Olmstead Subcabinet Meeting Agenda

Monday, March 22, 2021 • 3:00 p.m. to 4:30 p.m.

Please register for the Subcabinet Meeting at
https://attendee.gotowebinar.com/register/5151100238091809036

1) **Roll Call / Question**
   What will your agency's success look like in two years as it relates to work of the Olmstead Plan?

2) **Agenda Review**

3) **Approval of Minutes**
   a) Subcabinet meeting on January 25, 2021 **3**

4) **Reports**
   a) Chair
   b) Director **11**
   c) Compliance

5) **Agenda Items**
   a) February 2021 Quarterly Report **15**
   b) Draft plan amendments for 3 measurable goals and **79**
      Review of the 2021 Olmstead Plan **99**
   c) Temporary suspension to the launch of workgroup Adults with Disabilities and the Criminal Justice System

6) **Discussion Item**
   a) Proposed structure and roles of Subcabinet and Executive Committee **87**

7) **Adjournment**

Next Subcabinet Meeting: April 26, 2021 – 3:00 p.m. – 4:30 p.m.

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Olmstead Subcabinet Meeting Agenda Item

March 22, 2021

Agenda Item:

4) Approval of Minutes
a) Subcabinet meeting on January 25, 2021

Presenter:

Commissioner Ho (Minnesota Housing)

Action Needed:

☒ Approval Needed

☐ Informational Item (no action needed)

Summary of Item:

Approval is needed of the minutes from the January meeting.

Attachment(s):

4a- Olmstead Subcabinet meeting minutes – January 25, 2021

[AGENDA ITEM 4a] DRAFT MINUTES ARE SUBJECT TO CHANGE BY FINAL APPROVAL OF SUBCABINET

Olmstead Subcabinet Meeting Minutes

Monday, January 25, 2021 • 3:00 p.m. to 4:30 p.m.

1) Call to Order

The meeting was held using GoTo Webinar. Commissioner Ho welcomed everyone and thanked them for attending.

Subcabinet members present: Jennifer Lemaille Ho, Minnesota Housing (MHFA); Larry Herke, Minnesota Department of Veterans Affairs (MDVA); Jodi Harpstead, Department of Human Services (DHS); Paul Schnell, Department of Corrections (DOC); Roberta Opheim, Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); Colleen Wieck, Governor's Council on Developmental Disabilities (GCDD); Mary Catherine Ricker, Minnesota Department of Education (MDE) joined at 3:51 p.m.

Designees present: Tim Henkel, Minnesota Department of Transportation (MNDOT); Blake Chaffee, Department of Employment and Economic Development (DEED); Mary Manning, Minnesota Department of Health (MDH); Scott Buetel, Minnesota Department of Human Rights (MDHR); Michelle Smith (DOC); Wendy Wulff, Metropolitan Council (MetC); Bruce West, Department of Public Safety (DPS); Daron Korte, Minnesota Department of Education (MDE) joined at 3:20 p.m.

Guests present: Mike Tessneer, Rosalie Vollmar, Shelley Madore, Diane Doolittle, Chloe Ahlf, Carolyn Sampson and Sue Hite-Kirk, Olmstead Implementation Office (OIO); John Patterson and Ryan Baumtrog (MHFA); Kristie Billiar (MnDOT); Erin Sullivan Sutton, Catherine Courcy, Dan Baker, Gloria Smith, Whitney Terrill, and Shireen Gandhi (DHS); Tom Delaney and Holly Andersen (MDE); Ann Schulte (MDH); Dee Torgerson, Department of Employment and Economic Development (DEED); Kate Erickson, Department of Corrections (DOC); Gerri Sutton, Metropolitan Council (MetC); Beth Bibus, Minnesota Management and Budget (MMB); and Daniel Gulya, North Dakota Olmstead Commission

Note: In the interest of time, all attendees to the GoToWebinar were not identified.

CART provider: Paradigm Captioning and Reporting Services, Inc.

2) Roll Call / Question

Commissioner Ho asked the agency attendee (Commissioner or designee) to identify themselves and answer the question below.

With the new COVID Relief Plan offered by President Biden, what piece of the plan best supports your agency as it relates to people with disabilities?

- **Commissioner Ho (MHFA)):** For Minnesota Housing, this would add an additional $25 Billion of emergency funds on top of $25 billion from the last stimulus bill signed in December 2020. This would provide more help for renters.
- **Commissioner Harpstead (DHS):** Extension of the federal emergency throughout 2021 will allow DHS to extend health care coverage for Medicaid and Minnesota Care for everyone, including people with disabilities.

- **Deputy Commissioner Chaffee (DEED):** With all the unemployment work during COVID emergency, he has not focused on the stimulus bill, however he will review it.
- **Assistant Commissioner Henkel (MNDOT):** The agency is hopeful to see additional funding in the form of transit that would allow for the provision of transit services and thereby provide the accessibility that is in dire need.
- **Commissioner Schnell (DOC):** Investment in vaccine relief as there are so many in the DOC system that are very ill.
- **Assistant Commissioner Manning (MDH):** Beyond what is in the Biden legislation, MDH is continuing to look at how to make distribution of the vaccine equitable.
- **Assistant Commissioner Buetel (MDHR):** What has been said by others about the vaccine distribution will impact agency work, such as extending leave options.
- **Commissioner Herke (MDVA):** Temporary housing has been a great help in regard to homelessness, and additional vaccines will help in the area of caregivers.
- **Deputy Commissioner West (DPS):** The expansion and broadening of vaccine distribution is very important to DPS.
- **Council Member Wulff (MetC):** Echoes comments by Deputy Commissioner Henkel with MNDOT.
- **Roberta Opheim (OMHDD):** The impact on other agencies and their work, such as housing, transportation, medical care, no evictions, etc., really help people with disabilities that OMHDD serves.
- **Colleen Wieck (GCDD):** While there is nothing in the bill regarding developmental disabilities, GCDD supports all the provisions.

3) Agenda Review

Commissioner Ho reviewed the agenda. There were no requested changes.

4) Approval of Minutes

a) Subcabinet meeting on December 21, 2020

Commissioner Ho asked if there are any changes needed to the minutes for the December meeting. There were no requested changes.

Motion: Approve December meeting minutes
Action: Motion – Chaffee Second – Buetel
In Favor: Vote was taken with 12 Ayes and 0 Nays

- MHFA – Aye
- DHS – Aye
- DEED – Aye
- MNDOT – Aye
- DOC – Aye
- MDH – Aye
- MDHR – Aye
- MDVA – Aye
- DPS - Aye
- Met Council – Aye
- OMHDD – Aye
- GCDD – Aye

5) Reports

a) Chair – There was no report from the Chair.

b) Director

Shelley Madore reviewed the Director's Report on page 13 of the packet. The report provided an overview of the work being completed by OIO.

c) Compliance Office – There was no report from the Compliance Office.

6) Agenda Items

a) 2021 Olmstead draft Plan amendments

Mike Tessneer gave a brief overview of the Plan amendment process. He presented the first round of amendments included in the packet. The proposed changes to the measurable goals were indicated with blackline and the reason for the change was also included. Mike reviewed the summary document on page 17. Upon acceptance of the amendments, they will be posted for public comment.

Motion: Accept the proposed amendments to be posted for public comment.
Action: Motion – Schnell Second – Harpstead
In Favor: Vote was taken with 12 Ayes and 0 Nays

- MHFA – Aye
- DHS – Aye
- DEED – Aye
- MNDOT – Aye
- DOC – Aye
- MDH – Aye
- MDHR – Aye
- MDVA – Aye
- DPS - Aye
- Met Council – Aye
- OMHDD – Aye
- GCDD – Aye

b) Public input process on 2021 Plan amendments

Shelley Madore reported on the upcoming Plan amendment public input process as part of the website presentation.

Questions/Comments

Roberta Opheim (OMHDD) asked about the use of the Tennessen Warning on the website when asking individuals to provide their comments, and when collecting other identifying information. Ms. Madore stated the Tennessen Warning will be added. If an individual does not agree to let us use their information, then the process stops.

Colleen Wieck (GCDD) stated that some individuals want to comment but do not want to be identified. They therefore go through a third party like GCDD. She asked if that process would continue, and if individuals could contact OIO staff via email. Ms. Madore responded yes to both.

c) Overview of Olmstead Implementation Office website

Shelley Madore provided an overview of the OIO website that is scheduled to launch on January 26, 2021.

Questions/Comments

Roberta Opheim (OMHDD) expressed concern about the Tell your Story part of the website. She asked for clarification if these would be interpreted as asking for a facilitated outcome of issues. She also wanted to know if the stories would be shared with agencies and/or published on the website for the general public to see.

Shelley Madore responded that stories would never be published on the website, although a person might be contacted to use a quote from their story. No identifying data such as zip code or county will be retrievable once an individual submits their story.

Commissioner Schnell (DOC) asked if the OIO website link will be shared with the Subcabinet agencies to be embedded in their websites. Ms. Madore responded, yes. She also indicated that as the communications team monitors website traffic, posts, and other activities, this will be shared with agency leads as appropriate.

d) Update on Big 6 workgroups

Shelley Madore provided an update on the Big 6 workgroups. There will be web pages dedicated to each of the workgroups. Meetings will start in April 2021. There will be a social media campaign tied to the rollout of the workgroups.

Questions/Comments

Commissioner Ho stated it will be good to have this work pushed to the next level as this is where the Subcabinet identified priority collaborative work.

7) Discussion Item

Mike Tessneer introduced the discussion and provided the background information. A separate handout was sent out with this information.

1) How can we improve the 2022 Olmstead Plan that results in outcomes that reflect the desires of people with disabilities?

Commissioner Schnell (DOC)

- Change our organization to really focus on much more person-centered approach as opposed to doing what the correction system expects. Recognize individual strengths and unique challenges.
- We want to look at this person-centered focus and really trying to understand the needs of people that come into our system and in this case really talking about those who have a range of disabilities. We need to make sure that we have programs that are responsive to them and their needs and don't leave them behind.
- We need to find out from the people we serve where we are hitting the mark and where we are not and add strategies to address the shortfalls.

Roberta Opheim (OMHDD)

- It's important for the public to understand the goals and how it builds on the future and what they really mean.

Colleen Wieck (GCDD)

- Having public input before the agencies propose amendments is a good idea.
- Early results from the Quality of Life study indicate declines in several areas. Post pandemic we should again focus on relationships, integration, rights and decision making.

Commissioner Harpstead (DHS)

- There is a lot of ongoing national discussion on getting people to a living wage. This also raises a question about subminimum wage for people with disabilities which is probably going to be a national issue in the next few years.

Assistant Commissioner Beutel (MDHR)

- Good opportunity to take some lessons learned during COVID on engagement activities with online tools. This has actually increased our reach to people statewide who may otherwise have trouble travelling to attend a meeting.

Commissioner Ho (MHFA)

- The COVID-19 Housing assistance effort was built to work online, and we learned that you need to have a strategy and alternate method for those who do not have online access or have other barriers such as non-English speaking people.

Deputy Commissioner Henkel (MNDOT)

- Transportation access is a desire of people with disabilities.
- We need to continue the work of partnerships between the agencies and the work of knowledge building and interagency data sharing. This will help to determine the strategic approaches for investment in this state.
- We need to continue working with the regional transportation coordinating councils to understand the accessibility needs and seeking strategies and investments across agencies and across the entire state in an effort to provide accessibility.

Assistant Commissioner Korte (MDE)

- We need to make sure to engage families, parents and students directly.
- There is a good example with the unified sports campaign through Special Olympics, which is extracurricular sports and other activities where students with disabilities and non-disabled peers play together. Students themselves are doing some great integration and inclusion for their fellow students with disabilities and helping them be a part of the whole school experience. This is a great model that we as agencies could learn from.

Commissioner Harpstead (DHS)

- The Blue Ribbon Commission created a proposal for examining equity in disability services, and as we continue to disaggregate data through COVID, it's very clear that a disproportionate number of white Minnesotans with disabilities are offered group home waivers and day services and a disproportionate number of Black, Indigenous, and people of color (BIPOC) individuals are offered Personal Care Assistance (PCA) services. We need to take a look at that to examine how that occurs.

Commissioner Herke (MDVA)

- With the veterans in our state home system, we do a very good job of listening and reacting and taking care of the needs. We probably need to listen a little closer to the veterans who are not in the system and find a way to be able to hear what they may need assistance with. About a third are helped by the Federal VA, so there's a large number of people that still need assistance.

2) How can we improve the 2022 Olmstead Plan to show systemic improvements over time?

Roberta Opheim (OMHDD)

- It would be nice to provide a broad outline where we're headed in the goals and then show specific goals of specific years. Use more general language to express the goals in terms of wanting people to live more independently, and have a place of their own.

Director Manning (MDH)

- Measurable goals in health often include data that have a negative outcome. It's difficult to put it into a positive context. It's hard to positively say that a little bit less of something bad is a good thing. It's difficult to show progress when progress is at such an individual level.

Commissioner Ho (MHFA)

- Many times the cumulative measures look like not much progress was made because they are flat or because something else impacts them. Sometimes you have to look at the metrics within the performance to see the improvement.
- How do we highlight where the system is performing better than it used to, even if it hasn't solved everything for everybody?

Commissioner Harpstead (DHS)

- What can we learn can from our disability services during COVID? There were a lot more remote services which could support people living in their own homes and getting support without having to live in congregate care setting and we still have affordable housing issues to deal with for people with disabilities to enable all of that.

Commissioner Ho (MHFA)

- It might be a good idea to use one of our meetings to reflect on what adaptations did we make during the pandemic that should inform how we proceed after the pandemic.

Council Member Wulff (MetC)

- One of the weird things about disability is your rights depend on what program you qualify for. We need to look at people as people and what their needs are rather than what programs they are in. And that should include looking at the actual needs in a culturally competent setting.

Roberta Opheim (OMHDD)

- We need to embed the philosophy that each person is a unique individual that they may have a disability, they may have an income problems, they may have a housing problem, but they have a life experience to that point that we should honor and listen to.

Commissioner Herke (MDVA)

- With homelessness, if we continue to provide the information that we have up, then we can start going at specific areas. Success for us is to be able to look at different groups of people and look at them, not by the color of their skin, but to look at them as it relates to age and some of other ways that can help us to determine how we can best serve people at the time.

8) Adjournment:

Commissioner Ho stated the next Subcabinet meeting is March 22, 2021.

With the Governor's first term halfway over, thinking about the two questions just asked, helps us to think about the Subcabinet's legacy in meeting the desires of people with disabilities and showing systematic improvements over time. She encouraged members to continue to think about what their agency has contributed and how the Subcabinet has collectively changed the way it listens and incorporates the perspective of people with disabilities. She further asked how to make sure the Subcabinet can take real action steps to make sure it is moving in the direction of specific goals of the plan, as well as the bigger picture items.

The meeting was adjourned at 4:26 p.m.

Next Subcabinet Meeting: March 22, 2021 – 3:00 p.m. – 4:30 p.m.

Olmstead Subcabinet Meeting Agenda Item

March 22, 2021

Agenda Item:

5) Reports
b) Director

Presenter:

Shelley Madore (OIO)

Action Needed:

☐ Approval Needed

☒ Informational Item (no action needed)

Summary of Item:

The OIO Director will provide the report on the work of the Olmstead Implementation Office.

Attachment(s):

5b) Director's Report

[AGENDA ITEM 5b]

Olmstead Implementation Office
Director's Report to Subcabinet Members
March 22, 2021

Director's Summary

I am happy to announce that OIO has met significant milestones:

- OIO website launched on February 20
- Newsletter Announcing website launch and Plan Amendment process was highlighted
- Presentation to Subcabinet members and staff on March 11 introducing the OIO Communications Team

Public Engagement

Time	Platform	Total Active Users	Activity	Total Audience
2/20 to 3/13	Website	799	91% increase	812
2/24 to 2/25	Newsletter	264	37.6% open rate	703
3/2 to 3/10	Social Media	780	3,028 people engaged with posts	21,612 people saw our posts

Olmstead Plan Amendments
A newsletter went out on February 24, 2021 describing the new website and announcing the Plan Amendment Participation page. The page includes an online form to submit amendment comments and to record responses. Additionally, social media posts were dedicated to talking about the plan amendment process. To date, 361 people went to the Plan Amendment Participant page.

Quality of Life Survey
A presentation of the final data collected on the Quality of Life Survey will be presented at the April Subcabinet meeting. A total of 552 surveys were completed and includes 51 from the BIPOC community.

Workgroups – Big 6
At this time, the staff is moving into the final phase of the Kick-Off meeting, now scheduled for early April. The webpages for each group have been written and prepared for member participation moving forward. The applications will be launched following the Kick-Off meeting.

There is a request to suspend The Adults with Disabilities and the Criminal Justice System workgroup.

I appreciate your time and consideration to give you this update on the work of the OIO staff. Thank you.

Shelley Madore

Director
Olmstead Implementation Office

[AGENDA ITEM 5b]

Olmstead Subcabinet Meeting Agenda Item

March 22, 2021

Agenda Items:

6(a) February 2021 Quarterly Report on Olmstead Plan Measurable Goals

Presenter:

Mike Tessneer (OIO)

Action Needed:

☒ Approval Needed

☐ Informational Item (no action needed)

Summary of Item:

This is a draft of the February 2021 Quarterly Report. Mike Tessneer will provide a brief overview of the Executive Summary on page 3 of the Report.

Attachment(s):

6a – February 2021 Quarterly Report on Olmstead Plan Measurable Goals

[AGENDA ITEM 6a]

Minnesota Olmstead Subcabinet

Quarterly Report on Olmstead Plan Measurable Goals

REPORTING PERIOD

Data acquired through January 31, 2021

To be Reviewed by Olmstead Subcabinet

on March 22, 2021

Contents

I. PURPOSE OF REPORT 3
EXECUTIVE SUMMARY 3
II. MOVEMENT FROM SEGREGATED TO INTEGRATED SETTINGS 5
QUARTERLY SUMMARY OF MOVEMENT FROM SEGREGATED TO INTEGRATED 5
TRANSITION SERVICES GOAL ONE 6
TRANSITION SERVICES GOAL TWO 11
TRANSITION SERVICES GOAL THREE 14
TRANSITION SERVICES GOAL FOUR 18
III. TIMELINESS OF WAIVER FUNDING 20
TIMELINESS OF WAIVER FUNDING GOAL ONE 20
IV. QUALITY OF LIFE MEASUREMENT RESULTS 24
V. INCREASING SYSTEM CAPACITY AND OPTIONS FOR INTEGRATION 27
PERSON-CENTERED PLANNING GOAL ONE 27
POSITIVE SUPPORTS GOAL ONE 29
POSITIVE SUPPORTS GOAL TWO 31
POSITIVE SUPPORTS GOAL THREE 32
EMPLOYMENT GOAL ONE 35
EMPLOYMENT GOAL FOUR 40
LIFELONG LEARNING AND EDUCATION GOAL ONE 41
TRANSPORTATION GOAL ONE 42
TRANSPORTATION GOAL FOUR 45
POSITIVE SUPPORTS GOAL FOUR 46
POSITIVE SUPPORTS GOAL FIVE 49
CRISIS SERVICES GOAL ONE 52
CRISIS SERVICES GOAL TWO 54
PREVENTING ABUSE AND NEGLECT GOAL TWO 56
PREVENTING ABUSE AND NEGLECT GOAL THREE 57
VI. COMPLIANCE REPORT ON WORKPLANS 60
VII. ADDENDUM 61
CRISIS SERVICES GOAL ONE 61
ENDNOTES 62

I. PURPOSE OF REPORT

This quarterly report provides the status of work being completed by State agencies to implement the Olmstead Plan. The goals related to the number of people moving from segregated settings into more integrated settings; the number of people who are no longer on the waiting list; and the quality of life measures will be reported in every quarterly report.

Reports are compiled on a quarterly basis. For the purpose of reporting, the measurable goals are grouped in four categories:

1. Movement of people with disabilities from segregated to integrated settings
2. Movement of individuals from waiting lists
3. Quality of life measurement results
4. Increasing system capacity and options for integration

This quarterly report includes data acquired through January 31, 2021. Progress on each measurable goal will be reported quarterly, semi-annually, or annually. This report will be reviewed by the Olmstead Subcabinet Executive Committee and recommended for acceptance by the Olmstead Subcabinet. After reports are accepted they are made available to the public on the Olmstead Plan website at Mn.gov/Olmstead. [i]

This quarterly report also includes Olmstead Implementation Office (OIO) compliance summary reports on the status of workplans.

EXECUTIVE SUMMARY

This quarterly report covers twenty-five measurable goals.[ii] As shown in the chart below, eleven of those goals were either met or are on track to be met. Three goals were categorized as not on track, or not met. For those three goals, the report documents how the agencies will work to improve performance on each goal. Five goals are in process.

Status of Goals – February 2021 Quarterly Report	Number of Goals
Met annual goal	8
On track to meet annual goal	3
Not on track to meet annual goal	0
Did not meet annual goal	3
In process	11
Goals Reported	**25**

Listed below are areas critical to the Plan where measurable progress is being made.

Progress on movement of people with disabilities from segregated to integrated settings

- During the last four quarters, 86 individuals left ICF/DD programs to more integrated settings. This exceeds the annual goal of 72. (Transition Services Goal One A)
- During the last four quarters, 915 individuals with disabilities under age 65 in a nursing facility longer than 90 days moved to more integrated settings. This exceeds the annual goal of 750. (Transition Services Goal One B)
- During the last four quarters, 1,190 individuals moved from other segregated settings to more integrated settings. This exceeds the annual goal of 500. (Transition Services Goal One C)

Timeliness of Waiver Funding Goal One

- There are fewer individuals waiting for access to a DD waiver. At the end of the current quarter 66% of individuals were approved for funding within 45 days. Another 27% had funding approved after 45 days.

Increasing system capacity and options for integration

- The utilization of the Person Centered Protocols continues to show improvement. During this quarter, of the eight person centered elements measured in the protocols, performance on all elements improved over the 2017 baseline. Five of the eight elements achieved 97% or higher. (Person-Centered Planning Goal One)
- The adherence to transition protocol continues to show improvement. During this quarter, 50% of case files adhered to transition protocols. (Transition Services Four)
- The number of individuals experiencing a restrictive procedure is lower, at 193 individuals this quarter compared to 210 in the previous quarter. (Positive Supports Goal One)
- The number of reports of use of restrictive procedures is higher, at 702 reports this quarter compared to 650 in the previous quarter. (Positive Supports Goal Two)
- The percentage of students receiving instruction in the most integrated setting increased 0.04% to 62.83%. (Education Goal One)
- Accessibility improvements were made to 16 accessible pedestrian signals, and 5.6 miles of sidewalks. (Transportation Goal One)
- On-time performance for Greater Minnesota Transit improved to 92.63%. (Transportation Goal Four B)
- The number of students experiencing emergency use of restrictive procedures and the number of incidents were greatly reduced, although this was substantially affected by COVID-19 school closures. (Positive Supports Four and Five)
- There were 13 fewer individuals who experienced a repeated abuse or neglect repeat episode. (Preventing Abuse and Neglect Goal Three)

The following measurable goals have been targeted for improvement:

- Transition Services Goal Two to decrease the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting.
- Transition Services Goal Three to increase the number of individuals leaving the Minnesota Security Hospital (MSH) to a more integrated setting.
- Positive Supports Three to reduce the number of reports of emergency use of mechanical restraints with approved individuals.
- Employment Goal One to increase the number of people receiving VRS and SSB services who are in competitive integrated employment.
- Employment Goal Four to increase the number of employed peer support specialists
- Crisis Services Goal One and Two to increase the number of children and adults who remain in the community after a mental health crisis.

II. MOVEMENT FROM SEGREGATED TO INTEGRATED SETTINGS

This section reports on the progress of five separate Olmstead Plan goals that assess movement of individuals from segregated to integrated settings.

QUARTERLY SUMMARY OF MOVEMENT FROM SEGREGATED TO INTEGRATED

The table below indicates the cumulative net number of individuals who moved from various segregated settings to integrated settings for each of the five goals included in this report. The reporting period for each goal is based on when the data collected can be considered reliable and valid.

Net number of individuals who moved from segregated to integrated settings during reporting period

Setting	Reporting period	Number moved
• Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	April - June 2020	9
• Nursing Facilities (individuals under age 65 in facility > 90 days)	April - June 2020	222
• Other segregated settings	April - June 2020	277
• Anoka Metro Regional Treatment Center (AMRTC)	Oct - Dec 2020	21
• Minnesota Security Hospital (MSH)[1]	Oct - Dec 2020	12
Total	--	**541**

More detailed information for each specific goal is included below. The information includes the overall goal, the annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance and the universe number when available. The universe number is the total number of individuals potentially affected by the goal. The universe number provides context as it relates to the measure.

[1] For the purposes of this report Minnesota Security Hospital (MSH) refers to individuals residing in the facility and committed as Mentally Ill and Dangerous and other civil commitment statuses and individuals under competency restoration treatment, Minn. R. Crim. R. 20.01.

TRANSITION SERVICES GOAL ONE: By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings[iii] will be 7,138.

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

	2014 Baseline	June 30, 2015	June 30, 2016	June 30, 2017	June 30, 2018	June 30, 2019	June 30, 2020
A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72	84	84	84	72	72	72
B) Nursing Facilities (NF) under age 65 in NF > 90 days	707	740	740	740	750	750	750
C) Segregated housing other than listed above	1,121	50	250	400	500	500	500
Total		**874**	**1,074**	**1,224**	**1,322**	**1,322**	**1,322**

A) INTERMEDIATE CARE FACILITIES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (ICFs/DD)

2020 goal

- For the year ending June 30, 2020 the number of people who have moved from ICFs/DD to a more integrated setting will be **72**

Baseline: January - December 2014 = 72

RESULTS:
The 2020 goal to move 72 people from ICFs/DD to a more integrated setting was **met**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period	Total number of individuals leaving	Transfers[iv] (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	138	18	62	**58**
2016 Annual (July 2015 – June 2016)	180	27	72	**81**
2017 Annual (July 2016 – June 2017)	263	25	56	**182**
2018 Annual (July 2017 – June 2018)	216	15	51	**150**
2019 Annual (July 2018 – June 2019)	298	20	58	**220**
2020 Annual (July 2019 – June 2020)	174	13	75	**86**
2020 Quarter 1 (July – September 2019)	39	3	12	**24**
2020 Quarter 2 (October – December 2019)	47	5	21	**21**
2020 Quarter 3 (January – March 2020)	63	5	26	**32**
2020 Quarter 4 (April – June 2020)	25	0	16	**9**

ANALYSIS OF DATA:
From July 1, 2019 – June 30, 2020, the number of people who moved from an ICF/DD to a more integrated setting was 86. This is 134 fewer people than moved in the previous year. The annual goal of 72 was met.

From April – June 2020, the number of people who moved from an ICF/DD to a more integrated setting was 9. This is 23 people fewer than the previous quarter. It is important to note that there are fewer ICFS/DD settings than in previous years, so the number of individuals leaving is expected to be less over time.

COMMENT ON PERFORMANCE:
DHS provides reports to counties about persons in ICFs/DD who are not opposed to moving with community services, as based on their last assessment. As part of the current reassessment process, individuals are being asked whether they would like to explore alternative community services in the next 12 months. Some individuals who expressed an interest in moving changed their minds, or they would like a longer planning period before they move.

For those leaving an institutional setting, such as an ICF/DD, the Olmstead Plan reasonable pace goal is to ensure access to waiver services funding within 45 days of requesting community services. DHS monitors and provides technical assistance to counties in providing timely access to the funding and planning necessary to facilitate a transition to community services.

DHS continues to work with private providers that have expressed interest in voluntary closure of ICFs/DD. Providers are working to develop service delivery models that better reflect a community–integrated approach requested by people seeking services. Minnesota State Operated Community Services (MSOCS) no longer has any ICFs/DD settings.

UNIVERSE NUMBER:
In June 2017, there were 1,383 individuals receiving services in an ICF/DD.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

B) NURSING FACILITIES

2020 goal

- For the year ending June 30, 2020, the number of people who have moved from Nursing Facilities (for persons with a disability under 65 in facility longer than 90 days) to a more integrated setting will be **750.**

Baseline: January - December 2014 = 707

RESULTS:
The 2020 goal to move 750 people (under age 65) from Nursing Facilities to a more integrated setting was **met**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period	Total number of individuals leaving	Transfers (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	1,043	70	224	**749**
2016 Annual (July 2015 – June 2016)	1,018	91	198	**729**
2017 Annual (July 2016 – June 2017)	1,097	77	196	**824**
2018 Annual (July 2017 – June 2018)	1,114	87	197	**830**
2019 Annual (July 2018 – June 2019)	1,176	106	190	**880**
2020 Annual (July 2019 – June 2020)	1,241	86	240	**915**
2020 Quarter 1 (July – Sept 2019)	289	29	49	**211**
2020 Quarter 2 (Oct – Dec 2019)	314	27	54	**233**
2020 Quarter 3 (Jan – Mar 2020)	329	20	60	**249**
2020 Quarter 4 (Apr – June 2020)	309	10	77	**222**

ANALYSIS OF DATA:
From July 1, 2019 – June 30, 2020, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 915, which is 35 more individuals than the previous year. The annual goal of 750 was met.

From April – June 2020, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 222, which is 27 fewer individuals than the previous quarter.

COMMENT ON PERFORMANCE:
DHS reviews data and notifies lead agencies of people who accepted or did not oppose a move to more integrated options. Lead agencies are expected to work with these individuals to begin to plan their moves. DHS continues to work with partners in other agencies to improve the supply of affordable housing and knowledge of housing subsidies.

In July 2020, the Housing Stabilization Services[2] benefit went into effect. These services include housing search and support services for individuals moving from homelessness (or other housing instability) to more stable housing situations. Because these are State plan services, people do not need to be on a waiver to access them. Minnesota is the first state in the nation to offer such a service through its Medicaid program.

[2] This was formerly called Housing Access Services and Housing Access Coordination.

[AGENDA ITEM 6a]

UNIVERSE NUMBER:
In June 2017, there were 1,502 individuals with disabilities under age 65 who received services in a nursing facility for longer than 90 days.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

C) SEGREGATED HOUSING

2020 goal

- For the year ending June 30, 2020, the number of people who have moved from other segregated housing to a more integrated setting will be **500.**

BASELINE: During July 2013 – June 2014, of the 5,694 individuals moving, 1,121 moved to a more integrated setting.

RESULTS:
The 2020 goal to move 500 people from segregated housing to a more integrated setting was **met**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

[Receiving Medical Assistance (MA)]

Time period	Total moves	Moved to more integrated setting	Moved to congregate setting	Not receiving residential services	No longer on MA
2015 Annual (July 14 – June 15)	5,703	**1,137 (19.9%)**	502 (8.8%)	3,805 (66.7%)	259 (4.6%)
2016 Annual (July 15 – June 16)	5,603	**1,051 (18.8%)**	437 (7.8%)	3,692 (65.9%)	423 (7.5%)
2017 Annual (July 16 – June 17)	5,504	**1,054 (19.2%)**	492 (8.9%)	3,466 (63.0%)	492 (8.9%)
2018 Annual (July 17 – June 18)	5,967	**1,188 (19.9%)**	516 (8.7%)	3,737 (62.6%)	526 (8.8%)
2019 Annual (July 18 – June 19)	5,679	**1,138 (20.0%)**	484 (8.5%)	3,479 (61.3%)	578 (10.2%)
2020 Annual (July 19 – June 20)	5,967	**1,190 (19.9%)**	483 (8.1%)	3,796 (63.6%)	498 (8.4%)
2020 Quarter 1 (July – Sept 2019)	1,520	**284 (18.7%)**	122 (8.0%)	954 (62.6%)	160 (10.5%)
2020 Quarter 2 (Oct – Dec 2019)	1,465	**320 (21.8%)**	120 (8.0%)	892 (61.0%)	133 (9.0%)
2020 Quarter 3 (Jan – Mar 2020)	1,520	**309 (20.3%)**	152 (10.0%)	952 (62.7%)	107 (7.0%)
2020 Quarter 4 (Apr – June 2020)	1,462	**277 (18.9%)**	89 (6.1%)	998 (68.3%)	98 (6.7%)

ANALYSIS OF DATA:
From July 1, 2019 – June 30, 2020, of the 5,967 individuals moving from segregated housing, 1,190 individuals (19.9%) moved to a more integrated setting. This is an increase of 52 people from 1,138 the previous year, however it is a decrease of 0.1% from the previous year. The annual goal of 500 was met.

From April – June 2020, of the 1,462 individuals moving from segregated housing, 277 individuals (18.9%) moved to a more integrated setting. This is a decrease of 32 (1.4%) from the previous quarter.

COMMENT ON PERFORMANCE:
During the last year, there were significantly more individuals who moved to more integrated settings (19.9%) than who moved to congregate settings (8.1%). This analysis also illustrates the number of individuals who are no longer on MA and who are not receiving residential services as defined below.

The data indicates that a large percentage (63.6%) of individuals who moved from segregated housing are not receiving publicly funded residential services. Based on trends identified in data development for Crisis Services Goal Four, it is assumed the majority of those people are housed in their own or their family's home and are not in a congregate setting.

COMMENT ON TABLE HEADINGS:
The language below provides context and data definitions for the headings in the table above.

Total Moves: Total number of people in one of the following settings for 90 days or more and had a change in status during the reporting period:

- Adult corporate foster care
- Supervised living facilities
- Supported living services (DD waiver foster care or in own home)
- Board and Care or Board and Lodge facilities

Moves are counted when someone moves to one of the following:

- More Integrated Setting (DHS paid)
- Congregate Setting (DHS paid)
- No longer on Medical Assistance (MA)
- Not receiving residential services (DHS paid)
- Deaths are not counted in the total moved column

Moved to More Integrated Setting: Total number of people that moved from a congregate setting to one of the following DHS paid settings for at least 90 days:

- Adult family foster care
- Adult corporate foster care (when moving from Board and Care or Board and Lodge facilities)
- Child foster care waiver
- Housing with services
- Supportive housing
- Waiver non-residential
- Supervised living facilities (when moving from Board and Care or Board and Lodge facilities)

Moved to Congregate Setting: Total number of people that moved from one DHS paid congregate setting to another for at least 90 days. DHS paid congregate settings include:

- Board and Care or Board and Lodge facilities
- Intermediate Care Facilities (ICFs/DD)
- Nursing facilities (NF)

No Longer on MA: People who currently do not have an open file on public programs in MAXIS or MMIS data systems.

Not Receiving Residential Services: People in this group are on Medical Assistance to pay for basic care, drugs, mental health treatment, etc. This group does not use other DHS paid services such as waivers,

home care or institutional services. The data used to identify moves comes from two different data systems: Medicaid Management Information System (MMIS) and MAXIS. People may have addresses or living situations identified in either or both systems. DHS is unable to use the address data to determine if the person moved to a more integrated setting or a congregate setting; or if a person's new setting was obtained less than 90 days after leaving a congregate setting. Based on trends identified in data development for Crisis Services Goal Four, it is assumed the majority of these people are housed in their own or their family's home and are not in a congregate setting.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

TRANSITION SERVICES GOAL TWO: By June 30, 2020, the percent of people under mental health commitment at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting[v] will be reduced to 30% (based on daily average). [Extended March 2020]

2020 goal

- By June 30, 2020 the percent awaiting discharge will be reduced to 30% or lower

Baseline: From July 2014 - June 2015, the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting was 36% on a daily average. [3]

RESULTS:
The 2020 overall goal was reported as not met in the August 2020 Quarterly Report. Progress on this goal will continue to be reported in as **in process**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Percent awaiting discharge (daily average)

Time period	Mental health commitment	Committed after finding of incompetency
2016 Annual (July 2015 – June 2016)	Daily Average = 42.5%[4]	
2017 Annual (July 2016 – June 2017)	**44.9%**	29.3%
2018 Annual (July 2017 – June 2018)	**36.9%**	23.8%
2019 Annual (July 2018 – June 2019)	**37.5%**	28.2%
2020 Annual (July 2019 – June 2020)	**36.3%**	22.7%
2021 Quarter 1 (July – September 2020)	**29.9%**	25.2%
2021 Quarter 2 (October – December 2020)	**41.7%**	28.4%

[3] The baseline included individuals at AMRTC under mental health commitment and individuals committed after being found incompetent on a felony or gross misdemeanor charge (restore to competency).
[4] The data for July 2015 - June 2016 was reported as a combined percentage for individuals under mental health commitment and individuals committed after being found incompetent on a felony or gross misdemeanor charge (restore to competency). After July 2016, the data is reported separately for the two categories.

ANALYSIS OF DATA:
The 2020 overall goal to reduce the percent of individuals awaiting discharge to 30% was not met. From July 2019 – June 2020, 36.3% of those under mental health commitment at AMRTC no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting. During the same period, the percentage of individuals awaiting discharge who were civilly committed after being found incompetent was 22.7%. The combined total of all individuals at AMRTC awaiting discharge was 29.5%. Although the combined total met the 30% or less target, the 2020 goal for people under mental health commitment was not met.

From October – December 2020, 41.7% of those under mental health commitment at AMRTC no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting. This is moving in the wrong direction and is 11.8% higher than the previous quarter. During the same period, the percentage of individuals awaiting discharge who were civilly committed after being found incompetent was 28.4%. The combined total of all individuals at AMRTC awaiting discharge was 33.6% compared to 27.3% in the previous quarter and moving in the wrong direction.

This goal is being reported as in process. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

From October – December 2020, 19 individuals at AMRTC under mental health commitment left and moved to an integrated setting. The table below provides information about those individuals who left AMRTC. It includes the number of individuals under mental health commitment and those who were civilly committed after being found incompetent on a felony or gross misdemeanor charge who moved to integrated settings.

Time period	Total number of individuals leaving	Transfers	Deaths	Net moved to integrated setting	Moves to integrated setting	
					Mental health commit ment	Committed after finding of incompetency
2017 Annual (July 2016 – June 2017)	267	155	2	**110**	**54**	56
2018 Annual (July 2017 – June 2018)	274	197	0	**77**	**46**	31
2019 Annual (July 2018 – June 2019)	317	235	1	**81**	**47**	34
2020 Annual (July 2019 – June 2020)	347	243	0	**104**	**66**	38
2021 Quarter 1 (July – September 2020)	100	77	0	**23**	**14**	9
2021 Quarter 2 (Oct – December 2020)	80	59	0	**21**	**19**	2

COMMENT ON PERFORMANCE:
Approximately one third of individuals at AMRTC no longer need hospital level of care, including those under a mental health commitment and those who need competency restoration services. Those committed after a finding of incompetency, accounted for approximately 50% of AMRTC's census in this quarter.

For individuals under mental health commitment, complex mental health and behavioral support needs often create challenges to timely discharge. When they move to the community, they may require 24 hour per day staffing or 1:1 or 2:1 staffing. Common barriers that can result in delayed discharges for those at AMRTC include a lack of housing vacancies and housing providers no longer accepting applications for waiting lists.

Community providers often lack capacity to serve individuals who exhibit these behaviors:

- Violent or aggressive behavior (i.e. hitting others, property destruction, past criminal acts);
- Predatory or sexually inappropriate behavior;
- High risk for self-injury (i.e. swallowing objects, suicide attempts); and
- Unwillingness to take medication in the community.

UNIVERSE NUMBER:
In Calendar Year 2017, 383 patients received services at AMRTC. This may include individuals who were admitted more than once during the year. The average daily census was 91.9.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

TRANSITION SERVICES GOAL THREE: By December 31, 2020, the average monthly number of individuals leaving Minnesota Security Hospital[5] to a more integrated setting will increase to 10 individuals per month. [Extended March 2020]

2020 goal

- By December 31, 2020 the average monthly number of individuals leaving to a more integrated setting will increase to 10 or more

Baseline: From January – December 2014, the average monthly number of individuals leaving Minnesota Security Hospital (MSH) to a more integrated setting was 4.6 individuals per month.

RESULTS:
The 2020 goal to increase the monthly number of individuals leaving to a more integrated setting to 10 was **not met**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period	Total number of individuals leaving	Transfers [iv] (-)	Deaths (-)	Net moved to integrated setting	Monthly average
2015 Annual (Jan – Dec 2015)	188	107	8	73	**6.1**
2016 Annual (Jan – Dec 2016)	184	97	3	84	**7.0**
2017 Annual (Jan – Dec 2017)	199	114	9	76	**6.3**
2018 Annual (Jan – Dec 2018)	212	130	3	79	**6.6**
2019 Annual (Jan – Dec 2019)	217	121	5	91	**7.6**
2020 Annual (Jan – Dec 2020)	129	67	9	53	**4.4**
2020 Quarter 1 (Jan – Mar 2020)	32	16	2	14	**4.7**
2020 Quarter 2 (Apr – June 2020)	38	23	4	11	**3.7**
2020 Quarter 3 (July – Sept 2020)	26	9	1	16	**5.3**
2020 Quarter 4 (Oct – Dec 2020)	33	19	2	12	**4.0**

ANALYSIS OF DATA:
From January 1 – December 31, 2020, the average monthly number of individuals leaving the facility to a more integrated setting was 4.4. The average number moving to an integrated setting decreased by 3.2 from the previous year and is 5.6 below the goal of 10. The 2020 goal of 10 was not met.

From October – December 2020, the average monthly number of individuals leaving the facility to a more integrated setting was 4.0. The average number moving to an integrated setting decreased by 1.3 from the previous quarter. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Discharge data is categorized into three areas to allow analysis around possible barriers to discharge. The table below provides a breakdown of the number of individuals leaving the facility by category. The

[5] For the purposes of this report Minnesota Security Hospital (MSH) refers to individuals residing in the St Peter facility and committed as Mentally Ill and Dangerous and other civil commitment statuses and individuals under competency restoration treatment, Minn. R. Crim. P. 20.01.

categories include: committed after being found incompetent on a felony or gross misdemeanor charge, committed as Mentally Ill and Dangerous (MI&D) and Other committed.

Time period	Type	Total moves	Transfers	Deaths	Moves to integrated
2015 Annual (January – December 2015)	Committed after finding of incompetency	99	67	1	31
	MI&D committed	66	24	7	35
	Other committed	23	16	0	7
	Total	**188**	**107**	**8**	**(Avg. = 6.1) 73**
2016 Annual (January – December 2016)	Committed after finding of incompetency	93	62	0	31
	MI&D committed	69	23	3	43
	Other committed	25	15	0	10
	Total	**187**	**100**	**3**	**(Avg. = 7.0) 84**
2017 Annual (January – December 2017)	Committed after finding of incompetency	133	94	2	27
	MI&D committed	55	17	6	32
	Other committed	11	3	1	7
	Total	**199**	**114**	**9**	**(Avg. = 6.3) 76**
2018 Annual (January – December 2018)	Committed after finding of incompetency	136	97	0	39
	MI&D committed	73	31	3	39
	Other committed	3	2	0	1
	Total	**212**	**130**	**3**	**(Avg. = 6.6) 79**
2019 Annual (January – December 2019)	Committed after finding of incompetency	138	89	1	48
	MI&D committed	73	33	4	36
	Other committed	6	1	0	5
	Total	**217**	**123**	**5**	**(Avg. = 7.4) 89**
2020 Annual (January – December 2020)	Committed after finding of incompetency	78	52	1	25
	MI&D committed	46	15	8	23
	Other committed	5	0	0	5
	Total	**129**	**67**	**9**	**(Avg. = 4.4) 53**
2020 Quarter 1 (Jan – Mar 2020)	Committed after finding of incompetency	19	13	0	6
	MI&D committed	11	3	2	6
	Other committed	2	0	0	2
	Total	**32**	**16**	**2**	**(Avg. = 4.7) 14**
2020 Quarter 2 (April – June 2020)	Committed after finding of incompetency	25	17	1	7
	MI&D committed	13	6	3	4
	Other committed	0	0	0	0
	Total	**38**	**23**	**4**	**(Avg. = 3.7) 11**
2020 Quarter 3 (July – Sept 2020)	Committed after finding of incompetency	13	6	0	7
	MI&D committed	11	3	1	7
	Other committed	2	0	0	2
	Total	**26**	**9**	**1**	**(Avg. = 5.3) 16**
2020 Quarter 4 (Oct – Dec 2020)	Committed after finding of incompetency	21	16	0	5
	MI&D committed	11	3	2	6
	Other committed	1	0	0	1
	Total	**33**	**19**	**2**	**(Avg. = 4.0) 12**

COMMENT ON PERFORMANCE:
The St Peter facility continues to experience increased challenges in discharging individuals to more integrated settings due to the COVID-19 pandemic. At times, community providers are unable to accept new admissions because they are experiencing staffing shortages due to illness or individuals they are currently serving have tested positive for COVID.

In addition to community provider's inability to serve new admissions, The St Peter facility has needed to restrict individual access to the community both in outings and passes. This has resulted in individuals being unable to practice community reintegration skills that are often required by the Forensic Review Panel, the Special Review Board, and/or community providers prior to an individual's discharge. In addition to COVID-related barriers, staff have noted challenges with finding placements that will accept individuals with criminal sexual conduct histories and meet accessibility needs for individuals who use a wheelchair.

Individuals committed to the facility are provided services tailored to their individual needs. DHS efforts continue to expand community capacity and continues to work towards the mission of the Olmstead Plan or decision by identifying individuals who could be served in more integrated settings.

MI&D committed and Other committed
Persons committed as Mentally Ill and Dangerous (MI&D), are provided acute psychiatric care and stabilization, as well as psychosocial rehabilitation and treatment services. The MI&D commitment is for an indeterminate period of time, and requires a Special Review Board recommendation to the Commissioner of Human Services, prior to approval for community-based placement (Minnesota Stat. 253B.18). Persons under other commitments receive services at the St Peter facility. Other commitments include Mentally Ill (MI), Mentally Ill and Chemically Dependent (MI/CD), Mentally Ill and Developmentally Disabled (MI/DD).

One identified barrier to discharge is the limited number of providers with the capacity to serve:
- Individuals with Level 3 predatory offender designation;
- Individuals over age 65 who require adult foster care, skilled nursing, or nursing home level care;
- Individuals with DD/ID with high behavioral acuity;
- Individuals who are undocumented; and
- Individuals whose county case management staff has refused or failed to adequately participate in developing an appropriate provisional discharge plan for the individual.

Some barriers to discharge identified by the Special Review Board (SRB), in their 2017 MI&D Treatment Barriers Report as required by Minnesota Statutes 253B.18 subdivision 4c(b) included:
- The patient lacks an appropriate provisional discharge plan;
- A placement that would meet the patient's needs is being developed; and
- Funding has not been secured.

Ongoing efforts are facilitated to enhance discharges for those served at Forensic Services, including:
- Collaboration with county partners to identify those individuals who have reached maximum benefit from treatment;
- Collaboration with county partners to identify community providers and expand community capacity (with specialized providers or utilization of Minnesota State Operated Community Services);

- Utilization of the Forensic Review Panel, an internal administrative group, whose role is to review individuals served for reductions in custody (under MI&D Commitment), and who may be served in a more integrated setting;
- The Forensic Review Panel also serves to offer treatment recommendations that could assist the individual's growth or skill development, when necessary, to aid in preparing for community reintegration.

  A summary of the Forensic Review Panel efforts include:
  - From January to March 2020: Reviewed 60 cases; recommended reductions for 9 cases with 10 being granted. (There are times the Special Review Board (SRB) supports a reduction that the Forensic Review Board did not recommend).
  - From April to June 2020: Reviewed 60 cases; recommended reductions for 25 cases. To date, 17 have been granted and 19 reviews are pending.
  - From July to September 2020: Reviewed 63 cases; recommended reductions for 22 cases. The SRB supported 22 reductions in custody and three petitions were withdrawn.
  - From October to December 2020: Reviewed 51 cases; recommended reductions for 10 cases. To date, the SRB has approved four reductions with a total of 18 cases pending.
- Collaboration with DHS/Direct Care and Treatment entities to expand community capacity and individualized services for a person's transitioning.

Committed after finding of incompetency

Individuals under competency restoration treatment, Minn. R. Crim. P. 20.01, may be served in any program at the facility. The majority of individuals are placed under a concurrent civil commitment to the Commissioner, as Mentally Ill. The limited purpose for this population is to stabilize the individual's mental health symptoms such that they can be served in a lower level of care.

Competency restoration treatment may occur with any commitment type, but isn't the primary decision factor for discharge. For this report, the "Committed after finding of incompetency" category represents any individual who had been determined by the court to be incompetent to proceed to trial, though not under commitment as MI&D (as transitions to more integrated settings for those under MI&D requires Special Review Board review and Commissioner's Order).

- Placement and programming for this population primarily (i.e. individuals under "treat to competency,") in a 32-bed unit that is located off the campus, but in the city of St. Peter.
- While AMRTC continues to provide care to those who may be under this legal status, individuals referred to the facility in St Peter are determined to no longer require hospital-level care.

DHS has convened a cross-division, cross-administration working group to improve the timely discharge of individuals at the St Peter facility and AMRTC who fall into this unique category of "Committed after findings of incompetency" Minn. R. Crim. P. 20.01. The focus is to identify barriers, current and future strategies to develop a continuum of care delivery in Minnesota as well as any needed efficiencies that could be developed to support movement to community, specifically from the St Peter facility and AMRTC. The group is looking at the full continuum from early recognition of symptoms to many levels of care delivery that needs to exist in Minnesota. Part of this work is reviewing discharge processes across AMRTC and the Forensic Mental health program with the aim of standardization in these sites resulting in improved outcomes for our patients.

UNIVERSE NUMBER:
In Calendar Year 2020, 502 unique patients received services at Forensic Services. This number reflects only counting an individual only once even if served more than once during the year. The average daily census was 358.19

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

TRANSITION SERVICES GOAL FOUR: **By June 30, 2020, 100% of people who experience a transition will engage in a process that adheres to the Person-Centered, Informed Choice and Transition protocol. Adherence to the transition protocol will be determined by the presence of the ten elements from the My Move Plan Summary document listed below. [People who opted out of using the My Move Summary document or did not inform their case manager that they moved are excluded from this measure.]**

Baseline: For the period from October 2017 – December 2017, of the 26 transition case files reviewed, 3 people opted out of using the My Move Plan Summary document and 1 person did not inform their case manager that they moved. Of the remaining 22 case files, 15 files (68.2%) adhered to the transition protocol.

RESULTS:
The 2020 overall goal was reported as not met in the November 2020 Quarterly Report. Progress on this goal will continue to be reported in as **in process**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period	Number of transition case files reviewed	Number opted out	Number not informing case manager	Number of remaining files reviewed	Number not adhering to protocol	Number adhering to protocol
Baseline Oct – Dec 2017	26	3	1	22	7 of 22 (31.8%)	**15 of 22 (68.2%)**
FY 18 Qtr 3 and 4 Jan – June 2018	59	11	5	43	5 of 43 (11.6%)	**38 of 43 (88.4%)**
FY 19 (July 18 - June 20)	78	20	4	54	19 of 54 (35.2%)	**35 of 54 (64.8%)**
FY 20 (July 19 - June 20)	158	27	11	120	26 of 120 (21.7%)	**94 of 120 (78.3%)**
FY21 Quarter 1 July - Sept 2020	5	1	0	4	2 of 4 (50.0%)	**2 of 4 (50.0%)**

ANALYSIS OF DATA:
The 2020 overall goal of 100% was not met. From July 2019 – June 2020, of the 158 transition case files reviewed, 27 people opted out of using the My Move Plan documents and 11 individuals did not inform their case managers that they were moving. Of the remaining 120 case files, 94 files (78%) adhered to the transition protocols. This goal is being reported as in process. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

For the period of July – September 2020, of the 5 transition case files reviewed, 1 person opted out of using the My Move Plan document. Of the remaining 4 files, 2 files (50%) adhered to the transition protocol. This is a decrease of 26% from the previous quarter of 76%.

The plan is considered to meet the transition protocols if all ten items below (from "My Move Plan" document) are present:

1. Where is the person moving?
2. Date and time the move will occur.
3. Who will help the person prepare for the move?
4. Who will help with adjustment during and after the move?
5. Who will take the person to new residence?
6. How will the person get his or her belongings?
7. Medications and medication schedule.
8. Upcoming appointments.
9. Who will provide support after the move; what they will provide and how to contact those people (include informal and paid support), including supporting the person to adjust to the changes?
10. Back-up plans for what the person will do in emergencies, such as failure of service provider to show up on schedule, unexpected loss of provider or mental health crisis.

In addition to reviewing for adherence to the transition protocols (use of the My Move Plan document), case files are reviewed for the presence of person-centered elements. This is reported in Person-Centered Planning Goal One.

COMMENT ON PERFORMANCE:

Due to the COVID pandemic, the Lead Agency Review team had to modify its onsite process to conducting reviews virtually. Only two lead agencies were reviewed during this time period. One county consistently demonstrated the use of My Move Plan Summary to help facilitate the person's move, 100% of the time when the case manager was aware of the move. For the 2 cases that did not adhere to the transition protocol, the My Move Plan Summary form was not present in the case file during the time of the review.

In April 2019, Lead Agency Review implemented changes to the sampling methodology utilized to identify transition cases. Prior to April 2019, a discrete transition sample was selected based on claims data for people who had moved within 18 months of the case file review period. As of April 2019, the Lead Agency Review team now reviews transition protocol compliance for anyone within the overall case file review sample who moved during the 18 month review period.

When findings from case file review indicate files do not contain all required documentation, the lead agency is required to bring all cases into full compliance by obtaining or correcting the documentation. Corrective action plans are required when patterns of non-compliance are evident. Because the move occurred prior to the lead agency site review, transition measures related to the contents of the My Move Plan Summary cannot be remediated.

However, lead agencies are provided information about which components of the My Move Plan were compliant/non-compliant for each of the transition cases that were reviewed.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

III. TIMELINESS OF WAIVER FUNDING

This section reports progress of individuals being approved for home and community-based services waiver funding. An urgency categorization system for the Developmental Disabilities (DD) waiver waiting list was implemented on December 1, 2015. The system categorizes urgency into three categories including Institutional Exit, Immediate Need, and Defined Need. Reasonable pace goals have been established for each of these categories. The goal reports the number of individuals that have funding approved at a reasonable pace and those pending funding approval.

TIMELINESS OF WAIVER FUNDING GOAL ONE: Lead agencies will approve funding at a reasonable pace for persons: (A) exiting institutional settings; (B) with an immediate need; and (C) with a defined need for the Developmental Disabilities (DD) waiver.

Baseline: From January – December 2016, of the 1,500 individuals assessed, 707 individuals or 47% moved off the DD waiver waiting list at a reasonable pace. The percent by urgency of need category was: Institutional Exit (42%); Immediate Need (62%); and Defined Need (42%).

Assessments between January – December 2016

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days
Institutional Exit	89	37 **(42%)**	30 (37%)
Immediate Need	393	243 **(62%)**	113 (29%)
Defined Need	1,018	427 **(42%)**	290 (30%)
Totals	**1,500**	**707 (47%)**	433 (30%)

RESULTS:
This goal is in process. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period: Fiscal Year 2018 (July 2017 – June 2018)

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	96	**63 (66%)**	26 (27%)	7 (7%)
Immediate Need	467	**325 (70%)**	118 (25%)	24 (5%)
Defined Need	1,093	**734 (67%)**	275 (25%)	84 (8%)
Totals	1,656	**1,122 (68%)**	419 (25%)	115 (7%)

[AGENDA ITEM 6a]

Time period: Fiscal Year 2019 (July 2018 - June 2019)

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	105	84 (80%)	18 (17%)	3 (3%)
Immediate Need	451	339 (75%)	98 (21.7%)	14 (3%)
Defined Need	903	621 (69%)	235 (26%)	47 (5%)
Totals	**1,459**	**1,044 (72%)**	**351 (24%)**	**64 (4%)**

Time Period: Fiscal Year 2020 (July 2019 – June 2020)

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	71	43 (61%)	22 (31%)	6 (8%)
Immediate Need	273	174 (64%)	84 (31%)	15 (5%)
Defined Need	786	443 (56%)	247 (32%)	96 (12%)
Totals	**1,130**	**660 (59%)**	**353 (31%)**	**117 (10%)**

Time Period: Fiscal Year 2021 Quarter 1 (July – September 2020)

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	18	11 (61%)	7 (39%)	0 (0)
Immediate Need	61	41 (67%)	15 (25%)	(8%)
Defined Need	163	108 (66%)	42 (26%)	13 (8%)
Totals	**242**	**160 (66%)**	**64 (27%)**	**18 (7%)**

ANALYSIS OF DATA:
From July – September 2020, of the 242 individuals assessed for the Developmental Disabilities (DD) waiver, 160 individuals (66%) had funding approved within 45 days of the assessment date. An additional 64 individuals (27%) had funding approved after 45 days. Only 18 individuals (7%) assessed are pending funding approval.

COMMENT ON PERFORMANCE:
Lead agencies receive monthly updates regarding the people who are still waiting for DD funding approval through a web-based system. Using this information, lead agencies can view the number of days a person has been waiting for DD funding approval and whether reasonable pace goals are met. If reasonable pace goals are not met for people in the Institutional Exit or Immediate Need categories, DHS directly contacts the lead agency and seeks remediation. DHS continues to allocate funding resources to lead agencies to support funding approval for people in the Institutional Exit and Immediate Need categories.

Lead agencies may encounter individuals pending funding approval on an intermittent basis, requiring DHS to engage with each agency to resolve individual situations. When these issues arise, a lead agency may be unfamiliar with the reasonable pace funding requirement due to the infrequent nature of this issue at their particular agency. DHS continues to provide training and technical assistance to lead

agencies as pending funding approval issues occur and has added staff resources to monitor compliance with reasonable pace goals.

Not all persons who are assessed are included in the above tables. Only individuals who meet the criteria of one of the three urgency categories are included in the table. If an individual's need for services changes, they may request an immediate reassessment or information will be collected during a future assessment.

Below is a summary table with the number of people pending funding approval at a specific point of time. Also included is the average and median days waiting of those individuals pending funding approval. The average days and median days information has been collected since December 1, 2015. This data does not include those individuals who had funding approved within the 45 days reasonable pace goal.

Number of People Pending Funding Approval by Category

As of Date	Total Number	Institutional Exit	Immediate Need	Defined Need
April 1, 2017	**201**	13	16	172
July 1, 2017	**237**	13	26	198
October 1, 2017	**152**	12	36	104
January 1, 2018	**89**	1	22	66
April 1, 2018	**60**	5	20	35
July 1, 2018	**94**	6	26	62
October 1, 2018	**114**	12	26	76
January 8, 2019	**93**	10	18	65
April 1, 2019	**79**	3	15	61
July 1, 2019	**96**	10	22	64
October 1, 2019	**125**	9	29	87
January 1, 2020	**117**	7	23	87
April 1, 2020	**135**	9	33	93
July 1, 2020	**132**	8	16	108
October 1, 2020	**113**	4	24	85
January 1, 2021	**97**	5	17	75

Average Number of Days Individuals are Pending Funding Approval by Category

As of Date	Institutional Exit	Immediate Need	Defined Need
April 1, 2017	91	130	193
July 1, 2017	109	122	182
October 1, 2017	136	120	183
January 1, 2018	144	108	184
April 1, 2018	65	109	154
July 1, 2018	360	115	120
October 1, 2018	112	110	132
January 8, 2019	138	115	144
April 1, 2019	278	113	197
July 1, 2019	155	125	203
October 1, 2019	262	132	197
January 1, 2020	216	167	205
April 1, 2020	252	152	198
July 1, 2020	318	239	228
October 1, 2020	504	223	289
January 1, 2021	447	345	283

Median Number of Days Individuals are Pending Funding Approval by Category

As of Date	Institutional Exit	Immediate Need	Defined Need
April 1, 2017	82	93	173
July 1, 2017	103	95	135
October 1, 2017	102	82	137
January 1, 2018	144	74	140
April 1, 2018	61	73	103
July 1, 2018	118	85	70
October 1, 2018	74	78	106
January 8, 2019	101	79	88
April 1, 2019	215	88	147
July 1, 2019	75	86	84
October 1, 2019	166	103	103
January 1, 2020	104	119	105
April 1, 2020	195	78	121
July 1, 2020	257	165	148
October 1, 2020	367	100	197
January 1, 2021	413	346	189

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported four months after the end of the reporting period.

IV. QUALITY OF LIFE MEASUREMENT RESULTS

This section includes reports on two quality of life measures. The National Core Indicator Survey and the Olmstead Plan Quality of Life Survey.

NATIONAL CORE INDICATOR (NCI) SURVEY

The results for the 2019 National Core Indicator (NCI) survey for individuals with intellectual and developmental disabilities were reported in March 2020. The national results of the NCI survey with state-to-state comparison are available at www.nationalcoreindicators.org. The Minnesota state reports are available at www.nationalcoreindicators.org/states/MN. In 2019, the sample size was 401.

Summary of National Core Indicator Survey Results from Minnesota in 2018 - 2019

Each year, NCI asks people with intellectual and developmental disabilities and their families about the services they get and how they feel about them. The results, along with other efforts, support data informed decision making and improvement efforts. The Minnesota Department of Human Services likes the NCI survey because:

- It allows a comparison of Minnesota's results with other states' results;
- The survey was designed for the specific populations interviewed or surveyed;
- It gathers feedback directly from people; and
- It is independently administered.

Each year a random sample of the people DHS supports with intellectual and/or developmental disabilities are invited to participate in this optional survey. In 2019, 401 people completed an interview. People who agree to participate meet the interviewer where and with whom they feel comfortable. For some questions, people that have a difficult time responding may choose to have another person answer for them. A selection of NCI results from 2016 to 2019 is summarized below.

Question	2015 - 2016		2016 - 2017		2017 - 2018		2018 - 2019	
	Yes	No	Yes	No	Yes	No	Yes	No
1. Do you have a paid job in your community?	41%	59%	35%	65%	39%	61%	34%	66%
2. Would you like a job in the community	52%	48%	47%	53%	50%	50%	50%	50%
3. Do you like where you work?	92%	8%	89%	11%	88%	12%	92%	8%
4. Do you want to work somewhere else?	34%	66%	28%	72%	32%	68%	26%	74%
5. Did you go out shopping in the past month?*	92%	8%	92%	8%	91%	9%	89%	11%
6. Did you go out on errands in the past month?*	91%	9%	89%	11%	90%	10%	89%	11%
7. Did you go out for entertainment in the past month? *	83%	17%	82%	18%	78%	12%	73%	27%
8. Did you go out to eat in the past month?*	86%	14%	89%	11%	88%	12%	87%	13%
9. Did you go out for a religious or spiritual service in the past month?*	46%	54%	47%	53%	44%	56%	43%	57%
10. Did you participate in community groups or other activities in community in past month?	37%	63%	43%	57%	42%	58%	41%	59%
11. Did you go on vacation in the past year?	58%	42%	48%	52%	50%	50%	52%	48%

[AGENDA ITEM 6a]

Question	2015 - 2016		2016 - 2017		2017 - 2018		2018 - 2019	
	Yes	No	Yes	No	Yes	No	Yes	No
12. Did you have input in choosing your home?	56%	44%	45%	55%	59%	41%	N/A	**
13. Did you have input in choosing your housemates?	34%	66%	22%	78%	35%	65%	N/A	**
14. Do you have friends other than staff and family?	83%	17%	82%	18%	80%	20%	84%	16%
15. Can you see your friends when you want to?	77%	23%	81%	19%	86%	14%	80%	20%
16. Can you see and/or communicate with family whenever you want?	94%	6%	87%	13%	90%	10%	89%	11%
17. Do you often feel lonely?	11%	89%	10%	90%	12%	88%	9%	91%
18. Do you like your home?	89%	11%	88%	12%	88%	12%	89%	11%
19. Do you want to live somewhere else?	29%	71%	26%	74%	25%	75%	23%	77%
20. Does your case manager ask what you want?	89%	11%	84%	16%	82%	18%	85%	15%
21. Are you able to contact case manager when you want?	87%	13%	89%	11%	86%	14%	88%	12%
22. Is there at least one place you feel afraid or scared?	30%	70%	18%	82%	26%	74%	22%	78%
23. Can you lock your bedroom?	42%	58%	45%	55%	53%	47%	58%	42%
24. Do you have a place to be alone at home?	99%	1%	98%	2%	98%	2%	97%	3%
25. Have you gone to a self-advocacy meeting?	30%	70%	29%	71%	29%	71%	26%	74%

*Asked the number of times an activity occurred in the past month. The "No" percentage indicates an answer of 0 times.
**Questions 12 and 13 were removed from the survey beginning in 2019.

Analysis of Data
The results of most questions remained fairly consistent. Questions with consistent increase or decrease of 5% or greater over the years include:

- Question 7: Did you go out for entertainment in the past month? **Decreased** from 83% to 73%
- Question 19: Do you want to live somewhere else? **Decreased** from 29% to 23%
- Question 23: Can you lock your bedroom? **Increased** from 42% to 58%

OLMSTEAD PLAN QUALITY OF LIFE SURVEY

The Olmstead Plan Quality of Life Survey: First Follow-Up 2018[6] report was accepted by the Olmstead Subcabinet on January 28, 2019. The analysis of the follow-up survey results shows that this long-term study is valuable and has helped to identify important characteristics affecting overall quality of life. Researchers recommend waiting a longer period of time before resurveying respondents.

Olmstead Plan Quality of Life Survey Second Follow-Up

The second follow-up survey was conducted throughout 2020. This survey engaged 550 individuals who participated in the longitudinal study. In addition this year's survey includes a new sample of 51 Minnesotans with disabilities who identify Black, Indigenous, and People of Color (BIPOC). The draft recommendations from the second follow-up survey will be reviewed by the Subcabinet at the March 22, 2021 Meeting.

As part of the Second Follow-Up survey, four briefs were released throughout. The final brief was released in November 2020[7]. The briefs address specific topics and along with survey results, can inform efforts to improve quality of life for Minnesotans with disabilities.

The briefs relate to the following areas:

1. Social integration and engagement - This brief speaks to opportunities to meaningfully interact with people outside of the disability system.
2. Freedom to make choices - This brief focuses on what the survey tells us about the decisions people make, the choices they have, and how policies can better support individual choice.
3. Perceived qualities of life - This brief focuses on what survey participants themselves tell us about their quality of life and what that suggests for areas of improvement.

Presence of close and valued relationships – This brief focused on how we all deserve the ability to develop friendships, but for some of us who receive services in settings designed to have control over us, it can be hard to develop these close relationships.

[6] Olmstead Plan Quality of Life Survey: First Follow-up 2018 Report is available on the Olmstead Plan website at www.mn.gov/olmstead

[7] Olmstead Quality of Life Survey briefs are available on the Olmstead Quality of Life website at http://theimprovegroup.com/olmstead-quality-life-survey

V. INCREASING SYSTEM CAPACITY AND OPTIONS FOR INTEGRATION

This section reports on the progress of measurable goals related to increasing capacity of the system and options for integration that are being reported in each quarterly report. The information for each goal includes the overall goal, annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance and the universe number, when available. The universe number is the total number of individuals potentially affected by the goal. This number provides context as it relates to the measure.

PERSON-CENTERED PLANNING GOAL ONE: **By June 30, 2020, plans for people using disability home and community-based waiver services will meet protocols. Protocols are based on the principles of person-centered planning and informed choice.**

Baseline: In state Fiscal Year (FY) 2014, 38,550 people were served on the disability home and community-based services. From July 1, 2016 – June 30, 2017 there were 1,201 disability files reviewed during the Lead Agency Reviews. For the period from April – June 2017, in the 215 case files reviewed, the eight required criteria were present in the percentage of files shown below.

Element	Required criteria	Percent
1	The support plan describes goals or skills that are related to the person's **preferences**.	74%
2	The support plan includes a global statement about the person's **dreams and aspirations**.	17%
3	Opportunities for **choice** in the person's current environment are described.	79%
4	The person's current **rituals and routines** are described.	62%
5	**Social**, leisure, or religious **activities** the person wants to participate in are described.	83%
6	Action steps describing what needs to be done to assist the person in achieving his/her goals or skills are described.	70%
7	The person's preferred **living** setting is identified.	80%
8	The person's preferred **work** activities are identified.	71%

RESULTS:

This goal is in process. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Table amounts are percentages

Time period Fiscal Year (Months)	(1) Preferences	(2) Dreams Aspirations	(3) Choice	(4) Rituals Routines	(5) Social Activities	(6) Goals	(7) Living	(8) Work
Baseline (April – June 2017)	74	17	79	62	83	70	80	71
FY18 (July 17 – June 18)	81.3	31.3	92.5	59.8	92.4	81.3	96.3	89.6
FY19 (July 18 – June 19)	91.8	58.4	97.9	59.8	96.0	95.3	98.7	99.0
FY20 (July 19 – June 20)	91.1	77.2	98.9	77.1	98.8	97.0	99.1	98.7
FY21 Q1 (July – Sept 2020)	94.0	75.9	98.8	72.3	97.6	98.8	97.6	98.8

ANALYSIS OF DATA:

For the period from July - September 2020, in the 83 case files reviewed, the eight required elements were present in the percentage of files shown above. Performance on all eight elements has continued to improve over the 2017 baseline. Five of the eight elements achieved 97% or above. The remaining three show consistent progress.

Total number of cases and sample of cases reviewed

Time period	Total number of cases (disability waivers)	Sample of cases reviewed (disability waivers)
Fiscal Year 18 (July 2017 - June 2018)	12,192	1,243
Fiscal Year 19 (July 2018 - June 2019)	4,240	515
Fiscal Year 20 (July 2019 - June 2020)	18,992	1,245
FY21 Quarter 1 (July – September 2020)	558	83

Lead Agencies Participating in the Audit [8]

Time period	Lead agencies
Fiscal Year 18 (July 2017 – June 2018)	(19) Pennington, Winona, Roseau, Marshall, Kittson, Lake of the Woods, Stearns, McLeod, Kandiyohi, Dakota, Scott, Ramsey, Big Stone, Des Moines Valley Alliance, Kanabec, Nicollet, Rice, Sibley, Wilkin
Fiscal Year 19 (July 2018 – June 2019)	(15) Brown, Carlton, Pine, Watonwan, Benton, Blue Earth, Le Sueur, Meeker, Swift, Faribault, Itasca, Martin, Mille Lacs, Red Lake, Wadena
Fiscal Year 20 (July 2019 – June 2020)	(20) Mahnomen, Koochiching, Wabasha, Goodhue, Traverse, Douglas, Pope, Grant, Stevens, Isanti, Olmsted, St. Louis, Hennepin, Carver, Wright, Crow Wing, Renville, Lac Qui Parle, Chippewa, Otter Tail
FY21 Q1 (July – Sept 2020)	(2) Mower, Norman

COMMENT ON PERFORMANCE:
The Lead Agency Review team looks at twenty-five person-centered items for the disability waiver programs (Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Disability Inclusion (CADI) and Developmental Disabilities (DD). Of those twenty-five items, DHS selected eight items as being cornerstones of a person-centered plan.

In January 2018, the Lead Agency Review process began requiring lead agencies to remediate all areas of non-compliance with the required person-centered elements. When the findings from case file review indicate files did not contain all required documentation, the lead agency is required to bring all cases into full compliance by obtaining or correcting the documentation. Corrective action plans are required when patterns of non-compliance are evident. For the purposes of corrective action, the person-centered measures are grouped into two categories: development of a person-centered plan and support plan record keeping.

Both counties reviewed during this reporting period were required to develop a corrective action plans in one of the categories of the person-centered measures.

UNIVERSE NUMBER:
In Fiscal year 2017 (July 2016 – June 2017), there were 47,272 individuals receiving disability home and community-based services.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it will be reported three months after the end of the reporting period.

[8] Agency visits are sequenced in a specific order approved by Centers for Medicare and Medicaid Services (CMS)

POSITIVE SUPPORTS GOAL ONE: By June 30, 2020, the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) who experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will not exceed 650. [Revised March 2020]

2020 goal

- By June 30, 2020 the number of individuals experiencing a restrictive procedure will not exceed 650 individuals

Annual Baseline: From July 2013 – June 2014 of the 35,668 people receiving services in licensed disability services, e.g., home and community based services, there were 8,602 BIRF reports of restrictive procedures, involving 1,076 unique individuals.

RESULTS:

The 2020 overall goal was reported as met in the November 2020 Quarterly Report. Progress on this goal will continue to be reported in as **in process**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period	Individuals who experienced restrictive procedure	Reduction from previous year
2014 Baseline (July 2013 – June 2014)	1,076 (unduplicated)	N/A
2015 Annual (July 2014 – June 2015)	867 (unduplicated)	209
2016 Annual (July 2015 – June 2016)	761 (unduplicated)	106
2017 Annual (July 2016 - June 2017)	692 (unduplicated)	69
2018 Annual (July 2017 - June 2018)	644 (unduplicated)	48
2019 Annual (July 2018 - June 2019)	642 (unduplicated)	2
2020 Annual (July 2019 - June 2020)	561 (unduplicated)	81
Quarter 1 (July - September 2020)	193 (duplicated)	N/A – quarterly number

ANALYSIS OF DATA:

From July 2019 – June 2020, the total number of people experiencing a restrictive procedure was 561. That is a decrease of 81 from 642 the previous year and a decrease of 515 from baseline. The overall goal to not exceed 650 individuals was met.

From July – September 2020, the total number of people who experienced a restrictive procedure was 193. This was a decrease of 17 from 210 the previous quarter. The quarterly numbers are duplicated counts. Individuals may experience restrictive procedures during multiple quarters in a year.

COMMENT ON PERFORMANCE:

There were 193 individuals who experienced a restrictive procedure this quarter:

- 181 individuals were subjected to Emergency Use of Manual Restraint (EUMR) only. This was a decrease of 10 people from last quarter. Such EUMRs are permitted and not subject to phase out requirements like all other "restrictive" procedures. These reports are monitored and technical assistance is available when necessary.

- 12 individuals experienced restrictive procedures other than EUMRs (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). This was a decrease of 7 from the previous quarter. DHS staff and the External Program Review Committee provide follow up and technical assistance for all reports involving restrictive procedures *other than* EUMR. It is anticipated that focusing technical assistance with this subgroup will reduce the number of individuals experiencing restrictive procedures and the number of reports (see Positive Supports Goal Three).

Under the Positive Supports Rule, the External Program Review Committee (EPRC) convened in February 2017 has the duty to review and respond to Behavior Intervention Reporting Form (BIRF) reports involving EUMRs. Beginning in May 2017, the EPRC conducted outreach to providers in response to EUMR reports. It is anticipated the EPRC's work will help to reduce the number of people who experience EUMRs through the guidance they provide to license holders regarding specific uses of EUMR. The purpose of EPRC engagement in these cases is to provide guidance to help reduce the frequency and/or duration of future emergency uses of manual restraint. The EPRC looks at trends in EUMR over six months to identify which providers currently need additional support. They also look at trends in 911 calls to monitor that decreases in EUMR are not replaced by increases in 911 calls.

During this quarter, the EPRC reviewed BIRFs, positive support transition plans, and functional behavior assessments. Based on the content within those documents, the committee conducted EUMR-related assistance involving 47 people. This number does not include people who are receiving similar support from other DHS groups. Some examples of guidance provided by committee members include discussions about the function of behaviors, helping providers connect with local behavior professionals or other licensed professionals, providing ideas on positive support strategies, and explaining rules and the law.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

POSITIVE SUPPORTS GOAL TWO: **By June 30, 2020, the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) will not exceed 3,500. [Revised March 2020]**

2020 goal

- By June 30, 2020 the number of reports of restrictive procedure will not exceed 3,500.

Annual Baseline: From July 2013 – June 2014 of the 35,668 people receiving services in licensed disability services, e.g., home and community based services, there were 8,602 BIRF reports of restrictive procedures, involving 1,076 unique individuals.

RESULTS:

The 2020 overall goal was reported as met in the November 2020 Quarterly Report. Progress on this goal will continue to be reported in as **in process**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period	Number of BIRF reports	Reduction from previous year
2014 Baseline (July 2013 – June 2014)	8,602	N/A
2015 Annual (July 2014 – June 2015)	5,124	3,478
2016 Annual (July 2015 – June 2016)	4,008	1,116
2017 Annual (July 2016 - June 2017)	3,583	425
2018 Annual (July 2017 - June 2018)	3,739	+156
2019 Annual (July 2018 - June 2019)	3,223	516
2020 Annual (July 2019 - June 2020)	3,126	97
Quarter 1 (July – September 2020)	702	N/A – quarterly number

ANALYSIS OF DATA:

From July 2019 – June 2020, the number of restrictive procedure reports was 3,126. That is a decrease of 97 from 3,223 the previous year and a decrease of 5,476 from baseline. The overall goal to not exceed 3,500 reports was met.

From July – September 2020, the number of restrictive procedure reports was 702. This was an increase of 52 from the previous quarter. The quarterly numbers are duplicated counts. Individuals may experience restrictive procedures during multiple quarters in a year.

COMMENT ON PERFORMANCE:

There were 702 reports of restrictive procedures this quarter.

- 631 reports were for emergency use of manual restraint (EUMR). Such EUMRs are permitted and not subject to phase out requirements like all other "restrictive" procedures. These reports are monitored and technical assistance is available when necessary.
    - Under the Positive Supports Rule, the External Program Review Committee (EPRC) has the duty to review and respond to BIRF reports involving EUMRs. Convened in February 2017, the Committee's work will help to reduce the number of people who experience EUMRs through the guidance they provide to license holders regarding specific uses of EUMR.
    - This is an increase of 80 reports of EUMR from the previous quarter.

- 71 reports involved restrictive procedures other than EUMR (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures).
    - The EPRC provides ongoing monitoring over restrictive procedures being used by providers with persons under the committee's purview. DHS staff provide follow up and technical assistance for all reports involving restrictive procedures that are not implemented according to requirements under 245D or the Positive Supports Rule. The close monitoring and engagement by the EPRC with the approved cases of emergency use of procedures enables DHS to help providers work through some of the most difficult cases of ongoing use of mechanical restraints. Focusing existing capacity for technical assistance primarily on reports involving these restrictive procedures is expected to reduce the number of people experiencing these procedures, as well as reduce the number of reports seen here and under Positive Supports Goal Three.
    - The number of non-EUMR restrictive procedure reports decreased by 28 from the previous quarter.

- 8 uses of seclusion or timeout involving 4 people were reported this quarter:
    - 8 reports of seclusion involving 4 people occurred at the St Peter facility (formerly known as Minnesota Security Hospital). This was a decrease of 4 from the previous quarter. As necessary, DHS Licensing Division investigates and issues correction orders for any violations of the Positive Supports Rule associated with use of mechanical restraint.
    - There were no reports of time out this quarter.
    - The combined number of seclusion or time out reports decreased by 5 from the previous quarter.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

POSITIVE SUPPORTS GOAL THREE: **Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544[vi], with limited exceptions to protect the person from imminent risk of serious injury. (Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and safety clips for safe vehicle transport).**

- **By June 30, 2020, the emergency use of mechanical restraints, other than the use of an auxiliary device[9] will be reduced to no more than 93 reports. [Revised March 2020]**

2020 Goal

- By June 30, 2020, reduce mechanical restraints, other than use of auxiliary devices, to no more than 93 reports

Baseline: From July 2013 - June 2014, there were 2,038 BIRF reports of mechanical restraints involving 85 unique individuals. In SFY 2019, of the 658 reports of mechanical restraints, 336 were for use of auxiliary devices to ensure a person does not unfasten a seatbelt in a vehicle. The number of reports other than use of auxiliary devices were 322.

[9] Auxiliary devices ensure a person does not unfasten a seat belt in a vehicle and includes seatbelt guards, harnesses and clips.

[AGENDA ITEM 6a]

RESULTS:
The 2020 overall goal was reported as not met in the November 2020 Quarterly Report. Progress on this goal will continue to be reported in as **in process**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

[This goal was revised in the March 2020 Olmstead Plan. Beginning in Fiscal Year 2020, the use of auxiliary devices is counted separately and will continue to be reported.]

Time period	Total number of reports (includes auxiliary devices)	Number of individuals at end of time period
2014 Baseline (July 2013 – June 2014)	2,083	85
2015 Annual (July 2014 – June 2015)	912	21
2016 Annual (July 2015 – June 2016)	691	13
2017 Annual (July 2016 – June 2017)	664	16
2018 Annual (July 2017 – June 2018)	671	13
2019 Annual (July 2018 – June 2019)	658	12
2020 Annual (July 2019 – June 2020)	530	10

Time period	Reports (other than seat belt devices)	Reports on use of auxiliary devices	Total number of reports (includes auxiliary devices)	Number of individuals at end of time period
2019 Annual Baseline (July 2018 – June 2019)	332	336	658	12
2020 Annual (July 2019 – June 2020)	273	257	530	10
2021 Q1 (July – Sept 2020)	**23**	40	63	10

ANALYSIS OF DATA:
From July 2019 – June 2020, the number of reports of mechanical restraints other than auxiliary devices was 273. That is a decrease of 59 from 332 the previous year. The overall goal to reduce to no more than 93 reports was not met. From July 2019 – June 2020, the total number of reports of mechanical restraints including auxiliary devices was 530 which is a decrease of 128 reports from the previous year.

From July – September 2020, the number of reports of mechanical restraints other than auxiliary devices was 23. This was a decrease of 21 from the previous quarter. At the end of the reporting period, the number of individuals for whom the use of mechanical restraint use was approved was 10. This remains unchanged over the last 3 quarters.

COMMENT ON PERFORMANCE:
Under the requirements of the Positive Supports Rule, in situations where mechanical restraints have been part of an approved Positive Support Transition Plan to protect a person from imminent risk of serious injury due to self-injurious behavior and the use of mechanical restraints has not been successfully phased out within 11 months, a provider must submit a request for the emergency use of these procedures to continue their use.

These requests are reviewed by the External Program Review Committee (EPRC) to determine whether they meet the stringent criteria for continued use of mechanical restraints. The EPRC consists of members with knowledge and expertise in the use of positive supports strategies. The EPRC sends its recommendations to the DHS Commissioner's delegate for final review and either time-limited approval or rejection of the request. The EPRC provides person-specific recommendations as appropriate to assist the provider to reduce the need for use of mechanical restraints. In situations where the EPRC believes a license holder needs more intensive technical assistance, phone and/or in-person consultation is provided by panel members.

The EPRC annually evaluates progress and determines if there are additional measures to be taken to reduce the use of mechanical restraint. The EPRC Annual Evaluation Report is available on the following webpage under the Annual Reports tab: https://mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/positive-supports/extension-request/eprc.jsp

Of the 63 BIRFs reporting use of mechanical restraint in Quarter 1:

- 40 reports involved auxiliary devices to prevent a person from unbuckling their seatbelt during travel. This is an increase of 12 from the previous quarter. The increase is likely due to people going into the community more frequently as Covid-19 restrictions were relaxed in Minnesota.

- 23 reports involved use of another type of mechanical restraint. This is a decrease of 33 from the previous quarter. The total number of people who experienced a mechanical restraint decreased by 5 people.
    - 20 reports involved 5 people who had the use of self-injury protection equipment (examples include helmets, splints, braces, mitts, and gloves) reviewed by the EPRC and approved by the Commissioner for the emergency use of mechanical restraint. This was a decrease of 29 reports from the previous quarter and a decrease of 2 people.
    - 3 reports involving 2 people, were submitted by the St Peter facility (formerly called Minnesota Security Hospital). This was a decrease of 3 reports from the facility. As necessary, DHS Licensing Division investigates and issues correction orders for any violations of the Positive Supports Rule associated with use of mechanical restraint.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

SEMI-ANNUAL AND ANNUAL GOALS

This section includes reports on the progress of measurable goals related to increasing capacity of the system and options for integration that are being reported semi-annually or annually. Each specific goal includes: the overall goal, the annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance.

EMPLOYMENT GOAL ONE: By September 30, 2019, the number of new individuals[10] receiving Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) who are in competitive integrated employment will increase by 14,820.

2019 Goal

- By September 30, 2019, the number of new individuals with disabilities working in competitive integrated employment will be **3,059.**

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

RESULTS:

The 2019 overall goal was reported as not met in the February 2020 Quarterly Report. Progress on this goal will continue to be reported in as **in process**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Number of Individuals Achieving Employment Outcomes

Time period Federal Fiscal Year (FFY)	Vocational Rehabilitation Services (VRS)	State Services for the Blind (SSB)	Annual Total	Cumulative Total
2015 Annual (FFY 15) October 2014 – September 2015	3,104	132	3,236	3,236
2016 Annual (FFY 16) October 2015 – September 2016	3,115	133	3,248	6,484
2017 Annual (FFY 17) October 2016 – September 2017	2,713	94	2,807	9,291
2018 Annual (FFY 18) October 2017 – September 2018	2,577	105	2,682	11,973
2019 Annual (FFY 19) October 2018 – September 2019	2,578	92	2,670	14,643
2020 Data (FFY 20) October 2019 – September 2020	2,005	66	2,071	16,714

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

ANALYSIS OF DATA:
From October 2018 – September 2019, the number of people with disabilities working in competitive integrated employment was 2,670. The 2019 annual goal of 3,059 was not met. This number represents a decrease of 12 from the previous year, and is 68 under baseline. In addition, the overall goal to increase the number in competitive integrated employment by 14,820 was not met.

From October 2019 – September 2020, the number of people with disabilities working in competitive integrated employment was 2,071. This is a decrease of 599 from the previous year and is 677 under baseline.

Additional information
The Workforce Innovation and Opportunity Act (WIOA) impact on Vocational Rehabilitation Services
The Workforce Innovation and Opportunity Act (WIOA) has significantly broadened the scope of services that VRS is required to provide to people with disabilities. Two categories of service required by WIOA have the greatest impact on VRS administered programs: Pre-Employment Transition Services and Limitations on the Use of Subminimum Wage (WIOA Section 511).

Pre-Employment Transition Services (Pre-ETS)
WIOA requires VRS to have Pre-ETS available statewide to all students with disabilities, ages 14 through 21. The five required Pre-Employment Transition Services are: (1) job exploration counseling; (2) work-based learning experiences; (3) post-secondary education counseling; (4) workplace readiness training; and (5) instruction in self advocacy.

In the 2020-2021 school year, this statewide mandate for services covers more than 45,000 students, ages 14 through 21 in Minnesota who are eligible for and receiving special education and related services based on information from the Minnesota Automated Reporting Student System (MARSS) and reported by the Minnesota Department of Education.

From October 1, 2019 to September 30, 2020 a total of 3,270 students received VRS Pre-Employment Transition Services. It's important to note that many students received more than just one of the required services.

Limitations on the Use of Subminimum Wage (WIOA Section 511)
Section 511 of WIOA addresses the subject of subminimum wage jobs, usually in segregated work settings such as sheltered workshops.

Young people who historically have been placed into subminimum wage employment – typically youth with developmental disabilities – are required to apply for VRS before they can be hired into a job that pays less than minimum wage. As a result, the number of youth with developmental disabilities referred to VRS increased significantly when WIOA Section 511 took effect in July 2016. In Federal Fiscal Year 2019 that number dropped again, for the second year in a row.

Youth Age 24 and Younger Referred for VR Services by Federal Fiscal Year (FFY)

FFY	All Youth Referrals	Youth with Autism	Youth with Intellectual Disabilities	Total	% of Total Referrals for Youth with DD
2015	2,833	581	367	948	33.5%
2016	3,064	680	517	1,197	39.1%
2017	3,425	873	826	1,699	49.6%
2018	3,192	888	594	1,482	46.4%
2019	3,029	852	543	1,395	46.1%
2020	2,465	732	411	1,143	46.4%

Adults currently working in jobs below the federal minimum wage in segregated settings must receive career counseling, information, and referral services, and discuss opportunities to pursue competitive, integrated employment in the community. These services are to be offered at six-month intervals during the first year and annually thereafter.

Minnesota's eight Centers for Independent Living (CILs) are the VRS designated representatives to provide the initial career counseling and information and referral (CC&I&R) services to adults working at minimum wage for 14(c) employers.

Year One of Section 511 implementation (July 23, 2016 – July 22, 2017), CIL staff provided career counseling and information and referral services to 11,991 adults working at sub-minimum wage. Of the adults who were provided these services 2,010 adults (16.76%) said they were interested in competitive integrated employment.

Year Two numbers as reported by the CILs for the period of July 23, 2017 – July 22, 2018:
- 10,237 individuals participated in the CC&I&R
- Of that total, 1,452 (14.18%) expressed interest in competitive integrated employment

Year Three numbers as reported by the CILs for the period of July 23, 2018 – July 22, 2019:
- 9,901 individuals participated in the CC&I&R conversation
- Of that total, 1,635 (17%) expressed interest in competitive integrated employment
- The most notable change for year three was the elimination of the guardian signature on the required Section 511 documentation. This change was implemented successfully and has allowed for easy access to the CC&I&R process.

Year Four numbers as reported by the CILs for the period of July 23, 2019 – July 22, 2020:
- 8,265 individuals participated in the CC&I&R conversation
- Of that total, 999 (12%) expressed interest in competitive integrated employment
- Due to the pandemic, many individuals were not working due to 14 (c) employers closing. This had a significant impact on the CILs being able to conduct CCI&R interviews with individuals. Any CCI&R conversations occurring after the pandemic were held virtually.

Year Five first half numbers as reported by the CILs for the period of July 23 – December 31, 2020:
- 3,105 individuals participated in the CC&I&R conversation
- Of that total, 406 (13%) expressed interest in competitive integrated employment

- Due to the pandemic, many individuals were not working due to 14 (c) employers closing. This had a significant impact on the CILs being able to conduct CCI&R interviews with individuals. Any CCI&R conversations occurring after the pandemic were held virtually.

WIOA impact on State Services for the Blind (SSB)
WIOA has significantly broadened the scope of services that SSB is required to provide to people with disabilities. Pre-Employment Transition Services, as required by WIOA, continues to have the greatest impact on SSB administered programs. WIOA requires SSB to have Pre-ETS available statewide to all students with disabilities, grade nine through age 21. The five required Pre-Employment Transition Services are: (1) job exploration counseling; (2) work-based learning experiences; (3) post-secondary education counseling; (4) workplace readiness experiences; and (5) instruction in self advocacy.

SSB considers a student with a disability to be: between the ages of 14 and 21; is in an educational program; and is eligible for and receiving special education or related services under Individuals with Disabilities Education Act or is an individual with a disability for purposes of section 504 of the act.

MDE has indicated in their "Unduplicated Child Count" report in 2020, that there are approximately 211 students in secondary education who are blind, visually impaired, or DeafBlind. This number only includes those students whose primary disability is blindness or DeafBlindness. Additionally some Pre-ETS students enrolled in post-secondary options are also served. Based on the current numbers, there is an estimate of 25 additional students, for a total of 236 students.

During the 2019-2020 school year SSB reached a total of 186 students, including secondary and post-secondary students.

MDE is able to provide SSB with additional information about the 211 students except for their name. The report included the school district and contact information for the district special education director. The SSB Pre-ETS Transition Coordinator is reaching out by phone to ask the special education directors to share information with the students about SSB and our services. Historically, we have found teachers to be the critical linking point for students accessing SSB services and so have high expectations for success with this effort. Based on this year's numbers, there are 49 students in secondary education who are not yet receiving services from SSB.

SSB has a small student population but are required to spend approximately 1.3 million dollars each Federal Fiscal Year. A concerted effort is made to provide outreach to every student statewide. SSB's Pre-ETS Blueprint lays out the yearly plan to provide those services.

For the time period of this report (October 1, 2019, through September 30, 2020) a total of 186 students received Pre-Employment Transition Services. It's important to note that some students received more than just one of the five required services.

COMMENT ON PERFORMANCE:
COVID-19 impact on services
Due to COVID-19, VRS and SSB quickly adjusted services to remote only beginning March 16, 2020 to current. The overall applications for services have significantly decreased during this time period (with a decrease of approximately 4,000 participants expected in FFY21 compared to FFY18) and many persons who are currently served have multiple disabilities including compromised immune systems. Many individuals in services at this time are not comfortable working in the community due to COVID-19 and

there has been a significant decrease in new applications for this same reason. This significant impact of decreased new applications and those choosing to postpone employment will affect the next several years.

Order of Selection

The DEED/VRS Order of Selection process is based on federal regulations, which require that a state VR agency that cannot serve ALL persons with disabilities who are seeking services must establish an Order of Selection that defines a priority system for who will be served first. VRS determines the number of functional limitations on an individual basis through the application and intake process. Since 2014, three of four categories had been closed.

Throughout 2019, VRS began a systematic attempt to contact all of the individuals on the waiting list to determine whether they were still interested, available, and in need of services. This effort reduced the number of people on the waiting list in Categories 2, 3 and 4 from more than 2,000 to 846 individuals.

In September 2020, the VR program began offering services to individuals and taking them off the waiting list in order of category and date of application. On November 30, 2020 VRS reopened Category 2 and Category 3 which had been closed since the fall of 2014. The reopening allowed VRS staff to immediately begin offering employment-related services to Minnesotans with disabilities. As of December 31, 2020, there are no people on the waiting list.

Of individuals found eligible for VRS services between October 1, 2019 and December 31, 2020 ninety-three percent (93%) of those accepted for services were from within Category 1.

Number of Individuals Served

From October 1, 2019 to September 30, 2020, Vocational Rehabilitation Services provided employment related services to 13,994 individuals (defined as VRS participants with an employment plan who are receiving services). The percentage of participants who are youth under the age of 25 continues to increase, now 57% compared to 50% four years ago. Students receive a variety of services and the focus is on obtaining paid work experience. Many students choose to go on to post-secondary schooling as part of their employment plan. It typically takes several years of VRS/SSB services to a new student before they achieve CIE.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported two months after the end of the reporting period.

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

2019 Goal

- By December 31, 2019, the number of employed peer support specialists will increase by **38.**

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

RESULTS:

The 2019 overall goal was reported as not met in the February 2020 Quarterly Report. Progress on this goal will continue to be reported in as **in process**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time Period	Number of employed peer support specialists	Increase from previous year	Increase over baseline
Baseline (as of April 30, 2016)	16	--	N/A
2017 Annual (as of December 31, 2017)	46	30	30
2018 Annual (as of December 31, 2018)	76	30	60
2019 Annual (as of December 31, 2019)	76	0	60
2020 Annual (as of December 31, 2020)	71	<5>	55

ANALYSIS OF DATA:

As of December 31, 2019 there were 76 certified peer support specialists employed by Assertive Community Treatment (ACT) teams, Intensive Residential Treatment Services (IRTS), and crisis residential facilities. The overall goal to increase by 82 over baseline was not met.

As of December 31, 2020, there were 71 certified peer support specialists employed by Assertive Community Treatment (ACT) teams, Intensive Residential Treatment Services (IRTS), and crisis residential facilities. This is a decrease of 5 from the previous year. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Of the 71 employed peer support specialists, 28 are employed by ACT teams and 43 are working in IRTS and crisis residential facilities. Most of the positions with ACT teams are full time. The number of full time positions in IRTS is increasing. These numbers do not reflect the number of peers working in Adult Rehabilitative Mental Health Services (ARMHS), advocacy organizations, or community support programs. The number of billable hours in ARMHS has been steadily increasing until recently.

COMMENT ON PERFORMANCE:

As of December 2020, there are 1,289 individuals who have successfully completed the peer training. Though the goal was not met, there has been some progress in the number of employed mental health peers in a number of services. Some, but not all, Certified Community Behavioral Health Clinics have peers at their clinics. Peers are also being hired as (non-reimbursable) staff in Community Support programs and a number of housing programs include a peer support specialist. DHS will continue to identify the barriers of employment for certified peer specialists, and possible strategies to address the barriers.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported the month after it is collected. The data is collected for a point in time only.

LIFELONG LEARNING AND EDUCATION GOAL ONE: By December 1, 2021, the percent of students with disabilities[vii], receiving instruction in the most integrated setting[viii], will increase to 63%

2020 Goal

- By December 1, 2020, the percent of students receiving instruction in the most integrated settings will increase to 62.75%

358 curb ramps,

Baseline: In 2013, of the 109,332 students with disabilities, 67,917 (62.1%) received instruction in the most integrated setting.

RESULTS:
Using the 2019 Child Count, the 2020 goal to increase to 62.75% was **met**.

Time Period	Total number of students with disabilities (ages 6 – 21)	Number of students with disabilities in most integrated setting	Percent of students with disabilities in most integrated setting
Baseline January – December 2013	109,332	67,917	62.11%
January – December 2014 (Dec 2014 Child Count)	110,141	68,434	62.13%
January – December 2015 (Dec 2015 Child Count)	112,375	69,749	62.07%
January – December 2016 (Dec 2016 Child Count)	115,279	5.671,810	62.29%
January – December 2017 (Dec 2017 Child Count)	118,800	74,274	62.52%
January – December 2018 (Dec 2018 Child Count)	123,101	77,291	62.79%
January – December 2019 (Dec 2019 Child Count)	126,693	79,595	62.83%

ANALYSIS OF DATA:
During 2019, of the 126,693 students with disabilities, 79,595 (62.8%) received instruction in the most integrated setting. This was an increase of 0.04% from the previous year and an increase of 0.72% over baseline. Using the 2019 Child count, the 2020 goal to increase to 62.5% was met.

COMMENT ON PERFORMANCE:
MDE will continue the supporting statewide implementation of Positive Behavioral Interventions and Supports (PBIS) and implementation of Regional Low Incidence Disability Projects (RLIP). These projects provide access to qualified educators, technical assistance and professional development to increase the number of students with disabilities, ages 6 – 21, who receive instruction in the most integrated setting.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one year after the end of the reporting period.

TRANSPORTATION GOAL ONE: By December 31, 2020, accessibility improvements will be made to (A) 6,600 curb ramps (increase from base of 19% to 49%); (B) 430 Accessible Pedestrian Signals (increase from base of 10% to 74%). By October 31, 2021, improvements will made to 55 miles of sidewalks.

A) Curb Ramps

By December 31, 2020, accessibility improvements will be made to 6,600 curb ramps bringing the percentage of compliant ramps to approximately 49%.

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

RESULTS:
The goal is **on track** to meet the 2020 goal of 6,600 improvements and already achieved the goal.

Time Period	Curb Ramp Improvements	Total curb ramp Improvements	PROW Compliance Rate
Baseline - Calendar Year 2012	--		19%
Calendar Year 2014	1,139	1,139	24.5%
Calendar Year 2015	1,594	2,733	28.5%
Calendar Year 2016	1,015	3,748	35.0%
Calendar Year 2017	1,658	5,406	42.0%
Calendar Year 2018	1,188	6,594	51.7%
Calendar Year 2019	358	6,952	52.2%

ANALYSIS OF DATA:
In 2019, the total number of curb ramps improved was 358, bringing the total improvements to 6,952 and a 52.2% compliance under PROW. The 2020 goal of 6,600 has already been achieved.

Due to COVID-19 hiring restrictions MnDOT was not able to provide a complete data set for the 2019 construction season. MnDOT is planning to complete the collection of the 2019 and 2020 construction this year. The information collected reflects about 30% of the total curb ramps constructed in 2019.

COMMENT ON PERFORMANCE:
While this is not a complete data set the sample indicates that performance is consistent with previous years.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one year after the end of the reporting period.

B) Accessible Pedestrian Signals

By December 31, 2020, an additional 430 Accessible Pedestrian Signals (APS) installations will be provided on MnDOT owned and operated signals bringing the number to 875 and the percentage to 74%.

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

RESULTS:

The 2020 goal to bring the number of APS to 875 (74% of system) was **not met**.

Time Period	Total APS in place	Increase over previous year	Increase over baseline
Baseline Calendar Year 2009	118 of 1,179 APS (10% of system)	N/A	N/A
Calendar Year 2014	454 of 1,179 APS (38% of system)	40	336
Calendar Year 2015	523 of 1,179 APS (44% of system)	69	405
Calendar Year 2016	595 of 1,179 APS (50% of system)	72	477
Calendar Year 2017	695 of 1,179 APS (59% of system)	100	577
Calendar Year 2018	770 of 1,179 APS (65% of system)	86	652
Calendar Year 2019	824 of 1,179 APS (70% of system)	43	706
Calendar Year 2020	840 of 1,174 APS (71% of system)	16	722

ANALYSIS OF DATA:

In Calendar Year 2020, an additional 16 APS installations were provided, bringing the number of APS signals to 840 and the percentage to 71% of the system. The 2020 overall goal of 875 was not met. In 2020, a total of 5 signal systems with APS were turned over to cities and counties reducing MnDOT's baseline to 1,174.

COMMENT ON PERFORMANCE:

MnDOT did not meet the 74% target for 2020. There are currently 62 signal systems slated for APS in 2021 which if installed will bring the number of APS to 902 and 76% system completion.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one year after the end of the reporting period.

C) Sidewalks

By October 31, 2021, improvements will be made to an additional 55 miles of sidewalks (for a total of 340.2) bringing total system compliance to 60%.

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

RESULTS:

The goal is **on track** to meet the 2021 overall goal and has already achieved the goal.

Time Period	Sidewalk Improvements	Cumulative sidewalk improvements	PROW Compliance Rate
Baseline - Calendar Year 2012	N/A		46%
Calendar Year 2015	12.41 miles	12.41 miles	47.3%
Calendar Year 2016	18.80 miles	31.21 miles	49%
Calendar Year 2017	28.34 miles	59.55 miles	56%
Calendar Year 2018	33.24 miles	92.79 miles	60%
Calendar Year 2019	5.6 miles	98.3 miles	62%

ANALYSIS OF DATA:

In Calendar Year 2019, improvements were made to an additional 5.6 miles of sidewalks. This brings the Public Right of Way compliance rate to 62%. The goal is on track to meet the 2021 overall and has already achieved the overall goal.

Due to COVID-19 hiring restrictions MnDOT was not able to provide a complete data set for the 2019 construction season. MnDOT is planning to complete the collection of the 2019 and 2020 construction this year. The collection for 2019 represents roughly 25% of the total sidewalk constructed.

COMMENT ON PERFORMANCE:

While this is not a complete data set the sample indicates that performance is consistent with previous years.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one year after the end of the reporting period.

TRANSPORTATION GOAL FOUR: By 2025, transit systems' on time performance will be 90% or greater statewide.

B) Greater Minnesota Transit

Ten year goals to improve on time performance:

- Greater Minnesota– improve to a 90% within a 45-minute timeframe

Baseline for on time performance in 2014 was:

- Greater Minnesota– 76% within a 45 minute timeframe

RESULTS:
The 2025 goal to improve Greater Minnesota transit system on time performance to 90% is **in process**. Results for Transit Link, Metro Mobility and Metro Transit was reported in the May 2020 Quarterly Report. Beginning with this August 2020 Quarterly Report, results for Greater Minnesota will be reported separately and on a semi-annual basis.

Time Period	On-time performance (within a 45-minute timeframe)
Calendar Year 2014 (Baseline)	76%
Calendar Year 2016	76%
Calendar Year 2017	78%
Calendar Year 2018	Not available
Calendar Year 2019	Not available
January – February 2020*	91.3%
July – December 2020	92.6%

* A new data collection methodology began in January of 2020 with providers reporting monthly. However, due to the COVID-19 pandemic, shifts in funding sources and reporting requirements, reporting was put on hold. Reporting resumed in July 2020.

ANALYSIS OF DATA:
During July – December 2020, on-time performance for Greater Minnesota Transit was 92.63%. This was an increase of 1.3% and is on track to meet the 2025 goal.

COMMENT ON PERFORMANCE:
In aggregate, providers are meeting the established performance requirement.

Information for on-time performance was not collected for 2018 or 2019 as the transition to the new methodology was being made. A new data collection methodology began in January of 2020 with providers reporting monthly. However, due to the COVID-19 pandemic, shifts in funding sources and reporting requirements, reporting was put on hold. Reporting resumed in July 2020.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported two months after it is collected.

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

2020 Goal

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

Baseline: During school year 2015-2016, school districts (which include charter schools and intermediate districts) reported to MDE that 3,034 students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting. In 2015-2016, the number of reported students receiving special education services was 133,742 students. Accordingly, during school year 2015-2016, 2.3% students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting.

RESULTS:
The 2020 goal to reduce by 79 students was **met**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period (School Year)	Students receiving special education services	Students who experienced restrictive procedure	Change from previous year
Baseline 2015-16 school year	133,742	3,034 (2.3%)	N/A
2017 Annual 2016-17 school year	137,601	3,476 (2.5%)	+ 442 (+0.2%)
2018 Annual 2017-18 school year	142,270	3,546 (2.5%)	+ 70 (+0.0%)
2019 Annual 2018-19 school year	147,605	3,603 (2.4%)	+ 71 (– 0.1%)
2020 Annual 2019-20 school year[11]	152,012	3,052 (2.0%)	<551> (–15.3%)

School districts reported that of the 152,012 students receiving special education services, restrictive procedures were used with 3,052 of those students (2.0%). This was a decrease of 551 students from the previous year and the percentage decreased by 15.3%. This data was substantially affected by COVID-19 school closures. The 2020 goal to reduce by 79 students was met. The actual number of reported special education students increased by 4,407 from the 2018-2019 school year.

The restrictive procedure summary data is self-reported to MDE by July 15 for the prior school year. The data included for 2015-16 through 2018-19 school years has been reviewed and confirmed as needed. The data includes all public schools, including intermediate districts, charter schools and special education cooperatives. The data for the 2019-20 school year is described in more detail in the 2021

[11] Data from 2019-20 was substantially affected by Covid-19-related school closures.

Restrictive Procedures Workgroup legislative report. The data includes all public schools, including intermediate districts, charter schools, and special education cooperatives.

The 2021 MDE report to the Legislature, "A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools" includes more detailed reporting on the 2019-20 school year data. The legislative report is available at: https://education.mn.gov/MDE/about/rule/leg/rpt/index.htm

2019-20 school year:

- Physical holds were used with 2,828 students down from 3,357 students in 2018-19.
- Seclusion was used with 753 students, down from 861 students in 2018-19.
- Compared to the 2018-19 school year, the average number of physical holds per physically held student is 4.5, down from 5.1; the average number of uses of seclusion per secluded student was 5.3, down from 6.5; and the average number of restrictive procedures per restricted student was 5.5, down from 6.3.

The table below shows this information over the last five school years.

School year	Number of students experiencing physical holds	Average number of holds per held student	Number of students experiencing seclusions	Average number of seclusions per secluded student
2015-16	2,743	5.7	848	7.6
2016-17	3,127	5.5	976	7.3
2017-18	3,465	5.4	824	7.6
2018-19	3,357	5.1	861	6.5
2019-20	2,828	4.5	753	5.3

COMMENT ON PERFORMANCE:
The 2016 through 2020 Restrictive Procedures Workgroups and MDE made significant progress in implementing the statewide plans developed by the Restrictive Procedures Workgroup stakeholders. The following sections on data quality and workgroup progress provide further detail.

Data Quality
School closures resulting from the COVID-19 pandemic, starting in March 2020, had a significant impact on the collection and analysis of both seclusion and physical holding data. The 2019-20 school year contained significantly fewer in-person school days than previous years, which contributed to significant decline in yearly numbers for the use of seclusions, physical holds, and total restrictive procedures. Because the data indicates that a downward trend was already underway prior to the COVID-19 pandemic, it is likely that reduced numbers would have been seen in 2019-20 even without school closures. However, this data should be interpreted with caution, as it is difficult to determine the effect of the COVID-19 pandemic as opposed to other possible reasons for such a decline.

For data reliability purposes, the student enrollment data is based on the state enrollment counts for students receiving special education services. It is worth noting that MDE does not have the ability to cross check the districts' reporting of students experiencing the use of physical holds with the quarterly reporting of students experiencing the use of seclusion. Accordingly, a student may be counted more than once if they are both physically held and secluded. In addition, a student may be counted more

than once if they move to another district and are physically held in both districts during the same school year.

Data on the staff development work activities and outcomes is described in more detail in the 2021 Restrictive Procedures Workgroup legislative report. Multiple districts reported a reduction in the use of restrictive procedures after implementing professional development grant activities over the past three school years. For the 2019-20 school year, the use of physical holding decreased by 25%, the use of seclusion decreased by 30% and the number of students experiencing the use of a seclusion decreased by 17%.

To improve data consistency and quality, MDE has updated the seclusion reporting form based upon feedback from the Restrictive Procedures Workgroup. MDE, in consultation with the Restrictive Procedures Workgroup, has also developed qualitative questions to collect strategies that districts have used successfully to decrease the use of restrictive procedures with their students. Districts will provide responses to these questions as part of annual summary data reporting in June 2021.

In addition, MDE conducted three trainings, with a total of 75 participants, to assist districts in understanding restrictive procedures laws and to assist them in developing processes to have more consistent understanding for terms and reporting. MDE is also exploring a transition to different data collection and analysis systems to facilitate data quality improvement for future years.

2020 Restrictive Procedures Workgroup
MDE continues to contract with Management Analysis and Development (MAD) to facilitate the restrictive procedures stakeholders workgroup meetings which began in December 2018. Facilitation focused on increasing stakeholder engagement in developing recommendations to the commissioner including specific and measurable goals, implementation of strategies, and outcome measures for reducing the use of restrictive procedures statewide.

The 2020 workgroup reached consensus on a revised statewide plan, which includes specific targets to reduce the use of seclusion and number of students experiencing the use of seclusion in the school setting. In addition, the revised plan includes a goal to compile strategies to recommend to school districts for reducing the use of restrictive procedures, working toward eliminating seclusion, and addressing disproportionalities related to the use of restrictive procedures, and specific actions in support of these goals.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported seven months after the end of the reporting period.

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

2020 Goal

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

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

RESULTS:

The 2020 goal to reduce by 562 incidents or 0.2 incidents per student was **met.** An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period	Incidents of emergency use of restrictive procedures	Students who experienced use of restrictive procedure	Rate of incidents per student	Change from previous year
Baseline (2015-16 school year)	22,028	3,034	7.3	N/A
2017 Annual 2016-17 school year	24,307	3,476	7.0	+ 2,257 incidents <0.3> rate
2018 Annual 2017-18 school year	25,052	3,546	7.1	+ 70 incidents +0.1 rate
2019 Annual 2018-19 school year	22,772	3,603	6.3	-2,280 incidents <0.8> rate
2020 Annual 2019-20 school year[12]	16,656	3,052	5.5	-5,872 uses <0.8> rate

ANALYSIS OF DATA:

During the 2019-20 school year there were 16,656 incidents of emergency use of restrictive procedures. There were 5.5 incidents of restrictive procedures per student who experienced the use of a restrictive procedure. There was a decrease of 5,872 incidents from the previous year. There was a decrease of students experiencing the use of a restrictive procedure and a decrease in the rate (0.8 incidents per student). The 2020 goal to reduce by 562 or 0.2 incidents per student was met. The overall goal to reduce by 2,251 or by 0.8 incidents was also met. This data was substantially affected by COVID-19 school closures.

[12] Data from 2019-20 was substantially affected by Covid-19-related school closures.

The restrictive procedures summary data is self-reported by school districts and the deadline for reporting the data to the Minnesota Department of Education (MDE) is July 15th for the prior school year. The data included in the 2015-16 through 2019-20 school years has been reviewed and confirmed as needed. The data is described in more detail for the respective years in the reports in A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools.

The 2021 MDE report to the Legislature, A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools includes more detailed reporting on the 2019-20 school year data. The legislative report is available at http://education.state.mn.us/MDE/about/rule/leg/rpt/index.htm

2019-20 school year:

- Based upon MDE enrollment data, 152,012 students received special education services, an increase of 4,407 students, or 3.0% from the 2018-19 school year.
- During the 2019-20 school year, Minnesota school districts reported a total of 12,679 physical holds and 3,977 seclusion uses for a total of 16,656 restrictive procedures uses.
- The total number of uses of restrictive procedures decreased by 6,116, or 26.9% from the 2018-19 school year, while the number of students who experienced a restrictive procedure decreased by 551, or 15.3%, to a total of 3,052. Consequently, the rate of use of restrictive procedures per student who experienced a restrictive procedure decreased from 6.5 during the previous school year to 5.5.
- The average number of physical holds per physically held student decreased from 5.1 in 2018-19 to 4.5 in 2019-20. The number of seclusion uses decreased by 28.8%, the number of students who were secluded decreased by 8.6% to 753 and the average number of seclusion uses per secluded student decreased from 6.3 to 5.3.

COMMENT ON PERFORMANCE:
The 2016 through 2020 workgroups and MDE made significant progress in implementing the statewide plans developed by the Restrictive Procedures Workgroup stakeholders. The following sections on quality and workgroup progress provide further detail:

Data Quality
School closures resulting from the COVID-19 pandemic, starting in March 2020, had a significant impact on the collection and analysis of both seclusion and physical holding data. The 2019-20 school year contained significantly fewer in-person school days than previous years, which contributed to significant decline in yearly numbers for the use of seclusions, physical holds, and total restrictive procedures. Because the data indicates that a downward trend was already underway prior to the COVID-19 pandemic, it is likely that reduced numbers would have been seen in 2019-20 even without school closures. However, this data should be interpreted with caution, as it is difficult to determine the effect of the COVID-19 pandemic as opposed to other possible reasons for such a decline.

For data reliability purposes, the student enrollment data is based on the state enrollment counts for students receiving special education services. MDE does not have the ability to cross-check district reports of students experiencing the use of physical holds with quarterly reporting of students experiencing the use of seclusion. Accordingly, the total number of students who experienced a

restrictive procedure shown in the table above includes students who may have been physical held and secluded, as well as students who only experienced physical holding or only seclusion. Students may be counted more than once if they move to another district and are physically held in both districts during the same school year.

Data on the staff development work activities and outcomes is described in more detail in the 2021 Restrictive Procedures Workgroup legislative report. Multiple districts reported a reduction in the use of restrictive procedures after implementing professional development grant activities over the past three school years. For the 2019-20 school year, the use of physical holding decreased by 25%, the use of seclusion decreased by 30% and the number of students experiencing the use of a seclusion decreased by 26%.

To improve data consistency and quality, MDE has continued updated the seclusion reporting form based upon feedback from the Restrictive Procedures Workgroup. MDE, in consultation with the Restrictive Procedures Workgroup, has also developed qualitative questions to collect strategies that districts have used successfully to decrease the use of restrictive procedures with their students. Districts will provide responses to these questions as part of annual summary data reporting in June 2021.

2020 Restrictive Procedures Workgroup

MDE has continued to benefit from working with a facilitator from Management Analysis and Development (MAD) to facilitate the restrictive procedures stakeholders workgroup meetings, which began in December 2018. Facilitation focused on increasing stakeholder engagement in developing recommendations to the commissioner, specific and measurable implementation, and outcome goals for reducing the use of restrictive procedures statewide.

The 2020 workgroup reached consensus on a revised statewide plan, which includes specific targets to reduce the use of seclusion and number of students experiencing the use of seclusion in the school setting. In addition, the revised plan includes a goal to compile strategies to recommend to school districts for reducing the use of restrictive procedures, working toward eliminating seclusion, and addressing disproportionalities related to the use of restrictive procedures, and specific actions in support of these goals.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported seven months after the end of the reporting period.

CRISIS SERVICES GOAL ONE: By June 30, 2019, the percent of children who receive children's mental health crisis services and remain in their community will increase to 85% or more. [Extended March 2020]

2019 Goal

- By June 30, 2019, the percent who remain in their community after a crisis will increase to 85%

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

RESULTS:

The 2019 overall goal to increase to 85% was reported as **not met** in the August 2020 Quarterly Report. Progress on this goal will continue to be reported as **in process**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period	Total Episodes	Community	Treatment	Other
Baseline (July 2013 – June 2014)	3,793	2,997 (79%)	--	--
2016 Annual (6 months data) January – June 2016	1,318	1,100 (83.5%)	172 (13.2%)	46 (3.5%)
2017 Annual (July 2016 – June 2017)	2,653	2,120 (79.9%)	407 (15.3%)	126 (4.8%)
2018 Annual (July 2017 – June 2018)	2,736	2,006 (73.3%)	491 (18.0%)	239 (8.7%)
2019 Annual (July 2018 – June 2019)*	3,809	2,742 (72.0%)	847 (22.2%)	220 (5.8%)
2020 Annual (July 2019 – June 2020)**	3,639	**2,643 (72.6%)**	832 (22.9%)	164 (4.5%)
July – December 2019	1,920	1,404 (73.1%)	425 (22.1%)	91 (4.7%)
January – June 2020	1,694	1,222 (72.1%)	399 (23.6%)	73 (4.3%)

* See Addendum for information about discrepancies in the reporting period from previously reported data.

** The annual totals are greater than the sum of the 2 semi-annual amounts. This is due to late submissions of reports throughout the year.

- Community = emergency foster care, remained in current residence (foster care, self or family), remained in school, temporary residence with relatives/friends.
- Treatment = chemical health residential treatment, emergency department, inpatient psychiatric unit, residential crisis stabilization, residential treatment (Children's Residential Treatment).
- Other = children's shelter placement, domestic abuse shelter, homeless shelter, jail or corrections, other.

ANALYSIS OF DATA:

From July 2018 – June 2019, of the 3,809 crisis episodes, the child remained in their community after the crisis 2,742 times or 72.0% of the time. This is 7.0% below baseline and 1.3% below the previous year. The June 30, 2019 overall goal to increase the percent of children who receive children's mental health crisis services and remain in the community to 85% or more was not met.

From July – June 2020, of the 3,639 crisis episodes, the child remained in their community after the crisis 2,643 times or 72.6% of the time. That is a 0.6% increase from 2019 and 6.4% below baseline.

COMMENT ON PERFORMANCE:
There has been an overall increase in the number of episodes of children receiving mental health crisis services, and more children being seen by crisis teams. The number of children receiving treatment services after their mental health crisis has increased by more than 30% since baseline and by almost 50% since December of 2016. While children remaining in the community after crisis is preferred, it is important for children to receive the level of care necessary to meet their needs at the time. DHS will continue to work with mobile crisis teams to identify training opportunities for serving children in crisis, and to support the teams as they continue to support more children with complex conditions and living situations.

When children are served by mobile crisis teams, they are provided a mental health crisis assessment in the community and receive further help based on their mental health need. Once risk is assessed and a crisis intervention is completed, a short term crisis plan is developed to assist the individual to remain in the community, if appropriate.

Mobile crisis teams focus on minimizing disruption in the life of a child during a crisis. This is done by utilizing a child's natural supports the child already has in their home or community whenever possible. It is important for the child to receive the most appropriate level of care. Sometimes that can be in the community and sometimes that may require a higher level of care. A higher level of care should not necessarily be perceived as negative if it is the appropriate level of care. There is no way to predict who will need which level of care at any given time or why. Having an assessment from the mobile crisis team will increase the likelihood that the person has the opportunity have a plan developed that will help them stay in the most integrated setting possible.

DHS has identified a trend that might be impacting the number of children remaining in the community. There has been an increase in individuals being seen in Emergency Departments (ED) for crisis assessments rather than in the community. With more individuals accessing crisis services from the ED there is a likelihood that they may be at a higher level of risk at the time they are seen by the crisis team and therefore more likely require a higher level of care.

DHS has worked with mobile crisis teams to identify training opportunities that would help increase their capacity to address the complexities they are seeing and has committed to providing trainings in identified areas specific to crisis response. This increases the teams' ability to work with individuals with complex conditions or situations effectively. DHS will continue to work with providers to explore trends that might be contributing to children presenting in crisis with the need for a higher level of care.

Due to COVID-19, there was a waiver put into place that allowed crisis assessments, and interventions to be done via phone. This allowed for crisis services to be available to individuals who may not be comfortable leaving their homes, and offered some help for children who were doing remote learning.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

CRISIS SERVICES GOAL TWO: By June 30, 2020, the percent of adults who receive adult mental health crisis services and remain in their community (e.g., home or other setting) will increase to 64% or more. [Extended March 2020]

Annual Goals

- **2020 Goal:** By June 30, 2020, the percent who remain in their community after a crisis will increase to 64%.

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

RESULTS:
The 2020 goal to increase to 64% was **not met**. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision.

Time period	Total Episodes	Community	Treatment	Other
2016 Annual (6 months data) January – June 2016	5,436	3,136 (57.7%)	1,492 (27.4%)	808 (14.9%)
2017 Annual (July 2016 - June 2017)	10,825	5,848 (54.0%)	3,444 (31.8%)	1,533(14.2%)
2018 Annual (July 2017 – June 2018)	11,023	5,619 (51.0%)	3,510 (31.8%)	1,894 (17.2%)
2019 Annual (July 2018 – June 2019)	12,599	6,143 (48.8%)	4,421 (35.1%)	2,035 (16.2%)
2020 Annual (July 2019 – June 2020)*	11,247	6,019 (53.5%)	3,864 (34.2%)	1,364 (12.1%)
July – December 2019	6,107	3,191 (52.2%)	2,112 (34.6%)	804 (13.2%)
January – June 2020	5,060	2,792 (55.2%)	1,715 (33.9%)	553 (10.9%)

* The annual totals are greater than the sum of the 2 semi-annual amounts. This is due to late submissions of reports throughout the year.

- Community = remained in current residence (foster care, self or family), temporary residence with relatives/friends.
- Treatment = chemical health residential treatment, emergency department, inpatient psychiatric unit, residential crisis stabilization, intensive residential treatment (IRTS)
- Other = homeless shelter, jail or corrections, other.

ANALYSIS OF DATA:
From July 2019 – June 2020, of the 11,247 crisis episodes, the adult remained in their community after the crisis 6,019 times or 53.5% of the time. This was an increase of 4.7% from the previous year and 4.3% below baseline. The 2020 overall goal to increase to 64% was not met.

From January – July 2020, of the 5,060 crisis episodes, the adult remained in their community after the crisis 2,792 times or 55.2% of the time. This was an increase of 3.0% from the previous semi-annual report.

COMMENT ON PERFORMANCE:
When individuals are served by mobile crisis teams, they are provided a mental health crisis assessment in the community and receive further help based on their mental health need. Once risk is assessed and

a crisis intervention is completed, a short term crisis plan is developed to assist the individual to remain in the community, if appropriate.

Mobile crisis teams focus on minimizing disruption in the life of an adult during a crisis by utilizing the natural supports an individual already has in their home or community for support whenever possible. It is important for individuals to receive the most appropriate level of care. Sometimes that can be in the community and sometimes that may be a higher level of care. A higher level of care should not necessarily be perceived as negative if it is the appropriate level of care. There is no way to predict who will need which level of care at any given time or why. Having an assessment from the mobile crisis team will increase the likelihood that the person has the opportunity to be assessed and have a plan developed that will help them stay in the most integrated setting possible. DHS has worked with mobile crisis teams to identify training opportunities that would help increase their capacity to address the complexities they are seeing and has committed to providing trainings in identified areas specific to crisis response. This increases the teams' ability to work with more complex clients/situations effectively.

DHS has identified a few trends that might be affecting the number of adults remaining in the community. There has been an increase in individuals being seen in the Emergency Department (ED) for crisis assessments rather than in the community. With more individuals accessing crisis services from the ED there is a likelihood that they may be at a higher level of risk at the time they are seen by the crisis team and therefore more likely to need a higher level of care. There has also been an increase in the number of crisis beds added over the past few years. This allows for adults to be referred to adult residential crisis beds following a crisis rather than remaining in the community.

DHS will continue to work with providers to ensure timely and accurate reporting and explore trends that might be contributing to individuals presenting in crisis with the need for a higher level of care. DHS will also continue to work with mobile crisis teams in order to identify training opportunities and provide support most needed for serving people in crisis.

Due to COVID-19, there was a waiver put into place that allowed crisis assessments, and interventions to be done via phone. This allowed for crisis services to be available to individuals who may not be comfortable leaving their homes, and offered some help for adults who are immune compromised, and the elderly community.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

PREVENTING ABUSE AND NEGLECT GOAL TWO: By January 31, 2022, the number of cases of vulnerable individuals being treated due to abuse and neglect will decrease by 30% compared to baseline. [Revised March 2019]

There are two measures for this goal:

(A) Decrease the number of emergency room visits and hospitalizations due to abuse and neglect

2019 Goal

- By April 30, 2019, establish a baseline

RESULTS:
The goal to establish a baseline has been **met.** The proposed baseline will be included as an amendment to this goal for the April 2021 Olmstead Plan Revision.

Proposed Baseline: During Calendar Year 2019, there were 39 cases of vulnerable individuals who were treated in an emergency room or hospital due to abuse or neglect.

Time Period	(A) Number of emergency room visits and hospitalizations
Calendar Year 2019	39

ANALYSIS OF DATA:
During calendar year 2019, there were 39 cases of emergency room visits and hospitalizations due to abuse and neglect. Cases are identified using clinical coding in the hospital discharge data base. The data was obtained from the Minnesota Hospital Association and includes nearly all hospitals and emergency departments in Minnesota.

Further analysis of the data is included below and shows that 74% of cases are with individuals in the age group 18 – 64 and 72% of the cases are in the Metro area.

Cases by age group:

Calendar Year	Total	0 – 17	18 – 64	65 and over
2019	39	7	29	3

Cases by geography (Metro vs. Greater MN):

Calendar Year	Total	Metro	Greater Minnesota
2019	39	28	11

COMMENT ON PERFORMANCE:
MDH staff continue to emphasize recognition, documentation and reporting of cases. Accurate documentation and reporting will allow for better tracking of progress and description of the true epidemiology of injury due to abuse and neglect. Epidemiologists continue to study the case definition of "vulnerable individual."

The public education campaign was initiated on July 1, 2017 and targeted providers who serve individuals with disabilities, individuals with disabilities, their families, and advocates who represent and

assist them. Targeted prevention efforts will be conducted in areas with higher rates of hospitalizations and ER visits due to abuse and neglect of vulnerable individuals.

The culture change messaging campaign funded in large measure by the Olmstead Implementation Office, with contributions from sister state agencies, is expected to help decrease these cases of abuse and neglect as we affirm the value and worth of each person.

(B) Decrease the number of medical treatments other than emergency room visits and hospitalizations due to abuse and neglect

2019 Goal

- By April 30, 2019, establish a baseline

RESULTS:
The goal to establish a baseline is **in process.**

The baseline for Measure B uses the Minnesota All Payer Claims Dataset (APCD). Based on the complexity of analyzing the data and the impact of COVID-19, the baseline is not available at this time. An amendment to this goal is being proposed for the April 2021 Olmstead Plan Revision to extend the deadline for establishing a baseline and annual goals for this measure.

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

2019 Goal

- By December 31, 2019, the number of vulnerable adults who experience more than one episode of the same type of abuse or neglect within six months will be reduced by 10% compared to the baseline.

BASELINE:
From July 2015 – June 2016, there were 2,835 individuals who experienced a substantiated or inconclusive abuse or neglect episode. Of those individuals, 126 (4.4%) had a repeat episode of the same type of abuse or neglect within six months.

RESULTS: Using Fiscal Year 2019 data**,** the 2018 goal to reduce by 10% was **met**.

Time Period	Total number of people	Number of repeat episode	Change from baseline
Baseline (July 2015 - June 2016)	2,835	126 (4.4%)	N/A
July 2016 – June 2017	2,777	114 (4.1%)	<12> <9.5%>
July 2017 – June 2018	2,484	94 (3.8%)	<32> <25.4%>
July 2018 – June 2019	2,452	81 (3.3%)	<45> <37.5%>

ANALYSIS OF DATA:

From July 2018 – June 2019, there were 2,452 people with a substantiated or inconclusive abuse or neglect episode[13]. Of those people, 81 (3.3%) experienced a substantiated or inconclusive abuse or neglect had a repeat episode of the same type within six months. This is a decrease of 45 from baseline which is a reduction of 37.5%. The 2019 goal was met.

Data is from reports of suspected maltreatment of a vulnerable adult made to the Minnesota Adult Abuse Reporting Center (MAARC) by mandated reporters and the public when a lead agency was responsible for response. Maltreatment report investigations handled by DHS Licensing or Minnesota Department of Health (MDH) are not included in this report.

Demographic Data for July 2018 – June 2019

Episode Types

Fiscal Year (FY)	Total Episodes	Emotional/ Mental	Physical	Sexual	Fiduciary Relationship	Not Fiduciary Relationship	Caregiver Neglect	Self - Neglect
2016	134	18	4	0	8	16	24	64
2017	124	14	12	2	3	13	28	52
2018	103	12	8	4	7	10	14	48
2019	98	15	10	2	4	10	13	44

Victim Gender

FY	Total	Female	Male
2016	126	73	53
2017	114	77	37
2018	94	52	42
2019	81	51	30

Victim Age Range

FY	Total	18 – 22	23 – 39	40 – 64	65 – 74	75 – 84	85 and over
2016	126	9	8	35	21	32	21
2017	114	5	5	32	20	27	25
2018	94	5	6	27	26	17	13
2019	81	5	7	23	11	17	18

Victim Race/Ethnicity

FY	Total	Caucasian	African American	American Indian	2 or more	Hispanic	Asian/Pacific Islander	Unknown
2016	126	112	3	5	4	1	0	1
2017	114	91	9	7	2	5	0	0
2018	94	79	6	3	0	1	1	4
2019	81	64	6	3	6	0	2	0

[13] Episodes include physical abuse, sexual abuse, emotional abuse, financial exploitation, caregiver or self-neglect.

[AGENDA ITEM 6a]

Offender Gender

FY	Total	Female	Male
2016	70	33	37
2017	74	30	44
2018	96	43	53
2019	94	42	51

Offender Age Range

FY	Total	18 – 22	23 – 39	40 – 64	65 – 74	75 – 84	85 and over
2016	70	3	14	38	7	6	2
2017	74	5	16	39	4	7	0
2018	96	1	12	41	41	12	9
2019	94	6	10	37	12	17	9

Offender Race/Ethnicity

FY	Total	Caucasian	African American	American Indian	2 or more	Hispanic	Asian/Pacific Islander	Unknown
2016	70	56	3	2	3	2	1	3
2017	74	52	4	4	3	5	0	6
2018	96	77	6	3	0	1	1	5
2019	94	71	11	3	6	0	2	1

COMMENT ON PERFORMANCE:

Counties have responsibility under the state's vulnerable adult reporting statute to assess and offer adult protective services to safeguard the welfare of adults who are vulnerable and have experienced maltreatment. The number of substantiated and inconclusive allegations is affected by the number of maltreatment reports opened for investigation.

Protection from maltreatment is balanced with the person's right to choice. People who are vulnerable may refuse interventions offered by adult protective services or supports that could protect them from abuse or neglect. Some incidents of repeat maltreatment may demonstrate a vulnerable adult's right to make decisions about activities, relationships and services. Use of restrictive services or legal interventions, like guardianship, are minimized in those instances.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported twelve months after the end of the reporting period.

VI. COMPLIANCE REPORT ON WORKPLANS

This section summarizes the ongoing review of workplan activities completed by OIO Compliance staff.

WORKPLAN ACTIVITIES

In order to achieve the measurable goals, the OIO and State agencies develop specific strategies and workplans. The OIO Compliance staff and the Subcabinet agencies use the workplans throughout the year to review the progress of the work and to direct any adjustments to the work if progress is not timely, or if changes to the workplans are needed based on actual experience in the field. The OIO Compliance staff notify the Subcabinet of any exceptions to the implementation of workplans on a quarterly and annual basis.

The first review of workplan activities occurred in December 2015. Ongoing reviews began in January 2016 and include activities with deadlines through the month prior and any activities previously reported as an exception. Beginning in 2020, the review of workplan activities is completed on a quarterly basis and reported in the Quarterly Reports.

The summary of the workplan activity reviews are below.

Number of Workplan Activities

Reporting period	Reviewed during time period	Completed	On Track	Reporting Exceptions	Exceptions requiring Subcabinet action
December 2015 – December 2016	428	269	125	34	0
January – December 2017	284	251	32	8	1
January – December 2018	219	207	5	7	0
January – December 2019	156	151	5	0	0
January 2020	10	10	0	0	0
February – April 2020	13	13	0	0	0
May – July 2020	28	28	0	0	0
August – October 2020	24	24	0	0	0

The February 2021 Quarterly Report does not include a report on quarterly review of workplans. Workplan activities will continue at the agency level. OIO Compliance will continue to review agency workplans if a measurable goal is reflecting insufficient progress.

VII. ADDENDUM

Data Discrepancy: Crisis Services Goal One

While preparing the numbers for the February 2021 Quarterly Report, DHS detected an issue with the numbers reported for 2019. The number of individuals remaining in the community after a crisis was transposed. The number reported was 2,724 (71.5%) and it should have been 2,742 (72.0%). This underreported the number by 18. Even with that increase, the 2019 goal was not met.

CRISIS SERVICES GOAL ONE: By June 30, 2019, the percent of children who receive children's mental health crisis services and remain in their community will increase to 85% or more. [Revised March 2020]

Previously Reported data in August 2020 Quarterly Report

- The 2019 overall goal to increase to 85% was **not met.**

Time period	Total Episodes	Community	Treatment	Other
2019 Annual (July 2018 – June 2019)	3,809	2,724 (71.5%)	847 (22.2%)	220 (5.8%)

Updated reported data for February 2021 Quarterly Report

- The 2019 overall goal to increase to 85% was **not met.**

Time period	Total Episodes	Community	Treatment	Other
2019 Annual (July 2018 – June 2019)	3,809	2,742 (72.0%)	847 (22.2%)	220 (5.8%)

ENDNOTES

[i] October 24, 2020, jurisdiction of the Federal Court ended.
[ii] Some Olmstead Plan goals have multiple subparts or components that are measured and evaluated separately. Each subpart or component is treated as a measurable goal in this report.
[iii] This goal measures the number of people exiting institutional and other segregated settings. Some of these individuals may be accessing integrated housing options also reported under Housing Goal One.
[iv] Transfers refer to individuals exiting segregated settings who are not going to an integrated setting. Examples include transfers to chemical dependency programs, mental health treatment programs such as Intensive Residential Treatment Settings, nursing homes, ICFs/DD, hospitals, jails, or other similar settings. These settings are not the person's home, but a temporary setting usually for the purpose of treatment.

[v] As measured by monthly percentage of total bed days that are non-acute. Information about the percent of patients not needing hospital level of care is available upon request.
[vi] Minnesota Security Hospital is governed by the Positive Supports Rule when serving people with a developmental disability.
[vii] "Students with disabilities" are defined as students with an Individualized Education Program age 6 to 21 years.
[viii] "Most integrated setting" refers to receiving instruction in regular classes alongside peers without disabilities, for 80% or more of the school day.

Olmstead Subcabinet Meeting Agenda Item

March 22, 2021

Agenda Items:

6 (b) Olmstead Plan Draft Plan Amendments

Presenter:

Mike Tessneer

Action Needed:

☒ Approval Needed (provisionally approve to go out for public comment)

☐ Informational Item (no action needed)

Summary of Item:

This includes the draft amendments to three Olmstead Plan measurable goals being proposed by the Subcabinet agencies. This is a supplement to the draft amendments reviewed in January.

Once provisionally approved by the Subcabinet the draft amendments will be posted for public comment.

Attachment(s):

6b – Draft Plan Amendments to Olmstead Plan Measurable Goals

Draft Plan Amendments to Olmstead Plan Measurable Goals

March 15, 2021

This document is a supplement to the Draft Plan Amendments that were reviewed by the Olmstead Subcabinet on January 25, 2021. It includes three additional amendments to Olmstead Plan measurable goals. The Olmstead Subcabinet will review these amendments on March 22, 2021.

The Olmstead Subcabinet will begin obtaining public comment on these amendments in March 2021 and the amendments are subject to change.

The measurable goals appear in the order that they occur in the Plan, with the page number and the reason for the change noted. Blackline changes indicate the edits to the original language from the Plan.

Contents

EMPLOYMENT GOAL FOUR (page 54)..... 3
POSITIVE SUPPORTS GOAL THREE (page 80) 4
PREVENTING ABUSE AND NEGLECT GOAL TWO (page 96)..... 6

EMPLOYMENT GOAL FOUR (page 54)

REASON FOR CHANGE

The 2019 overall goal was not achieved. The goal is being extended and annual goals reset based on performance in 2020. Between 2019 and 2020 there was a 9% decrease, impacted in part by COVID-19. The new targets take into consideration that decline and project 7% growth per year from 2020 performance.

This proposed amendment for this goal replaces the amendment reviewed at the January 25, 2021 Subcabinet meeting. It was updated based on newly available data for 2020.

Goal Four: By December 31, 2022, ~~2019,~~ the number of Peer Support Specialists who are employed by mental health service providers will increase ~~by~~ to 82.

Baseline: As of April 30, 2016, there are 16 certified peer support specialists employed by Assertive Community Treatment (ACT) teams or Intensive Residential Treatment Services (IRTS) throughout Minnesota. As of December 31, 2020, there were 71 employed peer support specialists.

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

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

- By December 31, 2021, the number of employed peer support specialists will be 76
- By December 31, 2022, the number of employed peer support specialists will be 82

POSITIVE SUPPORTS GOAL THREE (page 80)

REASON FOR CHANGE
The 2020 overall goal was not achieved using the current measure. The goal is being changed to focus on duration instead of frequency of use, as it is believed to be more likely to indicate progress over time. Frequency of use will continue to be collected and reported to provide context.

Goal Three: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, with limited exceptions to protect the person from imminent risk of serious injury. Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and use of an auxiliary device to ensure a person does not unfasten a seatbelt in a vehicle.

- **By June 30, 2022 the average duration of emergency use of mechanical restraint (other than an auxiliary device)[1] as reported on BIRF reports will be reduced to 192 hours per month for individuals with Commissioner approval and 7.7 hours per month for individuals with a developmental disability in the Forensic Mental Health Program.**

There are two measures for this goal

(A) Individuals with Commissioner approval[2]

Baseline: From July 1, 2019 - June 30, 2020, the average duration of emergency use of mechanical restraint (other than an auxiliary device) as reported on the BIRF was 213 hours per month. These reports were for 7 people.

Annual Goals for the emergency use of mechanical restraints (other than auxiliary devices)
- By June 30, 2021, the average duration will be reduced to no more than 202 hours per month
- By June 30, 2022, the average duration will be reduced to no more than 192 hours per month

(B) Individuals with a developmental disability served in the Forensic Mental Health Program[3]

Baseline: From July 1, 2019 - June 30, 2020, the average duration of emergency use of mechanical restraint (other than an auxiliary device) as reported on the BIRF was 8.5 hours per month. These reports were for 13 people.

Annual Goals for the emergency use of mechanical restraints (other than auxiliary devices)
- By June 30, 2021, the average duration will be reduced to no more than 8.1 hours per month
- By June 30, 2022, the average duration will be reduced to no more than 7.7 hours per month

---

[1] Auxiliary devices ensure a person does not unfasten a seat belt in a vehicle and includes seat belt guards, harnesses and clips.
[2] Use of mechanical restraints are approved by the DHS Commissioner and are monitored by experts in positive supports who provide on-going technical assistance.
[3] ~~Minnesota Security Hospital (MSH)~~ Forensic Mental Health Program is governed by the Positive Supports Rule when serving people with a developmental disability.

~~By June 30, 2020 the emergency use of mechanical restraints, other than use of an auxiliary device~~[45] ~~will be reduced to no more than 93 reports.~~

~~Baseline: In SFY 2014, there were 2,038 BIRF reports of mechanical restraints involving 85 unique individuals. In SFY 2019, of the 658 reports of mechanical restraints, 336 were for use of auxiliary devices to ensure a person does not unfasten a seatbelt in a vehicle. The number of reports other than use of auxiliary devices were 322.~~

~~**Annual Goals** to reduce the use of mechanical restraints:~~

- ~~By June 30, 2020, reduce mechanical restraints, other than use of auxiliary devices, to no more than 93 reports~~

PREVENTING ABUSE AND NEGLECT GOAL TWO (page 96)

REASON FOR CHANGE
A baseline has now been established for measure A. The annual goals have been reset based on the baseline. Based on the complexity of the measure and the impact of COVID-19, the deadline is being extended for establishing a baseline and annual goals for measure B.

Goal Two: By December ~~January~~ 31, 2022, the number of cases of vulnerable individuals being treated due to abuse and neglect will decrease by 15% ~~30%~~ compared to baseline.

There are two measures for this goal:

(A) Emergency room visits and hospitalizations

Baseline: During Calendar Year 2019, there were 39 cases of vulnerable individuals[4] who were treated in an emergency room or hospital due to abuse or neglect.

Annual Goals to decrease number of emergency room visits and hospitalizations due to abuse and neglect

- ~~By April 30, 2019, establish a baseline~~
- By ~~January~~ December 31, 2020, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 5% ~~10%~~ compared to baseline
- By ~~January~~ December 31, 2021, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 10% ~~20%~~ compared to baseline
- By ~~January~~ December 31, 2022, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 15% ~~30%~~ compared to baseline

(B) Medical treatment(s) other than emergency room or hospital

Annual Goals to decrease number of medical treatments other than emergency room visits and hospitalizations due to abuse and neglect

- By December 31, 2021, ~~April 30, 2019,~~ establish a baseline and annual goals
- ~~By January 31, 2020, the number of medical treatments due to abuse and neglect will be reduced by 10% compared to baseline~~
- ~~By January 31, 2021, the number of medical treatments due to abuse and neglect will be reduced by 20% compared to baseline~~
- ~~By January 31, 2022, the number of medical treatments due to abuse and neglect will be reduced by 30% compared to baseline~~

---

[4] The data was obtained from the Minnesota Hospital Association and includes nearly all hospitals and emergency departments in Minnesota. Cases are identified using clinical coding in the hospital discharge data base. Persons of all ages were included in this measure.

Olmstead Subcabinet Meeting Agenda Item

March 22, 2021

Agenda Items:

7 (a) Proposed structure and roles of Subcabinet and Executive Committee

Presenter:

Commissioner Ho

Action Needed:

☐ Approval Needed

☒ Informational Item (no action needed)

Summary of Item:

This is a handout of a presentation that provides an overview of proposed changes to the roles of Subcabinet and Executive Committee

Attachment(s):

7a – Proposed structure and roles of Subcabinet and Executive Committee

Subcabinet Restructure Purpose

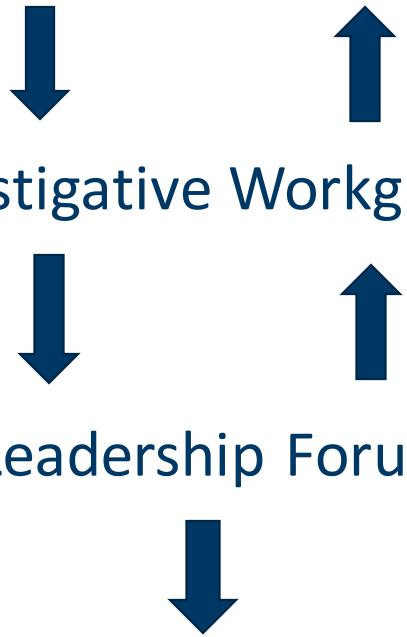
- Focusing the Subcabinet meetings on high-level strategy and policy decisions that drive change and continue to adhere to compliance oversight mandates
- Giving permission to Agency Leads to create new policy initiatives through workgroups and public engagement
- Promoting greater public input into development of the Plan through focused engagement, workgroups, and future Plan amendments

New Opportunities for Subcabinet Meetings to Consider

- Interactive presentations via Zoom meetings
- Plain language and graphic presentations to help audience engage with dense meeting packet materials
- Commissioner presentations on goals and successes
- Educational opportunities from community members
- Public presentations
- National Best Practices discussions

Engagement Restructuring

People with Disabilities - OIO Engagement Findings



Workgroup Vision

Workgroups:

- Agency Subject Matter Experts or other identified agency leader on group topic
- Engage with public, review comments
- Collect and analyze data, review comments
- Explore new policies and strategies
- Provide recommendations to Leadership Forum on future expansion of the MN Olmstead Plan
- Workgroups will meet for 9 months, on average

Workgroup Membership

Members

- People with Disabilities
- Family members and caregivers
- Service and nonprofit community providers
- Citizens interested in helping people with disabilities live their best lives
- State Agency Subject Matter Experts
- Other state agencies (Ombudsman for Long-Term Care, American Indian Elder Desk, Deaf and Hard of Hearing, Minnesota Council on Disabilities)

Agency Lead Forum Vision

Agency Lead Forum:

- Replaces current Executive Committee
- Allows in-depth discussion of an agency's capacity to implement a new idea. How can these new ideas go from theory to action?
- Ensures significant evaluation through public engagement
- Agency Leads are now prepared to communicate new ideas to the Commissioners for consideration around future Plan expansion

Leadership Forum Structure

- One representative from each Subcabinet agency, GCDD, and OMHDD
- Monitor major cross-agency initiatives such as the Big 6 workgroups and provide direction when needed.
- Conduct review and approval of Quarterly Reports.
- Draft semi-annual summary of progress for respective Commissioner to deliver to the Subcabinet
- Explores intersectionality of services
- Meets up to 6 times per year, minimally 4 times per year

Proposed Leadership Forum Meeting

2021	Compliance	General Discussion	Subcabinet Prep
March	2021 Plan Review for Approval	Discussion of restructure	Two-year vision for your agency
April	Establish Agency Lead, Calendar, Role of Exec. Comm.	Workgroup reviews, Results Based Accountability	None
June	May 2021 Quarterly Report	RBA workshops Workgroup Reviews	None
August	None	Workgroup Reviews	Employment Reports
October	August 2021 Quarterly Report	Workgroup Reviews – Amendment Reports	Success Measurements
December	November 2021 Quarterly Report	Workgroup Reviews – Amendment Reports	Plan Amendments

Subcabinet Meeting Schedule

2021	Compliance	Suggested Focus Discussion
January	Plan Amendments	Systemic Change
April	Olmstead Plan 2021 Quality of Life Survey Initial Findings Report	What will your agency's success look like in two years as it relates to the work of the Olmstead Plan?
October	May 2021 Quarterly Report	Employment (or Workgroup report that has been completed)
December	August 2021 Quarterly Report November 2021 Quarterly Report	What would a five-year success vision for your agency look like as it relates to the Olmstead Plan.

Supplemental Handout for
March 22, 2021
Olmstead Subcabinet Meeting

This handout includes the following meting materials:

- Agenda item 6b - 2021 Olmstead Plan Revision with proposed amended goals

Olmstead Subcabinet Meeting Agenda Item

March 22, 2021

Agenda Items:

6(b) 2021 Olmstead Plan Revision

Presenter:

Mike Tessneer

Action Needed:

☐ Approval Needed

☒ Informational Item (no action needed)

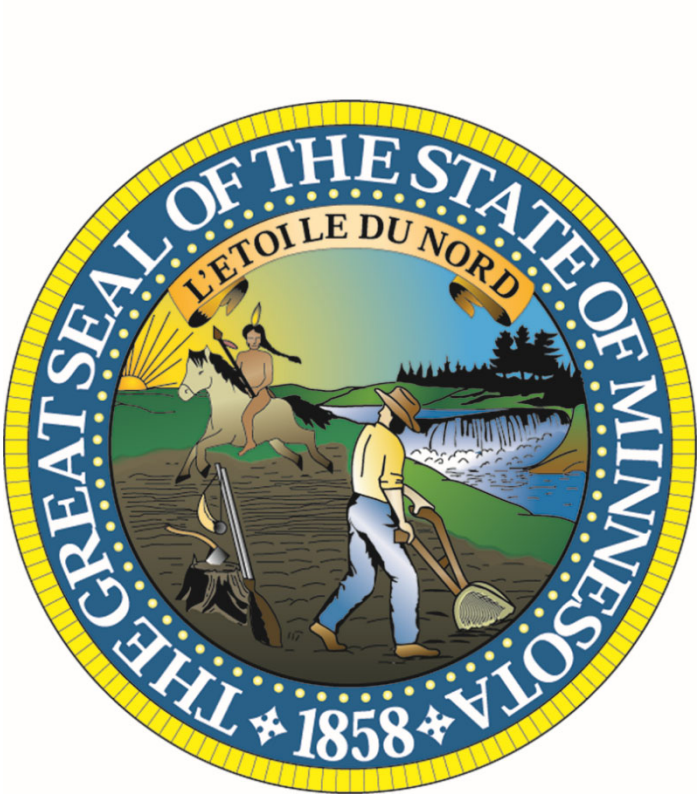
Summary of Item:

This draft version of the April 2021 Revision of the Plan includes the proposed amendments to the Plan that were provisionally approved by the Subcabinet at the January 25 and March 22, 2021 meetings. There will be additional edits prior to the April 26, 2021 Subcabinet Meeting where the Plan will be reviewed for approval. This document is being made available to provide context for the proposed amendments to measurable goals. Track changes indicate changes from the March 2020 Revision. This document will be available on the public website for reference during the public comment period.

Attachment(s):

6(b) – Draft version of 2021 Olmstead Plan (track changed)

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



April 2021~~March 2020~~ Revision

Feedback

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

Method	Steps to follow
Online	Go to: Mn.gov/Olmstead Click "Contact Us" and follow instructions for the online form
Email	Send an email to this address: MNOlmsteadPlan@state.mn.us
Mail	Send a letter to: Olmstead Implementation Office 400 Wabasha Street N, Suite 400 St. Paul, MN 55102
Phone	Speak to a staff member at the Olmstead Implementation Office, or leave your comment on voicemail: 651-296-8081

This document is available in alternative formats to individuals with disabilities by calling the Olmstead Implementation Office at 651-296-8081, or by emailing MNOlmsteadPlan@state.mn.us

For translations of this publication write to MNOlmsteadPlan@state.mn.us or call 651-296-8081.

Contents

INTRODUCTION AND BACKGROUND INFORMATION 9
Introduction 10
Background Information 10
Olmstead v. L.C. 10
Why does Minnesota have an Olmstead Plan? 11
Developing Minnesota's Olmstead Plan 12
Olmstead Subcabinet vision statement 13
Demographics and implications 13
Plan development and public comments 14
The August 2015 Plan 14
June 2016 Plan Amendment 16
First Plan Amendment Process: February 2017 Plan 16
Second Plan Amendment Process: March 2018 Plan 17
Third Plan Amendment Process: March 2019 Plan 17
Fourth Plan Amendment Process: March 2020 Plan 18
Where to learn more? 18
MEASURABLE GOALS 19
Topic Areas and Measurable Goals 20
Measurable goals 21
Format of topic areas 22
Measurable Goals at a Glance 23
Person-Centered Planning 35
What this topic means 35
Definition of Person-Centered Planning 36
Statement of core values and principles of Person-Centered Planning 36
Vision statement 37
Measurable goals 37
Rationale 39
Transition Services 41
What this topic means 41
Vision statement 42
Measurable goals 42
Rationale 44

Housing and Services 47
What this topic means 47
Vision statement 47
Measurable goals 48
Rationale 48
Employment 51
What this topic means 51
Vision statement 52
Measurable goals 52
Rationale 54
Lifelong Learning and Education 57
What this topic means 57
Vision statement 57
Measurable goals 58
Rationale 59
Timeliness of Waiver Funding 64
What this topic means 64
Vision statement 64
Measurable goals 65
Rationale 66
Transportation 68
What this topic means 68
Vision statement 68
Measurable goals 69
Rationale 71
Healthcare and Healthy Living 74
What this topic means 74
Vision statement 74
Measurable goals 75
Rationale 76
Positive Supports 77
What this topic means 77
Vision statement 78
Measurable goals 79
Rationale 82

Crisis Services 87
What this topic means 87
Vison statement 87
Measurable goals 87
Rationale 89
Community Engagement 93
What this topic means 93
Vision statement 94
Measurable goals 94
Rationale 95
Preventing Abuse and Neglect 97
What this topic means 97
Vision statement 97
Measurable goals 97
Rationale 99
Assistive Technology 104
What this topic means 104
Vision statement 106
Measurable goals 107
Strategies 107
PLAN MANAGEMENT AND OVERSIGHT 108
Plan Management and Oversight 109
Olmstead Subcabinet and Olmstead Implementation Office 109
Quality assurance and accountability 109
Development and oversight of workplans 109
Quality of Life survey 110
Dispute referral and oversight 111
Updating and extending the Olmstead Plan 111
Communications and public relations 112
Cross-agency coordination of data strategies 112
Cross-agency coordination of legislative and funding strategies 113
Definitions of key terms 116
Common Acronyms 124

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Minnesota Olmstead Subcabinet

~~March 23, 2020~~

~~On behalf of the Olmstead Subcabinet, I present this March 2020 revision of Minnesota's Olmstead Plan. At the core of this plan is the belief that to become a better Minnesota, we must become *One Minnesota*. All Minnesotans, regardless of disability or disability type, must have access to inclusive, community-based services and have meaningful opportunities to live, learn and work in integrated settings.~~

~~In addition to the work that is being done to advance the Plan, the Olmstead Subcabinet is operating under an Executive Order, which charges the Subcabinet to identify and address barriers to, and disparities in, providing services and meaningful opportunities in the most integrated settings. The Subcabinet is also charged with engaging communities with the greatest disparities in health outcomes for individuals with disabilities and working to identify and address barriers to equitable health outcomes.~~

~~Over the next year, the Olmstead Subcabinet is focusing on how Subcabinet members can collaborate with each other and the community to make progress on those big and important charges. I am also thrilled to announce new leadership in this effort as Shelley Madore, a long-time disabilities rights advocate, is stepping into the role of Director of the Olmstead Implementation Office to help lead the Subcabinet and the state on these issues.~~

~~As we look ahead, I am aware that the state has much work to do. But there is so much potential and promise in the energy and commitment of the Walz Flanagan Administration, the Olmstead Subcabinet, and the Olmstead Implementation Office. I am excited about confronting the challenges ahead and working with people across Minnesota to ensure that our state makes systemic changes to improve the lives of people with disabilities and to create a better Minnesota.~~

~~Jennifer Leimaile Ho, Chair~~
~~Olmstead Subcabinet~~

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INTRODUCTION AND BACKGROUND INFORMATION

Introduction

The State of Minnesota is firmly committed to ensuring that people with disabilities experience lives of inclusion and integration in the community. We envision a Minnesota where people with disabilities have the opportunity, both now and in the future, to live close to their families and friends and as independently as possible, to work in competitive integrated employment, to be educated in integrated settings, and to participate in community life.

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

Background Information

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

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

Olmstead v. L.C.

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

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

[1] "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.,"* U.S. Department of Justice, Civil Rights Division, June 22, 2011, Question 12, p. 4 ("DOJ Statement"), http://www.ada.gov/olmstead/q&a_olmstead.htm, last visited December 16, 2016.
[2] *Olmstead v. L.C.,* 527 U.S. 581 (1999).
[3] DOJ Statement, p. 1, *citing* 42 U.S.C. §12101(a)(2).
[4] 42 U.S.C. §12132.
[5] 28 C.F.R. §35.130(d).
[6] 28 C.F.R. pt. 35, App. A (2010)(addressing §35.130).
[7] *Olmstead v. L.C.,* 527 U.S. 581 (1999).

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

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

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

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

Why does Minnesota have an Olmstead Plan?

Minnesota has an Olmstead Plan to ensure that Minnesotans with disabilities have opportunities for lives of integration and inclusion. To this end, former Governor Mark Dayton issued Executive Orders in 2013 and 2015 that formed an Olmstead Subcabinet and charged the Subcabinet with developing and implementing an Olmstead Plan. On March 29, 2019, Governor Tim Walz issued Executive Order 19-13 to continue the role of the Subcabinet.[12] Moreover, we know that implementing a comprehensive, effectively working Plan will keep the State accountable to complying with the letter and spirit of the *Olmstead* decision and the ADA.

Beyond that, however, Minnesota has an Olmstead Plan to fulfill an agreement made in the settlement of a class action lawsuit in U.S. District Court in a case called *Jensen v. DHS.*[13] *Jensen* involved people with developmental disabilities who had been residents of a Department of Human Services (DHS) facility. In 2011, that case resolved in a settlement agreement, which included a provision for an Olmstead Plan. The settlement agreement stated: "the State and the Department shall develop and implement a comprehensive *Olmstead* plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs in the "most Integrated Setting," and is consistent and in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S.582 (1999).

[8] *Olmstead,* 527 U.S. at 607.
[9] 28 C.F.R. §35.130(b)(7).
[10] *Olmstead,* 527 U.S. at 603.
[11] *Assistant Attorney General Thomas E. Perez Testifies Before the U.S. Senate Committee on Health, Education, Labor and Pensions.* Washington, D.C., Thursday, June 21, 2012, http://www.justice.gov/crt/opa/pr/speeches/2012/crt-speech-120621.html, last visited December 16, 2016.
[12] Executive Orders 13-01, 15-03 and 19-13 are available on the Olmstead website, Mn.gov/Olmstead.
[13] *Jensen, et. al. v. Department of Human Services, et. al.,* Civil No. 09-cv-1775 (DWF/BRT).

Developing Minnesota's Olmstead Plan

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

In January 2013, former Governor Mark Dayton issued Executive Order 13-01 establishing a subcabinet to develop and implement a comprehensive plan supporting freedom of choice and opportunity for people with disabilities. In January 2015, Governor Dayton issued Executive Order 15-03 which further defined the role and nature of the Olmstead Subcabinet and the Olmstead Implementation Office (OIO).

In January 2019, Governor Tim Walz designated Commissioner Jennifer Leimaile Ho of the Minnesota Housing Finance Agency as the chair the Subcabinet.

On March 29, 2019, Governor Tim Walz issued Executive Order 19-13, to continue the role of the Subcabinet and expand its membership to include the Department of Public Safety, Department of Veterans Affairs, and the Metropolitan Council.

The Olmstead Subcabinet includes the following State agencies and entities:

- Department of Corrections
- Department of Education
- Department of Employment and Economic Development
- Department of Health
- Department of Human Rights
- Department of Public Safety
- Department of Human Services
- Department of Transportation
- Department of Veteran Affairs
- Metropolitan Council
- Minnesota Housing Finance Agency
- Office of the Ombudsman for Mental Health and Developmental Disabilities
- Governor's Council on Developmental Disabilities

Olmstead Subcabinet vision statement

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

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

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

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

Demographics and implications

To better understand how to make the Subcabinet's vision a reality, demographic information was reviewed about the State's population of people with a disability. Although this Olmstead Plan applies to people with disabilities as defined in the ADA,[14] available demographic data used a different definition of disability, one that excluded persons living in congregate settings.[15] Nevertheless, the information we have still helps us understand essential features and trends about the populations of Minnesotans with disabilities.

For example, data shows that 19% of Minnesotans with disabilities live in poverty ~~at a higher rate than~~ compared to 9% of all Minnesotans ~~without disabilities;~~[16] and ~~that~~ the highest rate~~s~~ of disabilities among ~~working age~~ Minnesotans are American Indians~~, and U.S. born African Americans.~~[17]

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

According to a 2018 study on homelessness in Minnesota, 64% of adults experiencing homelessness reported a serious mental illness, 57% reported a chronic physical health condition and 24% reported a substance abuse disorder. 77% of adults reported at least one of these conditions.[18]

---

[14] 42 U.S.C. § 12102 The term "disability" means, with respect to an individual: (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.

[15] Data from the American Community Survey and Decennial Census and Population Estimates, via Minnesota Compass, http://www.mncompass.org/demographics/, last accessed March 1, 2021.

[16] Ibid.

[17] Ibid.

[18] Wilder Research, "201~~5~~85 Minnesota Homeless Study Fact Sheet," ~~2015, 3.~~ http://mnhomeless.org/minnesota-homeless-study/reports-and-fact-sheets/2018/2018-homeless-characteristics-fact-sheet-5-19.pdf, last accessed March 1, 2021.~~January 24, 2020.~~

Recent media attention has focused on one disability that has increased dramatically. According to the Centers for Disease Control, autism has increased from a prevalence rate of 1 in 1,000 in 1970, to 1 in 150 in 2000, to 1 in 68 in 2012 to 1 in 59 in 2014, to 1 in 54 in 2016.[19]

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

Plan development and public comments

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

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

- The development of the August 2015 Olmstead Plan
- The June 2016 Plan amendment to incorporate additional goals and strategies
- The first annual Plan review and amendment process, which resulted in a revised February 2017 Plan
- The second annual Plan review and amendment process, which resulted in the March 2018 Plan
- The third annual Plan review and amendment process, which resulted in the revised March 2019 Plan.
- The fourth annual Plan review and amendment process, which resulted in this March 2020 Plan.

The August 2015 Plan

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

All public comments were reviewed and distributed to the appropriate State agencies so that the agency teams would consider them in the drafting and implementation of the Plan. Several themes emerged from stakeholder comments.[20] The majority of the comments related to the 11 theme areas below.

[19] CDC, "Autism Spectrum Disorders: Data & Statistics." http://www.cdc.gov/ncbddd/autism/data.html, last accessed March 1, 2021.~~January 24, 2020.~~

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

Theme Definitions

1) **Options and Choices** – People expressed that a "one size fits all" plan will not work. An array of options needs to be funded and available for people to meet the needs and choices of individuals.

2) **Financial Resources** – People noted that rates for reimbursement of service and affordability of service are important. They also noted that there should be adequate funding for services.

3) **Quality Assurance/Accountability** – People expect agencies to be accountable for the goals within the Plan. Work needs to be transparent and consistent in order for the public to hold agencies accountable.

4) **Access** – People shared that not everyone can access the programs/services. This may be physical access, lack of awareness about programs/services, and/or policy barriers that prevent access.

5) **Risk** – People expressed concern about personal safety. People perceive the opportunity to try different things as a risk, particularly if there is no option to return to what they were doing previously.

6) **Person-Centered** – People felt strongly that individuals should be able to make informed decisions in all areas of their lives.

7) **Barriers/Disincentives** – People shared that there are many policies that prevent individuals, families and businesses from achieving the Olmstead vision.

8) **Engagement** – People said that individuals with disabilities should be meaningfully involved in the direction of those policies and other things that impact their lives.

9) **Data** – People are dissatisfied with many of the data sources being used. They expressed that data need to be robust and understandable. Many people felt that as a State we collect a great deal of data about our citizens.

10) **Training and Technical Assistance** – People said that training and technical assistance is needed for everyone.

11) **Accessible Communications** – People were dissatisfied with the level of accessibility in State communications. Providing accessible communications will lead to transparency and awareness.

The public comments helped to determine the scope of the Plan, the topics it contains, and what outcomes the Plan should achieve. The August 2015 Plan focused on setting measurable goals to both: 1) increase opportunities for people with disabilities to receive services that best meet their individual needs in the most integrated setting; and 2) improve service delivery to promote a better quality of life. On September 29, 2015, the Court approved the State's August 2015 Olmstead Plan.

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

June 2016 Plan Amendment

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

First Plan Amendment Process: February 2017 Plan

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

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

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

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

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

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

Second Plan Amendment Process: March 2018 Plan

The Olmstead Subcabinet undertook a second annual Plan review and amendment process beginning in October 2017. The process began with a review by the Subcabinet of the 40 measurable goals and associated strategies in the Plan to determine if there was a justification to propose amendments. A draft of proposed amendments was reviewed by the Olmstead Subcabinet in December 2017.

An initial public comment period was held from December 20, 2017 to January 31, 2018. The public comment period included public listening sessions, focus groups, and written input in various formats. More than 200 people participated in the listening sessions and focus groups and more than 100 comments were received from people with disabilities, families, supporters, lead agencies, providers and others. Significant numbers of comments were received in the areas of Person-Centered Planning, Employment, Housing and Community Engagement.

The Olmstead Subcabinet considered public comment received in the initial public comment period and provisionally approved a revised set of proposed amendments in February 2018. A second public comment period was held from February 27, 2018 to March 13, 2018. The public comment period included a series of eight regionally based video conferences as well as opportunities to submit written comments. More than 71 comments were received during the second public comment period. Areas with the greatest response included Employment, Transportation and Community Engagement and general comments related to Services and Supports.

After consideration of public comments, the Olmstead Subcabinet reviewed and approved this March 2018 Plan on March 26, 2018. As a result of the approved changes, this March 2018 Plan contains 38 measurable goals.

Third Plan Amendment Process: March 2019 Plan

The Olmstead Subcabinet undertook a third annual Plan review and amendment process beginning in September 2018. The process began with a review by the Subcabinet of the 38 measurable goals and associated strategies in the Plan to determine if there was a justification to propose amendments. A draft of proposed amendments was reviewed by the Olmstead Subcabinet in December 2018.

An initial public comment period was held from December 20, 2018 to January 31, 2019. The public comment period included public listening sessions and written input in various formats. Approximately 150 individuals participated in the listening sessions or provided written comments. More than 200 comments were received from people with disabilities, families, supporters, service providers and others. Significant numbers of comments were received in the areas of Person-Centered Practices, Transition Services, Housing, Employment, Community Engagement and Communication.

The Olmstead Subcabinet considered public comment received in the initial public comment period and provisionally approved a revised set of proposed amendments in February 2019. A second public comment period was held from February 26, 2019 to March 11, 2019. The public comment period included two video conferences, a conference call, a focus group as well as opportunities to submit written comments. More than 49 comments were received during the second public comment period from 41 individuals. Areas with the greatest response included Housing, Education and Transportation.

After consideration of public comments, the Olmstead Subcabinet reviewed and approved this March 2019 Plan on March 25, 2019. As a result of the approved changes, this March 2019 Plan contains 38 measurable goals.

Fourth Plan Amendment Process: March 2020 Plan

The Olmstead Subcabinet undertook a fourth annual Plan review and amendment process beginning in October 2019. An initial public comment period was held from October 14, 2019 to November 29, 2019. The public comment period included six public listening sessions and written input. Approximately 142 individuals participated in the listening sessions or provided written comments. More than 380 comments were received from people with disabilities, families, supporters, services providers and others. Significant numbers of comments were received in the areas of Person-Centered Practices, Housing and Services, Employment, Education, Transportation, Health Care and Healthy Living, Preventing Abuse and Neglect, Assistive Technology and the Direct Care and Support Services Workforce Shortage.

A draft of proposed amendments was reviewed by the Olmstead Subcabinet in December 2019. A second public comment period was held from January 6, 2020 to January 31, 2020. The public comment period included three listening sessions, three videoconferences and the opportunity to provide written input. More than 300 comments were received during the second public comment from approximately 72 individuals. Areas with the greatest response included Person-Centered Practices, Transition Services, Housing and Services, Employment, Positive Supports, Crisis Services and the Direct Care and Support Services Workforce Shortage.

After consideration of public comments, the Olmstead Subcabinet reviewed and approved this March 2020 Plan on March 23, 2020. As a result of the approved changes, this March 2020 Plan contains 38 measurable goals.

Fifth Plan Amendment Process: April 2021

Where to learn more?

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

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

MEASURABLE GOALS

Topic Areas and Measurable Goals

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

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

Measurable goals

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

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

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

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

The following criteria were used for setting measurable goals:

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

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

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

- **Strategic**: Each measurable goal sets its outcomes and activities over a defined number of years.

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

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

Format of topic areas

Each topic area contains eight sections as described below:

- **Stakeholder comments**
  This section includes comments from stakeholders that voice the thoughts of people with disabilities on the topic area.
- **What this topic means**
  This section provides a narrative description of the topic area.
- **Vision statement**
  This section contains a vision statement that describes the State's aspirations for the topic area.
- **Measurable goals**
  This section contains one or more measurable goals that meet the criteria described above.
- **Rationale**
  This section includes statements that support the reasons that the particular measurable goals were selected to be the appropriate measurements for the activities within the topic area and the status of funding for the goals in the topic area.
- **Strategies**
  This section contains several key strategies that will need to be implemented to accomplish the measurable goals in that area. Responsible agencies develop workplans that include steps for implementing these strategies. The workplans will be posted on the Olmstead website and reviewed regularly by the Subcabinet.
- **Responsible agencies**
  This section lists the State agencies that will be primarily responsible for the implementation of the activities described in the topic area.

Measurable Goals at a Glance

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

Person-Centered Planning (DHS, DEED, MDE, ADM)

GOAL ONE: ~~By June 30, 2020, p~~Plans for people using disability home and community-based waiver services will meet protocols based on the presence of eight required criteria. Protocols are based on the principles of person-centered planning and informed choice. By June 30, 2022, the eight required criteria will be present at a combined rate of 90%.

~~**GOAL TWO:** By 2019, increase the percent of individuals with disabilities who report that they exercised informed choice, using each individual's experience regarding their ability to make or have input into major life decisions and everyday decisions, and to be always in charge of their services and supports, as measured by the National Core Indicators (NCI) survey.~~

~~**(A) Annual Goals** for the percent reporting they have input into major life decisions:~~

- ~~By 2015, the percent will increase to ≥ 45%~~
- ~~By 2016, the percent will increase to ≥ 50%~~
- ~~By 2017, the percent will increase to ≥ 55%~~
- ~~By 2018, the percent will be 58% or higher~~
- ~~By 2019, the percent will be 58% or higher~~

~~**(B) Annual Goals** for the percent reporting they have input in everyday decisions:~~

- ~~By 2015, the percent will increase to ≥ 84%~~
- ~~By 2016, the percent will increase to ≥ 85%~~
- ~~By 2017, the percent will increase to ≥ 85%~~
- ~~By 2018, the percent will be 90% or higher~~
- ~~By 2019, the percent will be 93% or higher~~

~~**(C) Annual Goals** the percent reporting they are always in charge of their services and supports:~~

- ~~By 2015, the percent will increase to ≥ 70%~~
- ~~By 2016, the percent will increase to ≥ 75%~~
- ~~By 2017, the percent will increase to ≥ 80%~~
- ~~By 2018, the percent will be 80% or higher~~
- ~~By 2019, the percent will be 80% or higher~~

Transition Services (DHS, DOC, MHFA)

GOAL ONE: By June 30, 2022, ~~20,~~ the number of people who have moved from segregated settings to more integrated settings will be 9,787. ~~7,138.~~

Annual Goals for the number of people moving from **(A)** ICFs/DD; **(B)** nursing facilities; and **(C)** other segregated settings

- By June 30, 2015, the number moving will be 874
- By June 30, 2016, the number moving will be 1,074
- By June 30, 2017, the number moving will be 1,224
- By June 30, 2018, the number moving will be 1,322
- By June 30, 2019, the number moving will be 1,322
- By June 30, 2020, the number moving will be 1,322
- By June 30, 2021, the number moving will be 1,322
- By June 30, 2022, the number moving will be 1,322

GOAL TWO: By June 30, 2022, ~~20,~~ the percent of people under ~~mental health~~ commitment at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting will be reduced to 30% (based on daily average).

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

- By June 30, 2016 the percent will reduce to ≤ 35%
- By June 30, 2017 the percent will reduce to ≤ 33%
- By June 30, 2018 the percent will reduce to ≤ 32%
- By June 30, 2019 the percent will reduce to ≤ 30%
- By June 30, 2020 the percent will reduce to 30% or lower
- By June 30, 2021 the percent will be maintained at 30% or lower
- By June 30, 2022 the percent will be maintained at 30% or lower

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GOAL THREE: By December 31, 2022, ~~20,~~ the average monthly number of individuals at Forensic Services moving to a less restrictive ~~leaving Minnesota Security Hospital to a more integrated~~ setting will increase to an average of 5 ~~10~~ individuals per month.

Annual Goals to increase average monthly number of individuals moving to a less restrictive setting: ~~leaving MSH:~~

- ~~By December 31, 2016 the number will increase to ≥ 7~~
- ~~By December 31, 2017 the number will increase to ≥ 8~~
- ~~By December 31, 2018 the number will increase to ≥ 9~~
- ~~By December 31, 2019 the number will increase to ≥ 10~~
- ~~By December 31, 2019 the number will increase to 10 or more~~
- By December 31, 2021 the number will be 4 or more
- By December 31, 2022 the number will be 5 or more

GOAL FOUR: By June 30, 2020, 90% ~~100%~~ of people who experience a transition will engage in a process that adheres to the Person-Centered, Informed Choice and Transition protocol. Adherence to the transition protocol will be determined by the presence of ten elements from the My Move Plan Summary document listed on page 43. [People who opted out of using the My Move Summary document or did not inform their case manager that they moved are excluded from this measure.]

Housing and Services (DHS, MHFA)

GOAL ONE: By June 30, 2022, ~~2020,~~ the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing will increase by 1,167. ~~5,569 (from 5,995 to 11,564 or about a 92% increase).~~

Annual Goals to increase the number living in the most integrated housing:

- ~~By June 30, 2019 the number will increase by 5,569 over baseline~~
- ~~By June 30, 2020 the number will increase by 5,569 over baseline~~
- By June 30, 2021, the number will be 569
- By June 30, 2022, the number will be 598

Employment (DHS, DEED, MDE, ADM)

GOAL ONE: By September 30, 2022, ~~19~~ the number of new individuals receiving Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) who are in competitive integrated employment will increase by 5,667. ~~14,820.~~

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

- ~~By September 30, 2015, the number will increase by 2,853~~
- ~~By September 30, 2016, the number will increase by 2,911~~
- ~~By September 30, 2017, the number will increase by 2,969~~
- ~~By September 30, 2018, the number will increase by 3,028~~
- ~~By September 30, 2019, the number will increase by 3,059~~
- By September 30, 2020, the number will increase by 2,072
- By September 30, 2021, the number will increase by 1,495
- By September 30, 2022, the number will increase by 2,100

GOAL TWO: By June 30, 2022, ~~20,~~ of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 6,283 ~~5,000~~ over baseline to 12,420 ~~11,137~~ in competitive integrated employment.

Annual Goals to increase the number in competitive integrated employment

- ~~By June 30, 2017, a data system will be developed.~~
- ~~By June 30, 2017, the number will increase by 1,500 individuals to 7,637~~
- ~~By June 30, 2018, the number will increase by 1,100 individuals to 8,737~~
- ~~By June 30, 2019, the number will increase by 1,200 individuals to 9,937~~
- ~~By June 30, 2020, the number will increase by 1,200 individuals to 11,137~~
- By June 30, 2021, the number will increase to 11,420
- By June 30, 2022, the number will increase to 12,420

GOAL THREE: By June 30, 2025, ~~2020,~~ the number of students with developmental cognitive disabilities, ages 19-21 that enter into competitive integrated employment will be 1,513.~~763.~~

Annual Goals for the number of students in competitive integrated employment:

- By June 30, 2016, the number will be 125
- By June 30, 2017, the number will be 188
- By June 30, 2018, the number will be 150
- By June 30, 2019, the number will be 150
- By June 30, 2020, the number will be 150
- By June 30, 2021, the number will be 150.
- By June 30, 2022, the number will be 150.
- By June 30, 2023, the number will be 150.
- By June 30, 2024, the number will be 150.
- By June 30, 2025, the number will be 150.

Employment (DHS, DEED, MDE, ADM)

GOAL FOUR: By December 31, 2022, ~~2019,~~ the number of Peer Support Specialists who are employed by mental health service providers will increase to ~~by~~ 82.

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

- ~~By December 31, 2017, the number will increase by 14~~
- ~~By December 30, 2018, the number will increase by 30~~
- ~~By December 30, 2019, the number will increase by 38~~
- By December 31, 2021, the number will be 76
- By December 31, 2022, the number will be 82

Lifelong Learning and Education (MDE, DHS, DOC)

GOAL ONE: By December 1, 2021 the percent of students with disabilities, receiving instruction in the most integrated setting, will increase to 63%.

Annual Goals to increase the percent of students with disabilities receiving instruction in the most integrated settings:

- By December 1, 2019 the percent will increase to 62.5%.
- By December 1, 2020 the percent will increase to 62.75%.
- By December 1, 2021 the percent will increase to 63%.

GOAL TWO: By June 30, 2025, ~~2020~~ the percent of students with disabilities who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase to 34.8% ~~36%~~ (from baseline of 29.8%). ~~31%).~~

Annual Goals to increase the percent of students entering an integrated postsecondary education setting in the fall after graduating are:

- ~~By June 30, 2019 the percent will increase to 35%~~
- ~~By June 30, 2020 the percent will increase to 36%~~
- By June 30, 2021, the percent will increase to 30.8%
- By June 30, 2022, the percent will increase to 31.8%
- By June 30, 2023, the percent will increase to 32.8%
- By June 30, 2024, the percent will increase to 33.8%
- By June 30, 2025, the percent will increase to 34.8%

~~**GOAL THREE:** By June 30, 2020, students with disabilities will have active consideration of assistive technology (AT) during the student's annual individualized education program (IEP) team meeting. Active consideration is based upon the "Special factors" requirement as described in Individuals with Disabilities Education Act (IDEA) of 2004.~~

~~**(A) Annual Goal** to increase the number of school districts that completed training in active consideration of assistive technology (AT)~~

- ~~By June 30, 2019, the number will increase to 21~~
- ~~By June 30, 2020, the number will increase to 31~~

~~**(B) Annual Goal** to increase the percent of students in school districts that have completed training in active consideration of assistive technology during their annual IEP team meeting:~~

- ~~By June 30, 2019, the percent will increase to 15%~~
- ~~By June 30, 2020, the percent will increase to 20%~~

Timeliness of Waiver Funding (DHS)

GOAL ONE: Lead agencies will approve funding at a reasonable pace for persons with a need for the Developmental Disabilities (DD) waiver. By June 30, 2022, the percentage of persons approved for funding at a reasonable pace for each urgency of need category will be: (A) Institutional exit ~~ing~~ (71%); ~~institutional settings;~~ (B) ~~with an i~~Immediate need (74%); and (C) ~~with a d~~Defined need (66%). ~~for the Developmental Disabilities (DD) waiver.~~

~~**(A) Persons exiting institutional settings will have funding approved at a reasonable pace, which means that:**~~

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

~~**(B) Persons with an immediate need will have funding approved at a reasonable pace, which means that:**~~

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

~~**(C) For persons with a defined need will have funding approved at a reasonable pace, which means that:**~~

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

Transportation (MnDOT, Met Council)

GOAL ONE: By December 31, 2020 accessibility improvements will be made to 6,600 curb ramps (increase from base of 19% to 49%) and 430 Accessible Pedestrian Signals (increase from base of 10% to 74%). By October 31, 2021 improvements will be made to 55 miles of sidewalks.

(A) Curb Ramps

- By December 31, 2020, accessibility improvements will be made to an additional 6,600 curb ramps.

(B) Accessible Pedestrian Signals (APS)

- By December 31, 2020, accessibility improvements will be made to an additional 430 APS installations.

(C) Sidewalk Improvements

- By October 31, 2021, improvements will be made to 55 miles of sidewalks.

Transportation (MnDOT, Met Council)

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

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

GOAL THREE: By 2025, expand transit coverage so that 90% of the public transportation service areas in Greater Minnesota will meet minimum service guidelines for access.

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

GOAL FIVE: By 2040, 100% percent of the target population will be served by regular route level of service for prescribed market areas 1, 2, and 3 in the seven county metropolitan area.

- By 2025, the percent of target population served by regular route level of service for each market area will be:
  - Market Area 1 will be 100%
  - Market Area 2 will be 95%
  - Market Area 3 will be 70%

Healthcare and Healthy Living (DHS, MDH)

GOAL ONE: By December 31, 2022, ~~2019,~~ the rate of adult public enrollees (with disabilities) who had an acute inpatient hospital stay that was followed by an unplanned acute readmission to a hospital within 30 days will be 20% or less.

GOAL TWO: By December 31, 2022, ~~2019,~~ the rate of enrollees with disabilities who used an emergency department for non-traumatic dental services will be 0.20% or less for children with disabilities and 1% or less for adults with disabilities.

Positive Supports (DHS, MDE, MDH, DOC)

Restrictive procedures for people with disabilities are prohibited except when used in an emergency situation. These goals seek reduction to the exceptions to restrictive procedures.

GOAL ONE: By June 30, 2022, ~~2020,~~ the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community-based services) who experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will not exceed 506. ~~650.~~

Positive Supports (DHS, MDE, MDH, DOC)

GOAL TWO: By June 30, 2022, ~~2020,~~ the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544 (for example, home and community-based services) will not exceed 2,821. ~~3,500.~~

GOAL THREE: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, with limited exceptions to protect the person from imminent risk of serious injury. Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and use of an auxiliary device to ensure a person does not unfasten a seatbelt in a vehicle. ~~By June 30, 2020, the emergency use of mechanical restraints, other than use of an auxiliary device will be reduced to no more than 93 reports.~~

~~**Annual Goals** to reduce the use of mechanical restraints, other than an auxiliary device:~~

- ~~By June 30, 2019, reduce to no more than 93 reports~~
- By June 30, 2022 the average duration of emergency use of mechanical restraint (other than an auxiliary device)46 as reported on BIRF reports will be reduced to 192 hours per month for individuals with Commissioner approval and 7.7 hours per month for individuals with a developmental disability in the Forensic Mental Health Program.

Annual Goals to reduce the use of mechanical restraints for individuals with Commissioner approval:

- By June 30, 2021, the duration will be no more than 202 hours per month
- By June 30, 2022, the duration will be no more than 192 hours per month

Annual Goals to reduce the use of mechanical restraints for individuals with DD in Forensic Mental Health Program:

- By June 30, 2021, the duration will be no more than 8.1 hours per month
- By June 30, 2022, the duration will be no more than 7.7 hours per month

GOAL FOUR: By June 30, 2024, ~~2020,~~ the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 735 ~~318~~ students or decrease to 1.94% ~~1.98%~~ of the total number of students receiving special education services.

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

- ~~By June 30, 2017, the number will be reduced by 80 or .02% of total students~~
- ~~By June 30, 2018, the number will be reduced by 80 or .02% of total students~~
- ~~By June 30, 2019, the number will be reduced by 79 or .02% of total students~~
- ~~By June 30, 2020, the number will be reduced by 79 or .02% of total students~~

- By June 30, 2020 the number will be reduced by 147 or 0.1% of total students
- By June 30, 2021 the number will be reduced by 147 or 0.1% of total students
- By June 30, 2022 the number will be reduced by 147 or 0.1% of total students
- By June 30, 2023 the number will be reduced by 147 or 0.1% of total students
- By June 30, 2024 the number will be reduced by 147 or 0.1% of total students

GOAL FIVE: By June 30, 2024, ~~2020,~~ the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 3,615 ~~2,251~~ or by 1.0 ~~0.8~~ incidents of restrictive procedures per student who experienced the use of restrictive procedures in the school setting.

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

- ~~By June 30, 2017, the number of incidents will be reduced by 563 or 0.2 per student~~
- ~~By June 30, 2018, the number of incidents will be reduced by 563 or 0.2 per student~~
- ~~By June 30, 2019, the number of incidents will be reduced by 563 or 0.2 per student~~
- ~~By June 30, 2020, the number of incidents will be reduced by 562 or 0.2 per student~~

- By June 30, 2021, the number of incidents will be reduced by 723 or 0.2 per student
- By June 30, 2022, the number of incidents will be reduced by 723 or 0.2 per student
- By June 30, 2023, the number of incidents will be reduced by 723 or 0.2 per student
- By June 30, 2024, the number of incidents will be reduced by 723 or 0.2 per student

Crisis Services (DHS, MDE)

GOAL ONE: By June 30, 2022, ~~2019,~~ the percent of children who receive children's mental health crisis services and remain in their community will increase to 85% or more.

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

- ~~By June 30, 2016, the percent will increase to 81%~~
- ~~By June 30, 2017, the percent will increase to 83%~~
- ~~By June 30, 2018, the percent will increase to 85%~~
- ~~By June 30, 2019, the percent will increase to 85%~~
- By June 30, 2020, the percent will increase to 80%
- By June 30, 2021, the percent will increase to 85%

GOAL TWO: By June 30, 2022, ~~20,~~ the percent of adults who receive adult mental health crises services and remain in their community (e.g., home or other setting) will increase to 65% ~~64%~~ or more.

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

- ~~By June 30, 2017, the percent will increase to 60%~~
- ~~By June 30, 2018, the percent will increase to 62%~~
- ~~By June 30, 2019, the percent will increase to 64%~~
- ~~By June 30, 2020, the percent will increase to 64%~~
- By June 30, 2021, the percent will increase to 55%
- By June 30, 2022, the percent will increase to 65%

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

The reporting period for this goal has ended. The Subcabinet approved the discontinuation of this measurable goal. DHS will continue to monitor this measure and annually report it to the Subcabinet.

GOAL FOUR: By June 30, 2022, ~~2019,~~ people in community hospital settings due to a crisis~~, will have appropriate community services within 30 days of no longer requiring hospital level of care, and~~ will have a stable, permanent home within 5 months after leaving the hospital.

(A) Annual Goals to increase percent of people who are housed five months after discharge from the hospital:

- ~~By June 30, 2017, the percent of people will increase to 83%~~
- ~~By June 30, 2018, the percent of people will increase to 84%~~
- ~~By June 30, 2019, the percent of people be 84% or higher~~
- By June 30, 2020, the percent of people be 78% or higher
- By June 30, 2021, the percent of people be 79% or higher
- By June 30, 2022, the percent of people be 80% or higher

~~**(B) Annual Goals** to increase the percent of people receiving services within 30 days after being discharged from the hospital:~~

- ~~By June 30, 2017, the percent of people will increase to 90%~~
- ~~By June 30, 2018, the percent of people will increase to 91%~~
- ~~By June 30, 2019, the percent of people will increase to 92% or higher~~

~~Crisis Services (DHS, MDE)~~

~~**GOAL FIVE:** By June 30, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary, placement within ten days.~~

~~**Annual Goals** to increase the percent of people receiving crisis services within ten days:~~

- ~~By June 30, 2018, the percent of people will increase to 87%~~
- ~~By June 30, 2019, the percent of people will increase to 88%~~
- ~~By June 30, 2020, the percent of people will increase to 90%~~

Community Engagement (OIO)

GOAL ONE: By June 30, 2022, ~~2020,~~ the number of individuals with disabilities who participate in Governor appointed Boards and Commissions~~, the Community Engagement Workgroup, Specialty Committee~~ and other Workgroups and Committees established by the Olmstead Subcabinet will increase to 245 members.

Annual Goals to increase the number of members with disabilities:

- ~~By June 30, 2018, the number will increase to 184 members~~
- ~~By June 30, 2019, the number will increase to 215 members~~
- ~~By June 30, 2020, the number will increase to 245 members~~
- By June 30, 2021, the number will increase to 215 members
- By June 30, 2022, the number will increase to 245 members

GOAL TWO: By April 30, 2022, ~~2020,~~ the (A) number of individuals with disabilities to participate in public input opportunities related to the Olmstead Plan, and (B) the number of comments received by individuals with disabilities (including comments submitted on behalf of individuals with disabilities) will increase by 20% ~~5%~~ over baseline.

Annual Goals to increase the numbers participating in public input opportunities and comments received:

- By April 30, 2021, the numbers will increase by 15% over baseline
- By April 30, 2022, the numbers will increase by 20% over baseline

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~~**GOAL THREE:** By March 31, 2022, the number of engagement activities related to Olmstead Plan's measurable goals will increase by 5% over baseline.~~

- ~~By March 31, 2021, a baseline will be established~~

Preventing Abuse and Neglect (MDH, DHS, MDE, OMHDD)

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

- Information and training on the use of the Minnesota Adult Abuse Reporting Center (MAARC)
- Recommendations regarding a "Stop Abuse" campaign
- Recommendations regarding the feasibility for creating a system for reporting abuse of children
- Analysis of data to develop materials for public awareness and targeted prevention activities
- Timetable for implementation of each element of the abuse prevention plan
- Recommendations for developing common definitions and metrics related to maltreatment

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

GOAL TWO: By December ~~January~~ 31, 2022, the number of cases of vulnerable individuals being treated due to abuse and neglect will decrease by 15% ~~30%~~ compared to baseline.

(A) Annual Goals to decrease the number of ER visits and hospitalizations due to abuse and neglect:

- ~~By April 30, 2019, a baseline will be established~~
- By December ~~January~~ 31, 2020, the number will be reduced by 5% ~~10%~~
- By December ~~January~~ 31, 2021, the number will be reduced by 10% ~~20%~~
- By December ~~January~~ 31, 2022, the number will be reduced by 15% ~~30%~~

(B) Annual Goals to decrease the number of medical treatments other than emergency room visits and hospitalizations due to abuse and neglect:

- By December 31, 2021, ~~April 30, 2019,~~ a baseline and annual goals will be established
- ~~By January 31, 2020, the number will be reduced by 10%~~
- ~~By January 31, 2021, the number will be reduced by 20%~~
- ~~By January 31, 2022, the number will be reduced by 30%~~

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

Annual Goals to reduce the number of people experiencing more than one episode of abuse

- By December 31, 2018, the number of people will be reduced by 5%
- By December 31, 2019, the number of people will be reduced by 10%
- By December 31, 2020, the number of people will be reduced by 15%
- By December 31, 2021, the number of people will be reduced by 20%

Preventing Abuse and Neglect (MDH, DHS, MDE, OMHDD)

GOAL FOUR: By July 31, 2025, ~~2020,~~ the number of students with disabilities identified as victims in determinations of maltreatment will decrease by 25% ~~10%~~ compared to baseline.

Annual Goals to reduce the number of students with disabilities indentified as victims in determinations of maltreatment:

- ~~By July 31, 2019, the number will decrease by 5% from baseline to 19~~
- ~~By July 31, 2020, the number will decrease by 10% from baseline to 18~~
- By July 31, 2021, the number will decrease by 5% from baseline to 29 students
- By July 31, 2022, the number will decrease by 10% from baseline to 26 students
- By July 31, 2023, the number will decrease by 15% from baseline to 23 students
- By July 31, 2024, the number will decrease by 20% from baseline to 20 students
- By July 31, 2025, the number will decrease by 25% from baseline to 17 students

Assistive Technology

- Strategies related to Assistive Technology are included in Person-Centered Planning, Transition Services, Employment and Lifelong Learning and Education topic areas.
- ~~Lifelong Learning and Education Measurable Goal 3 relates to Assistive Technology.~~

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

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Person-Centered Planning

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

What this topic means

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

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

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

Terms like "person-centered planning" and "person-driven planning" are distinct, but they share the fundamental principle that **government and service providers begin by listening to individuals about what is important to them in creating or maintaining a personally valued, community life. Planning of supports and services is not driven or limited by professional opinion or available service options but focused on the person's preferences and whole life context.** Effective support and services are identified to help people live, learn, work, and participate in their preferred communities and on their own terms. Many state and federal policies now mandate person-centered delivery of long-term services and supports. In January 2014, the Centers for Medicare and Medicaid Services (CMS) issued a rule that applies to all Home and Community-Based Services; this rule provides a description of a person-centered service plan. The full rule, 42 CF.R. Pt. 430, 431 et al, is available at

http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf (§441.725 contains the description of a person-centered service plan).

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

Definition of Person-Centered Planning

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

Statement of core values and principles of Person-Centered Planning

Person-centered planning embraces the following values and principles:

- People (with an authorized representative, if applicable) direct their own services and supports when desired.
- The quality of a person's life including preferences, strengths, skills, relationships, opportunity, and contribution is the focal point of the plan.
- The individual who is the focus of the plan (or that person's authorized representative) chooses the people who are involved in creating the context of the plan.
- Discovery of what is important to and for the person is not limited to what is currently available within the system or from professionals.
- People are provided sufficient information, support and experiences to make informed choices that are meaningful to them and to balance and take responsibility for risks associated with choices.
- Services, treatments, interventions and supports honor what is important to people (e.g. their goals and aspirations for a life, overall quality of life) and promote dignity, respect, interdependence, mastery and competence.
- Plans include sufficient proactive support and organization to prevent unnecessary life disruption and/or loss especially during transition periods or crisis recovery.

- Community presence, participation, and connection are expected and supported through the use of natural relationships and community connections in all aspects of the plan to assist in ending isolation, disconnection and disenfranchisement of the individuals.
- The process is based on mutually respectful partnerships that empower the person who is the focus of the plan and is respectful of his or her important relationships and goals.
- The context of a person's unique life circumstances includes: culture, ethnicity, language, religion, gender and sexual orientation. All aspects of the person's individuality, when expressed, are acknowledged, embraced, and valued in the planning process.

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

Vision statement

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

Measurable goals

Goal One: ~~By June 30, 2020, p~~Plans for people using disability home and community-based waiver services will meet protocols based on the presence of eight required criteria. ~~.~~ Protocols are based on the principles of person-centered planning and informed choice.

By June 30, 2022, the eight required criteria will be present at a combined rate of 90%.

Baseline: In state fiscal year 2014, 38,550 people were served on the disability home and community-based services. From July 1, 2016 – June 30, 2017 there were 1,201 disability files reviewed during the Lead Agency Reviews. For the period from April – June 2017, in the 215 case files reviewed, the eight required criteria were present in the percentage of files shown below. The combine rate was 67%.

1. The support plan describes goals or skills that are related to the person's preferences. (74%)
2. The support plan includes a global statement about the person's dreams and aspirations. (17%)
3. Opportunities for choice in the person's current environment are described. (79%)
4. The person's current rituals and routines are described. (62%)
5. Social, leisure, or religious activities the person wants to participate in are described. (83%)
6. Action steps describing what needs to be done to assist the person in achieving his/her goals or skills are described. (70%)
7. The person's preferred living setting is identified. (80%)
8. The person's preferred work activities are identified. (71%)

Goal Two: By 2019, increase the percent of individuals with disabilities who report that they exercised informed choice, using each individual's experience regarding their ability: to make or have input into major life decisions and everyday decisions, and to be always in charge of their services and supports, as measured by the National Core Indicators (NCI) survey.

(A) By 2019, the percent of people with intellectual and developmental disabilities (I/DD) who report they have input into major life decisions[21] will be 60% or higher.

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

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

- By 2015, the percent will increase to ≥ 45%
- By 2016, the percent will increase to ≥ 50%
- By 2017, the percent will increase to ≥ 55%
- By 2018, the percent will be 58% or higher
- By 2019, the percent will be 60% or higher

(B) By 2019, the percent of people with intellectual and developmental disabilities who make or have input in everyday decisions[22] will be 93% or higher.

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

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

- By 2015, the percent will increase to > 84%
- By 2016, the percent will increase to > 85%
- By 2017, the percent will increase to ≥ 85%
- By 2018, the percent will be 90% or higher
- By 2019, the percent will be 93% or higher

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

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

(C) By 2019, the percent of people with disabilities other than I/DD who are always in charge of their services and supports[23] will be 80% or higher.

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

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

- By 2015, the percent will increase to > 70%
- By 2016, the percent will increase to > 75%
- By 2017, the percent will increase to ≥ 80%
- By 2018, the percent will be 80% or higher
- By 2019, the percent will be 80% or higher

Rationale

- The primary focus in this area is to assure that person-centered planning principles, including meaningful informed choice, are included in the planning process for all persons. This will begin with those receiving disability home and community-based service waivers because they are a known group and an evaluation system is in place to sample plans on a routine basis. This group of people would also be under the federal requirements for person-centered planning for home and community-based services which took effect in March 2014. The intent is to extend the person-centered planning requirements across populations beyond those using home and community-based services.
- The National Core Indicator (NCI) survey is a **sample survey** and has been validated for people with developmental disabilities. The NCI survey has been expanded for use by older adults and people with disabilities at risk of nursing facility level of care.
- The Quality of Life Survey has been validated across all ages, all settings, and all disability groups.
- There is sufficient funding to implement these goals.
- An important aspect for many people with disabilities is support through the use of assistive technologies. As part of the Person-Centered, Informed Choice and Transition Protocol, individuals are assessed to determine the need for materials, equipment, or assistive technology and, if an individual plan includes assistive technology, that technology will be acquired and tested in the environment where it will be used.
- In Fiscal year 2017 (July 2016 – June 2017), 47,272 individuals received disability home and community-based services.

Strategies

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

- Define and initiate person-centered planning services to assist people with disabilities in expressing their needs and preferences about quality of life.
- Expand person-centered planning principles across more populations to include Medical Assistance recipients using mental health or home care services, those served through DEED, MDE, those leaving correctional facilities, and those requiring a coordinated plan between education, human

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

services, and/or health. Provide training on person-centered planning practices and informed choice to people with disabilities and their families, counties, tribes, and providers.

- Actively promote and encourage implementation of best practices and person-centered strategies that support individualized service and housing options through, for example, Housing Options Best Practices Forum and communities of practice on person-centered planning and transition protocols.
- Evaluate progress towards goals, and determine if additional strategies will be necessary to provide everyone receiving services through one of the four disability home and community-based service waivers with person-centered plans, that include meaningful informed choice.
- Develop materials and training to guide professionals who inform people with disabilities about their rights and their individual abuse prevention plans to increase understanding of rights and the effectiveness of planning. [Note: professionals include providers (who are responsible for abuse prevention plans), case managers, qualified professionals overseeing Personal Care Assistance services, etc.]

Evaluate the Effectiveness of Person-Centered Planning Principles and Techniques

- Use the established protocols to measure the quality of plans and the extent to which they contain required elements of person-centered planning through regular county and state audits. These audits will include technical assistance and/or improvement plans as indicated.
- Through the MnCHOICES assessment tool, assess whether assistive technology will be considered as part of an individual's support plan, and at reassessments, monitor access to and effective use of technology.
- DHS will work with System of Technology to Achieve Results (STAR) Program on strategies to increase awareness of, and monitor effective use of assistive technology as a means to increase quality of life and outcomes for people with disabilities.

Incorporate Assistive Technology Assessment into Person-Centered Planning Processes

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

Expand, diversify and improve the pool of workers who provide direct care and support services in order to produce meaningful progress towards alleviating the direct care and workforce shortage in Minnesota

- Increase worker wages and/or benefits.
- Expand the worker pool to ensure that people with disabilities have the workforce they need to live, learn, work and enjoy life in the most integrated setting.
- Improve the workforce by enhancing training for direct care and support professionals.
- Increase job satisfaction (including quality of the job).
- Raise public awareness by promoting direct care and support careers.
- Promote service innovation.
- Enhance data collection.

Responsible Agencies

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

Transition Services

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

What this topic means

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

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

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

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

Vision statement

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

Measurable goals

Goal One: By June 30, ~~2020~~ 2022, the number of people who have moved from segregated settings to more integrated settings[24] will be 9,782. ~~7,138.~~

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

	2014 Base line	June 30, 2015	June 30, 2016	June 30, 2017	June 30, 2018	June 30, 2019	June 30, 2020	June 30, 2021	June 30, 2022	Cumulative Total
(A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72*	84	84	84	72	72	72	72	72	612 ~~468~~
(B) Nursing Facilities (NF) under age 65 in NF > 90 days	707*	740	740	740	750	750	750	750	750	5,970 ~~4,470~~
(C) Segregated housing other than listed above	1,121	50	250	400	500	500	500	500	500	3,200 ~~2,200~~
Total	**1,900**	**874**	**1,074**	**1,224**	**1,322**	**1,322**	**1,322**	**1,322**	**1,322**	**9,782 ~~7,138~~**

* Calendar Year 2014

Goal Two: By June 30, 2022, ~~2020,~~ the percent of people under ~~mental health~~ commitment at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting[25] will be reduced to 30% (based on daily average).

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

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

- By June 30, 2016 the percent awaiting discharge will be reduced to ≤ 35%
- By June 30, 2017 the percent awaiting discharge will be reduced to ≤ 33%
- By June 30, 2018 the percent awaiting discharge will be reduced to ≤ 32%
- By June 30, 2019 the percent awaiting discharge will be reduced to ≤ 30%
- By June 30, 2020 the percent awaiting discharge will be reduced to 30% or lower
- By June 30, 2021 the percent awaiting discharge will be maintained at 30% or lower
- By June 30, 2022 the percent awaiting discharge will be maintained at 30% or lower

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

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

Goal Three: By December 31, 2022,~~2020,~~ the average monthly number of individuals ~~leaving Minnesota Security Hospital~~ at Forensic Services[26] moving to a less restrictive ~~more integrated~~ setting will increase to an average of 5 ~~10~~ individuals per month.

Baseline: During 2017 - 2020, for individuals committed under MI&D and other commitments, the average number of individuals moving to a less restrictive setting was approximately 3 per month.

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

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

- By December 31, 2021 the average monthly number of individuals moving to a less restrictive setting will be 4 or more
- By December 31, 2022 the average monthly number of individuals moving to a less restrictive setting will be 5 or more

- ~~By December 31, 2016 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 7~~
- ~~By December 31, 2017 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 8~~
- ~~By December 31, 2018 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 9~~
- ~~By December 31, 2019 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 10~~
- ~~By December 31, 2020 the average monthly number of individuals leaving to a more integrated setting will increase to 10 or more~~

Goal Four: By June 30, 2020, ~~100~~ 90% of people who experience a transition will engage in a process that adheres to the Person-Centered, Informed Choice and Transition protocol. Adherence to the transition protocol will be determined by the presence of the ten elements from the My Move Plan Summary document listed below. [People who opted out of using the My Move Summary document or did not inform their case manager that they moved are excluded from this measure.]

Baseline: For the period from October 2017 – December 2017, of the 26 transition case files reviewed, 3 people opted out of using the My Move Summary document and 1 person did not inform their case manager that they moved. Of the remaining 22 case files, 15 files (68.2%) adhered to the transition protocol.

1. Where is the person moving?
2. Date and time the move will occur.
3. Who will help the person prepare for the move?
4. Who will help with adjustment during and after the move?
5. Who will take the person to new residence?

[26] For the purpose of this goal,~~Plan,~~ Forensic Services (formerly known as Minnesota Security Hospital) ~~(MSH)~~ refers to individuals residing in the facility and committed as m~~M~~entally i~~I~~ll and d~~D~~angerous and other commitment statuses. ~~and individuals under competency restoration treatment, Minn. R. Crim. P. 20.01.~~

6. How the person will get his or her belongings.
7. Medications and medication schedule.
8. Upcoming appointments.
9. Who will provide support after the move; what they will provide and how to contact those people (include informal and paid support), including supporting the person to adjust to the changes.
10. Back-up plans for what the person will do in emergencies, such as failure of service provider to show up on schedule, unexpected loss of provider or mental health crisis.

Rationale

- Individuals exiting institutional settings may be included in the housing goal when they move into integrated housing.
- Individuals at AMRTC fall into one of two categories: 1) individuals under mental health commitment; and 2) individuals civilly committed after being found incompetent on a felony or gross misdemeanor charge (restore to competency). For individuals under mental health commitment, discharge planning and discharge are under the authority of the AMRTC and the lead agency. For individuals who were civilly committed after being found incompetent on a felony or gross misdemeanor charge, discharge planning and discharge are under the authority of the criminal court. For ~~the AMRTC goal~~ Goal Two, progress will be measured ~~only~~ for all individuals at AMRTC. ~~those individuals under mental health commitment.~~
- Forensic Services (formerly known as Minnesota Security Hospital) has been serving two groups: people who are committed under Mentally Ill and Dangerous (MI&D) and other commitments and people who are committed after a finding of incompetency (this may include people with disabilities). During 2021, Forensic Services will cease to serve people who are found incompetent and committed under a Mental Illness (MI) commitment type. Therefore, beginning in 2021, Goal Three will only pertain to people committed under MI&D and other commitments. This includes individuals whose behavior demonstrates that they need to be served under a very restrictive setting such as Forensic Services. The transition rate for this group is much slower than those committed as MI after finding of incompetency. Accordingly, the baseline and annual goals have been adjusted for this population.
- In recent years, there has been an increase of patients referred to Forensic Services under MI&D Commitment, who also have a diagnosis of developmental disability or a related condition, and/or brain injury. This population requires intensive transition planning which typically takes years to find and/or create a successful placement.
- Individuals leaving Forensic Services ~~MSH~~ may move to a more integrated setting, transfer to a treatment facility or transfer to a correctional setting. For the Goal Two, ~~MSH goal,~~ progress will be measured ~~only~~ for those individuals moving out of the facility to a less restrictive setting, even if the new setting is not fully community integrated. ~~leaving to more integrated settings.~~ An example would include moving to a treatment facility in the community. While those facilities are not fully community-integrated, they are less restrictive than Forensic Services. Secure units at Forensic Services are considered one of the most restrictive settings in the State. Therefore, transition to any other non-secure setting out of a Forensic Services facility is a move to a less restrictive setting. It is believed that from a quality of life perspective, it is valid to track the people who move from the facility to a less restrictive setting.
- It is projected that the census of ICFs/DD will decrease over time, therefore the number of people who leave an ICF/DD over time will also decrease.

- A standardized informed choice process is in place to determine how many individuals in segregated settings would choose or not oppose moving to a more integrated setting.
- The "Person-Centered, Informed Choice and Transition Protocol" was adopted in February 2016 and is being implemented.
- There are existing funds to support these goals.
- In June 2017, there were 1,383 individuals receiving services in an ICF/DD and there were 1,502 individuals with disabilities under age 65 who received services in a nursing facility for longer than 90 days.
- In Calendar Year 2017, 383 patients received services at AMRTC. This may include individuals who were admitted more than once during the year. The average daily census was 91.9.
- In Calendar Year 2020, ~~2017, 581~~ 502 unique patients received services at Forensic Services. ~~MSH.~~ This may include individuals who were admitted more than once during the year. The average daily census was 358.2. ~~4.~~

Strategies

Improve Ability to Gather Information about Housing Choices

- The "Person-Centered, Informed Choice and Transition Protocol" was adopted in February 2016 and is being implemented for all people who receive long-term services and supports to determine the number of individuals who would choose or do not oppose moving to a more integrated setting.

Implement New Transition Protocols

- A "Person-Centered, Informed Choice and Transition Protocol" is being used with individuals moving to more integrated settings from segregated settings to ensure that planning includes what is important to the individual as well as for the individual. The protocol aligns with the Jensen Settlement Agreement, the five principles of transition planning, and relevant components of the final rule of Home and Community-Based Services standards.
- Implement the federal rule governing Home and Community-Based Services (HCBS) settings requiring assessment and person-centered planning practices.

Increase Service Options for Individuals Making Transitions

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

Monitor and Audit the Effectiveness of Transitions

- Develop materials to help people with disabilities, families and guardians understand options, answer questions and connect with those who can assist them in making an informed choice and planning for a transition.
- Lead agencies and the State will conduct audits of transition planning done by counties and providers to determine and gather the degree to which the transition meets the Person-Centered,

Informed Choice and Transition protocol. DHS will monitor and report to the Subcabinet: the number of transition case files reviewed; the number of people opting out of the My Move Summary document; the number of people who did not inform their case manager of their move; the number of case files that had the My Move Summary document; and the number of those documents that included the ten required elements.

- DHS will focus technical assistance and other strategies toward the areas that have the lowest compliance.
- Monitor both the number and percent of AMRTC patients under civil commitment after being found incompetent on a felony or gross misdemeanor charge and those under civil commitment for mental health treatment.
- DHS, DEED and DOC will work together to ensure efficient and successful transitions for people leaving DOC facilities and entering community services.

Responsible Agencies

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

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Housing and Services

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

What this topic means

Housing and Services is about:

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

Housing and Services is not about closing potentially segregated settings. According to the Department of Justice: "Individuals must be provided the opportunity to make an informed decision.... Public entities must take affirmative steps to remedy this history of segregation and prejudice in order to ensure that individuals have an opportunity to make an informed choice. Such steps include providing information about the benefits of integrated settings; facilitating visits or other experiences in such settings; and offering opportunities to meet with other people with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers. Public entities also must make reasonable efforts to identify and address any concerns or objections raised by the individual or another relevant decision-maker." [27]

Vision statement

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

[27] "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.", U.S. Department of Justice, Civil Rights Division, June 22, 2011, Question 5, pg. 2.

Measurable goals

Goal One: By June 30, 2022, ~~2020,~~ the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing will increase by 1,167. ~~5,569 (from 5,995 to 11,564 or about a 92% increase).~~

Baseline: In State Fiscal Year 2014, there were an estimated 38,079 people living in segregated settings.[28] Over the last 10 years, 5,995 individuals with disabilities moved from segregated settings into integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing.[29] From July 2014 – June 2020, an additional 5,388 individuals moved into integrated housing of their choice (an annual average of 898).

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

- ~~By June 30, 2019, there will be an increase of 5,569 over baseline to 11,564 (about 92% increase)~~
- ~~By June 30, 2020, there will be an increase of 5,569 over baseline to 11,564 (about 92% increase)~~
- By June 30, 2021, the number of individuals moving into integrated housing will be 569
- By June 30, 2022, the number of individuals moving into integrated housing will be 598

Rationale

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

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

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

Strategies

Create More Affordable Housing

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

Improve the Ability to Gather Information about Housing Choices

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

Improve Future Models for Housing in the Community

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

Implement new Medicaid Housing Stabilization Services[30] benefit for people with disabilities or disabling conditions who have housing instability.

Increase use of Minnesota Supplemental Aid Housing Assistance for people with disabilities who are eligible have more resources to pay for housing.

Responsible Agencies

- Department of Human Services
- Minnesota Housing Finance Agency

[30] Housing Stabilization Services is a benefit that went into effect in July 2020. This was formerly called Housing Access Services and Housing Access Coordination.

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Employment

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

What this topic means

Employment is about:

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

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

Employment Statistics

According to the Cornell University Yang-Tan Institute on Employment and Disability Status Report (data for 2018~~7~~, published in 2021~~9~~)[31]:

- The employment rate of working-age people (ages 21 to 64) with disabilities in Minnesota was 48.5%.~~49.0%.~~ For the general population it was 82.3% ~~85.7%.~~
- The percentage of working-age people with disabilities who were unemployed and actively looking for work was 11.3%.~~7.1%.~~ For people without a disability who were actively looking for work it was 15.0%. ~~19.3%.~~
- The percentage of working-age people with disabilities working full-time/full-year was 27.4% ~~26.9%~~ with average annual earnings of $41,800. ~~40,400.~~ For working-age people without disabilities, 61.3% ~~63.6%~~ were working full-time/full-year with average annual earnings of $52,700. ~~50,600.~~

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

Based on statistics reported by DEED from October 20198- September 20202019:

- Vocational Rehabilitation Services (VRS) provided services to 13,994 ~~15,676~~ persons under Title I of the Rehabilitation Act, all of whom were individuals with a significant disability.
- State Services for the Blind (SSB) provided vocational rehabilitation services to 1,033 persons who are blind, visually impaired, and DeafBlind.
- There are approximately 296,000 Minnesotans between the ages of 18 and 64 with one or more long-lasting disabilities, of which approximately 6% received State Vocational Rehabilitation Services.
- For comparison, 14% of unemployed Minnesotans utilized the services of the State's CareerForce Locations during Calendar Year 2019.

Vision statement

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

Measurable goals

Goal One: By September 30, 2022 ~~2019~~ the number of ~~new~~ individuals[32] who are in competitive integrated employment as a result of receiving Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) ~~who are in competitive integrated employment~~ will increase by 5,667.~~14,820.~~

Baseline: In 2014, Vocational Rehabilitation Services and State Services for the Blind helped 2,738 people with significant disabilities find competitive integrated employment. In 2019, VRS and SSB helped 2,670 people find competitive integrated employment.

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

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

- By September 30, 2020, the number in competitive integrated employment will increase by 2,072
- By September 30, 2021, the number in competitive integrated employment will increase by 1,495
- By September 30, 2022, the number in competitive integrated employment will increase by 2,100

[32] ~~"New" individuals mean~~ This includes individuals who were closed successfully from the Vocational Rehabilitation program. This is an unduplicated count of people working successfully in competitive integrated jobs. These numbers are based on historical trends for annual successful employment outcomes.

Goal Two: By June 30, 2022, ~~2020,~~ of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 6,283 ~~5,000~~ over baseline to 12,420 ~~11,137~~ in competitive integrated employment.

Baseline: In 2014, of the 50,157 people age 18-64 in Medicaid funded programs, 6,137 were in competitive integrated employment. Medicaid funded programs include: Home and Community-Based Waiver Services, Mental Health Targeted Case Management, Adult Mental Health Rehabilitative Services, Assertive Community Treatment and Medical Assistance for Employed Persons with Disabilities (MA-EPD).

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

- ~~By June 30, 2017, a data system will be developed to measure the following: the number of individuals who are working in competitive integrated employment; the number of individuals not working in competitive integrated employment; and the number of individuals not working in competitive integrated employment who would choose or not oppose competitive integrated employment.~~
- ~~By June 30, 2017, the number of individuals in competitive integrated employment will increase by 1,500 individuals over baseline to 7,637.~~
- ~~By June 30, 2018, the number of individuals in competitive integrated employment will increase by 1,100 individuals over baseline to 8,737.~~
- ~~By June 30, 2019, the number of individuals in competitive integrated employment will increase by 1,200 individuals over baseline to 9,937.~~
- ~~By June 30, 2020, the number of individuals in competitive integrated employment will increase by 1,200 individuals over baseline to 11,137.~~

- By June 30, 2021, the number of individuals in competitive integrated employment will increase to 11,420
- By June 30, 2022, the number of individuals in competitive integrated employment will increase to 12,420

Goal Three: By June 30, 2025, ~~2020,~~ the number of students with developmental cognitive disabilities, ages 19-21 that enter into competitive integrated employment will be 1,513. ~~763.~~

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

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

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

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

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

- By June 30, 2016 ~~(using fiscal years 2015 and 2016 data)~~, the number of students ~~with Developmental Cognitive Disabilities (DCD)~~ in competitive integrated employment will be 125.
- By June 30, 2017, the number of ~~additional~~ students in competitive integrated employment will be 188.

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

- By June 30, 2018, the number of ~~additional~~ students in competitive integrated employment will be 150.
- By June 30, 2019, the number of ~~additional~~ students in competitive integrated employment will be 150.
- By June 30, 2020, the number of ~~additional~~ students in competitive integrated employment will be 150.
- By June 30, 2021, the number of students in competitive integrated employment will be 150.
- By June 30, 2022, the number of students in competitive integrated employment will be 150.
- By June 30, 2023, the number of students in competitive integrated employment will be 150.
- By June 30, 2024, the number of students in competitive integrated employment will be 150.
- By June 30, 2025, the number of students in competitive integrated employment will be 150.

Goal Four: ~~By~~ By December 31, 2022, ~~2019,~~ the number of Peer Support Specialists who are employed by mental health service providers will increase ~~by~~ to 82.

Baseline: As of April 30, 2016, there are 16 certified peer support specialists employed by Assertive Community Treatment (ACT) teams or Intensive Residential Treatment Services (IRTS) throughout Minnesota. As of December 31, 2020, there were 71 employed peer support specialists.

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

- ~~By December 31, 2017, the number of employed peer support specialists will increase by 14~~
- ~~By December 30, 2018, the number of employed peer support specialists will increase by 30~~
- ~~By December 30, 2019, the number of employed peer support specialists will increase by 38~~
- By December 31, 2021, the number of employed peer support specialists will be 76
- By December 31, 2022, the number of employed peer support specialists will be 82

Rationale

- The second goal targets 50,157 working age individuals with disabilities in certain Medicaid funded programs who are receiving Long Term Services and Supports and/or Mental Health treatment services. These are programs where there is the most opportunity for strategies to be carried out to

increase competitive integrated outcomes. Some individuals served in these programs also receive Extended Employment services under Vocational Rehabilitation Services.

- ~~The Post School Outcome is a sample survey and does not represent the entire population.~~ ~~This will be used until a broader set of measures is developed. At that time the baseline and measurable goals will be revised.~~
- Students with Developmental Cognitive Disability (DCD) are at the greatest risk of entering into a segregated employment setting after leaving high school. In setting the baseline and goal, a sample of Post School Outcome data was used. The Post School Outcome is a sample survey and does not represent the entire population.
- In the next five years, there is a projected increase in excess of 20,000 individuals seeking competitive integrated employment through VRS. These individuals include students exiting school or DHS programs.
- There is existing funding to support these goals.

Strategies

Implement the Employment First Policy

- Implement the Minnesota Employment First Policy which encourages competitive integrated employment.
- Implement E1MN interagency agreements between DHS and DEED to align systems so that common customers get seamless and timely support to make informed choices and meet employment goals.

Utilize Data System to Measure and Evaluate Integrated Employment

- Agencies will continue to collaborate on efforts to determine the best ways to use data and common measures to evaluate employment services and measure increases in competitive integrated employment.

Reform Funding Policies to Promote Competitive Integrated Employment

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

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

- Adopt the evidence-based practice of engaging youth in paid work before exiting school.
- Build capacity at state/regional levels by expanding these evidence-based and promising practices~~, such as:~~
    - Project SEARCH (youth)
    - Employment Capacity Building Cohort (ECBC) (youth)
    - Pre-Employment Transition Services (Pre-ETS) (youth)
    - Individual Placements and Supports (IPS) Employment program (for adults with serious mental illness)
- Provide training, technical assistance, public information and outreach regarding competitive integrated employment to individuals and families, providers, educators, vocational rehabilitation services, staff, county and tribal case managers, and other stakeholders.

- Increase awareness of and education about ways that Assistive Technology products, services and resources can support competitive integrated employment outcomes. Increase employment opportunities for certified peer specialists by mental health service providers.

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

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

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

- Implement federal requirements regarding employment under the Centers for Medicare and Medicaid Services Home and Community-Based Services Rule, the federal rule that governs waivered services for individuals with disabilities.

Promote tools for support professionals and people with disabilities to achieve employment goals

- Promote tools available on the Disability Hub MN that provide resources in exploring work options, setting goals, and achieving employment success.
    - Promote the use of the work toolkit to lead agencies as a go to place for resources and tools when supporting people in employment.
    - Promote the use of Charting the LifeCourse tool as a way to support person-centered planning in the context of employment.

Provide technical assistance to support transitions to competitive integrated employment

- Provide assistance to day and employment services providers that are shifting business models to support competitive integrated employment.

Implement upcoming changes to Prevocational services in a manner that supports competitive integrated employment

- Upon federal approval, all center-based work will be transitioned to prevocational services, which will be time limited for new recipients.

Responsible Agencies

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

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Lifelong Learning and Education

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

What this topic means

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

The federal Individuals with Disabilities Education Act (IDEA) of 2004[33] requires that students with disabilities receive special education services in the least restrictive environment appropriate to meet their needs. This means that removal from regular education classes occurs only when a student cannot be successfully educated in regular classes, even with supplemental aids and services. When a student is removed from the regular educational environment for part of the day, the student must still be educated with non-disabled peers as much as possible.

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

Vision statement

People with disabilities will experience an inclusive education system at all levels and lifelong learning opportunities that enable the full development of individual talents, interests, creativity, and mental and physical abilities. They will be educated in the most integrated educational setting from preschool through grade twelve and will transition to the most integrated post-secondary setting or employment.

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

Measurable goals

Goal One: By December 1, 2021 the percent of students with disabilities[34], receiving instruction in the most integrated setting[35], will increase to 63%.

Baseline: In 2013, of the 109,332 students with disabilities, 67,917 (62.1%) received instruction in the most integrated setting.

Annual Goals to increase the percent of students with disabilities receiving instruction in the most integrated settings:

- By December 1, 2019, the percent ~~of students with disabilities receiving instruction in the most integrated setting~~ will increase to 62.5%.
- By December 1, 2020, the percent ~~of students with disabilities receiving instruction in the most integrated setting~~ will increase to 62.75%.
- By December 1, 2021, the percent ~~of students with disabilities receiving instruction in the most integrated setting~~ will increase to 63%.

Goal Two: By June 30, 2025, ~~2020~~ the percent of students with disabilities who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase to 34.8% ~~36%~~ (from the ~~2020~~2016 baseline of 29.8%~~31%~~).

Baseline: Based on 2020 ~~2014~~ Minnesota's Statewide Longitudinal Education Data System (SLEDS), of the 7,212 ~~6,749~~ students with disabilities who graduated statewide in 2020~~14~~, a total of 2,151 (29.8%) ~~2,107 (31%)~~ enrolled in the fall of 2020 ~~2014~~ into an integrated postsecondary institution.

Annual Goals to increase the percent of students with disabilities enrolling in an integrated postsecondary education setting in the fall after graduating are:

- ~~By June 30, 2019, the percent will increase to 35%~~
- ~~By June 30, 2020, the percent will increase to 36%~~

- By June 30, 2021, the percent will increase to 30.8%
- By June 30, 2022, the percent will increase to 31.8%
- By June 30, 2023, the percent will increase to 32.8%
- By June 30, 2024, the percent will increase to 33.8%
- By June 30, 2025, the percent will increase to 34.8%

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

Goal Three: By June 30, 2020, students with disabilities will have active consideration of assistive technology (AT) during the student's annual individualized education program (IEP) team meeting. Active consideration is based upon the "Special factors" requirement as described in Individuals with Disabilities Education Act (IDEA) of 2004.

There are two measures for this goal:

(A) School districts trained in active consideration

Baseline: From December 2016 to December 2018, fifteen school districts have completed MDE training in active consideration of assistive technology (AT) during the student's annual individualized education program (IEP) meeting to ensure education in the most integrated setting.

Annual Goals to increase the number of school districts that completed MDE training in active consideration of assistive technology (AT):

- By June 30, 2019, the number of school districts that completed AT training will increase to 21.
- By June 30, 2020, the number of school districts that completed AT training will increase to 31.

(B) Students with disabilities in districts trained in active consideration

Baseline: From December 2016 to December 2018, 11.1% (15,106 of 136,245) of students with disabilities statewide (K-12) are served in school districts that have completed MDE training in active consideration of AT during the student's annual individualized education program (IEP) team meeting to ensure education in the most integrated setting.[36]

Annual Goals to increase the percent of students with disabilities statewide in school districts that have completed training in active consideration of assistive technology during their annual IEP team meeting:

- By June 30, 2019, the percent of students with disabilities in school districts that have completed MDE training will increase to 15%.
- By June 30, 2020, the percent of students with disabilities in school districts that have completed MDE training will increase to 20%.

Rationale

Goal One

- In 2013, Minnesota schools identified and provided special education services to 109,332 students with disabilities ages 6 to 21, as reported on the IDEA Section 618 Data. Of that number, 67,917 students with disabilities (62.1%) received instruction in regular classes 80% or more of their school day. Of that number, 41,415 students with disabilities (37.9%) received instruction in regular classes less than 79% or less of their school day.
- A particular focus of attention includes students with Autism Spectrum Disorders or Developmental Cognitive Disabilities ages 6 – 18, who comprised 19.9% of students with disabilities. However, this same student group comprised 12.6% of students with disabilities receiving instruction in regular classes for 80% or more of their school day.
- Using a percentage measure more accurately reflects the proportion of students with disabilities receiving instruction in the most integrated setting based on the true annual number of students with disabilities each year. The annual number of students with disabilities changes every year, and

[36] Source: MDE 2017 Child Count data for trained school districts and the state total, not including intermediate school districts and educational cooperatives.

as such poses a shifting denominator for the goal calculations. Using a percentage measurement adjusts for these annual shifts in the number of students with disabilities.

- Increasing the percentage of students in the most integrated setting by 0.25% equates to moving 300 students into the most integrated settings each year, with an increase of 600 students over two years.
- The annual number of students with disabilities receiving instruction in the most integrated setting will also be reported for purposes of clarity and transparency, and will continue to be available to the public on the MDE Data Center website.
- This goal is in alignment with MDE's State Performance Plan/Annual Performance Report (SPP/APR), as reported to The Office of Special Education Programs (OSEP) and required by the Individuals with Disabilities Education Act (IDEA). SPP/APR is developed with and reviewed by broadly representative groups of internal and external stakeholders. The primary advisory group is the Minnesota Special Education Advisory Panel (SEAP). The membership of SEAP is representative of stakeholders in Minnesota and includes parents of children with disabilities, individuals with disabilities, and special education professionals.

Goal Two

- Minnesota's Statewide Longitudinal Education Data System (SLEDS) data tracks the successful same-year transition of students from high school graduation directly into fall enrollment in institutions of higher education. The public SLEDS data also includes enrollment in accredited certificate and one year programs.
- Ideal performance for this goal is defined as students with disabilities enrolling in an accredited institution of higher education in the fall of the same year as their graduation (as opposed to delayed enrollment to the next year).
- Using a percentage more accurately reflects the proportion of students with disabilities enrolling in integrated postsecondary education based on the true annual number of students with disabilities graduating from high school in each year. The annual number of students with disabilities graduating from high school changes every year, and as such poses a shifting denominator for the goal calculations.
- The annual number of students with disabilities enrolling in integrated postsecondary education will continue to be reported to the Subcabinet, and will continue to be available to the public on the SLEDS data website.

~~**Goal Three**~~

- ~~The Individuals with Disabilities Education Act (IDEA) requires states to ensure that, to the maximum extent appropriate, children with disabilities, are educated with children who are nondisabled (34 C.F.R. 300.114). Minnesota Rule requires school districts to ensure student are placed in the least restrictive environment and to include parents in any decisions concerning placement (Minnesota Rule 3525,3010). As part of the "special factors" requirement in the Individuals with Disabilities Education Act, IEP teams must "consider whether the child requires assistive technology devices and services." (34 C.F.R. §300.324(a)(2)(v)).~~
- ~~Potential outcomes of active consideration of assistive technology in supporting education in the most integrated setting are:~~
  - ~~The student is educated in the most integrated setting without the use of AT. No further action is needed.~~
  - ~~The student is educated in the most integrated setting with the use of AT. The use of AT should be documented in the IEP and continued in use.~~

- ~~The student may or may not be using AT, but is not educated in the most integrated setting. The IEP team should explore other AT strategies that can be of benefit.~~
- ~~No one on the IEP team knows enough to determine if AT can be of benefit. The IEP team needs to add membership with information and knowledge of AT.~~

Strategies

Goal One

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

- Continue the expansion of the Positive Behavioral Interventions and Supports (PBIS) to improve the capacity of school districts to include students in integrated classrooms, and reduce the disciplinary removal of students from the classrooms. In 2016-2017, there were 137,601 students with disabilities, and 19,488 disciplinary actions involving students with disabilities (i.e. an out of school suspension for one day or more, expulsion or exclusion). MDE annually reviews disciplinary actions for disproportionality related to student disability and race/ethnicity, in an annual report to the legislature. As of August 2019 there are 769 or 37% of Minnesota schools implementing PBIS, impacting an estimated 350,000 students. (40% of all students)

Continue Strategies to Effectively Support Students with Low-Incidence Disabilities

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

Improve Graduation Rates for Students with Disabilities

- Continue the implementation of the IDEA State Performance Plan (SPP), including the State Systemic Improvement Plan (SSIP) and the State Identfied Measurable Result (SIMR). Application of these strategies has proven successful in increasing graduation rates for students with disabilities.
- Implement Minnesota's State Personnel Development Grant, designed to reduce dropout rates and improve graduation outcomes for American Indian children and youth with disabilities through the implementation of evidence-based practices. Increase the number of American Indian teachers in special education through support of higher education partnerships.

Broaden the Effective Use of Person-Centered Planning Principles and Techniques

- Continue the Person-Centered Planning pilot of the Minnesota State Interagency Committee (MNSIC) Interagency Coordination Model. This incorporates person-centered planning practices into the Individualized Education Program (IEP) process. The cohorts will be supported with tools and practices learned from the previous rounds of pilot programming.

Continue the Expansion of Assistive Technology (AT) Teams Project

- Continue to expand AT Teams Projects, designed to support school district AT Teams in providing services that are in alignment with legal standard and best practices in AT. A matrix of potential AT determinations will be provided to each district team, which will gather data for MDE as part of the team's agreement for participation in the AT Teams Project. MDE utilizes implementation fidelity and scale-up measures to evaluate the extent to which school districts apply MDE training for active consideration of AT in individualized education program (IEP) meetings. This data will be used to evaluate implementation and impact in school districts for students with disabilities.

Analyze Minnesota Special Education Setting Data to Identify Underrepresentation of Student Groups

- Analyze Minnesota annual special education setting data to specifically identify student disability and race/ethnicity categories that are underrepresented in the state's students with disabilities educated in the most integrated setting.
- Use annual analysis of data to develop or revise strategies specifically for these underrepresented student groups to increase the proportion educated in the most integrated setting.
- Annual analysis will be reported to the Olmstead Subcabinet and be available to the public at MDE's online Data Center (under Data Reports and Analytics).

Improve Reintegration Strategies for Students Returning Back to Resident Schools

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

Goal Two

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

- Utilize the "Postsecondary Resource Guide-Successfully Preparing Students with Disabilities." This resource guide and training modules provide regional technical assistance to IEP teams including youth and families, to increase the number of students with disabilities who enter into integrated, postsecondary settings.
- MDE will continue working with the National Secondary Transition Technical Assistance Center (NSTTAC) to provide regional capacity building training for the purpose of increasing the number of students with disabilities who are in a postsecondary education setting by 2020.
- MDE will partner with TRIO Student Support Services at institutions of higher education in order to increase postsecondary enrollment of recent high school graduates. MDE will continue to disseminate Minnesota Postsecondary Resource Guides and share on-line training resources. These resources are currently located on the Normandale Community College website at http://www.normandale.edu/osdresources.
- MDE will collaborate with DEED/VRS and local school districts to develop a transition framework to provide guidance and alignment for programs for transition age students (14-21). This framework will provide statewide alignment for local school districts on scope and sequence and the Pre-Employment Transition Services (Pre-ETS) framework.

~~**Goal Three**~~

~~**Annually Evaluate Effectiveness and Impact of Current MDE Training and Technical Assistance for Active Consideration of AT to Ensure Education in the Most Integrated Setting**~~

- ~~Continue to host AT Teams Projects, designed to support school district AT Teams in providing services that are in alignment with legal standard and best practices in AT. Target districts for this goal will be AT Teams Project participants. There are currently 31 school districts actively participating in the AT Teams Project.~~
- ~~Develop protocols for consideration of AT that includes documentation to record the four potential outcomes and to demonstrate that AT consideration was effective.~~
- ~~Each target district will gather baseline data on the outcome of consideration of AT for the students on whose IEP team they serve. A matrix of potential determinations will be provided to each team member, which will then be provided to MDE as part of the team's agreement for participation in the AT Teams Project.~~

- ~~It is a best practice to document the decision making process used to consider the student's need for assistive technology. For example a statement regarding the discussion of assistive technology needs may be documented in the minutes of the IEP meeting and may be included in other components of the IEP.~~
- ~~MDE will develop an implementation fidelity and scale-up measures to evaluate the extent to which school districts apply MDE training for active consideration of AT in individualized education program (IEP) meetings. This data will be used to evaluate implementation and impact in school districts for students with disabilities.~~

~~**Analyze Data to Determine Impact of Training on Active Consideration**~~

- ~~Compare the percentages of students with disabilities educated in the most integrated setting (Education Goal One) of school districts completing MDE training, compared to their own previous annual percentages, to measure impact of training within the school district.~~
- ~~Compare the percentages of students with disabilities educated in the most integrated setting (Education Goal One) of school districts completing MDE training, compared to all other school districts, to measure impact of training within the school district and in annual state data,~~
- ~~Annually review the effectiveness of current MDE training strategies for school districts to use active consideration of assistive technology as a strategy for ensuring the education of students with disabilities in the most integrated setting (Education Goal One).~~
- ~~Develop alternative measures to evaluate the impact of AT training for students with disabilities who may remain in the same instructional setting, but may experience quality of life improvements as a result of the school district completing AT training.~~

Responsible Agencies

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

Timeliness of Waiver Funding

What this topic means

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

The urgency of each individual's need for waiver services varies. Some people are wanting to move from institutional settings; some people are at serious risk of institutionalization because they lack supports to remain in the community; some people in the community are not at risk of institutionalization, but will need waiver services within a year in order to remain in the community. Access to waiver funding and services is prioritized according to levels of urgency. Access to funding will move at a reasonable pace, according to urgency of need.

A new urgency categorization system for the Developmental Disabilities (DD) waiver waiting list was implemented on December 1, 2015. The new system categorizes urgency into three categories including Institutional Exit, Immediate Need, and Defined Need. Reasonable pace goals have been established for each of these categories.

Lead agencies receive monthly updates regarding the people who require waiver funding approval through a web-based system. Using this information, lead agencies can view the number of days since a person's assessment and whether reasonable pace goals are met. If reasonable pace goals are not met for people in the Institutional Exit or Immediate Need categories, DHS directly contacts the lead agency and seeks remediation. DHS prioritizes funding resources to lead agencies to support funding approval for people in the Institutional Exit and Immediate Need categories.
In this topic area, we will use statutory priorities for accessing waiver service planning and funding so that funding for waiver services moves at a reasonable pace according to urgency of need.

Vision statement

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

Measurable goals

Goal One: Lead agencies will approve funding at a reasonable pace for persons with a need for the Developmental Disabilities (DD) waiver.~~:~~

- **By June 30, 2022, the percentage of persons approved for funding at a reasonable pace for each urgency of need category will be: (A) Institutional exit (71%): ~~ing institutional settings;~~ (B) ~~with an i~~Immediate need (74%); and (C) ~~with a d~~Defined need (66%). ~~for the Developmental Disabilities (DD) waiver.~~**

Baseline:
From January – December 2016, of the 1,500 individuals assessed, 707 individuals or 47% moved off the DD waiver waiting list at a reasonable pace. The percentages by urgency of need category were: Institutional Exit (42%); Immediate Need (62%); and Defined Need (42%).

Assessments between January – December 2016

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days
Institutional Exit	89	37 **(42%)**	30 (34%)
Immediate Need	393	243 **(62%)**	113 (29%)
Defined Need	1,018	427 **(42%)**	290 (28%)
Totals	**1,500**	**707 (47%)**	433 (29%)

(A) Persons exiting institutional settings will have funding approved at a reasonable pace, which means that:

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

(B) Persons with an immediate need will have funding approved at a reasonable pace, which means that:

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

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

(C) Persons with a defined need of requiring services within a year of assessment will have funding approved at a reasonable pace, which means that:

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

Rationale

- The CADI waiver waiting list was eliminated in October 2016. DHS will continue to monitor access to CADI waiver services.
- The reasonable pace guidelines outlined above were implemented on December 1, 2015. Lead agencies were trained on the new data system, urgency categories and reasonable pace guidelines.
- Limits on growth are based on legislative appropriations and the federally approved waiver plan. The federally approved DD waiver plan currently has a limit on funding growth of 300 persons/year.
- An individual will be identified as having a "future need" if, after assessment, the individual does not meet criteria for the other three categories (institutional exit, immediate need, and defined need) and instead identified a future need for services that is over a year from the assessment date. An individual with a future need will be placed on a waiver eligibility list, but will not be placed on the waiting list. People will be offered an assessment annually, or any time that their needs or situation change. At that point, the reasonable pace standards will be applied.
- Kentucky and Tennessee have implemented similar urgency categories for individuals. The experience from these states shows that people in the emergent categories have funding approved quickly. DHS anticipates that the urgency category populations will be similar to the experience of those states.

Strategies

Reform Waiver Funding Approval to Incorporate Urgency of Need

- Implement new urgency of need categorization system and report to the Subcabinet and the legislature as required.
- Due process protections available to people with disabilities will be modified as necessary, to reflect new protocols.
- DHS will complete an analysis of baseline data on urgency of need and reasonable pace. The analysis will consider the needs of persons waiting, potential options to meet their needs, and the evaluation of existing programs to determine if there are changes which would enable programs to be more effective.

Implement Initiatives to Achieve Reasonable Pace Guidelines

- Lead agencies receive monthly updates regarding the people who are pending funding approval for the DD waiver through a web-based system. Using this information, lead agencies can view the number of days since a person's assessment and whether reasonable pace goals are met. If reasonable pace goals are not met for people in the Institutional Exit or Immediate Need categories, DHS directly contacts the lead agency and seeks remediation. DHS continues to allocate funding resources to lead agencies to support funding approval for people in the Institutional Exit and Immediate Need categories.
- Lead agencies may encounter funding approval situations on an intermittent basis, requiring DHS to engage with each agency to resolve individual situations. When an issue arises, a lead agency may be unfamiliar with the reasonable pace funding requirement due to the infrequency of this issue at their particular agency. DHS continues to provide training and technical assistance to lead agencies

as funding approval issues occur and has added staff resources to monitor compliance with reasonable pace goals.

Responsible Agency

- Department of Human Services

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Transportation

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

What this topic means

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

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

Vision statement

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

Measurable goals

Goal One: By December 31, 2020, accessibility improvements will be made to: (A) 6,600 curb ramps (increase from base of 19% to 49%); (B) 430 accessible pedestrian signals (increase from base of 10% to 74%); and (C) by October 31, 2021, improvements will be made to 55 miles of sidewalks.

(A) Curb Ramps

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

- By December 31, 2020 accessibility improvements will be made to an additional 6,600 curb ramps[37] bringing the percentage of compliant ramps to approximately 49%.

(B) Accessible Pedestrian Signals

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

- By December 31, 2020, an additional 430 Accessible Pedestrian Signals (APS) installations will be provided on MnDOT owned and operated signals bringing the number to 875 and the percentage to 74%.

(C) Sidewalks

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

- By October 31, 2021 improvements will be made to an additional 55 miles of sidewalks bringing total system compliance to 60%.

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

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

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

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

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

Goal Three: By 2025, expand transit coverage so that 90% of the public transportation service areas in Greater Minnesota will meet minimum service guidelines for access.

Greater Minnesota transit access is measured against industry recognized standards for the minimal level of transit availability needed by population size. Availability is tracked as span of service, which is the number of hours during the day when transit service is available in a particular area. The measure is based on industry recognized standards and is incorporated into both the Metropolitan Council Transportation Policy Plan and the MnDOT "Greater Minnesota Transit Investment Plan." [38]

Baseline: In December 2016, public transportation in Greater Minnesota was meeting minimum service guidelines for access 47% on weekdays, 12% on Saturdays and 3% on Sundays.

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

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

Baseline for on time performance in 2014 was:

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

Ten year goals to improve on time performance:

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

Goal Five: By 2040, 100% percent of the target population will be served by regular route level of service for prescribed market areas 1, 2, and 3 in the seven county metropolitan area.

Baseline: The percentage of target population served by regular route level of service for each market area is as follows: Market Area 1 = 95%; Market Area 2 = 91%; and Market Area 3 = 67%. [39]

- By 2025, the percent of target population served by regular route level of service for each market area will be:
  - Market Area 1 will be 100%
  - Market Area 2 will be 95%
  - Market Area 3 will be 70%

[38] Greater Minnesota Transit Investment Plan is available at http://www.dot.state.mn.us/transit/reports/index.html.

[39] Transit Market Area I has the highest density of population, employment and lowest automobile availability in the region. These are typically Urban Center communities and has the highest potential for transit ridership in the region. Transit Market Area II has high to moderately high population and employment densities. Much of this area is categorized as Urban but has approximately half the ridership potential of TMA I. Transit Market Area III has moderate density. These areas are typically Urban with large portions of Suburban and Suburban Edge communities and has approximately half the ridership potential of TMA II.

Rationale

Goal One

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

Goal Two

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

Goal Three

- The goal is linked to the system expansion goal which appears in state statute and has a timeframe of ten years. Meeting the legislative goal is important to realizing the overarching vision of the Olmstead Plan because the availability of transit is consistently identified as important by the disability community as integral to living an independent, integrated life.
- The goal ensures that system expansion has appropriate geographic balance and service variety to provide for a variety of trip needs.
- Achieving the first four years of the goal is realistic based on current funding forecasts from Minnesota Management and Budget (MMB). In the fifth year and beyond, the goal will likely not be met without increased funding for Greater MN transit from the Minnesota legislature.
- The primary barriers in achieving the goal are: (1) budgetary; (2) not being able to determine at a population level the degree to which meeting public transit goals provides benefit to the Olmstead population; and (3) the impact of reduced capacity in program specific transportation to individuals' overall transportation access.

Goal Four

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

Goal Five

- Metro Area Public Transit utilization is measured by distinct market areas for regular route level of service. This measure estimates demand potential for all users of the regular route system. The market area is created based on analysis that show the demand for regular route service is driven primarily by population density, automobile availability, employment density and intersection density (walkable distance to transit).
- This measure is based on industry standards incorporated into the Transportation Policy Plan's - Regional Transit Design Guidelines and Performance Standards. The Metro Area also provides non-regular route services in areas that are not suitable for regular routes, such as dial-a-ride transit.
- The percentage for each market area will be reported on an annual basis to determine if progress is being made toward the goals.

Strategies

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

- Accessibility improvements are included as part of any project meeting the alterations threshold, as required by the ADA, to ensure program consistency and ongoing investment. In general, the alteration threshold is met when there is a pavement project such as a mill and overlay, bridge rehabilitation, or signal replacement. The four year schedule of projects is found in MnDOT's State Transportation Improvement Plan (STIP).[40]
- MnDOT will continue to work with our local partners though our project development process to encourage additional accessibility improvements whenever possible.

Increase Involvement in Transportation Planning by People with Disabilities

- MnSHIP was updated in 2017 and the investment levels will be reassessed as part of the plan update. MnSHIP is developed with significant public input and sets investment targets, including those for accessibility improvements, for the agency based on system conditions and revenue.

Improve the Ability to Assess Transit Ridership by People with Disabilities

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

Improve Transit Services for People with Disabilities

- MnDOT, the Metropolitan Council, and local transit systems are the responsible parties with DHS providing a significant support and coordinating role. The agencies will collaborate through

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

established planning processes and contract oversight to ensure that continual progress to the targets is being made.

- On time performance efforts will be focused initially on those services with poor on time performance.

Responsible Agencies

- Department of Transportation
- Metropolitan Council

Healthcare and Healthy Living

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

What this topic means

Healthcare is "the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions."[41]

Healthy living is making choices which are intended to improve a person's health. For example, healthy living includes having support to be active every day, to eat healthy foods, and to use medicine safely and as prescribed.

Health disparities are defined as significant differences in "the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates."[42] Health disparities for people with disabilities present barriers to full integration. Some problems with access to healthcare that exist for many Minnesotans have a significant impact on people with disabilities. For example, some people with disabilities may not be able to schedule dental appointments on a regular basis because there are not enough dentists and dental hygienists able to provide care. This is due to location (in parts of Greater Minnesota, there are not enough dental practitioners to serve all people); to affordability (not everyone has insurance coverage that includes dental care); and to some providers not knowing how to serve people with disabilities. Many people with disabilities develop other diseases (hypertension, heart disease, diabetes, stroke, cancer) at a higher frequency than people without disabilities. Some people with disabilities die at a much younger age than people without disabilities.[43]

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

Vision statement

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

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

Measurable goals

Goal One: By December 31, 2022, ~~2019,~~ the rate of adult public enrollees (with disabilities) who had an acute inpatient hospital stay that was followed by an unplanned acute readmission to a hospital within 30 days will be 20% or less.

One quality indicator used by hospitals includes monitoring readmissions that occur within 30 days of discharge from a hospital. Historically, individuals with disabilities are readmitted to the hospital at a higher rate than people without disabilities. This measure allows for analysis of discharge planning processes and effectiveness of follow-up care.

Baseline: In Calendar Year 2014, of the 28,773 adults with disabilities with an acute inpatient hospital stay, 5,887 (20.46%) had an unplanned acute readmission within 30 days. During the same time period, of the 3,735 adults without disabilities with an acute inpatient hospital stay, 295 (7.90%) had an unplanned acute readmission within 30 days.

Goal Two: By December 31, 2022, ~~2019,~~ the rate of enrollees with disabilities who used an emergency department for non-traumatic dental services will be 0.20% or less for children with disabilities and 1% or less for adults with disabilities.

One way to monitor access to dental care is to measure how many individuals use the emergency department for non-traumatic dental services. The desired outcome is for people to access dental services in dental clinics not emergency departments.

(A) Children using an emergency department (ED) for non-traumatic dental services

Baseline: In Calendar year 2014, of the 75,774 children with disabilities, 314 (0.41%) used an emergency department for non-traumatic dental services. During the same timeframe, of the 468,631 children without disabilities, 1,216 (0.26%) used an emergency department for non-traumatic dental services.

Annual Goal

- By December 31, 2022, ~~19,~~ the rate for children with disabilities using an ED for non-traumatic dental services will be 0.20% or less

(B) Adults using an emergency department (ED) for non-traumatic dental services

Baseline: In Calendar year 2014, of the 166,852 adults with disabilities, 3,884 (2.33%) used an emergency department for non-traumatic dental services. During the same timeframe, of the 377,482 adults without disabilities, 6,594 (1.75%) used an emergency department for non-traumatic dental services.

Annual Goal

- By December 31, 2022, ~~2019,~~ the rate for adults with disabilities using an ED for non-traumatic dental services will be 1.0% or less

Rationale

- Monitoring the number of enrollees (adults and children) who used an emergency department for non-traumatic dental services will give a more complete picture of the level of access of people with disabilities to dental care.
- Monitoring the number and percentage of adult public program enrollees [with disabilities] who had an acute inpatient hospital stay that was followed by an unplanned acute readmission to a hospital within 30 days allows for analysis of discharge planning processes and effectiveness of follow-up care.
- Measuring access to health care does not provide an indication of the health care outcome achieved for the individual. Measures for health care outcomes need to be established.

Strategies

Improve Dental Care for People with Disabilities

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

Expand the Use of Health Care Homes and Behavioral Health Homes

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

Improve Access to Health Care for People with Disabilities

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

Responsible Agencies

- Department of Human Services
- Minnesota Department of Health

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Positive Supports

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

What this topic means

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

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

Department of Human Services (DHS)

Restrictive procedures for individuals with disabilities are prohibited except when used in an emergency situation.[44] The Legislature codified these requirements for providers of disability services when it passed Minn. Stat. Chapter 245D, which applies to the majority of disability services, including home and community-based service waivers, and services provided in an Intermediate Care Facility for Persons with Developmental Disabilities. As of August 31, 2015, with the adoption of the Positive Supports Rule, those same requirements apply to all services and facilities licensed by the Commissioner of Human Services when provided to a person with developmental disabilities. The statute and the rule prohibit restrictive intervention, except for:

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

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

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

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

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

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

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

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

Vision statement

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

Measurable goals

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

Goal One: By June 30, 2022, ~~2020~~ the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. rule, Part 9544, (for example, home and community-based services) who experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will not exceed 506. ~~650.~~

Annual Baseline: In FY 2014 of the 35,668 people receiving services in licensed disability services, e.g., home and community-based services, the number of unique individuals who experienced a restrictive procedure was 1,076.

Goal Two: By June 30, 2022, ~~2020,~~ the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544 (for example, home and community- based services) will not exceed 2,821. ~~3,500.~~

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

Goal Three: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544[45], with limited exceptions to protect the person from imminent risk of serious injury. Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and use of an auxiliary device to ensure a person does not unfasten a seatbelt in a vehicle.

- **By June 30, 2022 the average duration of emergency use of mechanical restraint (other than an auxiliary device)[46] as reported on BIRF reports will be reduced to 192 hours per month for individuals with Commissioner approval and 7.7 hours per month for individuals with a developmental disability in the Forensic Mental Health Program.**

There are two measures for this goal

(A) Individuals with Commissioner approval[47]

Baseline: From July 1, 2019 - June 30, 2020, the average duration of emergency use of mechanical restraint (other than an auxiliary device) as reported on the BIRF was 213 hours per month. These reports were for 7 people.

Annual Goals for the emergency use of mechanical restraints (other than auxiliary devices)

- By June 30, 2021, the average duration will be reduced to no more than 202 hours per month
- By June 30, 2022, the average duration will be reduced to no more than 192 hours per month

(B) Individuals with a developmental disability served in the Forensic Mental Health Program[48]

Baseline: From July 1, 2019 - June 30, 2020, the average duration of emergency use of mechanical restraint (other than an auxiliary device) as reported on the BIRF was 8.5 hours per month. These reports were for 13 people.

Annual Goals for the emergency use of mechanical restraints (other than auxiliary devices)

- By June 30, 2021, the average duration will be reduced to no more than 8.1 hours per month
- By June 30, 2022, the average duration will be reduced to no more than 7.7 hours per month

[45] ~~Forensic Services (formerly known as Minnesota Security Hospital) (MSH) is governed by the Positive Supports Rule when serving people with a developmental disability.~~

[46] Auxiliary devices ensure a person does not unfasten a seat belt in a vehicle and includes seat belt guards, harnesses and clips.

[47] Use of mechanical restraints are approved by the DHS Commissioner and are monitored by experts in positive supports who provide on-going technical assistance.

[48] ~~Minnesota Security Hospital (MSH)~~ Forensic Mental Health Program at Forensic Services (formerly known as Minnesota Security Hospital) is governed by the Positive Supports Rule when serving people with a developmental disability.

~~**By June 30, 2020 the emergency use of mechanical restraints, other than use of an auxiliary device[49] will be reduced to no more than 93 reports.**~~

~~Baseline: In SFY 2014, there were 2,038 BIRF reports of mechanical restraints involving 85 unique individuals. In SFY 2019, of the 658 reports of mechanical restraints, 336 were for use of auxiliary devices to ensure a person does not unfasten a seatbelt in a vehicle. The number of reports other than use of auxiliary devices were 322.~~

~~**Annual Goals** to reduce the use of mechanical restraints:~~

- ~~By June 30, 2020, reduce mechanical restraints, other than use of auxiliary devices, to no more than 93 reports~~

Goal Four: By June 30, 2024, ~~2020,~~ the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 735 ~~318~~ students or decrease to 1.94% ~~1.98%~~ of the total number of students receiving special education services.

Annual Baseline: During school year 2018-2019, ~~2015-2016,~~ school districts (which include charter schools and intermediate districts) reported to MDE that 3,603 ~~3,034~~ students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting. In 2018-2019, ~~2015-2016,~~ the number of reported students receiving special education services was 147,605 ~~133,742~~ students. Accordingly, during school year 2018-2019, ~~2015-2016,~~ 2.4% ~~2.3%~~ of students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting.

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

- ~~By June 30, 2017 the number of students experiencing emergency use of restrictive procedures will be reduced by 80 students or .02% of the total number of students receiving special education services.~~
- ~~By June 30, 2018 the number of students experiencing emergency use of restrictive procedures will be reduced by 80 students or .02% of the total number of students receiving special education services.~~
- ~~By June 30, 2019 the number of students experiencing emergency use of restrictive procedures will be reduced by 79 students or .02% of the total number of students receiving special education services.~~
- ~~By June 30, 2020 the number of students experiencing emergency use of restrictive procedures will be reduced by 79 students or .02% of the total number of students receiving special education services.~~

- By June 30, 2020 the number will be reduced by 147 students or 0.1% of the total number of students receiving special education services.
- By June 30, 2021 the number will be reduced by 147 students or 0.1% of the total number of students receiving special education services.
- By June 30, 2022 the number will be reduced by 147 students or 0.1 % of the total number of students receiving special education services.

~~[49] Auxiliary devices ensure a person does not unfasten a seat belt in a vehicle and includes seatbelt guards, harnesses and clips.~~

- By June 30, 2023 the number will be reduced by 147 students or 0.1% of the total number of students receiving special education services.
- By June 30, 2024 the number will be reduced by 147 students or 0.1% of the total number of students receiving special education services.

Goal Five: By June 30, 2024, ~~2020,~~ the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 3,615 or by 1.0 ~~2,251 or by 0.8~~ incidents of restrictive procedures per student who experienced the use of restrictive procedures in the school setting.

Annual Baseline: During school year 2018-2019, ~~2015-2016,~~ school districts (which include charter schools and intermediate districts) reported 22,772 ~~22,028~~ incidents of emergency use of a restrictive procedure in the school setting. In school year 2018-2019, ~~2015-2016,~~ the number of reported students who had one or more emergency use of restrictive procedure incidents in the school setting was 3,603 ~~3,034~~ students receiving special education services. Accordingly, during school year 2018-2019, ~~2015-2016~~ there were 6.3 ~~7.3~~ incidents of restrictive procedures per student who experienced the use of a restrictive procedures in the school setting.

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

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

- By June 30, 2021, the number will be reduced by 723 incidents, or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.
- By June 30, 2022, the number will be reduced by 723 incidents or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.
- By June 30, 2023, the number will be reduced by 723 incidents or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.
- By June 30, 2024, the number will be reduced by 723 incidents or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.

Rationale

Goals One - Three

- Progress towards these goals will be measured through incident tracking from Behavioral Intervention Reporting Forms (BIRFs). Individuals who experience the use of a restrictive procedure while receiving services by a 245D licensed provider (a provider of disability services, for example: home and community-based services) will be identified through submitted BIRFs. Providers are

required to submit BIRFs to DHS and the Ombudsman for Mental Health and Developmental Disabilities for any sort of behavioral intervention, including all restrictive procedures, within 3-5 days of their use.

- For the purposes of Goal One and Goal Two, the baseline includes reports of mechanical restraints, self-injury protection equipment, seat belt restraints, time-out, seclusion and penalty consequences. ~~For Goal Three, the baseline includes only reports about mechanical restraints, self-injury equipment and seat belt restraints.~~
- Providers are required to submit a single report for each use of manual restraint, emergency use of manual restraint and seclusion. For other practices, such as the use of seat belt clips or deprivation procedures, they may report multiple incidents in a week in one report. In order to understand the utilization trends it is important to know the number of individuals experiencing restrictive procedures and the number of incidents or application of emergency use of restrictive procedures. (Further information is available in the Positive Support Transition Plan Instructions[50], which implements the Minnesota Statute, Chapter 245D.)
- These measures are reasonable because they track every incident of restrictive procedures in their respective areas.
- Mechanical restraints are approved through a review process by a team of clinicians who also provide technical assistance and monitoring of the plans to reduce use of restraints.
- The Positive Supports Rule (Minn. Rule, part 6544) that went into effect in August 2015 for providers with 245A licenses who serve people with developmental disabilities also report through the BIRF system.
- DHS believes the targets to be realistic based upon the experience from other states and Minnesota's success following positive supports training.
- For Goals One and Two, the targets are being reset to maintain performance achieved over the last four~~three~~ years. In 2020, ~~19,~~ the number of individuals experiencing a restrictive procedure was 561 ~~642~~ and the number of BIRF reports of restrictive procedures was 3,126. ~~3,223.~~
- For Goal Three, frequency of use can often increase as the duration of use decreases. Changing from a frequency measure to a duration measure will show improvements in a meaningful way.
- For Goal Three, uses of seatbelt auxiliary devices are not included in this measure because, unlike other mechanical restraint data that will likely continue to trend downwards, seatbelt restraint data may trend upwards as a person spends more time in their community and visits family or friends, and might also increase as a person practices and learns about safe riding skills.

Goals Four - Five

- Progress towards these goals will be measured through incident tracking from annual restrictive procedure summary reports.
- Baseline data includes students who experience the use of a restrictive procedure by school staff while in the school setting as well as the number of restrictive procedure incidents. A restrictive procedure includes physical holds and seclusions, as defined in Minnesota Statutes section 125A.0941. Summary student data will be identified by an annual restrictive procedure summary report submitted by school districts to the Minnesota Department of Education (MDE) on an annual

[50] Positive Support Transition Plan Instructions are available at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810B-ENG

basis. That data will be summarized in the annual legislative report submitted on February 1 of each year.

- The accuracy of reporting the use of restrictive procedures has increased over the years as a result of improved and expanded training. Due to this accuracy increase, MDE has seen an increase in reports. The baseline has been adjusted to reflect the most accurate recent data collected on restrictive procedures.
- The number of students receiving special education services varies each year. Reporting by number of incidents alone does not accurately reflect performance. A secondary measure of a percentage reduction is included to allow for fluctuations in the total number of students.
- The number of students experiencing restrictive procedures varies each year. Reporting by number of incidents alone does not accurately reflect performance. A secondary measure of a rate per student is being added to allow for fluctuations in the total number of students experiencing restrictive procedures.
- MDE and school districts provided training to staff to assure common definitions were used to make reporting more consistent. During this training it became evident that there were different definitions of reporting across school districts and across the State. MDE continues to work toward ensuring the accuracy of reporting.
- There is funding to support actions related to the current goals.

Strategies

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

- Continue to implement the Positive Supports Rule (Minnesota Rules Chapter 9544) which became effective on August 31, 2015. This rule prohibits the use of restrictive procedures except in emergencies. The rule also requires training, technical assistance, and mentoring to disability service providers on positive support practices and the statutory and rule requirements.
- Continue the expansion of the Positive Behavioral Interventions and Supports (PBIS) which improves the capacity of school districts to include students in integrated classrooms. As of August 2020, ~~19,~~ there are 803 or 39% ~~769 or 37%~~ of Minnesota schools implementing PBIS, impacting an estimated 378,000 students (43% of total students). ~~350,000 students. (40%% of total students)~~
- Continue ~~to implement DHS's "Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports," which is a~~ collaboration between DHS and MDE to build system capacity locally engaging with schools, providers, counties, tribes, people with disabilities, families, advocates, and community members. ~~The s~~Strategies will be expanded across other agencies as applicable in the future. ~~-~~There will be regular reporting on progress, and recommendations to address barriers and increase capacity. Resources on statewide planning and best practices are available on the Positive Supports Minnesota website.
- Continue implementation of training for the Department of Corrections staff on crisis intervention teams, motivational interviewing, traumatic brain injury, and Aggression Replacement Training (ART)[51] as appropriate for correctional settings.

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

- Monitor data systems that: (1) assess progress in the reduction of the emergency use of restrictive procedures; (2) assess the number of individuals experiencing restrictive procedures and the

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

number of incidents or applications of restrictive procedures; and (3) to identify situations to be targeted for technical assistance.

- Improve data reporting tools to increase the accuracy, completeness and timeliness of the information.
- Annually evaluate progress and determine if there are additional measures to be taken to reduce the use of mechanical restraints that are used to prevent imminent risk of serious injury due to self-injurious behaviors. The external review committee provides oversight and technical assistance.
- Publish annual reports on the progress in reducing the use of restrictive procedures and recommendations.
- Work with the MDH to evaluate opportunities to coordinate tracking with DHS and reduce use of restrictive procedures for people with disabilities in MDH-licensed facilities.
- Continue to implement MDE's Statewide Plan to Reduce the Use of Restrictive Procedures and eliminate the use of seclusion.
- MDE will document progress in Statewide Plan implementation and summarize restrictive procedure data in the annual legislative report submitted by February ~~March~~ 1 of each year. MDE will track individual uses of seclusion on students receiving special education services by requiring districts to submit quarterly reports to MDE about individual students who have been secluded. These reports will assist MDE and the Restrictive Procedures Work Group in identifying areas of concern and developing strategies for eliminating the use of seclusion.
- MDE will award ~~four~~ district~~s a~~ grant~~s~~ to implement positive behavior supports in an effort to reduce the rates of restrictive procedure use with students with disabilities. Participating school districts will measure the fidelity to which the defined positive behavior supports are in place. Information gathered from grantees over the course of the grant will inform schools, districts, and MDE about measuring and making systemic changes that result in the reduction of rates of restrictive procedures use through implementing positive behavior supports.
- Restrictive procedures may only be used in the school setting in an emergency, by licensed professionals, who have received training which includes positive behavioral interventions, de-escalation, alternatives to restrictive procedures, and impacts of physical holding and seclusion.
- MDE will provide evidence-based strategies to use with students with disabilities who have significant needs that result in self-injurious or physically aggressive behaviors.
- MDE will collaborate with DHS to expand the list of effective evidence-based strategies for districts to use to increase staff capacity and reduce the use of restrictive procedures.

Reduce the Use of Seclusion in Educational Settings

- Engage the Restrictive Procedures Work Group[52] at least annually to review restrictive procedure data, review progress in implementation of the Statewide Plan, and discuss further implementation efforts and revise the Statewide Plan as necessary.
- Engage the Restrictive Procedures Work Group to gather, develop, and review information to share with school districts in working toward the elimination of seclusion and to identify and consider strategies to address disproportionalities related to the use of restrictive procedures. ~~Subgroups, composed of s~~Stakeholders~~,~~ within the workgroup will use this information to inform the development of trainings and resources. ~~These r~~Resources and other information gathered and

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

reviewed will be ~~posted to MDE's Restrictive Procedures webpage and/or otherwise~~ shared with the public. ~~ly distributed.~~

- Engage the Restrictive Procedures Work Group to make recommendations to MDE and the legislature on how to eliminate the use of seclusion in schools for students receiving special education services and modify the Statewide Plan to reflect those recommendations. The recommendations shall include the funding, resources, and time needed to safely and effectively transition to a complete elimination of the use of seclusion on students receiving special education services.
- MDE is working with a consultant to facilitate the Restrictive Procedures Stakeholder Work Group meetings for the purpose of increased stakeholder engagement in recommending to the Commissioner specific and measurable implementation and outcome goals for reducing the use of restrictive procedures.

Responsible Agencies

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

Crisis Services

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

What this topic means

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

Vison statement

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

Measurable goals

Goal One: By June 30, 2022, ~~2019,~~ the percent of children who receive children's mental health crisis services and remain in their community will increase to 85% or more.

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

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

- ~~By June 30, 2016, the percent who remain in their community after a crisis will increase to 81%~~
- ~~By June 30, 2017, the percent who remain in their community after a crisis will increase to 83%~~
- ~~By June 30, 2018, the percent who remain in their community after a crisis will increase to 85%~~
- ~~By June 30, 2019, the percent who remain in their community after a crisis will increase to 85%~~
- By June 30, 2020, the percent who remain in their community after a crisis will increase to 80%
- By June 30, 2021, the percent who remain in their community after a crisis will increase to 85%

Goal Two: By June 30, 2022, ~~2020,~~ the percent of adults who receive adult mental health crises services and remain in their community (e.g., home or other settings) will increase to 65% ~~64%~~ or more.

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

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

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

- ~~By June 30, 2018, the percent who remain in their community after a crisis will increase to 62%~~
- ~~By June 30, 2019, the percent who remain in their community after a crisis will increase to 64%~~
- ~~By June 30, 2020, the percent who remain in their community after a crisis will increase to 64%~~
- By June 30, 2021, the percent who remain in their community after a crisis will increase to 55%
- By June 30, 2022, the percent who remain in their community after a crisis will increase to 65%

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

Update on Progress of Goal Three

The reporting period for this goal has ended. The Subcabinet approved the discontinuation of this measurable goal. DHS will continue to monitor this measure and annually report it to the Subcabinet.

Goal Four: By June 30, 2022, ~~2019,~~ people in community hospital settings due to a crisis, ~~will have appropriate community services within 30 days of no longer requiring hospital level of care and, within 5 months after leaving the hospital, and they~~ will have a stable, permanent home within 5 months after leaving the hospital.

~~There are two measures for this goal:~~

~~**(A) Stable Housing**~~

Baseline: From July 2014 – June 2015, 81.9% of people discharged from the hospital due to a crisis were housed five months after the date of discharge compared to 80.9% in the previous year. From July 2017-June 2018, 77.8% were housed five months after the date of discharge.

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

- ~~By June 30, 2017, the percent of people who are housed five months after discharge from the hospital will increase to 83%.~~
- ~~By June 30, 2018, the percent of people who are housed five months after discharge from the hospital will increase to 84%.~~
- ~~By June 30, 2019, the percent of people who are housed five months after discharge from the hospital will be 84% or higher.~~
- By June 30, 2020, the percent of people who are housed five months after discharge from the hospital will be 78% or higher.
- By June 30, 2021, the percent of people who are housed five months after discharge from the hospital will be 79% or higher.
- By June 30, 2022, the percent of people who are housed five months after discharge from the hospital will be 80% or higher.

~~**(B) Community Services**~~

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

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

- By June 30, 2017, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 90%.
- By June 30, 2018, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 91%.
- By June 30, 2019, the percent of people who receive appropriate community services within 30-days from a hospital discharge will be 92% or higher

Goal Five: By June 30, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary placement within ten days.

Baseline: From July 2015 – June 2016, of the people on Medical Assistance who were referred for clinically appropriate crisis services, 85.4% received those services within 10 days. The average number of days was 2.3.

Annual Goals to increase the percent of people receiving crisis services within ten days:

- By June 30, 2018, the percent of people who receive crisis services within 10 days will increase to 87%.
- By June 30, 2019, the percent of people who receive crisis services within 10 days will increase to 88%.
- By June 30, 2020, the percent of people who receive crisis services within 10 days will increase to 90%.

Rationale

- The State will reform crisis services across programs and funding sources to create a system that delivers timely responses to crisis and reduces the unnecessary use of restrictive and segregated settings. Crisis services will address any diagnosis, including complex or multiple conditions. The goals measure impact of reform of services in three areas: children's mental health; adult mental health; and disability home and community-based waivers.
- Inadequate level of crisis services may result in people being unnecessarily hospitalized or placed in other segregated settings. Goal three measures the impact of improved crisis services on individuals receiving waiver services. Improvement in crisis services is projected to decrease the number of individuals who no longer receive waiver services. By expanding in home intervention and short term residential services, people will avoid unnecessary hospitalizations or other restrictive services.
- Crisis services do three things: (1) stabilize a person in their current setting; (2) triage to determine if more intensive services are necessary; and (3) divert people from unnecessarily accessing segregated settings. The most effective measure for crisis services is maintaining stability in their current setting. This can be influenced by timely and appropriate crisis services and increased capacity of community providers delivering positive supports strategies.
- $11.65 million additional state investment for mental health expansion was authorized in the 2017 legislative session.
- Timely access to crisis services which are clinically appropriate is a best practice.

Goals One - Three

Baselines and measurement of progress is based on people who receive a crisis service for the count of incidents and individuals. Whether or not a person remains in their community is determined in one of three ways.

- For children's mental health crisis services, where/how the incident is resolved is recorded and reported. Any resolution where the child remains at home or in school is considered "remaining in their community".
- Effective January 1, 2016, adult mental health crisis providers were required to report the location of residence after a crisis event into the Mental Health Information System (MHIS). Prior to January 1, 2016, mental health providers only reported if the individual was admitted to an inpatient psychiatric unit.
- For waiver services, an analysis was performed to measure whether or not the crisis service in each episode was a residential or community-based service and whether or not the person left the waiver (stopped community-based services) following a crisis episode. A person could go to the emergency room, and maybe even have a short period of hospitalization, and still be counted as remaining in the community, as long as they return in a short period of time and do not lose home and community-based waiver services.

Goal Four

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

~~**Goal Five**~~

~~- This goal uses data that is reflective of people accessing crisis residential, crisis stabilization and inpatient hospital stays after receiving crisis service referrals with data from the Mental Health Information System (MHIS) and Medical Assistance (MA) claims data from MMIS.~~

Strategies

Evaluate Effectiveness of Crisis Services

- Monitor the utilization of crisis services to determine:
    - the number of individuals who use crisis services
    - the number of individuals demitted from where they live or work after a crisis episode
    - timeliness of crisis interventions
    - length of time crisis services are used, and
    - barriers to stable services, and permanent housing.

- Evaluate the capacity (strengths and barriers) of the crisis system to provide timely access to in home intervention and residential crisis services and identify solutions, including: development of additional crisis residential homes and mobile crisis services, increased specialized staffing and/or streamlined processes to efficiently authorize and access funding.
- Evaluate the length of time an individual remains in a residential crisis setting when stable, and reasons for delay in returning to their living situation. Identify solutions to expedite the development of permanent housing and service options to more quickly move people out of crisis homes when this level of service is no longer needed.

Implement Additional Crisis Services

- The implementation of the $50 million investment in mental health services began during the 2016-2017 biennium. The expansion resulted in:
    - Increase access to children's mental health crisis services in schools (Goals 1, 2~~, 5~~)

- Increase capacity of mental health crisis services providers to respond to the needs of people with complex needs (i.e., co-existing mental health and intellectual/ developmental disabilities) (Goals 1, 2~~, 5~~)
- Expand and enhance Assertive Community Treatment (ACT) teams (Goal 4)
- Expand housing with supports (Goal 4)
- Expand mobile crisis teams (Goals 1, 2, 4)

- Expansion of home and community-based crisis services is in process and will result in:
  - Development of residential crisis options throughout the state to have timely access to crisis services that are clinically appropriate.
    - Collaboration with counties will increase in-home respite capacity.
    - Development of additional crisis respite beds.
    - Development of additional mobile crisis intervention capacity and clinical expertise that supports providers and families so that people remain in their homes, jobs, and community.
    - Annual evaluation to determine the number of crisis respite beds that are necessary to meet the needs and develop additional capacity if necessary.
- DHS developed a single point of access and streamlined referral requirements to improve the quality of the crisis response outcomes for people with disabilities. The initial phase began September 1, 2015 and is targeted to persons with developmental or intellectual disabilities in crisis and at risk of losing their current placement.

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

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

Responsible Agencies

- Department of Human Services
- Minnesota Department of Education

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Community Engagement

Stakeholder Comments	Stakeholder
"Give people a chance to show that we can do it, yes, we can. Everybody deserves a chance and everybody learns differently. Everyone has a dream where they want to live, work and be happy."	Patricia Ann Wallace (2013)
"By including self-advocacy, peer-to peer support, and leadership training into the Olmstead Plan, self-advocates would have an increased ability to create change within the system that impacts their lives on a daily basis."	Laura Birnbaum (2013)

What this topic means

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

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

Community engagement is defined by the Community Engagement Workgroup as a process of working collaboratively with and through groups of people, primarily people with disabilities, their families, and friends to address issues affecting the lives and well-being of people with disabilities.

The Community Engagement Workgroup operates under a charter with the Subcabinet and is made up of community members. The Workgroup supports and guides the Olmstead Subcabinet and Olmstead Implementation Office (OIO) on implementation of the Olmstead Plan, to ensure a person-centered approach is utilized and that there is active community engagement. The strategic focus of the workgroup include:

- Creating recommendations and highlighting best practices for inclusive and accessible public input processes for the annual Plan amendment process;
- Supporting implementation of a communication plan for diverse communities with disabilities; and
- Strengthening community engagement between members of disability communities, the OIO, and Subcabinet agencies on matters impacting the implementation of the Olmstead Plan.

Community Engagement with the public ensures two-way communication which will provide critical feedback for implementation of the Olmstead Plan. The framework for achieving meaningful, effective and inclusive community engagement includes:

1. Humanity, Dignity and Empowerment
   "We are the experts of our own lives."
2. Person-Centered Listening and Learning
   "Listen to each individual person and what he/she dreams and hopes for their lives and communities."

3. Diversity, Accessibility and Equity
   "Be intentional and proactive about bringing under-represented communities to the decision-making table and taking down barriers to engagement and participation."
4. Transparency and Accountability
   "Be clear about how decisions are made, how our feedback informed those decisions, and who is accountable for implementing those decisions."
5. Active Leadership, Inclusion and Participation
   "People with disabilities must be involved in decision-making that directly affects our lives."

Vision statement

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

Measurable goals

Goal One: By June 30, 2022, ~~2020,~~ the number of individuals with disabilities who participate in Governor appointed Boards and Commissions~~, the Community Engagement Workgroup, Specialty Committee~~ and other Workgroups and Committees established by the Olmstead Subcabinet will increase to 245 members.

Baseline: Of the 3,070 members listed on the Secretary of State's Boards and Commissions website, 159 members (5%) self-identified as an individual with a disability. In 2017, the Community Engagement Workgroup and the Specialty Committee had 16 members with disabilities.

Annual Goals to increase the number of individuals with disabilities participating in Governor's appointed Boards and Commissions~~, Community Engagement Workgroup, Specialty Committee,~~ and other Workgroups and Specialty Committees established by the Olmstead Subcabinet:

- ~~By June 30, 2018, the number will increase to 184 members~~
- ~~By June 30, 2019, the number will increase to 215 members~~
- ~~By June 30, 2020, the number will increase to 245 members~~
- By June 30, 2021, the number will increase to 215 members
- By June 30, 2022, the number will increase to 245 members

Goal Two: By April 30, 2022, ~~2020,~~ the (A) number of individuals with disabilities to participate in public input opportunities related to the Olmstead Plan, and (B) the number of comments received by individuals with disabilities (including comments submitted on behalf of individuals with disabilities) will increase by 20% ~~5%~~ over baseline.

Baseline: From December 20, 2018 – March 11, 2019, there were 192 individuals who participated in public input opportunities related to Olmstead Plan. The number of comments received was 249.

Annual Goals to increase the number of individuals with disabilities participating in public input opportunities and the number of comments received:

- By April 30, 2021, the numbers will increase by 15% over baseline
- By April 30, 2022, the numbers will increase by 20% over baseline

~~**Goal Three: By March 31, 2022, the number of engagement activities related to Olmstead Plan's measurable goals will increase by 5% over baseline.**~~

- ~~By March 31, 2021, a baseline will be established.~~

Rationale

- Meaningful community engagement is individual and can be difficult to define. Community engagement is a process that recognizes the value of creating ongoing, long-term relationships for the benefit of the greater community. It brings an interactive, collective problem-solving element into the process that capitalizes on the collective strengths of the various stakeholders.
- There is a need for quality, meaningful and intentional engagement. Addressing the following questions will allow for measurement of opportunities for engagement and show progress in the goals.
    - How are Subcabinet agencies designing outreach efforts to reach people with disabilities?
    - What are the barriers that people with disabilities experience when participating in engagement efforts?
    - How can those barriers be addressed?
    - How can decisions affecting people with disabilities be more transparent?
    - How can people with disabilities have an impact when they participate in engagement activities?
    - How can Subcabinet agencies better communicate among themselves and people with disabilities?
    - How can Subcabinet agencies improve outreach to people with disabilities?

Strategies

Increase the Awareness of People with Disabilities of Opportunities to Participate on Governor Appointed Boards and Commissions

- OIO will promote participation on Boards and Commissions for people with disabilities using a dedicated web page to showcase opportunities to serve, educational materials, and an online exploration tool to help people find options that best fit their skills.

Create a Process that Encourages Participation of People with Disabilities in Providing Input on the Olmstead Plan

- OIO will encourage public participation in Olmstead Plan Amendments using a dedicated web page to include information on the amendment process, educational materials, and multiple opportunities to participate in public and online forums.

Strengthen communication among the Subcabinet, OIO, state agencies, people with disabilities and the general public to ensure messages are accessible and effective.

- OIO will increase engagement among all stakeholder groups by raising awareness of the Olmstead Plan and its purpose through social media, enhanced website user experiences, and educational tools.

~~**The Community Engagement Workgroup will provide the OIO and Subcabinet with recommendations regarding key elements of the Olmstead Plan as specified by the charter.**~~

Design and implement community engagement activities to increase participation by people of color and indigenous communities.

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Preventing Abuse and Neglect

What this topic means

Research shows that vulnerable adults and children (including individuals with disabilities) are at a higher risk for maltreatment (abuse and neglect[53]) than the population as a whole, and that allegations of maltreatment in this population are under reported. The Olmstead Plan website will include trend data on the occurrence of abuse and neglect and violent crimes.

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

Vision statement

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

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

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

Measurable goals

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

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

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

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

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

Update on Progress of Goal One
The Olmstead Subcabinet reviewed and accepted the Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities on January 29, 2018. Staff from DHS, MDH, MDE and OMHDD reviewed the recommendations and proposed new workplan items which were approved by the Subcabinet. In 2021,~~19,~~ the Subcabinet expects to convene a workgroup ~~work with members of the Specialty Committee and others~~ to identify recommendations that might be best addressed through broader community action.

Goal Two: By December 31, ~~January 31,~~ 2022, the number of cases of vulnerable individuals being treated due to abuse and neglect will decrease by 15% ~~30%~~ compared to baseline.

There are two measures for this goal:

(A) Emergency room visits and hospitalizations

Baseline: During Calendar Year 2019, there were 39 cases of vulnerable individuals who were treated in an emergency room or hospital due to abuse or neglect.

Annual Goals to decrease number of emergency room visits and hospitalizations due to abuse and neglect

- ~~By April 30, 2019, establish a baseline~~
- By December ~~January~~ 31, 2020, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 5% ~~10%~~ compared to baseline
- By December ~~January~~ 31, 2021, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 10% ~~20%~~ compared to baseline
- By December ~~January~~ 31, 2022, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 15% ~~30%~~ compared to baseline

(B) Medical treatment(s) other than emergency room or hospital

Annual Goals to decrease number of medical treatments other than emergency room visits and hospitalizations due to abuse and neglect

- By December 31, 2021 ~~April 30, 2019,~~ establish a baseline and annual goals
- ~~By January 31, 2020, the number of medical treatments due to abuse and neglect will be reduced by 10% compared to baseline~~
- ~~By January 31, 2021, the number of medical treatments due to abuse and neglect will be reduced by 20% compared to baseline~~

- ~~By January 31, 2022, the number of medical treatments due to abuse and neglect will be reduced by 30% compared to baseline~~

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

Baseline: From July 2015 – June 2016, there were 2,835 individuals who experienced a substantiated or inconclusive abuse or neglect episode. Of those individuals, 126 (4.4%) had a repeat episode of the same type of abuse or neglect within six months.

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

- By December 31, 2018, the number of people who experience more than one episode will be reduced by 5% compared to baseline
- By December 31, 2019, the number of people who experience more than one episode will be reduced by 10% compared to baseline
- By December 31, 2020, the number of people who experience more than one episode will be reduced by 15% compared to baseline
- By December 31, 2021, the number of people who experience more than one episode will be reduced by 20% compared to baseline

Goal Four: By July 31, 2025, ~~2020,~~ the number of students with disabilities statewide identified as victims in determinations of maltreatment will decrease by 25% ~~10%~~ compared to baseline.

Baseline: From July ~~2015~~ 2017 to June 2018, ~~2016,~~ there were 32 ~~20~~ students with a disability statewide identified as victims in determinations of maltreatment.

Annual Goals to reduce the number of students with disabilities statewide identified as victims in determinations of maltreatment:

- ~~By July 31, 2019, the number of students with disabilities identified as victims in determinations of maltreatment will decrease by 5% from baseline to 19 students.~~
- ~~By July 31, 2020, the number of students with disabilities identified as victims in determinations of maltreatment will decrease by 10% from baseline to 18 students.~~
- By July 31, 2021, the number will decrease by 5% from baseline to 29 students.
- By July 31, 2022, the number will decrease by 10% from baseline to 26 students.
- By July 31, 2023, the number will decrease by 15% from baseline to 23 students.
- By July 31, 2024, the number will decrease by 20% from baseline to 20 students.
- By July 31, 2025, the number will decrease by 25% from baseline to 17 students.

Rationale

- It is well-known that people with disabilities are subject to abuse and neglect at rates much greater than the population as a whole. It is also well-known that incidents of abuse and neglect are under-reported by the population as a whole, but particularly among people with disabilities. The advent of the MAARC system presents an opportunity for the State of Minnesota to not only have a

centralized reporting protocol for all incidents of abuse and neglect in adults, but will provide the opportunity to analyze data from the reporting system that will allow for targeting information and remediation activities to the areas where they can have the biggest impact. The development of a comprehensive abuse prevention plan at this time will ensure that the state identifies opportunities for using this new resource in multiple ways to promote prevention of abuse and neglect and includes the best opportunities in future budgets and work plans.

- A key factor in reducing the level of abuse and neglect is to increase the ability of people with disabilities and their families to know their rights and to identify and report incidents of suspected abuse and neglect. A campaign targeted at informing the general public can be a major boost to turning around the current under-reporting of these incidents.
- The MAARC system provides a "one number" capability for anyone, including mandated reporters and the general public, to report suspected abuse or neglect and removes the confusing complexity of the multiple reporting point system that previously existed. It is reasonable to actively consider whether a similar centralized system for reporting suspected abuse or neglect for children under 18 can similarly improve the complicated child protection system.
- The Minnesota Hospital Association (MHA) currently tracks reasons for ER visits and hospitalizations by International Classification of Diseases (ICD) codes and by Universal Billing (UB) codes. These ICD and UB codes indicate incidents of abuse and neglect that resulted in an ER visit or hospitalization, as well as indicators of an individual's vulnerability. The MHA data, which is shared with MDH, captures information on any individual who receive services at a hospital; pre-baseline work was ~~is being~~ conducted to review and update appropriate abuse and neglect codes as codes to~~which~~ better identify individuals who are vulnerable. This includes individuals who receive services licensed by either MDH or DHS.
- ~~Five years of MHA data (2010-2014) were analyzed to determine the number of vulnerable individuals who received services from facilities licensed by either MDH or DHS, and had been treated at a hospital due to abuse or neglect. This data was analyzed to determine existing patterns and geographic areas which reflect a higher incidence of abuse or neglect. Preliminary analysis suggested that differential documentation is occurring among hospitals, limiting the usefulness of the original method. Reviewing and expanding both the abuse/neglect codes and codes indicating vulnerable individuals combined with training for hospital coders should resolve this issue. MDH anticipates needing adequate time to develop and incorporate this enhanced methodology.~~
- The baseline data for the measure in Goal Three was gathered through the MAARC system. This included the number of vulnerable adults who were the subject of a report of suspected maltreatment who were the subject of another report for the same type of maltreatment within a six month time period. This measure only includes reports where the allegation is determined to be substantiated or inconclusive following investigation. Additional data collected on the vulnerable adult by the MAARC includes age, race, ethnicity, gender, disability/impairment, and licensed services received.
- Baseline data for Goal Four from the 2017-2018 ~~2015-2016~~ data year includes ~~identified~~ the number of students with disabilities statewide identified as victims in determinations of maltreatment at schools, as well as locations of those schools. The number of determinations (i.e. confirmed victim cases) will serve as an annual measure for this goal in subsequent years. Analysis of this data will continue to include identification of schools, specifically schools with multiple determinations of maltreatment. The accuracy of reporting maltreatment of students with disabilities has increased over the years as a result of improved and expanded training. Due to this accuracy increase, MDE

has seen an increase in reports. The baseline has been adjusted to reflect the most accurate recent data collected on student maltreatment

- Schools that are identified as having multiple (more than one) determinations of maltreatment involving students with disabilities as victims annually will be offered MDE training and resources to improve awareness of child maltreatment issues and mandated reporting requirements. This assistance will provide staff with the technical skills and support to address challenging behaviors, and implement practices to prevent child maltreatment in the future.

Strategies

Goal One

Develop Educational Campaign for Mandated Reporters and Professional Caregivers

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

Develop Public Awareness Campaign

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

Goal Two

Use Data to Identify Victims and Target Prevention

- Analyze MHA data on vulnerable individuals who have been the victim of abuse and neglect.
- Analyze provider claims data and validate data from the electronic health records.
- Continue to train hospital and clinic-based health information management staff charged with coding clinicians' notes in order to improve accuracy of codes assigned.
- Identify patterns and geographic areas for targeted prevention efforts.

Monitor and Improve Accountability of Providers

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

Goal Three

Develop Remediation Strategies for Providers and Professional Caregivers

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

Goal Four

Utilize School Tracking Database

- Utilize database to track and identify schools that have multiple determinations of maltreatment of students with a disability (i.e. confirmed victim cases.) This data will be used to provide those schools with focused MDE training and technical assistance. The number of schools in this category will continue to be annually reported to the Olmstead Subcabinet in a data table.
- Annual reporting to the Subcabinet of number of students with disabilities identified as victims in determinations of maltreatment will also include explanation of this number as a percentage of the state population of students with disabilities, and in relation to the number of reports received by MDE annually.

Continue and Expand Training for School Personnel

- MDE will award district grants to implement positive behavior supports in an effort to reduce the rates of maltreatment of students with disabilities. Participating school districts will measure the fidelity to which the defined positive behavior supports are in place. Information gathered from grantees over the course of the grant will inform schools, districts, and MDE about measuring and making systemic changes that result in the reduction of maltreatment through implementing positive behavior supports.
- MDE participates in quarterly meetings with metro child protection screeners to understand current child protection trends and ensure reporting requirements are being met.
- MDE continues to collaborate with MAARC regarding reports of maltreatment involving vulnerable students over the age of 18.
- Provide targeted MDE technical assistance, training, and support to schools through:

- Annual training for schools on child maltreatment and mandated reporting requirements, PBIS, restrictive procedures, and discipline.
- Develop web based trainings and informational materials on relevant topic areas (mandated reporting, child maltreatment, effective school and classroom discipline practices, etc.) to distribute to schools and incorporate into school/staff development trainings.

Improve School Accountability for Training

- Collect annual verification from school districts indicating all school employees have been trained on mandated reporter duties and protections from retaliation when a report is made in good faith. Targeted MDE technical assistance and training will be provided to schools that cannot provide annual verification.

Responsible Agencies

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

Assistive Technology

What this topic means

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

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

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

Definition of assistive technology

Assistive technology is "any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. This definition does not include a medical device that is surgically implanted, or the replacement of such a device." [54]

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

- The evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in the individual's customary environments;
- Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities;
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- Training or technical assistance for individuals with a disability or, if appropriate, that individual's family; and
- Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of that individual. [55]

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

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

[54] 20 U.S.C. Chapter 33, Section 1401 (25)
[55] 20 U.S.C. Chapter 33, Section 1401 (26)

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

Programs and services related to assistive technology

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

Department of Human Services

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

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

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

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

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

Department of Education

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

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

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

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

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

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

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

Services provided by STAR include:

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

  During State Fiscal Year 2018, STAR loaned 623 assistive technology devices to 623 Minnesotans for short-term use. Of the device loans made, 513 were to assist the individual in determining if the AT met their needs. Of that group, 95% made a decision on whether it met their needs.

- **Device Demonstration:** Demonstrations allow consumers to compare features and benefits of a specific device or device category. The purpose of a demonstration is to assist with decision making. A demonstration may lead to a formal evaluation or a request for a short-term loan to trial a device. During State Fiscal Year 2018, STAR demonstrated 206 assistive technology devices to 297 Minnesotans. Of the 206 demonstrations conducted, 98% made a decision on whether the AT met their needs.

- **Open-Ended Device Loans:** In certain limited circumstances, open-ended device loans are for Minnesotans who need assistive technology in education, employment, and certain community environments, such as hospice or assisted living. Open-ended loans allow a borrower to keep a device for as long as it is needed. For many borrowers this is the only resource they have available. During State Fiscal Year 2018, 188 Minnesotans received AT through this program, saving consumers $275,069.

- **Minnesota's Guide to Assistive Technology website**: In June 2018, a cross-agency assistive technology workgroup launched Minnesota's Guide to Assistive Technology website[56] created to increase awareness of assistive technology and provide information to help Minnesotans with disabilities consider, select, and use assistive technology at home, school, work and in their communities.

Vision statement

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

[56] Minnesota's Guide to Assistive Technology website is available at https://mn.gov/admin/at/

Measurable Goals and Strategies

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

~~Measurable goals~~

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

Strategies

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

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

PLAN MANAGEMENT AND OVERSIGHT

Plan Management and Oversight

Olmstead Subcabinet and Olmstead Implementation Office

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

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

The Executive Order further directed the Subcabinet to adopt procedures that would include clarifying and defining the role of the OIO. The Subcabinet adopted procedures in March 2015 and has updated those procedures regularly since then, most recently in December 2018. The procedures establish a dual role for the OIO: (1) quality assurance and accountability, including compliance evaluation, verification and oversight; and (2) engagement with the community, especially people with disabilities, including on-going management of communications and the Quality of Life survey. On March 29, 2019, Governor Walz issued Executive Order 19-13, which continues the role of the OIO and the Subcabinet's ability to define its role through procedures.

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

Quality assurance and accountability

Development and oversight of workplans

In order to achieve the measurable goals, the OIO and State agencies develop specific strategies and workplans. Each measurable goal is supported by several key strategies, which are articulated in the Plan. Key strategies are supported by workplans.

Workplans describe the action items that agencies will use to support the strategies and goals. For each strategy identified in the Plan, the workplans identify a series of key activities, expected outcomes, deadlines and the agency or agencies responsible for implementation. Workplans are the purview of the responsible State agencies. With the assistance of the OIO, the agencies develop the workplans to encompass anticipated action items over 1-2 years. Those workplans are submitted to, and approved by, the OIO compliance staff on behalf of the Olmstead Subcabinet and are made available to the public on the Olmstead website.

The OIO compliance staff and the Subcabinet agencies will use the workplans throughout the year to review the progress of the work and to direct any adjustments to the work if progress is not timely, or if changes to the workplans are needed based on actual experience in the field, including results from the Quality of Life survey. The OIO Compliance staff will notify the Subcabinet of any exceptions to the implementation of workplans on a quarterly and annual basis. When new measurable goals or strategies

are adopted by the Subcabinet, the agencies will develop accompanying workplans within a reasonable period of time and present them to OIO compliance staff on behalf of the Subcabinet.

The OIO Director of Compliance maintains a schedule for reporting on the activities in the workplans. The frequency of reporting to OIO and the Subcabinet will be determined by taking into account specific deadlines that are critical to achieving the outcomes specified in the measurable goals. The reporting schedule is provided to the Subcabinet and available to the public on the Olmstead website. By regularly reviewing the progress of the workplans, both the Subcabinet and the public will be able to see that work is being done to support the achievement of the measurable goals in the Olmstead Plan.

Compliance evaluation, verification and oversight

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

The Subcabinet will hold regular meetings at least six times per year and will schedule additional meetings as necessary to complete its work. The Director of Compliance will present a summary of compliance activities to the Subcabinet on a quarterly basis and by exception.

The Subcabinet will provide periodic written reports to the public detailing progress on the measurable goals, which will be made available on the Olmstead website. These reports will also be provided to the Court by the Department of Human Services while the implementation of the Plan remains under the jurisdiction of the Court.

Quality of Life survey

The OIO Director will have primary responsibility for the oversight of regular surveys of people with disabilities to determine quality of life. The Quality of Life survey is a tool to measure quality of life of people with disabilities over time. The survey examined:

- How well people with disabilities are integrated into and engaged with their community.
- How much autonomy people with disabilities have in day to day decision making.
- Whether people with disabilities are working and living in the most integrated setting that they choose.
- How effective assistive technology is for people with disabilities who use it.

The initial Quality of Life survey was based upon a face to face meeting between a person with a disability and a surveyor. The initial survey report was completed in March 2018 and included a sample of more than 2,000 respondents. This survey report provided important baseline data against which future surveys results can be measured.

In January 2019, the "Olmstead Plan Quality of Life Survey: First Follow-up 2018" report was completed. A total of 511 people completed the follow-up survey. Follow-up survey respondents were selected from a random sample of 2,005 baseline survey respondents. The goal is to track progress of quality of life over an extended period of time. Researchers caution noticeable change is difficult to detect in a short period. When comparing data from the baseline to the follow-up survey, which took place in the span of one year, the results have not yet significantly shifted. People with disabilities reported their

overall quality of life to be “good” - Minnesota’s average baseline score (76.6) and follow-up score (77.4) were similar. The scale was from “very bad” to “very good.”

Researchers detected no definitive changes but some interesting information surfaced.

- The data showed the more people get out and are allowed to interact with the broader community, their quality of life increases. Outing interaction scores are low. Minnesota’s baseline average score (37.7) and follow-up (36.5) were similar. This indicates people are generally segregated from the broader community during daily activities. Finding ways to further integrate daily activities will help to improve quality of life for the focus population.

- We now know there are differences in quality of life for different regions of the state. Depending on where people live, they will have different experiences. For example, while there are fewer outing interactions in the Metro Area, this area has a higher score for decision control. Variables impacting these scores may range from how agencies provide services to how providers network with each other.

- Respondents’ perceived they have a moderate ability to make their own choices. Minnesota’s average baseline score (66.2) and follow-up score (67.6) remained close. However, if you take a closer look, you find that respondents with guardians report less decision control and a lower quality of life than respondents without a guardian. This contrast is more pronounced when we examine the types of guardianships. People with public guardians tend to have a lower quality of life than those with private guardians.

Initial analysis of the follow-up survey results have shown the nature of a long-term study is valuable and has already helped to identify important characteristics affecting overall quality of life. Researchers recommend waiting a longer period of time before resurveying respondents.

The next survey is expected to be conducted in the summer of 2020. The 2020 survey will include analysis by race and ethnicity for the Quality of Life measures. The results of each Quality of Life survey will be shared with the Subcabinet and State agencies that are implementing the Plan so that they can evaluate whether changes should be made in these activities. The results of each Quality of Life survey will be shared with the public.

Dispute referral and oversight

The OIO began work under the original Olmstead Plan to put in place a system for effectively working with people with disabilities that have a need for assistance in resolving disputes. Working with State agencies, the OIO established a set of protocols for referring people with disabilities to the most appropriate offices. All referrals and agency responses are monitored for timeliness and responsiveness to the issues raised. The OIO will continue to work with State agencies to improve performance under the dispute resolution processes.

Updating and extending the Olmstead Plan

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

As the Subcabinet agencies continue to implement the processes and improvements described in the measurable goals, much will be learned regarding what practices are having a positive impact on the quality of life for people with disabilities. As improvements are made in the ability to gather and use better data, there will likely be opportunities to adjust the goals to accomplish improvements more quickly or in a better way.

In addition to its on-going oversight of workplans, the Subcabinet and State agencies will undertake an annual review process to evaluate whether the measurable goals should be amended for future years. The Subcabinet will seek public comment regarding the existing measurable goals. Based on that feedback and the experience of the agencies over the preceding year, State agencies will develop a set of proposed amendments to the measurable goals and present them to the Subcabinet for review and approval. Any amendments that are provisionally approved by the Subcabinet will be posted for review by the public, and will allow for a specific public comment period of at least 30 days. Following the comment period, the Subcabinet will consider whether any changes to the proposed amendments are warranted as a result of the public comments. Any subsequent changes to the proposed amendments will be posted for a brief public review period prior to adoption of the amendments to the Plan by the Subcabinet.

In 2018, the Olmstead Subcabinet undertook a strategic review of the Plan. The strategic review considered results of the Quality of Life survey, achievements under the measurable goals, and feedback from a variety of stakeholders. The strategic review will help inform ongoing efforts to ensure that the Plan is effective.

Communications and public relations

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

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

The OIO will continue to implement the Communications Plan that guides the direct communication messages and activities of the OIO. OIO will establish Olmstead communication guidelines for materials developed by State agencies.

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

Cross-agency coordination of data strategies

Within each of the topic areas in this Olmstead Plan, there is at least one strategy that requires better and different collection and/or analysis of data in order to change certain key processes, to establish baselines against which progress can be measured or to measure outcomes. Because these strategies involving data are so pervasive within the Plan, the Subcabinet, OIO, and State agencies will continue to work together to develop and implement meaningful methods of cross-agency collaboration around these strategies.

Cross-agency coordination of legislative and funding strategies

Within each of the topic areas in this Olmstead Plan, there are activities described that are essential to the accomplishment of the outcomes described in the measurable goals. Each of these activities is subject to funding and policy directives that are the result of State or Federal appropriations and legislative and regulatory actions. Significant changes in the appropriations and regulatory processes at either the State or Federal level may impact the ability of State agencies to achieve Plan goals within the time frames specified in the Plan.

In order for certain changes in activity to occur, it may be necessary for State agencies to propose and pursue statutory changes or regulatory waivers. It may also be necessary for State agencies to request authorization to redirect funding or to request additional funding in order to accomplish certain outcomes. The need for such statutory, regulatory and funding requests may become apparent as more and better data is available to analyze the outcome of the activities anticipated by the Plan.

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

Feedback

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

Method	Steps to follow
Online	Go to: Mn.gov/Olmstead Click "Participate" and follow instructions for the online form
Email	Send an email to this address: MNOlmsteadPlan@state.mn.us
Mail	Send a letter to: Olmstead Implementation Office 400 Wabasha Street N, Suite 400 St. Paul, MN 55102
Phone	Speak to a staff member at the Olmstead Implementation Office, or leave your comment on voicemail. 651-296-8081

This document is available in alternative formats to individuals with disabilities by calling the Olmstead Implementation Office at 651-296-8081, or by emailing MNOlmsteadPlan@state.mn.us

For translations of this publication write to MNOlmsteadPlan@state.mn.us or call 651-296-8081.

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Definitions of key terms

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

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

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

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

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

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

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

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

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

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

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

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

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

Disability: See persons/people with a disability

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

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

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

Extended Employment: The Extended Employment (EE) Program is a performance-based state funded program administered by DEED that annually provides ongoing employment support services for nearly 5000 workers with the most significant disabilities. Services are provided through performance-based contracts with a statewide network of non-profit Commission on Accreditation of Rehabilitation Facilities (CARF) accredited Extended Employment Providers. Service payments are based on reported work hours and reimbursed at differing rates for supported, community and center-based employment. [See Minnesota Statutes §268A.15 and Minnesota Rules parts 3300.2005 – 3300.2055]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subminimum wage: A wage less than the established federal minimum wage that may be permitted under an exemption in the Fair Labor Standards Act (FLSA) that provides for the employment of certain individuals at wage rates below the minimum wage, including individuals whose earning or productive capacity is impaired by a physical or mental disability. In order to pay a subminimum wage to an individual with a disability, the employer must obtain a certificate from the U.S. Department of Labor

and conduct periodic time and productivity studies to establish the rate of payment based on performance norms. [See http://www.dol.gov/compliance/topics/wages-subminimum-wage.htm]

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

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

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

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

Workforce Innovation and Opportunity Act (WIOA): WIOA is the federal Workforce Innovation and Opportunity Act signed into law on July 22, 2014. WIOA supersedes the Workforce Investment Act (WIA) of 1998 and amends the Rehabilitation Act of 1973, the Wagner-Peyser Act and the Adult Education and Family Literacy. Disability service and employment policy provisions that affect people with disabilities include a priority focus on youth with disabilities and their preparation for competitive integrated employment. At a state level, memorandums of understanding must be developed between Vocational Rehabilitation, Education, Assistive Technology and the Medicaid agency. WIOA also sets limits on the use of the Special Subminimum wage including new requirements for oversight and review. Most of the provisions in WIOA became effective July 1, 2015. The WIOA provisions on Subminimum wage provisions became effective on July 22, 2016. More information on WIOA can be found on the US Department of Labor website at: http://www.doleta.gov/wioa/

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Common Acronyms

ACT - Assertive Community Treatment

ADA – Americans with Disabilities Act

ADM – Department of Administration

AMRTC – Anoka Metro Regional Treatment Center

APS – Accessible Pedestrian Signals

AT – Assistive Technology

BIRF – Behavior Intervention Reporting Form

CADI - Community Access for Disability Inclusion

DCD – Developmental Cognitive Disabilities

DD – Developmental Disabilities

DEED – Minnesota Department of Employment and Economic Development

DHS – Minnesota Department of Human Services

DOC – Minnesota Department of Corrections

DOJ – United States Department of Justice

EE – Extended Employment

FACT - Forensic Assertive Community Treatment

HCBS – Home and Community-Based Services

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

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IPS – Individual Placement and Supports

MA – Medical Assistance

MAARC – Minnesota Adult Abuse Reporting Center

MA-EPD – Medical Assistance for Employed Persons with Disabilities

MCF - Minnesota Correctional Facility

MCOTA – Minnesota Council on Transportation Access

MDE – Minnesota Department of Education

MDH – Minnesota Department of Health

MDHR – Minnesota Department of Human Rights

MHCP – Minnesota Health Care Programs

MHFA – Minnesota Housing Finance Agency

MMB - Minnesota Management and Budget

MnDOT – Minnesota Department of Transportation

~~MNSCU - Minnesota State Colleges and Universities~~

MnSHIP - Minnesota State Highway Investment Plan

MSA – Minnesota Supplemental Aid

~~MSH – Minnesota Security Hospital~~

MSHS – Minnesota Specialty Health System

NCI – National Core Indicators

OIO – Olmstead Implementation Office

PBIS – Positive Behavioral Interventions and Supports

SAM - Self-Advocates Minnesota

SSB – State Services for the Blind

SFY – State Fiscal Year

VR – Vocational Rehabilitation

VRS—Vocational Rehabilitation Services

WIOA – Workforce Innovation Opportunity Act