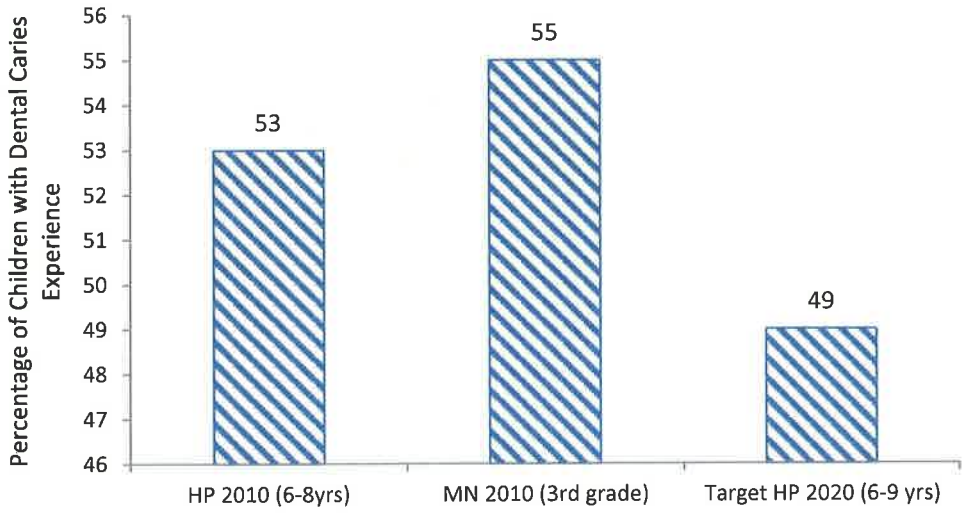
Dental caries is a disease in which acids produced by the action of bacteria on the teeth lead to loss of minerals from the enamel and dentin. If unchecked, caries can result in destruction of tooth structure, inadequate tooth function, unsightly appearance, pain, infection, and ultimately tooth loss. According to a study published in the American Journal of Public Health, dental visits or dental problems account for 117,000 hours of school lost per 100,000 children.[17]

It also affects nutrition, growth and weight gain. According to the CDC, dental caries/tooth decay, though preventable, remains the most common chronic disease of children ages 6 to 19. It is four times more common than asthma among ages 14 to 17 years. Nationally, treating caries costs an estimated $3,513 per 1,000 children.[18]

Early Childhood Caries (ECC) affect children age birth to 71 months of age. It is defined as the presence of one or more decayed surfaces (non-cavitated or cavitated lesions), missing teeth (due to caries) or filled tooth surfaces in any primary tooth.[19] According to National Health and Nutrition Examination Surveys (NHANES) prevalence of ECC among US children 2 to 4 years increased from 18.5% (1988-1994) to 23.7% (1999-2004).[20]

Generally, prevalence of dental caries in children is measured through the ASTDD Basic Screening Survey (BSS) tool.[21] In 2010, the Minnesota Department of Health conducted its first BSS on students in third grade attending public schools. The survey showed 55% of children in third grade had caries experience (history of dental caries) which was slightly higher than the nation (53%) for children 6-8 years. The state had 11% higher prevalence then the Healthy People 2010 target (42%).

Figure 2: Dental Caries Experience in Children
Comparison of HP2010, HP2020 with MN Data



Date Sources: HP2010-NHANES 1999-2004, MN 2010-Minnesota BSS 2010 on third graders, Target HP2020 NHANES

Dental Caries Experience in Adolescents

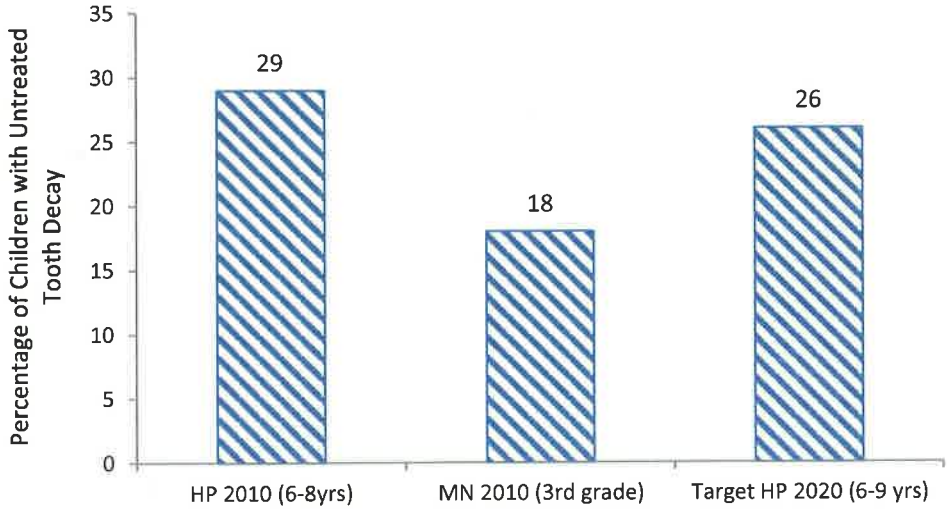
According to NHANES data 1999-2004, 56.1% adolescents (age 15 years) nationwide had caries experience. Data also showed higher prevalence in females (60.1%) than males (52.7%)[22].

Untreated Tooth Decay (caries) in Children

Untreated tooth decay is one of the best predictors of future caries activity. HP2010 report showed that the nation could not achieve the target set for this indicator as 19% (target for HP2010 was 9%) of children age 2-4 years and 29% (target for 2010 was 21%) of children ages 6-8 years had untreated dental decay. State level BSS 2010 data indicated only 18% of third graders had untreated tooth decay which was even lower than the set target for HP2020 of 25.9%.

Nationally, untreated tooth decay for adolescents age 15 years (18%) was higher than the target set for HP2010 (15%). Therefore, for HP2020, the bar for this indicator has not been raised and the target has been kept almost the same (15.3%).

Figure 3: Untreated Tooth Decay in Children
Comparison of HP2010, HP2020 with MN Data



Date Sources: HP2010-NHANES 1999-2004, MN 2010-Minnesota BSS 2010 on third graders, Target HP2020 NHANES

Untreated Tooth Decay (caries) in adults

Generally, people throughout their lives are susceptible to dental caries. Adults, like children and adolescents can experience new decay on the crown and can also develop caries on the root surfaces of teeth. According to NHANES data for 1999-2004 reported for the HP2010 final report, nationwide 27.8% adults, ages 35-44 years and 18% of adults, age 65 years and above had untreated caries.[23]

Periodontal disease: Gingivitis and Periodontitis

Periodontal disease including gingivitis and periodontitis are bacterial infections, which affect gums and bone supporting the teeth and can cause tooth loss if left untreated.[24]

During 2009–2010, 45% of adults aged 45–64 years had moderate or severe periodontitis. Prevalence was significantly higher for Hispanic and non-Hispanic black adults (59% and 60%, respectively) compared with non-Hispanic white adults (39%). Among adults aged 65–74 years, 58% had moderate or severe periodontitis. Hispanics had a higher prevalence of periodontitis (74%) compared with non-Hispanic whites (53%).[25]

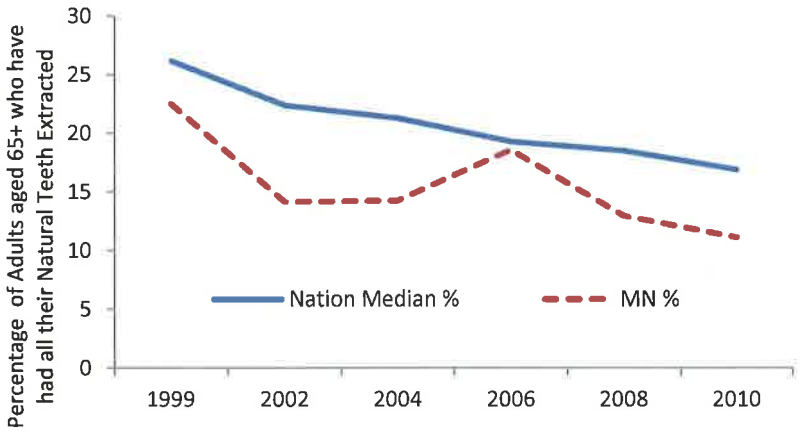
According to CDC, 4 to 12 percent of adults in the US are affected by gum diseases. Cigarette smoking causes half of the cases of severe gum disease and prevalence of gum diseases is three times higher in smokers than non-smokers.[26] Periodontal diseases are recognized as the "sixth complication" of diabetes.[27] Expert committee on 'Diagnosis and Classification of Diabetes

Mellitus', referred periodontal disease as one of the pathological conditions often found in adults with diabetes.[28]

Tooth Loss in adults

A full dentition is defined as having 28 natural teeth, exclusive of third molars (the wisdom teeth) and teeth removed for orthodontic treatment or as a result of trauma. In adults, tooth decay and periodontal (gum) disease are the most common reasons for tooth loss. At national and state level BRFSS data in figure 4 shows declining trends since 2006 for adults ages 65 and above who have had all their natural teeth extracted. The decline is much sharper in Minnesota as compared to the nation. In 2010, median percentage for adults aged 65+ who have had all their natural teeth extracted was higher for the nation (16.9%) than the state (11.2%).[29]

Figure 4: Adults Aged 65+ who have had all their Natural Teeth Extracted

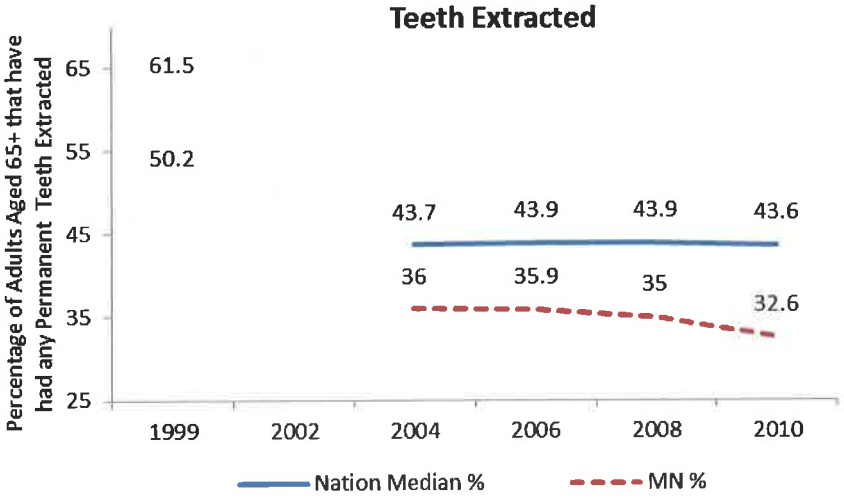


Data source: BRFSS 1999-2010

Figure 4 shows that nationally and locally, over the past 10 years, percentage of adults ages 65 and above who have had all their natural teeth extracted has declined. Rate of decline was higher at the state level (50.2%) compared to the national level (35.5%).

The following graph shows trend between the years 2004 to 2010 for percentage of adults ages 65 and above who have had any **permanent teeth** extracted. Not much change was observed nationally whereas, state level trend show a decline of 4%. In 2002 BRFSS survey, data on this indicator was not collected.

Figure 5: Adults Aged 65+ that have had any permanent Teeth Extracted

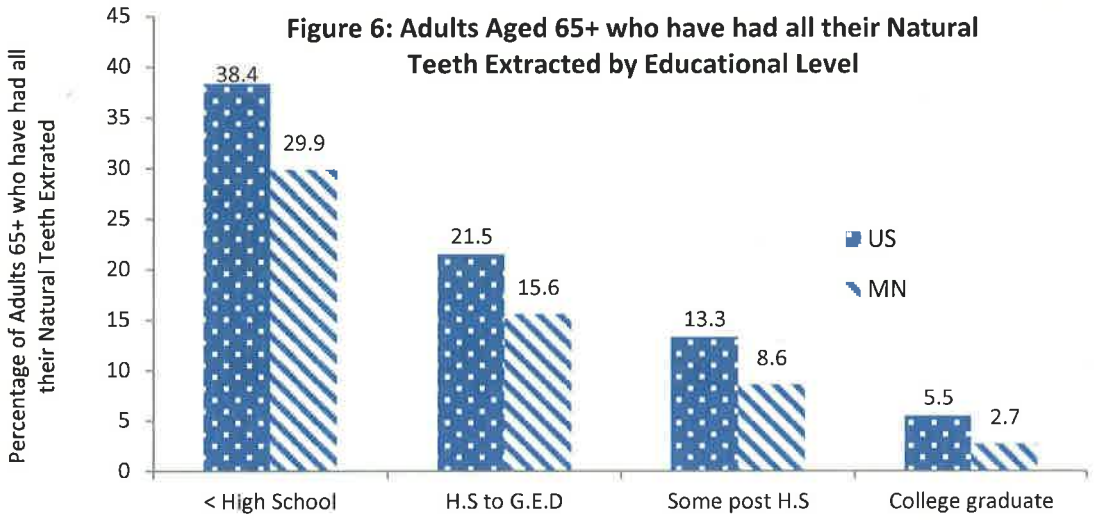


Data source: BRFSS 1999-2010

Oral Health Disparity in Adults

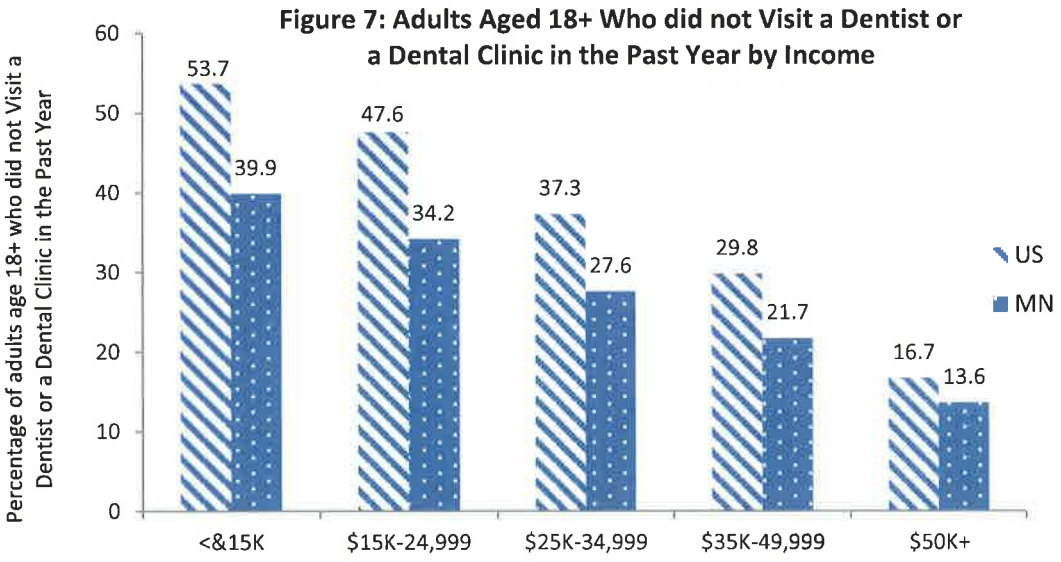
Health disparities are differences that socially disadvantaged populations experience in the burden of disease and opportunities to achieve optimal health.[30] Multiple factors contribute to create health disparities such as race or ethnicity, gender, education or income, disability, geographic location (rural/urban), inadequate access to health care or individual and behavioral factors.

Figures 6 and 7 reflect the phenomenon of disparity. They depict that adults with lower socioeconomic status (measured by level of education and personal income) had poorer dental health. For example, the percentage of adults 65+ who have had all their natural teeth extracted was higher in individuals who did not finish high school and was lowest in individuals with a college degree. Although these graphs show a slightly better picture of adults living in Minnesota compared to the nation, there are an estimated 73,714 individuals age 65 and older in the state who have experienced tooth loss and related discomfort such as improper mastication and loss of function of food chewing ability.



Data source: BRFSS 1999-2010

Figure 7 presents an inverse relationship between the income levels in adults aged 18+ who did not visit a dentist or dental clinic in the past year. The figure shows that as the income increases, percentage of adults 18+ who did not visit a dentist or a dental clinic in the past year decreases. National and state level data show that at each income level, the state had lower percentage of adults 18+ who did not visit a dentist or dental clinic in the past year compared to the nation.



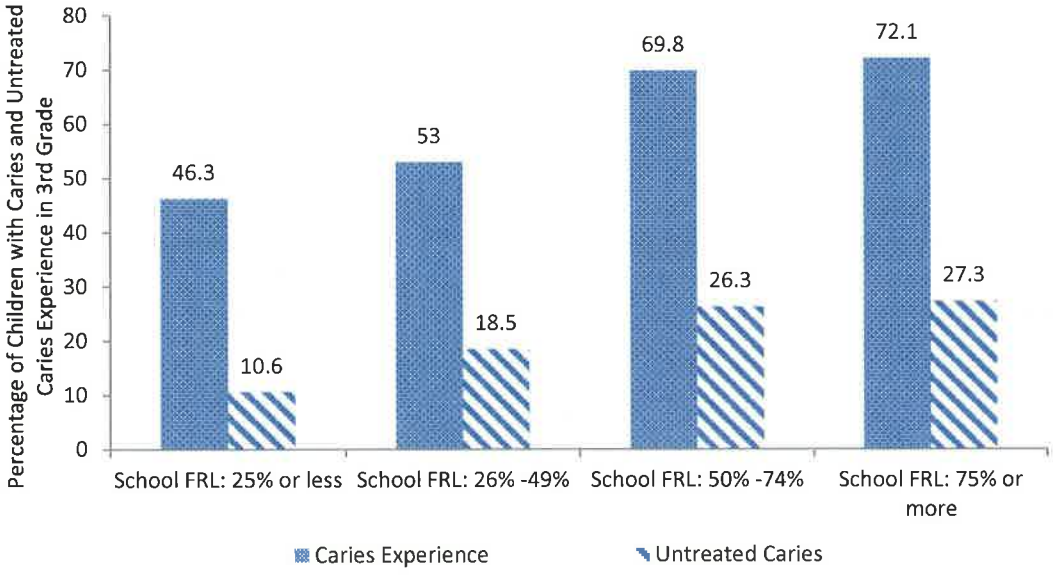
Data source: BRFSS 1999-2010

Oral Health Disparity in Children

In general, lower-income communities bear a disproportionate burden of oral diseases and conditions. A schools' Free or Reduced Lunch (FRL) eligibility status can be used as a proxy for community socio-economic status. Minnesota BSS 2010 indicated a positive correlation between oral health indicators and FRL eligibility status among children in third grade. Schools with higher proportions of students on/or qualified for FRL program performed worse on all the oral health indicators measured on BSS.

Despite progress in reducing dental caries in the United States, sharp disparities exist across income levels. Figure 8 reflects disparity in children in Minnesota. In general, schools with 25 percent or fewer students on/or qualified for FRL program had better oral health status than their peers in schools with 75 percent or more of students were qualified for the FRL program. Generally, the caries seen in individuals of all ages from poor families is more likely to be untreated than caries in children who live above the poverty level.

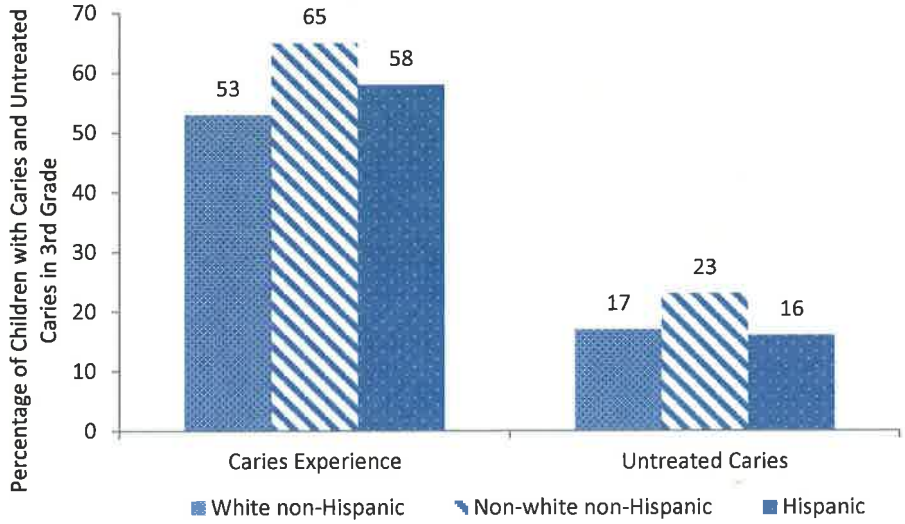
Figure 8: Caries and Untreated Caries Experience in Students in 3rd Grade by Free and Reduced Lunch Eligibility



Data source: Minnesota BSS 2010 on third graders

Ethnicity is another risk factor which compromises oral health as shown in the figure 9. Non-white non-Hispanic children are more likely to experience caries and untreated caries as compared to white non-Hispanics and Hispanic children in third grade.

Figure 9: Caries and Untreated Caries Experience in Students in 3rd Grade by Race



Data source: Minnesota BSS 2010 on third graders

Birth Defects

The most common oral birth defects are cleft lip and cleft palate; facial and oral malformations that occur within the first six to eight weeks of pregnancy.[31] Cleft lip and palate is the fourth most common birth defect in the US with about one oral birth defect per 700 births. It's commonly prevalent in Asian, Latino or Native Americans. Cleft lip with and without cleft palate affects boys twice as much as girls, whereas cleft palate without cleft lip affects girls twice as much as boys. The average treatment costs for treating cleft lip or cleft palate per patient over their lifetime has been estimated by NIH about $250,000.[32] In most cases, the cause of oral clefting is unknown. Most scientists believe it is due to a combination of genetic and environmental factors.[33] Cleft palate usually makes breastfeeding difficult because babies cannot suck properly. Children born with cleft palate may also have frequent ear infections which can eventually cause hearing loss. Speaking clearly is another challenge for children with this type of anomaly.

MDH birth defect surveillance system recorded 403 cases of oro-facial abnormalities for the 361,109 births between 2005 and 2009.[34]

Oral Cavity and Pharyngeal Cancers

Oral cavity and cancers of the pharynx represent about 2.4% of all cancer sites combined. These cancers are found on lip (excluding skin of the lip), tongue, salivary glands, gum, mouth, pharynx, oropharynx, and hypo pharynx. According to the American Cancer Society (ACS) estimates for the US population, in the year 2012, 40,250 (Males: 28,540, Females: 11,710) new cases will be diagnosed and 7,850 (Males: 5,440, Females: 2,410) people will die of this type of cancers.[35]

Over the five-year period from 2005 to 2009, each year in Minnesota, an average of 419 cases of oral/pharyngeal cancer was diagnosed (4.6% of all new cancer cases) and 111 people died (1.2% of all the cancer related mortality) from this cancer.[36]

Incidence, Mortality and Lifetime Risk by Age and Gender

The average annual incidence and mortality rates for oral cavity and pharyngeal cancer from 2005 to 2009 were 11.4 and 2.0 per 100,000 respectively in Minnesota. The incidence rate was significantly lower in females (7.2 per 100,000 females) than males (16.4 per 100,000 males) for the above reporting period. Average mortality rate for the state (2.0 per 100,000) was lower than the average for the nation (2.5 per 100,000).

Table 2 below shows that in Minnesota, median age at diagnosis for males is 61 year and for females is 63 years. Table also depicts higher lifetime risk of diagnosis and death for males as compared to females.

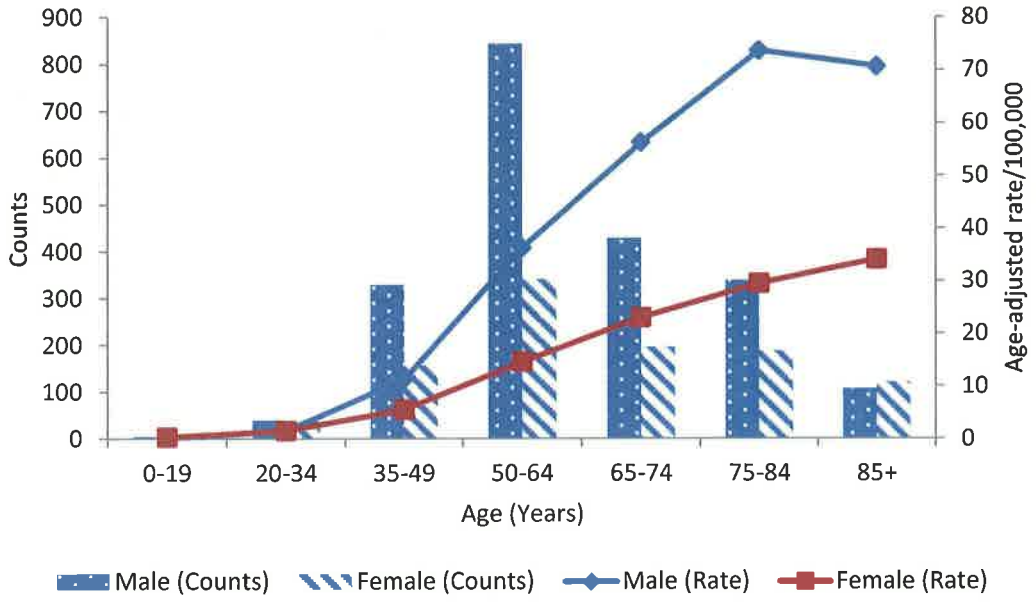
Table 2 Median Age at Diagnosis/Death and Lifetime Risk of Diagnosis/Death from Oral Cavity and Pharynx Cancer 2006-2008

Indicators	Males	Females
Median age at diagnosis (in years)	61	63
Median age at death (in years)	68	75
Lifetime risk of diagnosis	1.7	0.8
Life time risk for death	0.3	0.2

Data Source: MCSS

Figure 10 shows that the incidence rate for OCPC, in both genders increases with age. More than two-thirds of the new cases are identified after the age of 74 years. Incidence rates are twice in males compared to females.

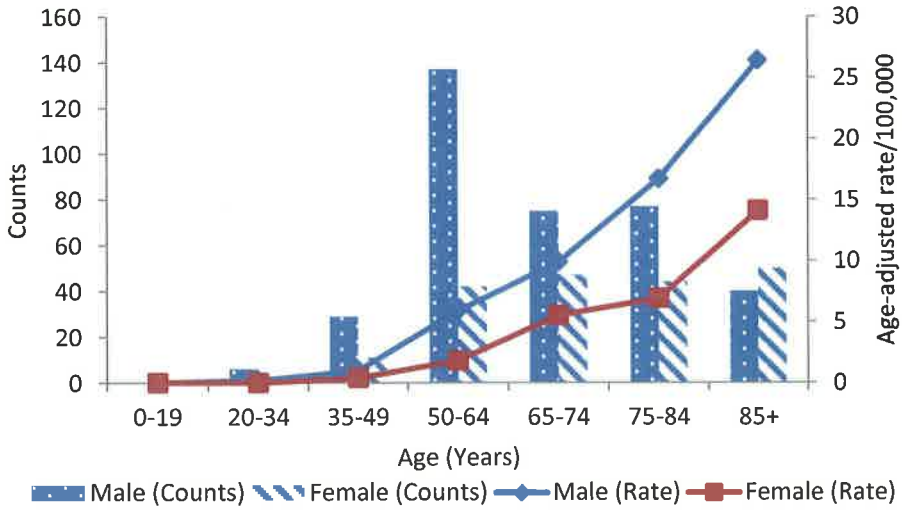
Figure 10: Incidence of Oral Cavity and Pharynx Cancer By Age and Gender, 2005-2009



Data Source: MCSS

Morality rates for OCPC increase sharply after age 64 years in both genders. Similar to incidence rates, females had lower rates of mortality by OCPC.

Figure 11: Mortality with Oral Cavity and Pharynx Cancer By Age and Gender, 2005-2009



Data Source: MCSS

Table 3 shows that five-year relative survival is highest for localized tumors (82.4%), whereas metastasized tumors have the lowest relative survival (34.9%). Most of the OCPCs in Minnesota are diagnosed at the regional stage. A little over one-third of the cases are diagnosed at the localized stage.

Table 3 Cases Distribution and Five-Year Relative Survival by Extent of Disease at Diagnosis Oral Cavity and Pharynx Cancer 2006-2008

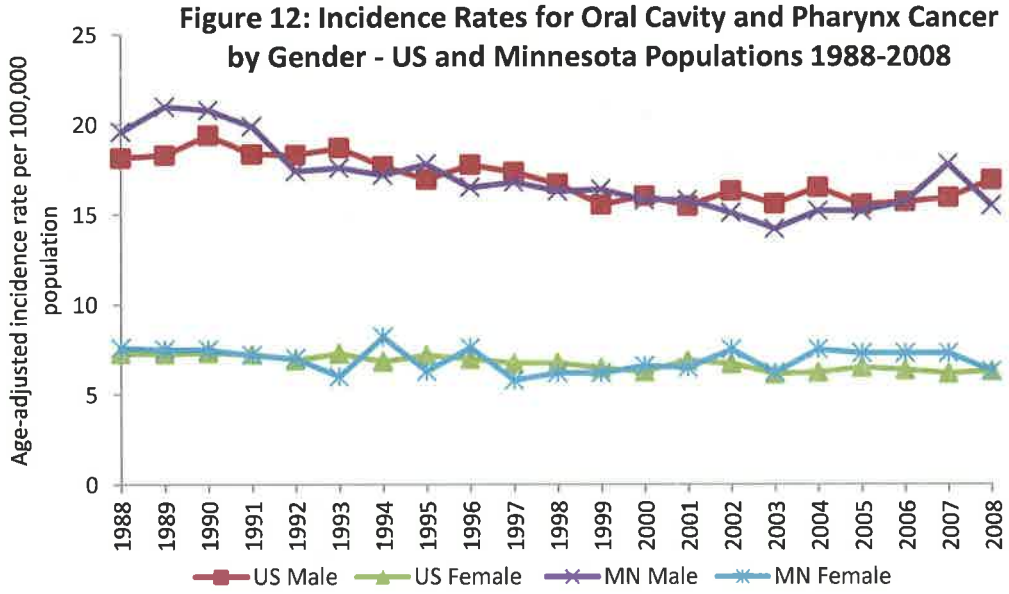
Stage at Diagnosis	Cases (%)	Five-year Relative
Localized (confined to primary site)	367.0	82.4
Regional (spread to regional lymph nodes)	38.8	57.3
Distant (cancer has metastasized)	11.3	34.9
Unstaged (Unknown)	7.2	50.5

Data Source: MCSS

Trends

In the state, from 1988 to 2008 incidence rate for OCPC for women has been stable. Among males, the rate declined significantly from 1988 to 2006 (figure 12). A slight increase was noticed in 2007. State's incidence rates were consistent with national rates.

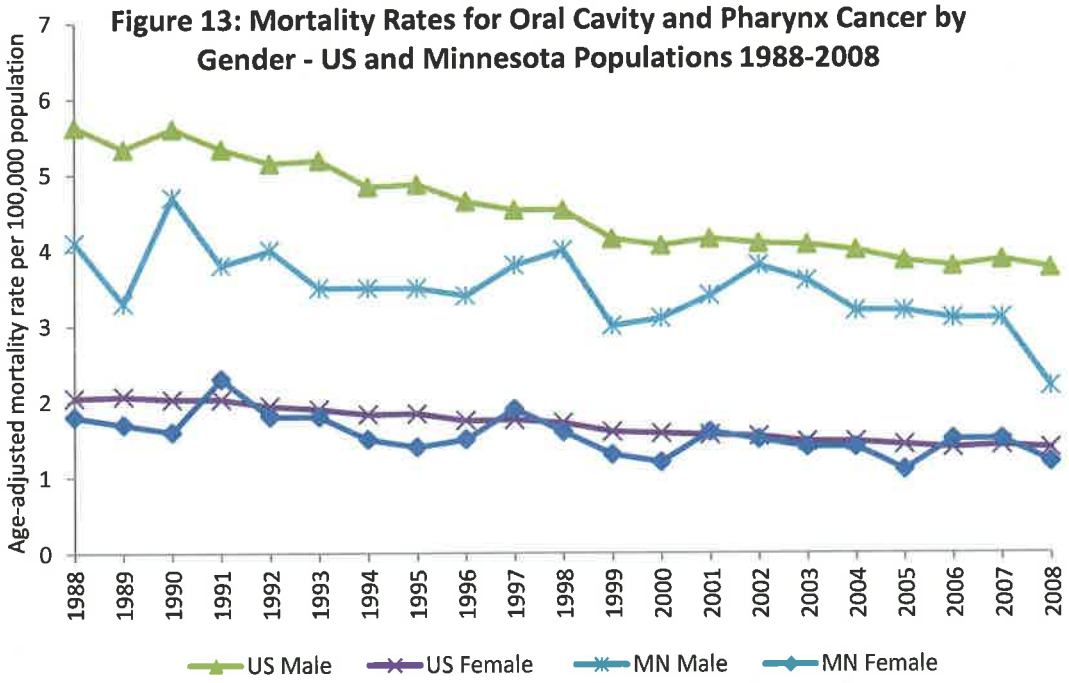
Figure 12: Incidence Rates for Oral Cavity and Pharynx Cancer by Gender - US and Minnesota Populations 1988-2008



Data Source: MCSS

Mortality rates for the state decreased significantly among males from 1988 to 2008. They were consistently lower than the national statistics. For females the rates were consistent and were closer to the national figures.

Figure 13: Mortality Rates for Oral Cavity and Pharynx Cancer by Gender - US and Minnesota Populations 1988-2008



Data Source: MCSS

Disparity

The average annual incidence rates among American Indians living in a Contract Health Service Delivery Area (CHSDA) were 17% higher than among American Indians living in the geographic areas covered by SEER (Surveillance Epidemiology and End Results). Table 4 shows that average annual incidence rates of OCPC were highest among CHSDA males followed by blacks. In females, American Indian females had highest incidence rate. Mortality rates were higher in Asian/pacific Islander populations.

Table 4: Oral Cavity and Pharyngeal Cancers Average Annual Rates by Race and Ethnicity in Minnesota

Race	Average Annual		Mortality Rate	
	Male	Female	Male	Female
Non-Hispanic white	16.2	6.8	2.8	1.2
Hispanic all races	6.9	7.3	~	~
Black	19.3	8.2	4.3	~
Asian/Pacific Islanders	13.9	8.0	8.8	~
American Indians	21.0	12.3	~	~
CHSDA*	25.2	~	~	~
All Races combined	16.4	7.2	3.0	1.2

Data Source: MCSS
**Contract Health Services Delivery Area*
~Race-specific rates based on fewer than 10 cases or deaths are not presented.

Risk Factors

Use of tobacco and heavy consumption of alcohol are widely considered major risk factors for OCPC.[37] Recently, human papillomavirus (HPV) exposure and infection have been documented as a strong risk factor for certain types of OCPC, particularly in men. A case-control study published in 2007 showed that independent of tobacco and alcohol use, HPV exposure and infection increase the risk of oropharyngeal squamous cell cancer. Most cases of OCPC are preventable. Reduction in exposure to tobacco and alcohol is the single most effective measure to lower the risk of developing this type of cancer.

Dental Hospital Visits

Access to dental care whether due to shortages of oral health care providers or providers not accepting uninsured or under insured populations have made hospital emergency rooms as a dental destination for the patients in pain and suffering. This recent phenomenon of increased utilization of Emergency Department (ED) for preventive and less severe oral health problems has serious financial implication to the overall health care system. Often the care being offered in ED may result in additional visits and corrective procedure as the ED staff is not generally trained in dealing with oral health problems.

Since the summer of 2010, few publications and reports have identified various aspects which are significantly important in reviewing the financial burden of these inappropriate admissions to ED.[38394041]Following observations were noted in these publications:

- Urgent care dental visits to ED were more pronounced among uninsured populations
- In 2007, over 10,000 visits to ED related to oral health occurred in one year period, costing nearly $5 million to the public programs
- Barriers to dental care including lack of insurance, dental provider not accepting Medicaid, lack of transportation, dental health literacy, cultural and societal habits were implicated in the realm of ED admissions

Hospital-treated Oral-dental conditions

For oral conditions, hospital discharge data based on primary diagnosis using ICD-9 (International Classification of Disease) can be divided into two categories – oral trauma and non-trauma. Hospital treated oral trauma includes broken tooth, open wound of internal structures of mouth etc. Whereas, non-trauma conditions include disorder of tooth development and eruption, abscess, periodontal diseases, gingivitis, dentofacial anomalies, malocclusion and other diseases of the internal structure of mouth.

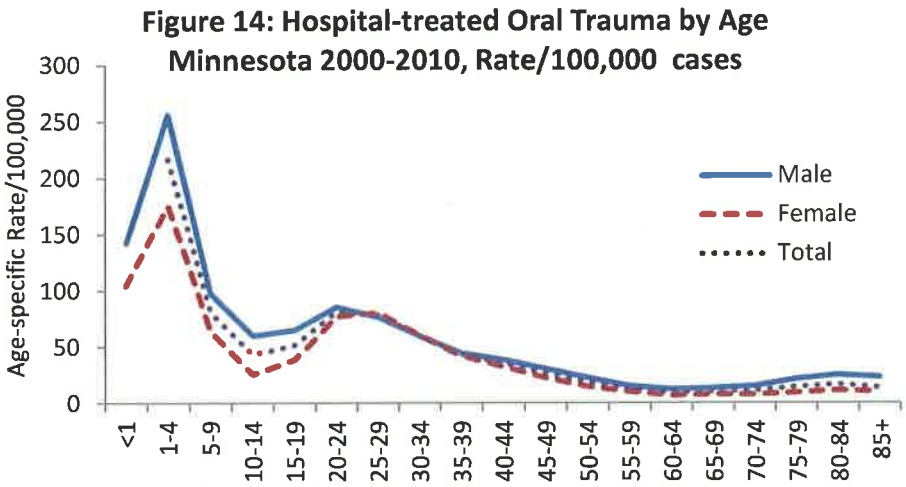
Table 5 shows that males contributed higher to ER visits with traumatic conditions, whereas females contributed more ER visits for non-traumatic oral conditions. More patients with non-traumatic condition were admitted in the hospital as compared to traumatic. Slightly lower than half of the patients visited ER with traumatic condition were from rural areas. This could be attributable to the availability of lesser number of dental offices in rural areas, compelling rural population to seek refuge in hospitals for non-traumatic oral conditions.

Table 5: Profile of Hospital Treated Patients with Traumatic and Non-traumatic Oral Conditions, 2000 - 2010

Patients	Traumatic		Non-traumatic	
	#	%	#	%
Total number of cases	32,553		136,982	
Male	18,816	57.8	65,340	47.7
Female	13,737	42.2	71,642	52.3
Urban Residents	20,443	62.8	74,655	54.5
Patients treated in Emergency	32,293	99.2	131,914	96.3
Patients hospitalized	260	0.8	5,068	3.7

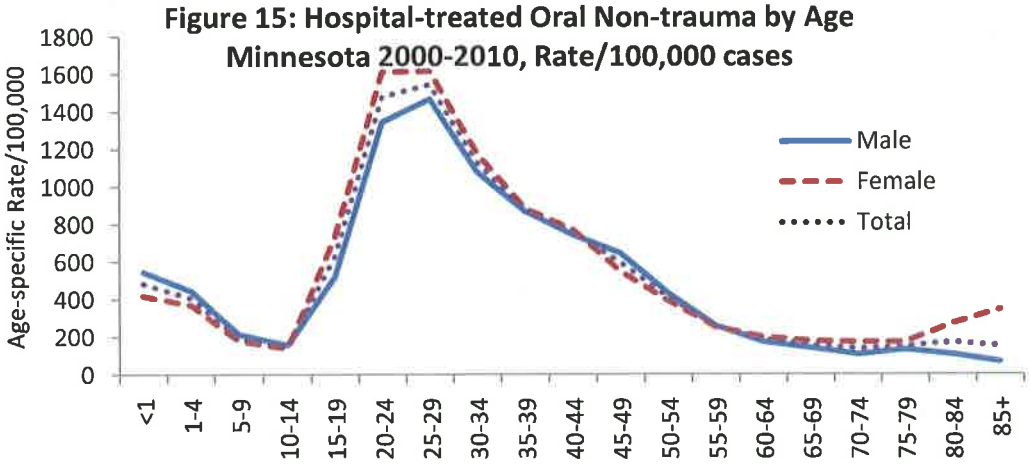
Data source: Statewide hospital discharge and emergency department uniform billing data from the Minnesota Hospital Association, 2000-2010

Figure 14 below presents that hospitalization rates for oral-dental conditions vary by age. Age specific rates for oral trauma are highest in children ages one to four followed by adults ages 20 to 29 years. Males and females show similar pattern.



Data source: Statewide hospital discharge and emergency department uniform billing data from the Minnesota Hospital Association, 2000-2010

Figure 15 depicts rates of hospital treated oral non-trauma cases by age. The most affected age group was 20 to 29 years of age. Age specific rates were higher in females then males in the same age categories.



Data source: Statewide hospital discharge and emergency department uniform billing data from the Minnesota Hospital Association, 2000-2010

Economic Impact

According to the World Health Organization (WHO), in some countries, oral diseases are the fourth most expensive diseases to treat.[42] According to CMS in 2011, dental services expenditure in the country was $108.4 billion.[43] Forty two percent of the amount was out-of-pocket payment. The following table shows hospital charges have increased since 2008 for trauma and non-traumatic conditions. If these charges are not being paid by the patient then they become the liability to the public service. The observed change is much higher in non-traumatic cases compared to traumatic which could be attributable to the under insured and uninsured population utilizing hospital service for their regular dental needs.

Table 6: Hospital Charges for Hospital-treated Trauma and Non-Traumatic Oral Condition

	Charges for Hospital-Treated Oral Trauma			Charges for Hospital Treated Oral Non-Traumatic		
	2008	2009-2010	% Change	2007-2008	2009-2010	% Change
Mean	$453.16	$483	6.6	$1,053.75	$1,148	8.9
Median	$187	$208	11.2	$242	$291	20.2
Total	$11,720,194	$12,755,259	8.8	$67,378,817.37	$80,356,318	19.3

Data source: Statewide hospital discharge and emergency department uniform billing data from the Minnesota Hospital Association, 2000-2010

Oral Diseases and Other Health Conditions

In recent years, rising chronic disease morbidity and mortality have emerged as threats to the well-being of populations. Research has demonstrated interrelationship between the chronic diseases and oral health. Studies have shown a strong association between periodontal (gum) disease and diabetes, cardiovascular diseases, stroke, respiratory infections, osteoporosis, HIV and adverse pregnancy outcomes.

Oral health and diabetes

As people with diabetes are more susceptible to contracting infections, they are more likely to have periodontal disease than people without diabetes. Periodontal disease is often considered the sixth complication of diabetes. People with uncontrolled diabetes are at even higher risk.[44,45,46]A study found that poorly controlled type 2 diabetic patients are more likely to develop periodontal disease than well-controlled diabetic patients.[47] Research also suggests that the relationship goes both ways as periodontal disease may make it more difficult for diabetic patients to control their blood sugar.

Severe periodontal disease can cause a rise in blood sugar. This increases risk for diabetic complications. Therefore, diabetic patients should be treated for periodontal disease to avoid complications. Children with diabetes often develop gum diseases earlier in life than those

without diabetes. Clinical studies have also shown that diabetic children show more plaque and gingival inflammation than non-diabetic children.[48]

Oral disease in pregnancy

According to the Pregnancy Risk Assessment Monitoring System (PRAMS) 2010, 63.7% pregnant women got their teeth cleaned 12 months prior to pregnancy. More than 50% of the pregnant women visited the dentist/dental clinic during their most recent pregnancy. Out of those who visited the dentists/dental clinic, 18% of pregnant women needed to see a dentist for a dental problem during their most recent pregnancy.[49] Studies have found that maternal oral health has significant implications for birth outcomes and baby's oral health. Periodontitis has been associated with poor pregnancy outcomes. A systematic review of studies was conducted to assess relationship between periodontitis and poor pregnancy outcome in 12 countries and three US states between 1996 and 2006. Twenty-four reviews demonstrated a positive relationship between periodontitis and preterm birth, low birth weight, or both.[50] Only 14 studies reported no relationship between periodontitis and poor pregnancy outcomes. However, another large U.S.-based Randomized Control Trial (RCT) did not find an association between periodontitis and preterm birth and low birth weight.[51] Racial, socio-economic and delayed treatment for periodontal diseases, are hypothesized by authors as a possible explanation for conflicting findings.

Although literature is available on the association between maternal oral health and child's caries experience, no conclusive evidence has been found yet. Therefore, more study and research is needed to ascertain this relationship. In oral health programs, emphasis should be on improving the pre-pregnancy and during pregnancy oral health condition of women[52].

Oral health and osteoporosis

Although more research is needed to assess the association between osteoporosis and tooth loss and periodontal disease, researchers cite that osteoporosis may be a risk factor for oral bone loss. Research findings suggest early detection of changes in bone density may be observed by dental health professionals with the use of high quality intra-oral dental radiographs. Some of the indicators such as loose teeth, severe gum disease, dentures that don't fit well and difficulty eating or speaking could be early sign of bone loss. [5354]

Oral health and cardiovascular disease

A few recent studies have shown that poor oral health combined with other risk factors may contribute to heart disease. On the other hand there are also a few studies refuting the possible link between periodontal disease and cardiovascular disease.[55]

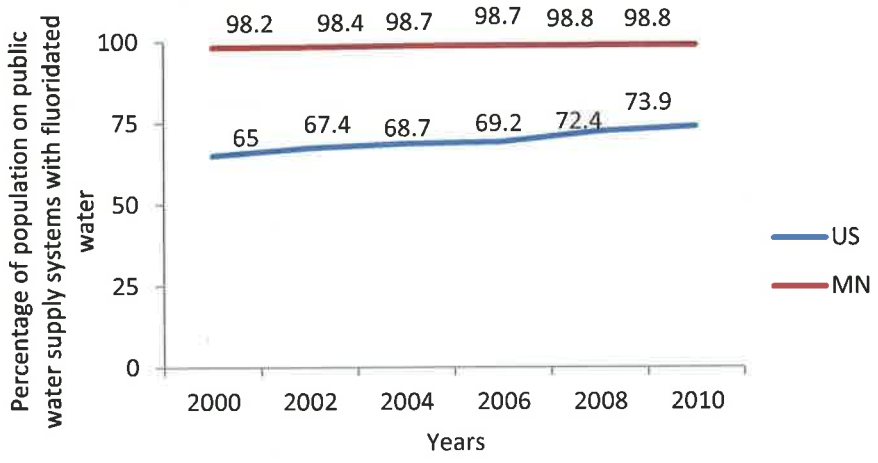
Chapter 5: Protective Factors Affecting Oral Disease

Community Water Fluoridation

Community water fluoridation has been recognized by CDC as one of the ten great public health achievements of 20th century.[56] It is one of the most cost-effective and equitable means to provide protection from tooth decay. CDC's economic analysis found that communities with more than 20,000 people where community water fluoridation costs 50 cents per person, every dollar invested yields approximately $38 savings in dental treatment cost.[57] Another study found that states where more than half of the communities have fluoridated water have 26% fewer decayed tooth surfaces per year in children 12 years old as compared to the states with less than one-quarter of the communities fluoridated.[58]

Figure 16 depicts that in 2010, 73.9% of the US population on public water systems was receiving fluoridated water whereas 98.8% of Minnesotans on public water systems were receiving fluoridated water. This ranks Minnesota 4th in the nation after Kentucky, Maryland and Illinois for percentage of state population on public water systems receiving fluoridated water. HP2020 target for the nation has been set to 79.6%. Although Minnesota is far ahead of the set target, significant work needs to be done to maintain its status, while striving to achieve optimal oral health for its population.

Figure 16: Percentage of Population on Public Water Supply Systems with Fluoridated Water



Data Source: Water Fluoridation Reporting System (WFRS)

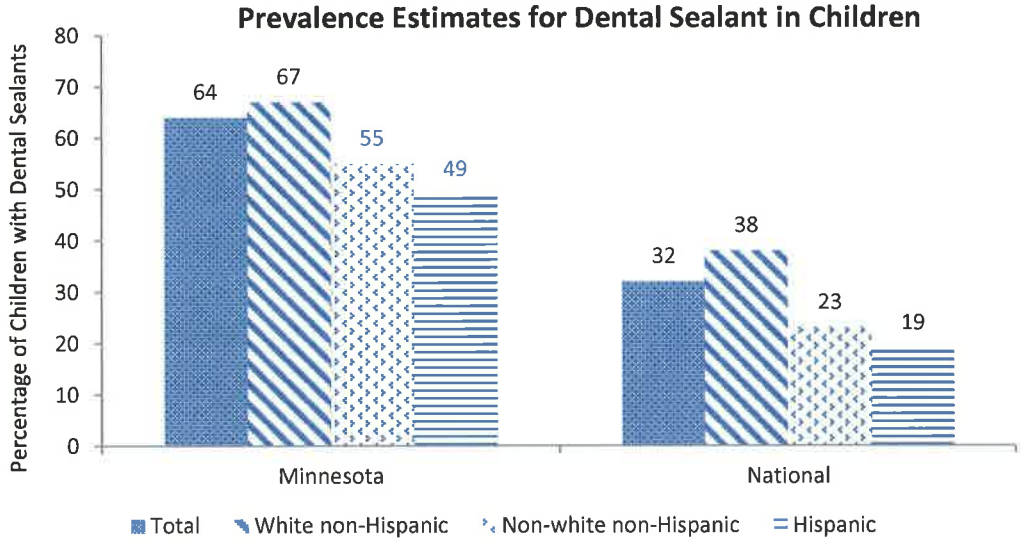
According to the CDC Water Fluoridation Reporting System (WFRS), as of April 2012, in all the 87 counties of Minnesota, more than 75% of the county population, which was connected to public water supply, had their drinking water fluoridated.

Approximately 25% (one million) of Minnesotans rely on private, household wells as their source of fresh water in their homes which may not have optimal levels of fluoride to prevent tooth decay in children.[59]

Dental Sealant Programs

The likelihood of developing pit and fissure decay begins early in life. Dental sealants (pit and fissure sealants) are effective in preventing decay and stopping the progression of early caries. A dental sealant is applied to the chewing surfaces of back teeth (molars) to prevent decay from occurring in the pits and fissures. Dental sealants are cost effective when given to children and adults who are at the highest risk of developing caries. They may last as long as five years. School-based sealant program have shown evidence in reducing oral health disparities.[60] Colorado estimated a $1.2 million in saving in a year if statewide sealant programs were implemented.[61]

Figure 17: Minnesota and National Population Prevalence Estimates for Dental Sealant in Children



Date Sources: Minnesota: BSS 2010 on third graders and National: NHANES 1999-2004

In 2011, after analyzing Basic Screening Survey findings, MDH established a coordinated school-based sealant program in five regional sites through its HRSA funding. MDH is also collaborating with DHS to achieve CMS Oral Health Initiative's goal of increasing the rate of children who have received dental sealants by ten percentage points. Other partners participating in these efforts include 3M, Delta Dental, Smiles Across America, and the School Nurse Organization of Minnesota (SNOM). The goal of the program is to improve community-based prevention services by strengthening the infrastructure and expanding the capacity of school-based pit-and-fissure sealant delivery programs in Minnesota. The school-based sealant program targets second grade students in high-risk schools (schools with a >50 percent of students eligible for the Free or Reduced Lunch Program).

In 2009, less than 25 percent of high-risk schools had sealant programs. As shown in the following table, today more than 29 percent of high-risk schools have MDH-sponsored or coordinated dental sealant programs.

Table 7: Elementary School with School-based Dental Sealant Program, Academic Year 2010-2011

2010-2011 School Year: Elementary Schools	#	%
Total Number of Elementary Schools	946	
Total Number of High-Risk schools	392	41.4
Total Number of High-Risk with a School-based Dental Sealant Program	115	29.3

Source: Minnesota Department of Education and Minnesota Department of Health, 2011.

Data collected by the state Oral Health Program show that one-third (34%) of the eligible children in second grade participated in the program. On average, three dental sealants per child were applied on participating second graders molar teeth. According to CMS 416 report for the Fiscal Year 2011 only 15% (n=90,300) of eligible children ages 6 to 9 years received a sealant on a permanent molar tooth.

Fluoride Varnish

Several emerging dental preventive strategies are in the scientific literature. Fluoride varnish is one of those. Fluoride varnish is a high concentration of fluoride in a resin base, intended for professional use as a cavity liner and de-sensitizing agent. Recently varnish has been widely used in children to help to prevent early childhood caries. Studies have shown fluoride varnish has a substantial caries-inhibiting effect in both permanent and primary teeth[62], which can also help arrest the caries process when applied early. Fluoride varnish has been found to be cost effective when dental service and non-hospital treatment costs can be 1.5 to 2 times higher. A study found improved clinical outcomes by 1.52 cavity-free months at a cost of $7.18 for each cavity-free month gained per child and $203 for each averted treatment[63].

Chapter 6: Risk Factors Affecting Oral Disease

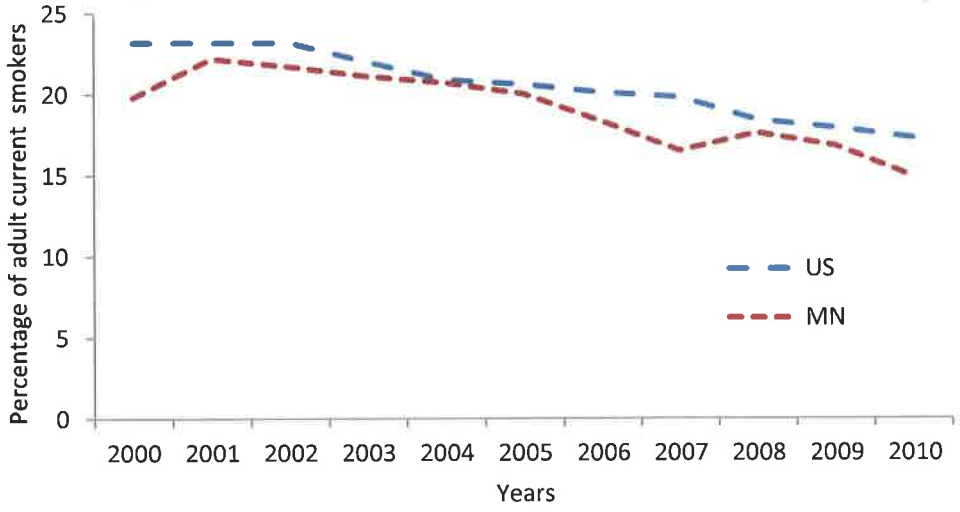
Tobacco Use

Tobacco is a known risk factor for oral cavity and pharyngeal cancers. Smoking and alcohol use are strongly associated with oral cancers, which are relatively common and have a poor prognosis compared with other types of cancer.

Smokers are four times more likely to develop gum diseases compared to non-smokers.[64] According to the American Academy of Periodontology, tobacco use may be one of the most significant risk factors in the development and progression of periodontal disease.

According to BRFSS[65] and the Minnesota Student Survey (MSS)[66] smoking rates have been on the decline statewide among adults and teenage students. Smoking rates among 12th graders, both nationally and locally, started to decline after peaking in 1998. In 2010, less than one in five high school seniors nationwide (19.5%) and in Minnesota (19.2%) reported smoking cigarettes in the past 30 days. Over the years, smoking rates have been higher among Minnesota students than their national counterparts. However, the downward trend since 1998 is more pronounced in Minnesota (1998 : 41.9%, 2010: 19.2%) than in the country (1997:36.4%, 2009: 19.5%).[67]

Figure 18: Adult Current Smokers - US Minnesota Comparison



Data Source: BRFSS 2000-2010

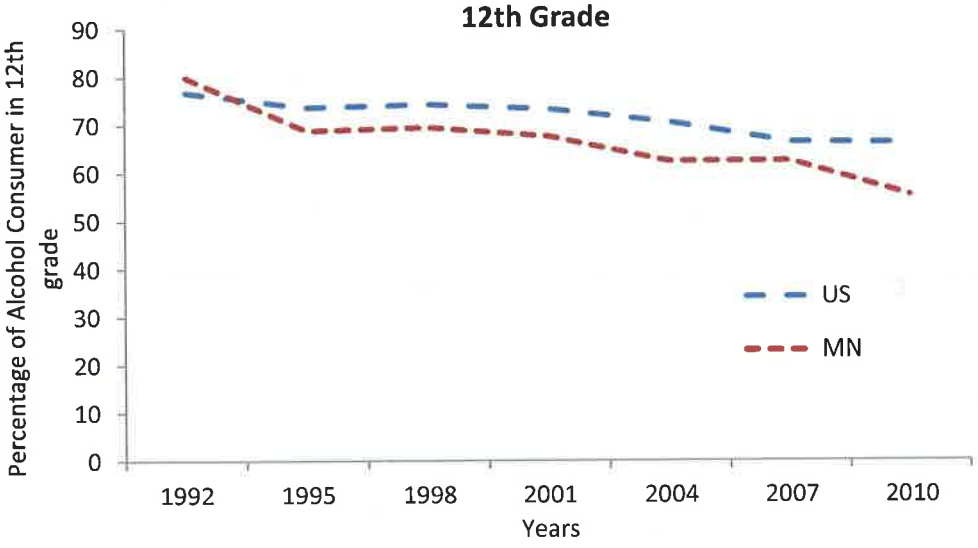
Beverage Consumption

There is a positive causal relationship between sugar sweetened beverage consumption and dental caries in children. There are 40.5 grams of sugar in a 12 oz. can of Coke (equivalent to 10 teaspoons of sugar). Sugar sweetened soda also has a high level of acidity which is associated with increased dental caries in children and youth.[68]

According to CDC, the most popular teen beverage as of spring 2010 was milk followed by water.[69] In 2007, about 49 percent of 6th grade to 12th grade students drink one to two glasses of milk per day, approximately 300 - 600 mg of calcium. For children and youth ages 9 to 18 years, the recommended daily intake of calcium is 1300 mg.[70] It is scientifically proven that intake of milk is good for bone including teeth.

In figure 19, alcohol use shows an overall declining pattern among 12th graders, both nationwide and in Minnesota.[71] In 1992 nationwide, more than three quarters of high school seniors reported using alcohol during the past year, compared to about two-thirds in 2010. In 1992, alcohol use by students in the state was higher than the national level. In 1995, the levels fall below the national level and remained that way ever since as shown in the following graph.

Figure 19: Percentage of Alcohol Consumption in Students in 12th Grade



Data source: Minnesota Student Survey, 1992-2010

Chapter 7: Access to Oral Health Care

Dental Professional Shortage Designation[72]

Health Professional Shortage Area (HPSA) is a designation given by the Department of Health and Human Services (DHHS) to identify shortages of primary medical, dental or mental health providers within a geographic area, population group or a facility. As of September 2012, there were 112 dental HPSAs in the state. More than half (66 out of 112) are low-income population designations. Based on the dentist Full Time Equivalent (FTE) data serving Medicaid and/or low-income populations in these areas, DHHS estimates that 166,200 people have access to dental services and 362,569 experience barriers. The majority of dental HPSAs are located in rural parts of the state. There are 13 HPSAs designated in Hennepin County (four population and nine facilities) and five in Ramsey County (two population and three facilities). In five other metropolitan counties (Anoka, Washington, Carver, Dakota and Scott), there are two correctional facilities and one Native American tribal population designations. Maps of dental HPSAs are presented in appendix B1 and B2.

Dental Workforce Capacity

The Office of Rural Health and primary Care (ORHPC) collects dental workforce data through professional licensing process. Table 8 presents comparison of state and national dental provider data.

Table 8: Ratio of Dental Provider Types per 100,000 Population

Dental Professionals	*Minnesota: Number per 100,000 population	**National: Number per 100,000 Population
Dentists (practicing)	3,244 (61 dentists per 100,000)	195,628 (63 dentists per 100,000)
Collaborative Agreement	274 (5 dentist per 100,000)	~
Pediatric Dental Specialists	77 (6 dentists per 100,000 children <18 years)	6,181 (8 dentists per 100,000 children <18 years)
Advanced Dental Therapists	~	~
Dental Therapists	25 (4 per 1,000,000)	~
Hygienists (practicing)	3,594 (68 per 100,000)	152, 000 (49 per 100,000)
Collaborative Agreement Hygienists	276 (5 per 100,000)	~
Dental Assistants (practicing)	6,288 (119 per 100,000 pop)	297,200 (96 per 100,000)

Total Minnesota population: 5,303,925; children under 18 years (24%): 1,267,638
****U.S. Population: 308,745,538; children under 18 years (24%): 73,172,69***

Dentist

Comparison in table 8 shows that the Minnesota has lower ratio of dentists per 100,000 population compared to the nation. This difference may increase in the future as Minnesota Board of Dentistry license renewal data and survey data from ORHPC 2009-2010, showed that 47 percent of the surveyed dentists were 55 years or older and rural dentists (median age 57 years) were older than the urban dentists (median age 53 years). Most of the dentists surveyed (57%) plan to practice in Minnesota for more than ten years whereas only seven percent work in small rural areas. Of dentists who planned to stop practicing, 21% planned to stop in the next five years. Solo practice is the most common type of practice especially in rural areas (44%) followed by small group practice (37%). One-third (74%) of the dentists were practicing in urban areas. The majority of these practicing dentists were male (77%) and 94% were white. Only 7% of these dentists had a collaborative agreement with a dental hygienist.

Pediatric Dentistry

Pediatric dental specialists are available in fewer than 20 of Minnesota's 87 counties. Many of these dentist specialists practice at more than one location. Most pediatric practices are clustered in and around the 7-county Minneapolis/St. Paul metropolitan area with very few, if any, located in rural Minnesota. In Greater Minnesota, pediatric dentists are most likely to be located in the larger cities such as Duluth, Rochester, St. Cloud, and Mankato.

Dental Hygienist

Dental hygienists are licensed professionals who specialize in preventive dental care. While most hygienists work in dental offices, Minnesota law allows health care organizations or nonprofit organizations that serve uninsured or publicly insured patients to employ dental hygienists to perform certain functions in some settings without the dentist first examining the patient. To do so, the hygienist must have a collaborative agreement with a supervising dentist. Minnesota Statute 150A. 10, Subd.1a gives this limited authorization to dental hygienists.

Out of 4,608 dental hygienists, who renewed their licenses, 72% were actively practicing in MN. According to the Minnesota Board of Dentistry (MBD) license renewal data and survey of ORHPC data 2008-2009, majority of the hygienist were females (98%) and were white (97%).

In the process of preparation for licensure as a hygienist, 69% received associate degree while 30% had bachelor or higher degree. Based on license information, half of the hygienists were 45 years or older (53 percent). Data from the survey showed that 80% of the hygienist workforce was serving the 75% of the population living in metropolitan areas (Minneapolis-St. Paul, St. Cloud, Rochester, Duluth-Superior, Fargo, Grand Forks and La Crosse).Only seven percent hygienists were serving 12% of the population in the rural areas. When hygienists were asked about collaborative agreement, 20% were even did not know whether they were practicing under a collaborative agreement of not. Only 6% had collaborative agreement with a dentist.

Dental Assistants

Dental assistants are allied dental personnel who work under supervision of a licensed dentist. Dental assistants may or may not be licensed or registered. This means that their application to become a licensed dental assistant is voluntary and duties vary accordingly. Thirteen Minnesota community and technical colleges offer dental assistant programs approved by the MBD. In 2009-2009, 7,146 dental assistants renewed their licenses in the state. According to the MBD license renewal data and survey of ORHPC data 2008-2009, out of those who renewed their licenses, 88% were actively practicing in the state. Almost whole dental assistants workforce is female (99%) and most of them are white (96%). Almost three quarters of them work in the urban areas. Data also showed that dental assistants were younger (median age 34 years) compared to dentists (media age urban ages 55 years and rural areas 57 year) in the state.

Enhancing Workforce Models and Creating New Providers

In 2009, Minnesota's governor signed a bill into law creating a new "midlevel" dental provider type. Under the bill two new types of practitioner are now recognized – a Dental Therapist (DT) and an Advanced Dental Therapist (ADT). This mid-level dental practitioner will work under the supervision of a licensed dentist. The purpose of this provider type is to extend dental care to underserved communities and to address access issues such as limited availability of dental providers, dental providers not accepting populations on public programs, uninsured patients and people living in rural areas.

The Minnesota state legislature will receive a report from the Minnesota Board of Dentistry in January 2014 regarding the impact of the new dental therapists on the delivery and access to services. The first class of dental therapy students graduated in December 2011. As of March 2013, there are 25 licensed Dental Therapist in the state. Out of these 25, 16 are practicing and all of them have established at least one Collaborative Management Agreement.

Oral Health Financing

Medicare and Medicaid are both government-sponsored and taxpayer-funded programs established in 1965. Medicare is designed to help with long-term care for the elderly ages 65 and older, while Medicaid jointly administered and funded by Federal and State governments covers medical, dental, and long-term healthcare costs for people with limited income. It is often a program of last resort for those without access to other resources.[73]

For Medicaid eligible individuals, ages 21 years and under, dental services are required to be provided according to a state established periodicity schedule such as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement. For EPSDT recipients services are not limited to emergency services but also include at a minimum, relief of pain and infections, restoration of teeth and maintenance of dental health.

In 2008, in a review of 16 states where dental utilization rates were 30% or less, CMS identified the following key barriers in children receiving adequate dental care.

- Limited availability of dental providers
- Low reimbursement rates
- Administrative burdens for providers
- Lack of clear information for beneficiaries about dental benefits
- Missed dental appointments
- Transportation
- Cultural and language competency
- Need for consumer education about the benefits of dental care[74]

Medicaid and CHIP cover comprehensive dental benefits for children, but 30% of children with private health insurance are uninsured for dental care. In 2010, more than 80% of low-income children with health insurance – whether Medicaid or private insurance – had a dental visit within the past 12 months, compared to half of low-income, uninsured children.[75]

According to CMS data for 2009, 16.8% population in the state was enrolled as Medicaid recipient which is nine percent increase from 2008 enrollees (15.4% of total population). The state's sharing of cost to Medicaid declined in 2009 (39%) compared to 2008 (49.6%).[76]

Table 9: Minnesota Indicators for Medicaid Recipients Birth through under the Age of 21 Years

Measures	*FFY2010*		*FFY2011*	
	Number	*Percent*	*Number*	*Percent*
Total individuals eligible for EPSDT for 90 continuous days	436,388		453,502	
Total eligible receiving any dental services [any service by or under the supervision of a dentist]	181,137	42	183,929	41
Total who did not receive dental services	255,251	58	269,573	59
Total eligible receiving a least one preventive dental services [by or under the supervision of a dentist]	162,986	33	164,432	36
Total eligible receiving dental treatment services [by or under the supervision of a dentist]	81,942	19	79,335	17
Total eligible (only children 6-9 years) receiving a sealant on a permanent molar tooth	14,273	17	13,590	15

Source: CMS 416 Report from the Department of Human Services. Reports are also publically available at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6793-ENG

The above table shows that the number of individuals eligible for EPSDT has increased by six percentage points. In 2010, percentage of eligibles receiving any dental services increased, whereas total eligibles receiving preventive dental service and dental treatment services showed a slight increase. The table shows that a vast majority of the population under 21 years of age is still not receiving dental services.

Chapter 8: Conclusion

This is the first burden of oral disease document for the state of Minnesota, presenting insight into the oral health profile for the state with baseline estimates and data trends based on the availability of data. The data presents existing disparities and identifies service gaps.

Caries experience of Minnesota children remains high and remarkable disparities continue to reflect in the burden of oral disease. This is further compounded by a skewed distribution of dental workforce in the state, with more dentists practicing in the urban areas, leaving a gap of service for vulnerable populations.

The absence of data on service coverage and disease estimates in pockets of the population is brought to the forefront by this report. Data is missing on dental caries experience or untreated caries among ages 2-4, 6-8, adolescents, and in the adult population, particularly among institutionalized elderly. Other areas where limited statewide data are available include pharyngeal and other oral cancers, burden of disease among migrant and native populations. Detailed information on sealant coverage in school age children, oral birth defects, and oral health of pregnant women is also limited.

However, despite these limitations, good preventive strategies and dental treatment services exist in the state, particularly in the form of water fluoridation and dental services for the non-minority populations and along the urban corridors, where notably more dental professionals practice.

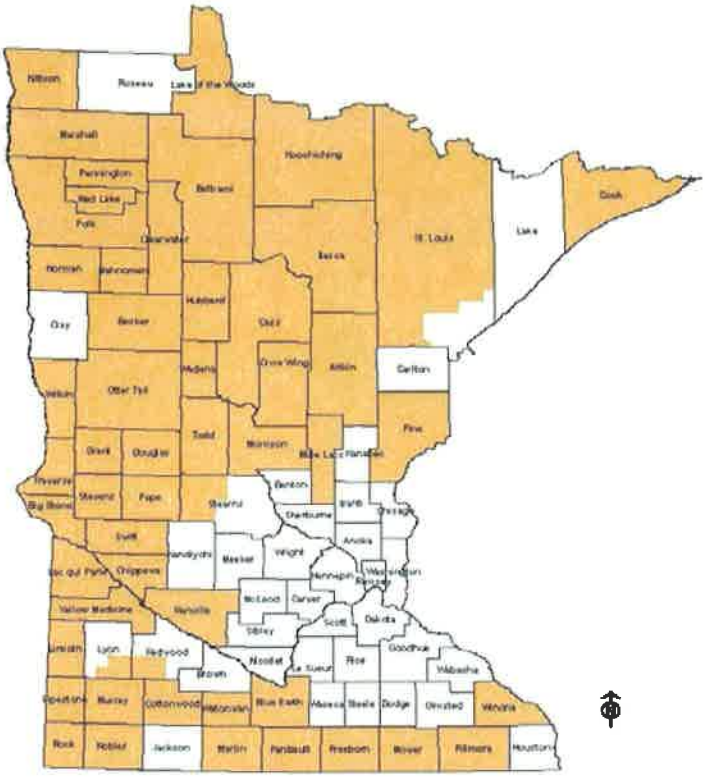
This burden of disease report presents the most current information on the oral health status in Minnesota. It is intended to provide information for decision making, policy development and implementation of preventive strategies to address oral health needs of the vulnerable populations in particular.

Appendix A: Acronyms

ACS	American Cancer Society
ADT	Advance Dental Therapist
ASTDD	Association of State and Territorial Dental Directors
BDIS	Birth Defects Information System
BRFSS	Behavioral Risk Factor Surveillance System
BSDH	Bachelor of Science in Dental Hygiene
BSS	Basic Screening Survey
CDC	Centers for Disease Control and Prevention
CHSDA	Contract Health Service Delivery Area
CMS	Centers for Medicare and Medicaid Services
CODA	Commission of Dental Accreditation
DHHS	Department of Health and Human Services
DHS	Department of Human Services
DT	Dental Therapist
ECC	Early Childhood Caries
ED	Emergency Department
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
FRL	Free or reduced lunch program
HHS	Health and Human Services
HIV	Human immunodeficiency virus
HP	Healthy People
HPSA	Health Professional Shortage Areas
HPV	Human Papilloma Virus
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine
LHI	Leading Health Indicator
MBD	Minnesota Board of Dentistry
MCSS	Minnesota Cancer Surveillance System
MDH	Minnesota Department of Health
MOHSAG	Minnesota Oral Health Data Advisory Group
MSS	Minnesota Student Survey
NHANES	National Health and Nutrition Examination Survey
NIH	National Institutes of Medicine
NRC	National Research Council
OH	Oral Health
OHP	Oral Health Program
ORHPC	Office of Rural Health and Primary Care
PRAMS	Pregnancy Risk Assessment Monitory System
RCT	Randomized control trial
SEER	Surveillance, Epidemiology, and End Results
SNOM	School Nurse Organization of Minnesota
UMN	University of Minnesota
US	United States
WFRS	Water Fluoridation Reporting System
YRBS	Youth Risk Behavior Surveillance System

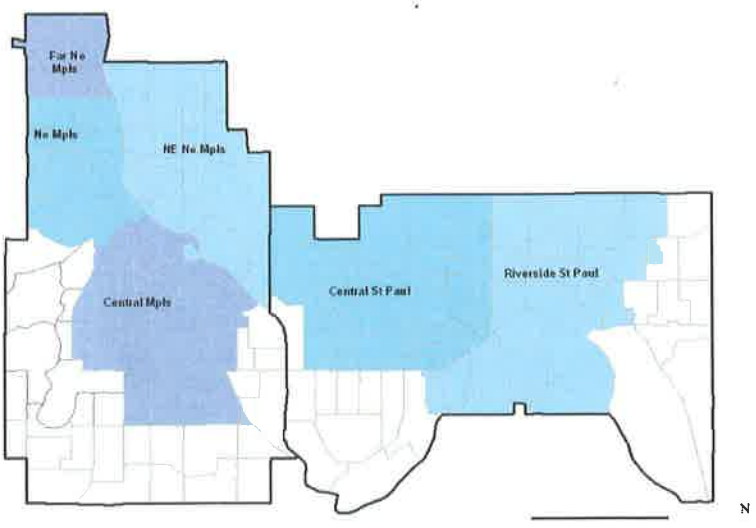
Appendix B: Maps

B1: Minnesota Dental Health Professional Shortage Areas by County (identified by mustard color)



Source: Minnesota Department of Health, Office of Rural Health and Primary Care, May 2012

B2: Minneapolis-Saint Paul Health Professional Shotage Area (identified by blue color)



Source: Minnesota Department of Health, Office of Rural Health and Primary Care, September 2010

References

[1]U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General--Executive Summary*. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

[2]Institute of Medicine. *Advancing Oral Health in America.* Washington, DC: The National Academies Press. 2011.

[3]U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Oral health in America: A report of the Surgeon General. Rockville, MD: National Institutes of Health, National Institute of Dental and Craniofacial Research; 2000, 33-59.

[4]U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Oral health in America: A report of the Surgeon General. Rockville, MD: National Institutes of Health, National Institute of Dental and Craniofacial Research; 2000, 155-88.

[5]StateMaster.com: Health Index by States. Accessed online June 21, 2011: http://www.statemaster.com/red/graph/hea_hea_ind-health-index&b_map=1

[6]Office of Geographic and Demographic Analysis. Office of the State Demographer/U.S Census. Accessed online June 2011: http://www.demography.state.mn.us/.

[7] U.S. Department of Commerce, United States Census Bureau Website. Accessed August 2013: http://www.census.gov/popest/data/state/totals/2012/index.html

[8]Social Determinants of Health. Centers for Disease Control. Accessed online April 2012: http://www.cdc.gov/socialdeterminants/Definitions.html

[9] Accessed online August 2013: http://www.ohe.state.mn.us/mPg.cfm?pageID=1873

[10] Stillwell, R., and Sable, J. (2013). *Public School Graduates and Dropouts from the Common Core of Data: School Year 2009–10: First Look (Provisional Data)* (NCES 2013-309rev). U.S. Department of Education. Washington, DC: National Center for Education Statistics. Retrieved [date] from http://nces.ed.gov/pubsearch.

[11] DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-243, Income, Poverty, and Health Insurance Coverage in the United States: 2011, U.S. Government Printing Office, Washington, DC. 2012

[12] Bishaw Alemayehu, U.S. Census Bureau, American Community Survey Briefs, ACSBR/11-01, Poverty 2010 &2011: 2011.

[13] U.S. Department of Labor, Local Area Unemployment Statistics, Accessed online July 2013: http://www.bls.gov/web/laus/laumstrk.htm

[14]Institute of Medicine. *Advancing Oral Health in America.* Washington, DC: The National Academies Press. 2011.

[15]Institute of Medicine and National Research Council. *Improving access to oral health care for vulnerable and underserved populations*. Washington, DC: The National Academies Press. 2011.

[16]Healthy People 2020 Summary of Objectives. Oral Health. Accessed online April 2012: http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/OralHealth.pdf

[17]Gift HC, Reisine ST, Larach DC. The social impact of dental problems and visits. American Journal of Public Health 1992; 82:1663-8.

[18]Yee R, Sheiham A. The burden of restorative dental treatment for children in Third World countries. International Dental Journal 2002; 52:7-10.

[19]Kaste LM, Drury TF, Horowitz AM, Beltran E. An evaluation of NHANES III estimates of early childhood caries. Journal of Public Health Dentistry 1999; 59(3):198-200.

[20]Bruce A, Gina T (2010), Trends in oral health by poverty status as measured by Health People 2010 objectives. Public Health Reports, Nov-Dec 2010/Vol 125: 817-830.

[21] National Center for Chronic Disease Prevention and Health Promotion Oral Health Resources. National Oral Health Surveillance System. Accessed online June 2011: http://www.cdc.gov/nohss/DSMain.htm

[22] U.S. Department of Health and Human Services, *Trends in Oral Health Status: United States, 1988-1994 and 1999-2004*, Centers for Disease Control and Prevention, National Center for Health Statistics, DHHS Publication No. (PHS) 2007-1698, Hyattsville MD, 2007.

[23]Preventing Dental Caries with Community Programs. Centers for Disease Control. Accessed online June 2011: http://www.cdc.gov/oralhealth/publications/factsheets/dental_caries.htm

[24]Types of Gum Disease. American Academy of Periodontology. Accessed online June 2011: http://www.perio.org/consumer/2a.html

[25] Eke PI, Dye BA, Wei L, Thornton-Evans GO, Genco RJ. Prevalence of periodontitis in adults in the United States: 2009 and 2010. J Dent Res 2012;91:914–20.

[26] Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers At A Glance 2011. Chronic Disease Prevention and Health Promotion. Centers for Disease Control. Accessed online April 2012: http://www.cdc.gov/chronicdisease/resources/publications/aag/doh.htm#aag

[27]Löe H: Periodontal disease: the sixth complication of diabetes mellitus. *Diabetes Care.*16:329–*334,* 1993.

[28]Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. *Diabetes Care.* 20:1183–*1197,* 1997.

[29] Centers for Disease Control. Office of Surveillance, Epidemiology and Laboratory Services, Behavioral Risk Factor Surveillance System. Accessed online July 2013: http://apps.nccd.cdc.gov/brfss/display.asp?state=MN&cat=OH&yr=2010&qkey=6606&grp=0&SUBMIT4=Go

[30]Centers for Disease Control. Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. Atlanta: U.S. Department of Health and Human Services; 2008.

[31]WebMD. Accessed online April 2012: http://www.webmd.com/oral-health/guide/cleft-lip-cleft-palate

[32]Long R E Jr, Improving Outcomes for the Patient with Cleft Lip and Palate: The Team Concept and 70 Years of Experience in Cleft Care. The Journal of Lancaster General Hospital Summer 2009 Vol. 4 – No. 2: 52-56.

[33]Facts about Cleft Lip and Cleft Palate. Centers for Disease Control. Accessed online July 2011: http://www.cdc.gov/ncbddd/birthdefects/cleftlip.html

[34] Minnesota Birth Defects Program Annual Report. 2009. Accessed online July 2011: http://www.health.state.mn.us/divs/eh/birthdefects/doc/2009report.pdf

[35]Minnesota Cancer Surveillance System (MCSS). Minnesota Department of Health. Accessed online June 2011: http://www.health.state.mn.us/divs/hpcd/cdee/mcss/

[36] Cancer in Minnesota, 1988 -2009. Report to the Minnesota Legislature 2013. Accessed in July 2013: http://www.health.state.mn.us/divs/hpcd/cdee/mcss/documents/cancerinmndec2012.pdf

[37]http://www.oralcancerfoundation.org/cdc/cdc_chapter3.htm

[38]Veerasathpurush A, Chin-Yu L, Shah A etl. Outcome in patients hospitalized for periapical abscess in the United States: an analysis involving the use of a nationwide inpatient sample. *J of American Dental Association* 2010; 141(9): 1107-1610.

[39]E. Davis, A. Deinard, and E. Maiga, "Doctor, My Tooth Hurts: The Costs of Incomplete Dental Care in the Emergency Room," . *J Publ Health Dent* 2010; 70(3): 205-210.

[40]The Pew center on the states, A Costly Dental Destination-Hospital Care Means States Pay Dearly, February 2012.

[41]Shottride E, Moore J, Use of emergency department for conditions related to poor oral health care. Final Report August 2010. Walsh Center for Rural Health Analysis.

[42]Accessed online June 2012. http://www.who.int/bulletin/volumes/83/9/editorial30905html/en/index.html

[43]Centers for Medicare and Medicaid Services. National health Expenditure Fact Sheet: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

[44] Accessed online June 2012. http://www.perio.org/consumer/mbc.diabetes.htm/

[45]Accessed online June 2012. http://www.perio.org/consumer/diabetes.htm

[46]Cutler C, Machen R, Jotwani R, et al. Heightened gingival inflammation and attachment loss in type 2 diabetics with hyperlipidemia. J Periodontol. 1999; 70:1313–21.

[47]Periodontal Disease and Diabetes - A Two Way Street Dual Highway? J. Deshmukh, M. Basnaker, Vinaya Kumar Kulkarni, G. Katti. People's Journal of Scientific Research Vol. 4(2), July 2011.

[48]Lalla, E., Cheng. B., Lal, S., Tucker, S., Greenberg, E., Goland, R., Lamster, I.B. 2006. Periodontal Changes in Children and Adolescents With Diabetes. Diabetes Care 29:295-299.

[49] Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS), Minnesota Department of Health, Division of Community and Family Health, Maternal and Child Health. This data was made possible by grant number IU01DP003117-01 from the Center for Disease Control and Prevention

[50]Clothier B, Stringer M, Jeffcoat MK. Periodontal disease and pregnancy outcomes: exposure, risk and intervention. *Best Pract Res Clin Obstet Gynaecol*. 2007; 21(3):451–466.

[51]Michalowicz BS, Hodges JS, DiAngelis AJ, et al. Treatment of periodontal disease and the risk of preterm birth. *N Engl J Med*. 2006; 355(18):1885–1894.

[52] Oral Health Care During Pregnancy Expert Workgroup, 2012. *Oral Health Care During Pregnancy: A National Consensus Statement – Summary of an Expert Workgroup Meeting.* Washington, DC: National Maternal and Child Oral Health Resource Center.

[53]Accessed online August 2012. http://www.netwellness.org/healthtopics/dentistry/osteoporosis.cfm

[54]Accessed online August 2012. http://www.niams.nih.gov/health_info/bone/bone_health/oral_health/default.asp

[55]Accessed online August 2012. http://www.sciencedaily.com/releases/2006/02/060223082229.htm

[56]Accessed online August 2012. http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm

[57]Griffin SO, Jones K, Tomar SL. An economic evaluation of community water fluoridation. *J Publ Health Dent* 2001; 61(2):78–86.

[58]Griffin SO, Gooch BF, Lockwood SA, Tomar SL. Quantifying the diffused benefit from water fluoridation in the United States. *Community Dent Oral Epidemiol* 2001; 29:120–129.

[59]Accessed online August 2012. https://apps.health.state.mn.us/mndata/drinkingwater

[60]Accessed online August 2012. http://www.mchoralhealth.org/pdhs/ohdentalsealantfactsheet.pdf

[61]Accessed online August 2012. http://www.cdphe.state.co.us/pp/oralhealth/impact.pdf

[62] Marinho, Valeria C, et al. Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews 7(2013):CD002279-CD002279.

[63] Quinonez, Rocio B, et al. Simulating cost-effectiveness of fluoride varnish during well-child visits for Medicaid-enrolled children. Archives of pediatrics & adolescent medicine 160.2 (2006):164-170.

[64]American Academy of Periodontology. Accessed online July 08, 2010: http://www.perio.org/consumer/smoking.htm

[65]Center for Disease Control: BRFSS. . Accessed online June 24, 2011: http://www.cdc.gov/brfss/index.htm

[66]Minnesota department of Health, Minnesota Student Survey. Accessed online June 24, 2011: http://education.state.mn.us/mde/Learning_Support/Safe_and_Healthy_Learners/Minnesota_Student_Survey/index.html

[67]Minnesota Student Survey 1992-2010 Trends. Minnesota Departments of Education, Health, Human Services, & Public Safety. Accessed online April 2012: http://www.health.state.mn.us/divs/chs/mss/trendreports/msstrendteport2010.pdf

[68]The Academy of General Dentistry. Soda Attack: Soft Drinks, Especially Non-colas and Iced Tea, Hurt Hard Enamel. Accessed online June 2011: http://www.knowyourteeth.com/infobites/abc/article/?abc=s&iid=295&aid=1166

[69] Centers for Disease Control (CDC). Physical Activity Levels of High School Students - United States, 2010. Accessed online June 2011: http://milk.procon.org/view.resource.php?resourceID=004361

[70]Minnesota Student Survey, 2007. Accessed online June 2011: http://www.health.state.mn.us/divs/chs/mss/statewidetables/mss07statetablesfinal.pdf

[71]Minnesota Student Survey, 2007. Accessed online June 2011: http://www.health.state.mn.us/divs/chs/mss/statewidetables/mss07statetablesfinal.pdf

[72]Health Professional Shortage Area (HPSA) Fact Sheet. Office of Rural Health and Primary Care, Minnesota Department of Health, 2012. Accessed online September 2012: http://www.health.state.mn.us/divs/orhpc/shortage/fact.pdf

[73]U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, 2008 National Dental Summary, January 2009.

[74]U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, 2008 National Dental Summary, January 2009.

[75]Kaiser Family Foundation. Oral Health in the US: Key Facts. June 2012. Accessed online Sept 2012: http://www.kff.org/uninsured/upload/8324.pdf

[76]Medicaid, Centers for Medicare & Medicaid Services. Minnesota Medicaid Statistics. . Accessed online Sept 2012: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/minnesota.html

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