

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



April 2022 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
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Email	Send an email to: <a href="mailto:MNOLmsteadPlan@state.mn.us">MNOLmsteadPlan@state.mn.us</a>
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](mailto:MNOLmsteadPlan@state.mn.us)

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## Minnesota Olmstead Subcabinet

April 25, 2022

On behalf of the Olmstead Subcabinet, I present this April 2022 annual revision of Minnesota's Olmstead Plan. All Minnesotans must have opportunities to make life choices about where they live, learn, work, and enjoy their lives in the most integrated settings alongside people without disabilities.

Governor Tim Walz and Lt. Governor Peggy Flanagan have continued their steadfast support of the Olmstead Plan. This past year, the Subcabinet agencies focused on enhancing efforts of informed choice and addressing inequities in accessing services by people from different racial and ethnic communities.

To support this work, the Subcabinet implemented new strategies to engage people with disabilities at all levels of the Plan. This included finalizing the launch of five new public/private workgroups. These workgroups seek to learn new opportunities through collaborative engagement.

The Subcabinet also established the Leadership Forum, which has the primary responsibility of monitoring the progress and operational implementation of the Olmstead Plan. The members work to identify areas where we're not seeing sufficient progress. The Leadership Forum members are responsible for making recommendations to the Subcabinet on Plan performance, including continuous improvement processes. The Subcabinet continues to oversee all changes to the Plan.

Finally, the Olmstead Implementation Office has significantly increased awareness of the Plan through a robust social media presence, cross-agency promotions, and multi-media outreach. These strategies have prompted increased public participation in Subcabinet, Leadership Forum meetings, and workgroup community engagement.

Although we have made significant engagement and operational changes this past year, the Subcabinet is keenly aware that much is still left to do. We will continue to challenge ourselves to look to the future. We will remain committed to the foundational promises of the first Olmstead Plan and look to continue evolving and building a Plan that supports the desires and needs of Minnesotans with disabilities.

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.”<sup>1</sup> It is named after a United States Supreme Court decision called “*Olmstead v. L.C.*”<sup>2</sup>

*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.”<sup>3</sup> With those words, Congress equated segregation with discrimination and, in Title II of the ADA, prohibited public entities from discriminating against individuals with disabilities.<sup>4</sup> Regulations implementing Title II require public entities to provide services in the *most integrated* setting appropriate to the needs of qualified individuals with disabilities.<sup>5</sup> 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.”<sup>6</sup> 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.<sup>7</sup> *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

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<sup>1</sup> “[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”), at [www.ada.gov/olmstead/q&a\\_olmstead.htm](http://www.ada.gov/olmstead/q&a_olmstead.htm), last visited March 31, 2022.

<sup>2</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

<sup>3</sup> DOJ Statement, p. 1, *citing* 42 U.S.C. §12101(a)(2).

<sup>4</sup> 42 U.S.C. §12132.

<sup>5</sup> 28 C.F.R. §35.130(d).

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

<sup>7</sup> *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.<sup>8</sup>

To comply with the integration mandate, public entities must reasonably modify their policies, procedures or practices to avoid discrimination.<sup>9</sup> 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.<sup>10</sup>

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.”<sup>11</sup>

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.<sup>12</sup> 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*.<sup>13</sup> *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). In October 2020, the U.S. District Court ended its jurisdiction.

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<sup>8</sup> *Olmstead*, 527 U.S. at 607.

<sup>9</sup> 28 C.F.R. §35.130(b)(7).

<sup>10</sup> *Olmstead*, 527 U.S. at 603.

<sup>11</sup> "[Assistant Attorney General Thomas E. Perez Testifies Before the U.S. Senate Committee on Health, Education, Labor and Pensions](https://www.justice.gov/crt/opa/pr/speeches/2012/crt-speech-120621.html)". Washington, D.C., Thursday, June 21, 2012, (<https://www.justice.gov/crt/opa/pr/speeches/2012/crt-speech-120621.html>), last visited March 31, 2022.

<sup>12</sup> Executive Orders 13-01, 15-03 and 19-13 are available on the [Olmstead website](https://mn.gov/olmstead) (<https://mn.gov/olmstead>).

<sup>13</sup> *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 of 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 Veterans 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,<sup>14</sup> available demographic data used a different definition of disability, one that excluded persons living in congregate settings.<sup>15</sup> 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 22.6% of Minnesotans with disabilities live in poverty compared to 8.3% of all Minnesotans<sup>16</sup> and the highest rate of disabilities among Minnesotans are American Indians.<sup>17</sup>

Minnesota's population is aging. In 2020, the current retirement-to-working age ratio was about 26%, but by 2035, the retirement-to-working age ratio is projected to be almost 36%.

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.<sup>18</sup>

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<sup>14</sup> 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.

<sup>15</sup> Data from the American Community Survey and Decennial Census and Population Estimates, via [Minnesota Compass](http://www.mncompass.org/demographics/) (www.mncompass.org/demographics/), last accessed March 31, 2022.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Wilder Research, "[Homelessness in Minnesota: Detailed Findings from the 2018 Minnesota Homeless Study](https://www.wilder.org/sites/default/files/imports/2018_HomelessnessInMinnesota_3-20.pdf)" (https://www.wilder.org/sites/default/files/imports/2018\_HomelessnessInMinnesota\_3-20.pdf), last accessed March 31, 2022.

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, to 1 in 44 in 2018.<sup>19</sup>

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
- Annual Plan review and amendment process, which resulted in a revised Plan in February 2017, March 2018, March 2019, March 2020, April 2021, and April 2022.

## 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.<sup>20</sup> The majority of the comments related to the 11 theme areas below.

### 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.

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<sup>19</sup> CDC, “[Autism Spectrum Disorders: Data & Statistics.](https://www.cdc.gov/ncbddd/autism/data.html)” (https://www.cdc.gov/ncbddd/autism/data.html), last accessed March 31, 2022.

<sup>20</sup> 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](#).

- 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 the March 2018 Plan on March 26, 2018. As a result of the approved changes, the March 2018 Plan contained 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 the March 2019 Plan on March 25, 2019. As a result of the approved changes, the March 2019 Plan contained 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 the March 2020 Plan on March 23, 2020. As a result of the approved changes, the March 2020 Plan contained 38 measurable goals.

### **Fifth Plan Amendment Process: April 2021**

The Olmstead Subcabinet undertook a fifth annual Plan review and amendment process beginning in December 2020. A draft of proposed amendments was reviewed by the Olmstead Subcabinet in January 2021. An initial public comment period was held from February 10, 2021 to March 12, 2021. This included one listening session and the opportunity to provide written input. Approximately 49 comments were received from 20 individuals or organizations.

A second draft of proposed amendments was reviewed by the Subcabinet in March 2021. A second public comment period was held from March 23, 2021 to April 6, 2021. This included the opportunity to provide written input. Seven individuals or organizations provided approximately 21 comments.

Areas with the most response included Person-Centered Planning, Housing and Services, Employment, Education, Transition Services, Crisis Services and Positive Supports. After consideration of public comments, one agency made a subsequent change to a goal. The Olmstead Subcabinet reviewed and approved the April 2021 Plan on April 26, 2021. As a result of the approved changes, the April 2021 Plan contains 33 measurable goals.

### **Sixth Plan Amendment Process: April 2022**

The Olmstead Subcabinet undertook a sixth annual Plan review and amendment process beginning in November 2021. The Olmstead Implementation Office (OIO) conducted an Olmstead Plan Survey from November 22, 2021 to December 31, 2021. The survey asked people to share their thoughts on how the Olmstead Plan is going. There were 199 respondents and approximately 336 comments.

A draft of proposed amendments was reviewed by the Olmstead Subcabinet in January 2022. A public comment period was held from February 15, 2022 to March 8, 2022. Approximately 10 comments were received from 34 respondents.

Areas with the most comments included Person-Centered Planning, Housing and Services, Waiver Funding, Employment, Community Engagement, Crisis Services, Transportation and Health Care. After consideration of public comments, the Olmstead Subcabinet reviewed and approved this April 2022 Plan on April 25, 2022. As a result of the approved changes, this April 2022 Plan contains 33 measurable goals.

### **Where to learn more?**

The [Olmstead website](https://mn.gov/olmstead) at Mn.gov/Olmstead, contains:

- Information related to the history of the Minnesota Olmstead Plan, including Executive Orders;
- Previous versions of the Olmstead Plan;
- 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.
- **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:** 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%.

### Transition Services (DHS, DOC, MHFA)

**GOAL ONE:** By June 30, 2022, the number of people who have moved from segregated settings to more integrated settings will be 9,782. The segregated settings include: (A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD); (B) individuals with disabilities under age 65 receiving services in a nursing facility for longer than 90 days; and (C) other segregated housing.

- By June 30, 2022, the number moving from ICFs/DD will be 612
- By June 30, 2022, the number moving from a nursing facility will be 5,970
- By June 30, 2022, the number moving from other segregated housing will be 3,200

**GOAL TWO:** By June 30, 2023, the percent of people under 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 25% (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% or lower
- By June 30, 2017 the percent will reduce to 33% or lower
- By June 30, 2018 the percent will reduce to 32% or lower
- By June 30, 2019 the percent will reduce to 30% or lower
- 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
- By June 30, 2023 the percent will be reduced to 25% or lower

**GOAL THREE:** By December 31, 2022, the average monthly number of individuals at Forensic Services moving to a less restrictive setting will increase to an average of 5 individuals per month.

**Annual Goals** to increase average monthly number of individuals moving to a less restrictive setting:

- By December 31, 2021 the number will be 4 or more
- By December 31, 2022 the number will be 5 or more

## Transition Services

(DHS, DOC, MHFA)

**GOAL FOUR:** By June 30, 2024, 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 person's support needs, how and when those needs will be met completing the My Move Plan Summary with the person or their legal representative, when applicable. [People who did not inform their case manager that they moved are excluded from this measure.]

- By March 31, 2023, establish a baseline

## Housing and Services

(DHS, MHFA)

**GOAL ONE:** By June 30, 2024, 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 2,467 (from 2021 through 2024).

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

- By June 30, 2021, the number will be 569
- By June 30, 2022, the number will be 598
- By June 30, 2023, the number will be 635
- By June 30, 2024, the number will be 665

## Employment

(DHS, DEED, MDE, ADM)

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

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

- 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, 2024, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 8,283 over baseline to 14,420 in competitive integrated employment.

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

- By June 30, 2021, the number will increase to 11,420
- By June 30, 2022, the number will increase to 12,420
- By June 30, 2023, the number will increase to 13,420
- By June 30, 2024, the number will increase to 14,420

## Employment

(DHS, DEED, MDE, ADM)

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

**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

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

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

- 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, 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% (from baseline of 29.8%).

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

- 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%

## 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 (71%); (B) Immediate need (74%); and (C) Defined need (66%).

## Transportation (MnDOT, Met Council)

**GOAL ONE:** By December 31, 2023, accessibility improvements will be made to (A) 10,299 curb ramps (increase from base of 19% to 79 %); (B) 490 Accessible Pedestrian Signals (increase from base of 10% to 79%); and (C) by December 31, 2023, improvements will be made to 113 miles of sidewalks.

### A – Curb Ramps

- By December 31, 2020, accessibility improvements will be made to an additional 6,600 curb ramps.
- By December 31, 2023, accessibility improvements will be made to an additional 10,299 curb ramps.

### B – Accessible Pedestrian Signals (APS)

- By December 31, 2020, accessibility improvements will be made to an additional 430 APS installations.
- By December 31, 2023, accessibility improvements will be made to an additional 490 APS installations.

### C – Sidewalk Improvements

- By October 31, 2021, improvements will be made to 55 miles of sidewalks.
- By December 31, 2023, improvements will be made to 113 miles of sidewalks.

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

**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, 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, 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, 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.

**GOAL TWO:** By June 30, 2022, 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.

**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 emergency use of mechanical restraints, other than use of an auxiliary device will be reduced to no more than 88 reports.

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

- By June 30, 2020, reduce to no more than 93 reports
- By June 30, 2021, reduce to no more than 93 reports
- By June 30, 2022, reduce to no more than 88 reports

## Positive Supports (DHS, MDE, MDH, DOC)

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

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

- 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, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 3,615 or by 1.0 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, 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, 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, 2020, the percent will increase to 80%
- By June 30, 2021, the percent will increase to 85%
- By June 30, 2022, the percent will increase to 85% or more

**GOAL TWO:** By June 30, 2022, 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% or more.

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

- By June 30, 2021, the percent will increase to 55%
- By June 30, 2022, the percent will increase to 65%

## Crisis Services (DHS, MDE)

**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.

**GOAL FOUR:** By June 30, 2022, 80% of people in community hospital settings due to a crisis will have a stable, permanent home within 5 months after leaving the hospital.

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

- 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

## Community Engagement (OIO)

**GOAL ONE:** By June 30, 2022, the number of individuals with disabilities who participate in Governor appointed Boards and Commissions 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, 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, 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% 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

**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 31, 2022, the number of cases of vulnerable individuals being treated due to abuse and neglect will decrease by 15% compared to baseline.

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

- By December 31, 2020, the number will be reduced by 5%
- By December 31, 2021, the number will be reduced by 10%
- By December 31, 2022, the number will be reduced by 15%

**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, a baseline and annual goals will be established

**GOAL THREE:** By December 31, 2022, 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%
- By December 31, 2022, the number of people will be reduced by 20%

## Preventing Abuse and Neglect

(MDH, DHS, MDE, OMHDD)

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

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

- 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.

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 Comments

- “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 [Home and Community-Based Services Rule](#); a description of a person-centered service plan is contained in §441.725.

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>.

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: 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 combined 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%)

## 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.
- 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](https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3825-ENG) (<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3825-ENG>), 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 2020 (July 2019 – June 2020), there were 58,289 individuals receiving disability home and community-based services. In Fiscal Year 2017, that number was 47,272.

## Strategies

### **Broaden the Effective Use of Person-Centered Planning Principles and Techniques for People with Disabilities**

- Define and initiate person-centered planning services to assist people with disabilities in expressing their needs and preferences about quality of life.
- Expand person-centered planning principles across more populations to include Medical Assistance recipients using mental health or home care services, those served through DEED, MDE, those leaving correctional facilities, and those requiring a coordinated plan between education, human services, and/or health. Provide training on person-centered planning practices and informed choice to people with disabilities and their families, counties, tribes, and providers.
- Actively promote and encourage implementation of best practices and person-centered strategies that support individualized service and housing options through, for example, Housing Options Best Practices Forum and communities of practice on person-centered planning and transition protocols.
- Evaluate progress towards goals, and determine if additional strategies will be necessary to provide everyone receiving services through one of the four disability home and community-based service waivers with person-centered plans, that include meaningful informed choice.
- Develop materials and training to guide professionals who inform people with disabilities about their rights and their individual abuse prevention plans to increase understanding of rights and the effectiveness of planning. [Note: professionals include providers (who are responsible for abuse prevention plans), case managers, qualified professionals overseeing Personal Care Assistance services, etc.]
- Plan for and begin the development of informed choice training for lead agencies. Training will include the requirements of providing a person, in an accessible format and manner that meets the individual's needs, the tools, information, and opportunities that the individual requires to understand all of their options. A plan including milestones will be achieved by March 31, 2023.

### **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.

### **Improve the Ability to Gather Information about Informed Choice in Decision Making**

- DHS will conduct a review of how the Department currently gathers data regarding informed choice in decision making. The review will:
  - identify existing projects related to assessing and measuring informed choice in decision making;
  - document the ways information regarding informed choice is currently collected;
  - prepare a summary analysis of the consistency and variation in data collected among tools and methodologies;
  - conduct an analysis of current tools as data collection instruments; and
  - identify recommendations regarding the assessment of informed choice in decision making by June 30, 2023.
- DHS will conduct a review of how the Department currently gathers information regarding race and ethnicity. The review will:
  - identify existing data on race and ethnicity across the Department;
  - prepare a summary analyzing consistency and variation in data collected between systems;
  - participate in DHS data standards project on race and ethnicity; and
  - identify recommendations regarding assessment of race and ethnicity in Olmstead reporting related to choice in decision making by June 30, 2023.

**Conduct a comprehensive review of Department of Corrections (DOC) policies and practices related to person-centeredness, inclusivity, accessibility and equity.**

- DOC will identify priority areas will be identified with recommendations for improvements.

### **Responsible Agencies**

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

## Transition Services

### Stakeholder Comments

- “There needs to be funding for people that are in a nursing facility less than 90 days who need new housing.” (DeJo Sathrum, 2014)

### What this topic means

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

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

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

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

### Vision statement

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

## Measurable goals

**Goal One: By June 30, 2022, the number of people who have moved from segregated settings to more integrated settings<sup>21</sup> will be 9,782. The segregated settings include:**

**(A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD);**

**(B) individuals with disabilities under age 65 receiving services in a nursing facility for longer than 90 days; and (C) other segregated housing.**

### **SETTING A: INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES**

By June 30, 2022, the number of people who have moved from Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD) to more integrated settings will be 612.

Baseline: During Calendar Year 2014, the number of individuals moving from ICFs/DD was 72.

**Annual Goals** for the number of people moving from ICFs/DD to more integrated settings:

- By June 30, 2015, the number of people moving will be 84
- By June 30, 2016, the number of people moving will be 84
- By June 30, 2017, the number of people moving will be 84
- By June 30, 2018, the number of people moving will be 72
- By June 30, 2019, the number of people moving will be 72
- By June 30, 2020, the number of people moving will be 72
- By June 30, 2021, the number of people moving will be 72
- By June 30, 2022, the number of people moving will be 72

### **SETTING B: NURSING FACILITIES**

By June 30, 2022, the number of people with a disability under age 65 in a nursing facility (for longer than 90 days) who have moved to a more integrated setting will be 5,970.

Baseline: During Calendar Year 2014, the number of individuals moving from nursing facilities was 707.

**Annual Goals** for the number of people moving from nursing facilities to more integrated settings:

- By June 30, 2015, the number of people moving will be 740
- By June 30, 2016, the number of people moving will be 740
- By June 30, 2017, the number of people moving will be 740
- By June 30, 2018, the number of people moving will be 750
- By June 30, 2019, the number of people moving will be 750
- By June 30, 2020, the number of people moving will be 750
- By June 30, 2021, the number of people moving will be 750
- By June 30, 2022, the number of people moving will be 750

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<sup>21</sup>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.

### **SETTING C: OTHER SEGREGATED HOUSING**

By June 30, 2022, the number of people who have moved from other segregated housing to a more integrated setting will be 3,200.

Baseline: From July 2013 – June 2014, of the 5,694 individuals moving, 1,121 moved to an integrated setting.

**Annual Goals** for the number of people moving from other segregated housing to more integrated settings:

- By June 30, 2015, the number of people moving will be 50
- By June 30, 2016, the number of people moving will be 250
- By June 30, 2017, the number of people moving will be 400
- By June 30, 2018, the number of people moving will be 500
- By June 30, 2019, the number of people moving will be 500
- By June 30, 2020, the number of people moving will be 500
- By June 30, 2021, the number of people moving will be 500
- By June 30, 2022, the number of people moving will be 500

**Goal Two: By June 30, 2023, the percent of people under 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<sup>22</sup> will be reduced to 25% or lower (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. In State Fiscal Year 2021, the percentage of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting was 27.6% 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% or lower
- By June 30, 2017 the percent awaiting discharge will be reduced to 33% or lower
- By June 30, 2018 the percent awaiting discharge will be reduced to 32% or lower
- By June 30, 2019 the percent awaiting discharge will be reduced to 30% or lower
- 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
- By June 30, 2023 the percent awaiting discharge will be reduced to 25% or lower

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<sup>22</sup> 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, the average monthly number of individuals at Forensic Services<sup>23</sup> moving to a less restrictive setting will increase to an average of 5 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.

**Annual Goals** to increase the average monthly number of individuals moving to a less restrictive 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

**Goal Four: By June 30, 2024, 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 person's support needs, how and when those needs will be met by completing the My Move Plan Summary with the person or their legal representative, when applicable. [People who did not inform their case manager that they moved are excluded from this measure.]**

- By March 31, 2023, establish a baseline

## 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 Goal Two, progress will be measured for all individuals at AMRTC.
- 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

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<sup>23</sup> For the purpose of this goal, Forensic Services (formerly known as Minnesota Security Hospital) refers to individuals residing in the facility and committed as mentally ill and dangerous and other commitment statuses.

brain injury. This population requires intensive transition planning which typically takes years to find and/or create a successful placement.

- Individuals leaving Forensic Services may move to a more integrated setting, transfer to a treatment facility or transfer to a correctional setting. For the Goal Two, progress will be measured for those individuals moving out of the facility to a less restrictive setting, even if the new setting is not fully community integrated. 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 September 2021, there were 779 individuals receiving services in an ICF/DD. In June 2017, that number was 1,383.
- In January 2020, there were 2,379 individuals with disabilities under age 65 who received services in a nursing facility for longer than 90 days. In June 2017, that number was 1,502.
- In Calendar Year 2021, 388 patients received services at AMRTC. This may include individuals who were admitted more than once during the year. The average daily census was 89.5. In Calendar Year 2017, there were 383 patients and the average daily census was 89.5.
- In Fiscal Year 2021 (July 1, 2020 to June 30, 2021), 454 patients received services in the Forensic Mental Health Program. During that same timeframe 46 residents received services in the Forensic Nursing Home. This may include individuals who were admitted more than once during the year. The average daily census for the Forensic Mental Health Program was 348.8 and for the nursing home it was 25.9.

## 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.

- Develop and publish improvements to the My Move Plan Summary form, identified through stakeholder engagement, which will promote a more person-centered planning process, maintaining the ten elements previously used in the My Move Plan summary.

#### **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 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 were completed with the person or their legal representative (if applicable) and included a description of the person's support needs, how and when those needs would be met.
- Revise the monitoring and compliance process of the My Move Plan Summary form to be individualized based on the assessed needs of the person moving, rather than the simple presence of all ten elements. For a period of six months upon implementation of the revised My Move Plan Summary form, DHS Lead Agency Review will validate the new monitoring and compliance process, including the current form and revised form in the data collection. Technical assistance, on the form will continue to be provided at lead agency reviews and by request of the lead agency.
- 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

## Housing and Services

### Stakeholder Comments

- “I have been trying to get rental assistance for ten months and 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.”<sup>24</sup>

### 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.

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<sup>24</sup> [“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 available at \(https://www.ada.gov/olmstead/q&a\\_olmstead.htm\).](https://www.ada.gov/olmstead/q&a_olmstead.htm)

## Measurable goals

**Goal One: By June 30, 2024, 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 2,467 (from 2021 through 2024).**

Baseline: In State Fiscal Year 2014, there were an estimated 38,079 people living in segregated settings.<sup>25</sup> 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.<sup>26</sup> 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, 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
- By June 30, 2023, the number of individuals moving into integrated housing will be 635
- By June 30, 2024, the number of individuals moving into integrated housing will be 665

## 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, 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.

## 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.

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<sup>25</sup> Based on [“A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report”](https://mn.gov/mnddc/future/pdf/olmstead/14-DAT-CFS.pdf) (https://mn.gov/mnddc/future/pdf/olmstead/14-DAT-CFS.pdf) and information from ICFs/DD and Nursing Facilities.

<sup>26</sup> 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.

- 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.
- DHS will conduct a review of how the Department currently gathers information regarding informed choice in housing services. The review will:
  - identify existing projects related to assessing and measuring informed choice in housing;
  - document the ways information regarding informed choice is currently collected;
  - prepare a summary analysis of the consistency and variation in data collected among tools and methodologies;
  - conduct an analysis of current tools as data collection instruments; and
  - identify recommendations regarding the assessment of informed choice in housing decisions by June 30, 2023.
- DHS will conduct a review of how the Department currently gathers information regarding race and ethnicity. The review will:
  - identify existing data on race and ethnicity across the Department;
  - prepare a summary analyzing consistency and variation in data collected between systems;
  - participate in DHS data standards project on race and ethnicity; and
  - identify recommendations regarding assessment of race and ethnicity in Olmstead reporting related to housing services by June 30, 2023.

#### **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.

#### **Improve access to Housing Stabilization Services<sup>27</sup> through Medical Assistance**

- Implement Moving Expenses option by December 31, 2022, to assure more people with disabilities or disabling conditions who have housing instability have access to the necessary funding and goods to help them move, within available federal funding
- Develop resources and make them available on the HB101 website. The resources and tools will provide information about Housing Stabilization Services to people with disabilities and the people who support them
- Seek input from providers on barriers to enrollment and service delivery, with a particular focus on providers from diverse communities.

#### **Increase use of Minnesota Supplemental Aid Housing Assistance for People with Disabilities to have more Resources to Pay for Housing.**

#### **Define the primary disabling conditions chronically homeless veterans experience and determine how to best address those needs**

- Minnesota Department of Veteran Affairs will develop a strategy that includes the following steps:
  - Analyze the disability data available in the Homeless Veteran Registry and identify system improvements to ensure sufficient data is being collected. (Quarter 1, 2022)

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<sup>27</sup> Housing Stabilization Services is a benefit that went into effect in July 2020. This was formerly called Housing Access Services and Housing Access Coordination.

- Roll-out Homeless Veteran Registry improvements; start the collection of data to create and define the benchmark; and assign a Homeless Programs Coordinator to the Olmstead Plan to advance these efforts. (Quarter 2, 2022)
- Analyze initial benchmark data and start to develop and define a goal and initial strategies to meet the goal. (Quarter 3, 2022)
- Finalize benchmark data, goal, and strategies to be implemented to meet the goal in subsequent years. (Quarter 4, 2022)

**Improve the response to the needs of individuals with disabilities on correctional supervision and experiencing unsheltered homelessness**

- Develop a process to track the number of persons with disabilities or disabling conditions who are on correctional supervision and are currently experiencing unsheltered homelessness.
- Identify the needs of these individuals
- Develop a response strategy to meet the needs of these individuals. This strategy will be included in the Homeless Mitigation Plan to be reported to the legislature by October 2022.

**Responsible Agencies**

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

# Employment

## Stakeholder Comments

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

## What this topic means

### Employment is about:

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

Employment is not about eliminating certain service options or closing specific facilities, instead it is about the state taking affirmative steps that include providing information about the benefits of integrated settings; facilitating visits or other experiences in such settings; and offering opportunities to meet people with disabilities who live, work and receive services in integrated settings, with their families, and with community providers. Public entities also must make reasonable efforts to identify and 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, published in 2021)<sup>28</sup>:

- The employment rate of working-age people (ages 21 to 64) with disabilities in Minnesota was 48.5%. For the general population it was 82.3%
- The percentage of working-age people with disabilities who were unemployed and actively looking for work was 11.3%. For people without a disability who were actively looking for work it was 15.0%.
- The percentage of working-age people with disabilities working full-time/full-year was 27.4% with average annual earnings of \$41,800. For working-age people without disabilities, 61.3% were working full-time/full-year with average annual earnings of \$52,700.

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<sup>28</sup>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 2019- September 2020<sup>29</sup>:

- There are approximately 294,000 Minnesotans between the ages of 18 and 64 with one or more long-lasting disabilities, of which approximately 142,000 (48.3%) were employed. This compares to an employment rate of 84.4% for Minnesotans between the ages of 18 and 64 with no disability.
- Vocational Rehabilitation Services (VRS) provided services to 13,994 persons under Title I of the Rehabilitation Act, all of whom were individuals with a significant disability.
- Approximately 5% of all working-age adults with a disability received State Vocational Rehabilitation Services or about 9% of those people who were not employed.
- State Services for the Blind (SSB) provided services to 1,334 persons who are blind, visually impaired, and DeafBlind.
- Approximately 14% of Minnesotans who have a disability have a visual disability, though not all may meet the eligibility criteria for SSB's vocational rehabilitation program. Approximately 3% of all working-age adults with a visual disability received State Vocational Rehabilitation Services from SSB.
- For comparison, 4% of unemployed Minnesotans utilized the services of the State's CareerForce Locations during Calendar Year 2020.

## 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 the number of individuals<sup>30</sup> who are in competitive integrated employment as a result of receiving Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) will increase by 5,667.**

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, 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

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<sup>29</sup> Source for Minnesota state information: <https://disabilitycompendium.org/compendium/2019-state-report-for-county-level-data-employment/MN>

<sup>30</sup> 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, 2024, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 8,283 over baseline to 14,420 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, 2021, the number in competitive integrated employment will increase to 11,420
- By June 30, 2022, the number in competitive integrated employment will increase to 12,420
- By June 30, 2023, the number in competitive integrated employment will increase to 13,420
- By June 30, 2024, the number in competitive integrated employment will increase to 14,420

**Goal** to develop new measure of individuals in competitive integrated employment

- By September 30, 2022 establish an E1MN<sup>31</sup> baseline to include:
  - The number of individuals served with a Medicaid waiver
  - The number of waiver recipients who received competitive integrated employment outcomes
  - The numbers by age, race and ethnicity

**Goal Three: By June 30, 2025, the number of students with developmental cognitive disabilities, ages 19-21 that enter into competitive integrated employment through the Employment Capacity Building Cohort (ECBC)<sup>32</sup> will be 1,513.**

**Annual Goals** for the number of students that enter competitive integrated employment through ECBC:

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

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<sup>31</sup> E1MN is Minnesota's state agency partnership to advance Employment First outcomes for youth and adults with disabilities.

<sup>32</sup> The Employment Capacity Building Cohort (ECBC) is an interagency activity of MDE, DEED, DHS and SSB, which engages local level community teams of school districts, vocational rehabilitation services, other county services, and community providers, in professional development and technical assistance focused on continuous improvement in rates of competitive integrated employment for students with cognitive disabilities ages 19 to 21 years.

**Goal Four: By December 31, 2022, the number of Peer Support Specialists who are employed by mental health service providers will increase 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, 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.
- A new measure and baseline is being developed for Employment Goal Two. Progress on the current measure will continue to be reported while the new measure is being established.
- As of 2020-2021, the Employment Capacity Building Cohort (ECBC) includes 31 community teams. The number of community teams fluctuates each year with the addition and exit of ECBC teams.
- 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.
- Implement E1MN (launched July 1, 2021) that works to deliver a seamless and timely employment support system for youth and adults with disabilities so they understand their options and get what they need to achieve and maintain competitive integrated employment.
- Continue providing services under the Engage, Plan, Find, Keep Framework<sup>33</sup> for people who receive a Medicaid waiver. The framework supports people at different phases of employment. The person's thoughts about competitive integrated work define where to start and how they progress through the phases of the framework.

### 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.
- DHS will conduct a review of how the Department currently gathers information regarding informed choice in employment. The review will:
  - identify existing projects related to assessing and measuring informed choice in employment;
  - document the ways information regarding informed choice is currently collected;

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<sup>33</sup> More information about the Engage, Plan, Find, Keep Framework is available on the [Disability Hub](#).

- prepare a summary analysis of the consistency and variation in data collected among tools and methodologies;
- conduct an analysis of current tools as data collection instruments; and
- identify recommendations regarding the assessment of informed choice in employment decisions by June 30, 2023.
- DHS will conduct a review of how the Department currently gathers information regarding race and ethnicity. The review will:
  - identify existing data on race and ethnicity across the Department;
  - prepare a summary analyzing consistency and variation in data collected between systems;
  - participate in DHS data standards project on race and ethnicity; and
  - identify recommendations regarding assessment of race and ethnicity in Olmstead reporting related to employment services by June 30, 2023.

### **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 implementation of evidence-based and promising practices:
  - 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 waived 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](#)<sup>34</sup> 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.

### **Promote Self-Determination in Education in the Most Integrated Setting**

- MDE will explore development of metrics (e.g. educational setting, self-determination metric, race/ethnicity disaggregation) and a process for measuring self-determination of students with cognitive and developmental disabilities in relation to educational setting placements by their Individualized Education Program (IEP) teams according to Minnesota Rule 3525.3010 (January through October 2022).
- MDE will partner with school districts in using the Arc Self-Determination Scale – Adolescent Version (Wehmeyer & Kelchner (Arc), 2014) to measure student self-determination in relation to educational setting placement (October 2022, through September 2023).
- MDE will use the results of measurement to begin developing a combined framework for self-determination and education in the most integrated setting for students with cognitive and developmental disabilities (October 2023 through June 2024).
- MDE will field validate the developed framework for self-determination and education in the most integrated setting for students with cognitive and developmental disabilities with partnering school districts (July 2024 through September 2025).

## **Responsible Agencies**

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

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<sup>34</sup> Disability Hub MN at [www.disabilityhubmn.org](http://www.disabilityhubmn.org) is a free statewide resource network that helps solve problems, navigate the system and plan for the future. It includes options and tools for managing health, benefits, work and housing.

## Lifelong Learning and Education

### Stakeholder Comments

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

### What this topic means

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

The federal Individuals with Disabilities Education Act (IDEA) of 2004<sup>35</sup> 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.

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<sup>35</sup> 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<sup>36</sup>, receiving instruction in the most integrated setting<sup>37</sup>, 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 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, 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% (from the baseline of 29.8%).**

Baseline: Based on 2020 Minnesota's Statewide Longitudinal Education Data System (SLEDS), of the 7,212 students with disabilities who graduated statewide in 2018, a total of 2,151 (29.8%) enrolled in the fall of 2018 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:

- 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%

## 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

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<sup>36</sup> "Students with disabilities" are defined as students with an Individualized Education Program age 6 to 21 years.

<sup>37</sup> "Most integrated setting" refers to receiving instruction in regular classes alongside peers without disabilities, for 80% or more of the school day.

with disabilities each year. The annual number of students with disabilities changes every year, and 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](http://sleds.mn.gov/) (<http://sleds.mn.gov/>).

## 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 2021, there are 829 or 40% of Minnesota schools implementing PBIS, impacting an estimated 391,272 students. (44% of all students)

### **Continue Strategies to Effectively Support Students with Low-Incidence Disabilities**

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

### **Improve Graduation Rates for Students with Disabilities**

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

### **Promote Self-Determination in Education in the Most Integrated Setting**

- MDE will explore development of metrics (e.g. educational setting, self-determination metric, race/ethnicity disaggregation) and a process for measuring self-determination of students with cognitive and developmental disabilities in relation to educational setting placements by their Individualized Education Program (IEP) teams according to Minnesota Rule 3525.3010 (January through October 2022).
- MDE will partner with school districts in using the Arc Self-Determination Scale – Adolescent Version (Wehmeyer & Kelchner (Arc), 2014) to measure student self-determination in relation to educational setting placement (October 2022, through September 2023).
- MDE will use the results of measurement to begin developing a combined framework for self-determination and education in the most integrated setting for students with cognitive and developmental disabilities (October 2023 through June 2024).
- MDE will field validate the developed framework for self-determination and education in the most integrated setting for students with cognitive and developmental disabilities with partnering school districts (July 2024 through September 2025).

### **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 Technical Assistance Center on Transition \(NTACT\)](https://transitionta.org/) at (<https://transitionta.org/>) 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](http://www.normandale.edu/osdresources) Resources and Links page 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.

### **Responsible Agencies**

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

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## **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%); (B) Immediate need (74%); and (C) Defined need (66%).**

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%)
<b>Totals</b>	<b>1,500</b>	<b>707 (47%)</b>	<b>433 (29%)</b>

***Category 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.

***Category 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.

***Category 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

- “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, 2023, accessibility improvements will be made to: (A) 10,299 curb ramps (increase from base of 19% to 79%); (B) 490 accessible pedestrian signals (increase from base of 10% to 79%); and (C) by December 31, 2023, improvements will be made to 113 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<sup>38</sup> bringing the percentage of compliant ramps to approximately 49%.
- By December 31, 2023 accessibility improvements will be made to an additional 10,299 curb ramps. bringing the percentage of compliant ramps to approximately 79%.

### (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%.
- By December 31, 2023, an additional 490 Accessible Pedestrian Signals (APS) installations will be provided on MnDOT owned and operated signals bringing the number to 935 and the percentage to 79%.

### (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%.
- By December 31, 2023 improvements will be made to an additional 113 miles of sidewalks bringing total system compliance to 64%.

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<sup>38</sup> ADA Title II Requirements for curb ramps at [www.fhwa.dot.gov/civilrights/programs/doj\\_fhwa\\_ta\\_glossary.cfm](http://www.fhwa.dot.gov/civilrights/programs/doj_fhwa_ta_glossary.cfm)

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

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

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

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

**Goal Three: By 2025, expand transit coverage so that 90% of the public transportation service areas in 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](#)."<sup>39</sup>

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

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<sup>39</sup> Greater Minnesota Transit Investment Plan is available at <http://www.dot.state.mn.us/transit/reports/index.html>.

**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%.<sup>40</sup>

- 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%

## **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.

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<sup>40</sup> 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.

- 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 \(STIP\)](#).<sup>41</sup>
- MnDOT will continue to work with our local partners through our project development process to encourage additional accessibility improvements whenever possible.

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<sup>41</sup> More information on STIP can be found at [www.dot.state.mn.us/planning/program/stip.html](http://www.dot.state.mn.us/planning/program/stip.html)

### **Increase Involvement in Transportation Planning by People with Disabilities**

- MnSHIP was updated in 2017 and the investment levels will be reassessed as part of the plan update. MnSHIP is developed with significant public input and sets investment targets, including those for accessibility improvements, for the agency based on system conditions and revenue.

### **Improve the Ability to Assess Transit Ridership by People with Disabilities**

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

### **Improve Transit Services for People with Disabilities**

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

### **Responsible Agencies**

- Department of Transportation
- Metropolitan Council

## Healthcare and Healthy Living

### Stakeholder Comments

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

### What this topic means

**Healthcare** is “the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.”<sup>42</sup>

**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.”<sup>43</sup> 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.<sup>44</sup>

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

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<sup>42</sup> American Heritage Medical Dictionary, “Healthcare.” Boston: Houghton Mifflin Harcourt Publishing, 2008, 236.

<sup>43</sup> Minority Health and Health Disparities Research and Education Act of 2000, [United States Public Law 106-525](http://www.gpo.gov/fdsys/pkg/PLAW-106publ525/pdf/PLAW-106publ525.pdf), available at <http://www.gpo.gov/fdsys/pkg/PLAW-106publ525/pdf/PLAW-106publ525.pdf>.

<sup>44</sup> As examples of studies showing health disparities for people with disabilities, review CDC [“Disability and Secondary Conditions” in Healthy People 2010](http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review_focus_area_06.pdf), (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](http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/02/mental-disorders-and-medical-comorbidity.html), February 2011, Robert Wood Johnson Foundation. Accessed March 31, 2022, <http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/02/mental-disorders-and-medical-comorbidity.html>.

## Vision statement

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

## Measurable goals

**Goal One: By December 31, 2022, 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, 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, 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, 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](https://mn.gov/dhs/assets/Dental_report_2015_tcm1053-166332.pdf)” ([https://mn.gov/dhs/assets/Dental\\_report\\_2015\\_tcm1053-166332.pdf](https://mn.gov/dhs/assets/Dental_report_2015_tcm1053-166332.pdf))
- Implement the “[Minnesota Oral Health Plan](https://www.health.state.mn.us/people/oralhealth/contact/stateplan.html)” (<https://www.health.state.mn.us/people/oralhealth/contact/stateplan.html>)
- Increase the number of providers and the level of access of people with disabilities to providers.

### Expand the Use of Health Care Homes and Behavioral Health Homes

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

### Improve Access to Health Care for People with Disabilities

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

### Develop key questions that will identify disparate health outcomes for people with disabilities

- MDH will expand data collection standards for people with disabilities across existing health care measures.
- Analysis of this data will identify areas of disparities and recommendations for interventions.

## Responsible Agencies

- Department of Human Services
- Minnesota Department of Health

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## Positive Supports

### Stakeholder Comments

- “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.<sup>45</sup> 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.

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<sup>45</sup> 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, 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.**

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, 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.**

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<sup>46</sup>, 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 emergency use of mechanical restraints, other than use of an auxiliary device<sup>47</sup> will be reduced to no more than 88 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, other than auxiliary devices:

- By June 30, 2020, reduce mechanical restraints to no more than 93 reports
- By June 30, 2021, reduce mechanical restraints to no more than 93 reports
- By June 30, 2022, reduce mechanical restraints to no more than 88 reports

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<sup>46</sup> Forensic Services (formerly known as MSH) is governed by the Positive Supports Rule when serving people with a developmental disability.

<sup>47</sup> Auxiliary devices ensure a person does not unfasten a seat belt in a vehicle and includes seatbelt guards, harnesses and clips.

**Goal Four: By June 30, 2024, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 735 students or decrease to 1.94% of the total number of students receiving special education services.**

Baseline: During school year 2018-2019, school districts (which include charter schools and intermediate districts) reported to MDE that 3,603 students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting. In 2018-2019, the number of reported students receiving special education services was 147,605 students. Accordingly, during school year 2018-2019, 2.4% 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, 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
- 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, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 3,615 or by 1.0 incidents of restrictive procedures per student who experienced the use of restrictive procedures in the school setting.**

Baseline: During school year 2018-2019, school districts (which include charter schools and intermediate districts) reported 22,772 incidents of emergency use of a restrictive procedure in the school setting. In school year 2018-2019, the number of reported students who had one or more emergency use of restrictive procedure incidents in the school setting was 3,603 students receiving special education services. Accordingly, during school year 2018-2019, there were 6.3 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, 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.
- 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](#)<sup>48</sup>, 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 years. In 2020, the number of individuals experiencing a restrictive procedure was 561 and the number of BIRF reports of restrictive procedures was 3,126.
- 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

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<sup>48</sup> 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, there are 803 or 39% of Minnesota schools implementing PBIS, impacting an estimated 378,000 students (43% of total students).
- Continue collaboration between DHS and MDE to build system capacity locally engaging with schools, providers, counties, tribes, people with disabilities, families, advocates, and community members. 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](https://mnpssp.org/) website (<https://mnpssp.org/>).
- Continue implementation of training for the Department of Corrections staff on crisis intervention teams, motivational interviewing, traumatic brain injury, and Aggression Replacement Training (ART)<sup>49</sup> 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 number of incidents or applications of restrictive procedures; and (3) to identify situations to be targeted for technical assistance.

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<sup>49</sup> 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.

- 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 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 district grants 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<sup>50</sup> 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. Stakeholders within the workgroup will use this information to inform the development of trainings and resources. Resources and other information gathered and reviewed will be shared with the public.
- 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

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<sup>50</sup> 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.

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

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

### What this topic means

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

### Vision statement

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

### Measurable goals

**Goal One: By June 30, 2022, 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, 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%
- By June 30, 2022, the percent who remain in their community after a crisis will increase to 85% or more

**Goal Two: By June 30, 2022, 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% 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, 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.

**Goal Four: By June 30, 2022, 80% of people in community hospital settings due to a crisis, will have a stable, permanent home within 5 months after leaving the hospital.**

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, 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

#### **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 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 varies yearly. Using a percentage measure allows for fluctuations in the total number of individuals receiving services in a year.

## **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)

- 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)
- 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 Infrastructure of Crisis Services System**

- DHS will expand Mobile Crisis Services by strengthening the state's mobile crisis infrastructure through ongoing increases in financial support to counties and tribes to staff 24-hour mobile crisis lines and increase capacity to take more calls. There will be additional tracking of call volume in the Minnesota Health Information System (MHIS) as well as additional data from the Suicide Lifeline centers who will be tracking the calls that result in a mobile crisis warm transfer. This includes collaboration with the Minnesota Department of Health for data sharing.
- DHS will increase capacity for children crisis response and community stabilization to increase outpatient access, including same-day or next-day appointments, for those in crisis. This will aid in keeping children in the community, by supporting them until long term mental health services are available.

#### **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.

### **Ensure Crime Victims with Disabilities have Access to Support Services**

- Provide training to programs serving crime victims so they will have a better understanding of the broad scope of disabilities, and a common understanding of how their program can improve safe, accessible options for crime victims.
- DPS will conduct a needs assessment to identify accessibility barriers in crime victims service program sites, and then create a plan to enhance accessibility in collaboration with Office of Justice Programs, crime victims and crime victim service providers.
- Programs will develop capability to define accessibility, understand what services are needed for crime victims with disabilities, and how to evaluate their program strengths and areas needing improvement to better serve crime victims with disabilities.
- Shelter programs will have a better understanding of disabilities survivors experience and a common understanding of how their shelter programs can improve safe, accessible options for survivors.

### **Develop a Juvenile Justice-Mental Health Continuum of Care that Aids Juvenile Justice Facilities and Child Welfare Service Staff in Coordinating their Response to Mental Health Crisis**

- Identify and address geographic, racial, cultural and socioeconomic gaps in mental health services.
- Develop process for consistent, collaborative communication and follow-up between facilities and treatment providers.
- Develop and distribute an updated inventory of all available service and placement options to facilities and providers
- Develop process to ensure placement and treatment is determined by criteria specific to each individual.
- Minnesota Juvenile Justice Advisory Committee's (JJAC) Mental Health Subcommittee will collaborate with DHS and MDH to develop the model.
- This work will begin January of 2022.
- Facilities and service providers will be provided the continuum tool with technical assistance provided by JJAC, DHS and MDH.

### **Responsible Agencies**

- Department of Human Services
- Minnesota Department of Education
- Department of Public Safety

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## Community Engagement

### Stakeholder Comments

- “Give people a chance to show that we can do it, yes, we can. Everybody deserves a chance and everybody learns differently. Everyone has a dream where they want to live, work and be happy.” (Patricia Ann Wallace, 2013)
- “By including self-advocacy, peer-to-peer support, and leadership training into the Olmstead Plan, self-advocates would have an increased ability to create change within the system that impacts their lives on a daily basis.” (Laura Birnbaum, 2013)

### 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).

The Community Engagement Plan being implemented by the Olmstead Implementation Office includes goals and strategies related to improving communication, coalition building and outreach, and supporting the Olmstead Plan amendment process.

The Community Engagement Plan is built on the following principles to achieve meaningful, effective and inclusive community engagement:

1. Humanity, Dignity and Empowerment  
*“We are the experts of our own lives.”*
2. Person-Centered Listening and Learning  
*“Listen to each person’s dreams and hopes for their life and community.”*
3. Diversity, Accessibility and Equity  
*“Proactively bring under-represented communities to the decision-making table by removing barriers to engagement and participation.”*
4. Transparency and Accountability  
*“Be clear about how the Subcabinet sets goals, how public input informs the process, and who is accountable for implementing the Plan.”*
5. Active Leadership, Inclusion and Participation  
*“People with disabilities must be involved in decision-making that directly affect their 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, the number of individuals with disabilities who participate in Governor appointed Boards and Commissions 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 and other Workgroups and Specialty Committees established by the Olmstead Subcabinet:

- 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, 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% 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

## 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 Effective Ways for People with Disabilities and their Supporters to Participate 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 stakeholder groups by raising awareness of the Olmstead Plan and its purpose through social media, enhanced website user experiences, and educational tools.
- OIO will strive to communicate information using plain language, and present materials in multiple languages and culturally appropriate ways.
- OIO will increase accessibility and inclusion by using the latest tools and technologies such as the website, social media, and online meetings.

### **Design and Implement Community Engagement Activities to Increase Participation of Communities with the Greatest Disparities in Health Outcomes and Access to Services**

- OIO will collaborate with community leaders to identify authentic, culturally appropriate messages.
- OIO will actively seek out ways to encourage members to participate in public meetings and other activities using social media and other engagement tools.

### **Build Coalitions and Enhance Outreach Efforts to Build Statewide Awareness of Minnesota's Olmstead Plan among all Minnesotans**

- OIO will convene interagency workgroups to explore barriers and address disparities to providing services and meaningful opportunities for all Minnesotans.
- OIO will convene a Community Input Group (CIG) to provide input into the effectiveness of OIO communication and engagement activities to target audiences and provide recommendations for improvement.

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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<sup>51</sup>) 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.
- 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

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<sup>51</sup> 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.

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, the Subcabinet expects to convene a workgroup to identify recommendations that might be best addressed through broader community action.

#### **Goal Two: By December 31, 2022, the number of cases of vulnerable individuals being treated due to abuse and neglect will decrease by 15% 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 December 31, 2020, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 5% compared to baseline
- By December 31, 2021, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 10% compared to baseline
- By December 31, 2022, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 15% 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, establish a baseline and annual goals

**Goal Three: By December 31, 2022, 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
- By December 31, 2022, the number of people who experience more than one episode will be reduced by 20% compared to baseline

**Goal Four: By July 31, 2025, the number of students with disabilities statewide identified as victims in determinations of maltreatment will decrease by 25% compared to baseline.**

Baseline: From July 2017 to June 2018, there were 32 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, 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 conducted to review and update appropriate abuse and neglect codes as codes to better identify individuals who are vulnerable. This includes individuals who receive services licensed by either MDH or DHS.
- 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 data year includes 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**

- 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 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.”<sup>52</sup>

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.<sup>53</sup>

Other Technologies will become more prevalent as Minnesota adopts 21<sup>st</sup> 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.

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<sup>52</sup> 20 U.S.C. Chapter 33, Section 1401 (25)

<sup>53</sup> 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 2021, STAR loaned 482 assistive technology devices to 482 Minnesotans for short-term use. Of the device loans made, 400 were to assist the individual in determining if the AT met their needs. Of that group, 99.6% 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 2021, STAR demonstrated 209 assistive technology devices to 263 Minnesotans. Of the 209 demonstrations conducted, 99.4% 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 2021, 246 Minnesotans received AT through this program, saving consumers \$531,585.
- **Minnesota Assistive Technology for All website:** As of October 2021, Minnesotans can access the Minnesota Assistive Technology for All website<sup>54</sup> to learn about equipment that is available for short or long-term loans. After creating an account on this online device library, borrowers can request device demonstrations or loans online.
- **Minnesota's Guide to Assistive Technology website:** In June 2018, a cross-agency assistive technology workgroup launched Minnesota's Guide to Assistive Technology website<sup>55</sup> 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. In 2021, the cross-agency assistive technology workgroup was reconvened and meets regularly. Website reviews are ongoing and revisions will be made as appropriate.

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<sup>54</sup> Minnesota AT for All website is available at <https://mn.at4all.com/>

<sup>55</sup> Minnesota's Guide to Assistive Technology website is available at <https://mn.gov/admin/at/>

## **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.

## **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 strategies throughout the Plan.

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, tribes, 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 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. The agencies develop the workplans to encompass anticipated action items over 1-2 years.

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.

## 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 up to 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 Leadership Forum on a quarterly basis and to the Subcabinet on a semi-annual 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.

## 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 second follow-up survey was conducted from August 2020 through February 2021. The [Olmstead Plan Quality of Life Survey: Second Follow-Up 2020 Final Report](#) was presented to the Subcabinet and accepted in April 2021. A total of 561 people completed the survey. This included 509 who participated in the baseline survey and 52 who were added to the sample (oversampled) to allow a more nuanced understanding of experiences of people who are Black, Indigenous and People of Color.

Highlights from the Second Follow-Up Survey include:

- The survey measures quality of life over time for a specific population in Minnesota: people who access services in potentially segregated settings. The overall quality of life score remains unchanged since 2017 (76.6 in 2017 compared to 77.6 in 2020). Despite millions of dollars in investments and well-intentioned initiatives, the needle on quality of life has not moved since 2017. In many areas, this data indicates a continued decline in integration that the State must reverse.
- The survey detected no definitive changes in the key elements measuring quality of life, although Black and multiracial participants reported the lowest quality of life scores.
- Participants had the same amount of power over decisions that affect them as in previous years (66.2 in 2017 compared to 67.4 in 2020). On average, paid staff made big decisions. Participants with publicly-funded guardians had less decision-making control and less integration on their outings than those with no guardian or a private (usually family) guardian.
- The average number of close relationships for participants decreased from 4.1 in 2017 to 3.4 in 2020. This decrease may have been impacted by COVID-19.
- The percent of participants who said they had at least five close relationships decreased from 62% in 2017 to 39% in 2020.

The survey aims to understand participants' daily activities and opportunities for engagement in the four weeks leading up to the survey. This includes how many hours they work, how much time they spend volunteering, how often they visit with friends and family, and how often they participate in community events.

- Participation in work, day programs and school declined dramatically, from 80 in 2018 to 44 in 2020.
  - Participants engaged with their communities far less. On average, participants had 16.9 outings per month in 2020 compared to 30.5 in 2018.
  - Individuals interacted with people in the community far less, from 36.5 in 2018 to 20.1 in 2020.
- COVID-19 had a clear impact on survey participants and findings. At the same time, we know from the 2017 and 2018 surveys that the pandemic is not the only factor that has stalled progress. Previous

surveys show that segregation was a problem before the pandemic disrupted day programs and social opportunities. In some instances, participants shared how providers and staff enforcing COVID-19 restrictions lowered their quality of life. We must document these impacts because this may be the only statewide survey that captured the experiences of people with disabilities in Minnesota during the pandemic.

Participants engaged with their communities far less during COVID-19. Only some could turn to the internet in place of in-person activities. This is partly because access to technology required to join online events is not universal. The survey did not ask whether participants had access to the internet, but 84% took the survey by phone rather than video call.

When asked specifically about COVID-19, 54% of participants said their life got worse during the pandemic because of lost income, fewer opportunities to be social, loss of community, restrictions on visitors, day program closures, and other pandemic-related restrictions. On the other hand, roughly 7% of participants said life was better or much better during the pandemic. One reason they shared was reduced stress from not having to participate in day activities and outings. This shows that people's quality of life could be better if they could make these decisions for themselves.

The results of each Quality of Life survey are 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 are shared with the public on the Olmstead website.

### **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.

## **Communications and public relations**

The OIO has primary responsibility for overseeing and managing communication about the Olmstead Plan with the general public, particularly with people with disabilities. OIO will establish guidelines for communication materials developed by State agencies to ensure they align with Olmstead principles and include plain language versions when appropriate.

In conjunction with State agencies, OIO will produce plain language versions of periodic reports on progress of Plan goals. The reports will provide accurate, timely and useful information about the vision, goals and activities of the Olmstead Plan in meaningful, accessible, and culturally appropriate ways. The reports and other related materials will be published on the OIO website. The desired outcome of these efforts is to raise awareness and understanding of the Olmstead 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, beginning in summer of 2021, the Subcabinet is convening a Workgroup to develop and recommend 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.

## 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. §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:** For purposes of this section, "informed choice" means a choice that adults who have disabilities and, with support from their families or legal representatives, that children who have disabilities make regarding services and supports that best meets the adult's or children's needs and preferences. Before making an informed choice, an individual who has disabilities must be provided, in an accessible format and manner that meets the individual's needs, the tools, information, and opportunities that the individual requires to understand all of the individual's options. [See Minn. Stat. §256B.4905, subd. 1a]

**Informed decision making:** "Informed decision making" means a process that provides accessible, correct, and complete information to help an individual who is accessing waiver services under sections 256B.092 and 256B.49 make an informed choice. This information must be accessible and understandable to the individual so that the individual is able to demonstrate understanding of the options. Any written information provided in the process must be accessible and the process must be experiential whenever possible. The process must also consider and offer to the individual, in a person-centered manner, the following: (1) reasonable accommodations as needed or requested by the individual to fully participate in the informed decision-making process and acquire the information necessary to make an informed choice; (2) discussion of the individual's own preferences, abilities, goals, and objectives; (3) identification of the person's cultural needs and access to culturally responsive services and providers; (4) information about the benefits of inclusive and individualized services and supports; (5) presentation and discussion of all options with the person; (6) documentation, in a manner prescribed by the commissioner, of each option discussed; (7) exploration and development of new or other options; (8) facilitation of opportunities to visit alternative locations or to engage in experiences to understand how any service option might work for the person; (9) opportunities to meet with other individuals with disabilities who live, work, and receive services different from the person's own services; (10) development of a transition plan, when needed or requested by the person, to facilitate the choice to move from one service type or setting to another, and authorization of the services and supports necessary to effectuate the plan; (11) identification of any barriers to assisting or implementing the person's informed choice and authorization of the services and supports necessary to overcome those barriers; and (12) ample time and timely opportunity to consider available options before the individual makes a final choice or changes a choice. [See Minn. Stat. §256B.4905, subd. 3a]

**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](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](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/>

## 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  
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