Olmstead Plan stakeholder feedback on October 2013 draft (10/10–10/31)

This document contains feedback received between October 10, 2013 and October 31, 2013 from the Minnesota Olmstead Plan website and email address. Comments included here refer to the October 2013 draft. Comment numbers continue from the previous stakeholder comments collection. Some text has been redacted to protect the privacy of individuals.

Information in these comments should be used only for Olmstead Planning purposes. **Do not use any identifying information in other documents.** Please review the Olmstead Plan website's Use Policy for more information.

Comment 147

-----Original Message-----
From: *DHS_Webmaster, DHS
Sent: Thursday, October 10, 2013 1:54 PM
Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 10/10/2013 AT 1:53:47 PM

NAME: *[Redacted Text]*
EMAIL: *[Redacted Text]*
DESCRIBE YOURSELF: I have a disability
COUNTY: Minnesota

COMMENTS:
1. It is crucial that corporate adult foster care be considered an institutional/segregated setting. In these settings people with disabilities do not have a choice about who they live with, who provides their services or how they spend their days.

2. People with disabilities need access to quality healthcare. Most doctors offices are not accessible to people with physical disabilities. (http://annals.org/article.aspx?articleid=1666710) It would be helpful for the Department of Health survey the accessibility of doctors offices across the state. This is a particularly serious problem in rural areas where the choices about which doctor to see are are limited.

3. Many people with disabilities who use wheelchairs and other mobility devices have serious barriers to accessing their communities when streets don''t have sidewalks, sidewalks don''t have proper curb cuts, and sidewalks, curb cuts and bus stops are not properly cleared in the winter. It is important for the State to set an expectation for local governments to develop plans to ensure that people with disabilities are able to safely navigate their communities.

Comment 148

-----Original Message-----
From: *DHS_Webmaster, DHS
Sent: Saturday, October 12, 2013 10:30 AM
Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 10/12/2013 AT 10:30:27 AM

NAME: *[Redacted Text]*
EMAIL: *[Redacted Text]*
DESCRIBE YOURSELF: I am a family member of someone with a disability
COUNTY: Dakota

COMMENTS:
Please mandate PCAs to teach skills to their clients, not just hang out with them.
Also, please do something for people with disabilities who don''t speak. We have taught our daughter sign language, but can''t get support for further attainment of. The funding isn''t there. Feel free to contact me for help with this. Thank you so much

---

Comment 149

From: *[Redacted Text]*
Sent: Monday, October 14, 2013 10:00 AM
To: *DHS_OPC Public; Bibus, Beth (MMB)
Cc: sen.bruce.anderson@senate.mn; Sheila.Luehrs@senate.mn
Subject: Commentary on October Olmstead Plan

Good morning -

Thank you for forwarding the October version of the Olmstead Plan. I have reviewed it several times over. I can, again, see the incorporation of more refinements. The piece that is glaringly missing still is the training - the comprehensive training. The findings delineated in the written plan, thus far, noted in the last bulleted point of page 10 of the 83 pages read as follows:

• Training and education will be necessary to overcome inertia and resistance to change. This training must include everyone—the general public; people with disabilities; employers; the state legislature; the executive branch; and state, county and tribal organizations, service providers/employees, and government staff.

The only place where I found such training mentioned as part of this plan was the transportation section....and then only relative to transportation.

It is imperative that the philosophy and "guts" of the Plan and the Promise need to be disseminated, in a meaningful way, to the general public, people with disabilities, employers, state legislature, executive

branch, state, county and tribal organizations, service providers and government staff.....and that it needs to happen much sooner than later.

As we speak, and with as much information out there already, one would think that our county Human Services Agency employees and supervisors would have received clear direction on the philosophy and would be acting accordingly. After all, the Olmstead Act is in place, regardless of whether the Plan is in place.

The subcabinet needs to be fully aware that some county agencies/agents, supported by unenlightened county attorneys, continue to ram-rod their less-than-Olmstead-like practices and determinations on people with disabilities and adversely targeting anyone and everyone who will advocate for the person.

Comprehensive Training Now - the agents need to know that the person with disabilities knows, that the legislator's know that the person knows and the agents know, that the Executive branches at the state and county level know what the rest of them know, and that the service provider's know. ..... how thing are intended to work under the promise of Olmstead..

And beyond that, the same people/agencies/providers need to have a clear understanding as to what will happen when that Promise is intentionally thwarted by any link in the chain. .....Any link..

Thank you,

[Redacted Text]

Comment 150

From: Stemper, Colin (MSCOD)
Sent: Monday, October 14, 2013 2:48 PM
To: *DHS_OPC Public
Subject: MSCOD Olmstead Response

Olmstead Draft Letter.pdf

To whom it may concern,

Please let the attached PDF serve as the Minnesota State Council on Disability's formal response to the latest Olmstead draft plan. Thank you.

Sincerely,

Colin Stemper, MPP
Minnesota State Council on Disability (MSCOD)
121 East 7th Place, Suite 107, St. Paul, Minnesota 55101
(651) 361-7809
www.disability.state.mn.us | Colin.Stemper@state.mn.us
Celeberating 40 years of service

[full text of attached document below]

To whom it may concern,

Established in 1973 by the state legislature, the Minnesota State Council on Disability (MSCOD) was created to advise the governor, state agencies, state legislature, and the public on disability policy. MSCOD advocates for policies and programs that advance the rights of Minnesota with disabilities, and has a vested interest in a positive outcome of the Olmstead planning process. The latest draft plan is a strong step in the right direction.

We are heartened to see that much of our previous feedback has been incorporated into the latest draft plan. Throughout the document, the Sub- Cabinet makes a commitment to collect more data, specifically regarding the transition process, housing, and education. Additionally, the plan sets measurable goals over multiple areas that can be used to determine if the plan is effective. Coupled with the suggestion that the state adopt an Employment First Policy, these features signal that significant progress will be made on employment, housing, and community supports for Minnesotans with disabilities.

Another component we are pleased to see is the amount of training that will take place surrounding this plan. We applaud the education outreach to federal contractors that will occur surrounding the new Section 503 rule. Moreover, training for government employees on performing person- centered planning will be vital to the success of the Olmstead process, and we are happy to see its inclusion.

The transportation section of the draft plan leaves some room for improvement, though. The plan sets actions in motion to gather data on how Minnesotans with disabilities use current transportation options in order to identify successes and areas for improvement. However, it is not clear what will be done once this baseline is established. What does the Sub-Cabinet propose doing with this information once it is collected? While gathering this data will prove useful, we can only speculate on the impact of its collection at this point.

This version of the Olmstead plan showcases the areas where MSCOD may assist the Sub-Cabinet and, when created, the Olmstead Implementation Office. In the future, we hope to be of assistance as this office monitors legislation that affects Minnesotans with disabilities. We also have a role to play on the Interagency Employment Panel and the Employment Practice Review Panel. We look forward to the positive role MSCOD can play in carrying out the vision of Olmstead.

Overall, this draft has filled in many details that were absent in previous plans. We look forward to the next draft plan and the subsequent inclusion of the Health Care and Healthy Living sections.

Sincerely,

Joan Willshire
Executive Director
Minnesota State Council on Disability

Comment 151

From: Heidi Kammer [mailto:hkammer@Resource-MN.org]
Sent: Tuesday, October 15, 2013 1:51 PM
To: *DHS_OPC Public
Cc: Heidi Kammer; Kelly Matter
Subject: Comment on Olmstead


201310151347.pdf

Good afternoon,

Please find attached the comment from RESOURCE.

Heidi

Heidi Kammer MSW, LICSW, LADC
RESOURCE, Inc.
1900 Chicago Avenue South
Minneapolis, MN 55404
612.752.8092 phone
FAX 612.752.8001 or 612.752.8051
hkammer@resource-mn.org
For over 50 years, RESOURCE has been empowering people to achieve greater personal, social and economic success. We do this by providing employment, training, chemical-health, mental-health, and disability services to help people discover their potential and achieve their dreams. Please visit us online at: www.resource-mn.org.

[full text of attached document below]

To Members of the Olmstead Subcabinet:

On behalf of RESOURCE I am submitting these comments regarding Minnesota's draft Olmstead plan released September 11, 2013 and Olmstead planning process generally. RESOURCE's mission is to empower people to achieve greater personal, social and economic success. We are committed to undoing racism and promoting diversity. We achieve our mission through provision of comprehensive mental and chemical health and workforce development services.

Minnesota's Olmstead plan will have far reaching implications for people with substance use disorders and/or mental illnesses but there has been very little engagement with mental health and chemical health communities throughout the planning process. We are deeply concerned that the needs of people with substance use disorders and/or mental illnesses are not reflected in the draft plans released to-date. We strongly urge you to create a separate section of the Olmstead plan dedicated to mental health and chemical health that is based on input from people knowledgeable about these issues.

The draft plans are overwhelmingly aimed at serving people with developmental and physical disabilities and focus almost exclusively on services and supports for those communities and show a lack of understanding about services and supports for people with mental health and chemical health needs.

With the proper treatment and supports people with substance use disorders and/or mental illnesses can recover. While some people will live with the symptoms of their illness for much of their lives, for many, the right treatment and support can reverse the disabling effects of their illness or prevent it from becoming disabling in the first place. This concept of "recovery"- that people can and do get better- needs to be an integral part of the Olmstead plan.

We also want to move our systems away from a "fail first" model where people must be overwhelmed by the symptoms of their illness and cycle in and out of the hospital, homelessness, the criminal justice system, etc. before receiving intensive services. Instead we want a system of care that provides comprehensive treatment services earlier to prevent people from having their lives significantly disrupted. Unfortunately, this focus on "early intervention" is not reflected in the draft plans.

The draft plans also do not address the need for broad continuum of chemical and mental health care that includes timely access to intensive treatment and services for those who need it. For our communities, accessing the right services at the right time is more important than the notion of the "most integrated" or "least restrictive" settings. While these concepts are extremely important, we also want people to be able to access more intensive treatment when they need it so they can get better and move on with their lives.

Thank you for the opportunity to comment

Heidi Kammer MSW, LICSW, LADC
RESOURCE
hkammer@resource-mn.org 612.752.8092
1900 Chicago Ave S., Minneapolis, MN 55404 (612)752-8001, TDD (612) 752-8019

Comment 152

From: Don Lavin [mailto:donl@arcmn.org]
Sent: Thursday, October 17, 2013 7:06 AM
To: *DHS_OPC Public
Cc: Steve Larson
Subject: Comments on Revised Olmstead Plan

The Arc Minnesota
Olmstead Letter.docx

Greetings,

I have attached comments on the revised Minnesota Olmstead Plan. These comments pertain to the transition of youth and employment of youth and adults with disabilities. Expect to see additional letters from The Arc Minnesota on other sections of the Plan.

Thank you!

Don Lavin
Interim Executive Director, The Arc Minnesota
800 Transfer Road, Suite 7A
St. Paul, MN 55114
Phone 651 604 8088 Fax 651 523 0829
donl@arcmn.org www.thearcofminnesota.org

[full text of attached document below]

Dear Lt. Governor Prettner Solon and OImstead Sub-Cabinet Members,

On behalf of The Arc Minnesota, we would like to express our appreciation to the Governor's Olmstead Planning Sub-Cabinet for its hard work, and on the development of a vastly improved working document! The October draft of Minnesota's Olmstead Plan offers much greater clarity in its vision as well as an improved framework for guiding inclusive community living and competitive employment of Minnesota's residents who live with disabilities. The Arc especially appreciates the Sub-Cabinet's efforts to link critical elements of the plan because it is challenging to achieve measured success in one area without a coordinated overlap with other critical areas including housing, education, employment, transportation, and social engagement opportunities. The revised plan offers a more coherent blueprint for improving public policies, encouraging better practices and partnerships to obtain tangible goals, and standardizing a framework for measuring our success through outcome metrics.

The Arc Minnesota has been working for decades on many provisions articulated in Minnesota's revised Olmstead Plan. The Arc's written position statements in such areas as self-determination, inclusion, education, employment, human and civil rights, housing, advocacy rights protection, and community engagement are closely aligned with values and transformational goals clearly established in the revised Plan. Although we see opportunities for improving this Plan, The Arc is excited by its promise to address unfinished business. For this reason, The Arc intends to a significant partner with the State of Minnesota in improving public policies and promoting promising practices so the broad community integration goals of youth and adults with intellectual and developmental disabilities are addressed and achieved.

In this letter, we would like to offer comments on specific sections of the Olmstead Plan pertaining to transition of youth and competitive employment of working-age youth and adults with disabilities. Expect to see additional comments and recommendations from The Arc Minnesota with respect to other sections of the Plan.

First, The Arc Minnesota is very excited to see a wider adoption of "Employment First" principles by Minnesota's State agencies and establishing an early timeframe to launch an Employment First Policy in Minnesota. Bravo!! An Employment First Policy is consistent with The Arc's Position Statement on

Employment that promotes the rights, abilities, and capacities of job seekers with intellectual and developmental disabilities to work in the right job at equitable, comparable pay and benefits with the right level of employment support.

It is well-documented people with intellectual and developmental disabilities are vastly underrepresented in the competitive labor force. And the State of Minnesota will not achieve measurable improvements following the same public policies and continuing the same disability support practices presently in force. A well-written Employment First Policy will not only raise the bar of public expectations about competitive employment but encourage new ways of thinking and engaging strengths-based employment practices to secure better outcomes. In implementing an Employment First Policy, Minnesota will join more than 25 states that have either implemented a formal legislative policy or Governor's Executive Order encouraging competitive employment as the first option.

The Arc would like to offer a few suggestions to strengthen the transition and employment sections of the plan. First, it is extremely important for the State of Minnesota to define what "Employment First" means to insure clarity as well as consistency in adopting statewide, cross-agency performance measurement standards. In 2007, the Minnesota Employment First Coalition adopted a working definition in its Employment First Consensus Summary Report. As a leader in the national Employment First movement, the Coalition has refined its definition and offers this recommended language: Employment First is the initiative to align vision, policies, resources, and practices to increase competitive employment in the general workforce, with or without supports, as the outcome of working-age citizens with disabilities, regardless of the level of disability. It is employment in which the individual is employer-paid and receives minimum or prevailing wages and benefits or is self-employed, and offers ordinary opportunities for integration and interactions with co-workers without disabilities, with customers, and/or the general public.

The overarching vision of Minnesota's draft Olmstead Plan is to support people to live, learn, work, and participate in the most integrated community settings. So it follows logically that integrated competitive employment in the workforce on the payroll of a business, at minimum or market rate wages and benefits, is the desired, optimal outcome. The Arc, therefore, recommends competitive employment is the appropriate standard of measurement to gauge Minnesota's performance progress over time. While other employment definitions and approaches are being used to support people with disabilities in Minnesota, establishing competitive employment (with or without supports) as the desired performance standard encourages optimum levels of inclusion as well as pursuit of natural workforce conditions.

In addition, The Arc strongly endorses principles of individual choice and self-determination. While individual choice is generally presumed a philosophical underpinning in many public policies and planning practices, "informed choice" is simply not occurring with respect to the competitive employment of youth and adults with disabilities. Minnesota needs to elevate the "choice" conversation because there is a clear lack of alignment in what people say they want (competitive jobs) and the outcomes attained. The expressed preferences of people with disabilities to be working, earning money, and using their talents, is inconsistent with annually reported outcomes regardless of the governmental entity. In Minnesota, less than three out of ten adults with intellectual and developmental disabilities

are actively working in competitive jobs. We can do much better than this! However, success is intentional. It will require reforms in shared expectations, policies, practices, in addition to rebalancing our public investments to adequately support proven employment practices and drive better outcomes.

Minnesota's Olmstead Plan needs not only to increase choices but also to actively encourage informed choices by people with disabilities, family members, and others who support them. Needless to say, stubbornly-held stereotypes and low expectations are common barriers blocking the competitive employment and post-secondary education and career training pathways of youth and adults with disabilities. "Informed choice" needs to be operationally defined in Minnesota so the range of options available to individuals is not reduced to answering simple yes or no questions. The truth is many youth and adults with significant disabilities lack adequate life experiences to fully grasp the range of choices and opportunities open to them. Informed choice can be operationalized by requiring a range of helpful experiential strategies. To illustrate, this could include: (1) disseminating facts about working with a disability, (2) promoting financial literacy such as understanding the economic implications of working and not working, (3) improving knowledge about disability benefits, Social Security work incentives, and healthcare planning, (4) speaking directly with self-advocates/peers and families who have experienced the benefits as well as challenges of integrated employment, (5) participating in guided tours of businesses to observe people with significant disabilities who are successfully employed, (6) learning about the use of assistive technologies or emerging practices such as discovery and customized employment, (7) securing a roster of organizations and/or professionals with proven track records in supporting individual job seekers obtain competitive employment success, and/or (8) engaging in other experiential activities such as time-limited job tryouts or work internships to affirm the values of a working life.

In summary, informed choice cannot be about checking boxes on a form but rather supporting people to process and weigh relevant, factual, and experiential information to make a personal decision. Person-centered planning practices can be modified to support these activities and raise the bar of expectations as well as connections to helpful community resources.

The Arc Minnesota is also pleased to see the Plan continues to focus on school-to-career transition of youth with disabilities. We appreciate that the Plan addresses the importance of increased access to both post-secondary education and training as well as competitive employment, and establishes performance benchmarks for schools to engage in evidence-based practices. The genesis of expectation begins in the formative years of childhood so it is very important for middle, secondary, and post-secondary schools to play a fundamental role in encouraging and preparing youth and families for a working life in adulthood. The Arc sees a valuable role it can play as a core partner during these school transition years working with both families and youth to fill information gaps, support informed choice, assist with connections to local community resources, and addressing individual advocacy needs.

The Arc Minnesota would like to advise the Sub-Cabinet about the importance of strengthening the workforce development training elements of the Plan so individuals with disabilities, family members, educators, business leaders, and the adult support professionals are better prepared and equipped with new skill sets they will need to obtain higher levels of competitive employment participation. Successful

organizational and systems change will require a well-trained workforce that: (1) understands the importance of redirecting service approaches; and (2) holds the technical knowledge to implement researched, evidence-based employment practices. The need for a better trained workforce cannot be underestimated in Minnesota's formula for producing better outcomes. This is especially true in our goal to guide the employment journeys of job seekers with the most complex and significant disabilities.

Finally, The Arc Minnesota believes funding strategies in support of individuals served under Home and Community-Based Waivered Services in Minnesota need to be strengthened to improve competitive employment opportunities and outcomes. Funding of individualized employment supports for persons served via Medical Assistance (MA) Waivered Services, for example, remains problematic and tends to favor maintenance of traditional, congregate service models and approaches. The recent MA rate restructuring process in Minnesota has accomplished little to motivate service providers or to incent new investments in the competitive employment of individuals with intellectual and developmental disabilities. For this reason, The Arc encourages Minnesota to consider wider, cross-agency adoption of strategies that adequately fund and reward individual competitive employment and wage outcomes similar to the Extended Employment funding formula currently used by DEED. If Minnesota's intent is to rebalance its performance in the direction of higher participation rates in competitive employment, then it must advance an adequate mix of funding by all State agencies to increase competitive employment outcomes to desired goals. Good intentions aside, existing funding formulas in the MA Waiver Service Menu tend to reinforce the status quo and offer few organizational or community incentives to take on reasonable risks in pursuit of new service directions, approaches, and practices.

In summary, while it's important for people to understand they have choice it is equally important to understand the consequences of these choices. Since competitive employment is a critical lynch pin to attaining other quality of life goals, Minnesota needs to encourage all citizens to consider the full possibilities and advantages of "a working life" as they make an informed choice that is optimal for them. Of course, this does not mean everyone will choose work. However, fundamental changes as proposed will help to attack the roots of low expectations and reinforce a core vision in Minnesota that anyone, including job seekers with significant disabilities, can obtain success in competitive employment with the right goals, practices, financial support, and partnership of a willing employer (unless self-employed).

Thank you for this opportunity to share comments about Minnesota's revised Olmstead Plan. And once again, The Arc congratulates the Sub-Cabinet for producing a working document that is bold but advances life opportunities and choices through carefully planned systems improvements. The Arc Minnesota, and its 12 regional chapters serving Minnesota's communities, stands ready to assist in any way possible to fulfill the promise of the Plan. Please feel free to call on us!

Best wishes,

Don Lavin
Interim Executive Director

Comment 153

From: Steve Larson [mailto:stevel@arcmn.org]
Sent: Thursday, October 17, 2013 10:50 AM
To: *DHS_OPC Public
Cc: Don Lavin; Mike Gude
Subject: Olmstead Comments

See attached comments.

Olmstead Comments 10.17.13.doc

Steve Larson
Senior Policy Director
The Arc of Minnesota
800 Transfer Road
Saint Paul, MN 55114

Office - 651 604 8077
Cell - 651 334 7970
stevel@arcmn.org

[full text of attached document below]

October 17, 2013

Dear Lt. Governor and Subcabinet Members:

Thank you for this comprehensive draft that strongly promotes self determination and accessing services and supports in the most integrated setting. The Arc Minnesota has been promoting these concepts for years and we hope that the Olmstead Plan will be the catalyst for substantial progress in these areas in years to come.

Nursing Home residents under 65, Intermediate Care Facilities/Developmental Disabilities (ICF/DD) residents, and Regional Treatment Center residents under 65 should have their needs highlighted upfront in our Olmsted Plan (p. 41). The original Olmstead Decision gave the right to these individuals living in institutions to live in the most integrated setting.

This draft Plan has the modest goal of moving 90 people by 12/31/14. We ask that this goal be reconsidered and that a more aggressive goal be established. The Plan should upfront acknowledge that there are 1300 (?) Minnesotans with disabilities under 65 living in nursing homes, 1700 residing in ICF/DD's, ____ individuals with disabilities living in St. Peter, and ____ individuals with disabilities living in the Anoka Metro Regional Treatment Center. Minnesota's Olmstead Plan must make the movement of these individuals a top priority. Funding is not an issue. Minnesota has a multi-million dollar federal

grant now called Moving Home Minnesota which should be prioritizing meeting the needs of these individuals.

Some areas that need to be more thoroughly addressed or strengthened include:

- Waiting Lists – Minnesota has 3000 individuals on the waiting list for the Developmental Disabilities waiver. The Plan should acknowledge this and have specific timeframes and goals for meeting the needs of these individuals.
- Quality Assurance and Accountability – Minnesota has done an inadequate job of promoting and measuring quality in our home and community based services. Legislation was passed in 2011 that established the Statewide Quality Council with the mission to develop a plan and structure to improve the quality of our services and supports. We support the strategies to measure quality in this current draft but would like to see them integrated with the work of the Statewide Quality Council.
- Timeframes & Goals – as stated above we support the philosophical direction of the October 8th Draft Olmstead Plan. However, we would like to see more specifics. What are the top ten or twenty goals that we will be publicly reviewing every year to measure our progress? Process goals are important (i.e. 500 individuals trained in person centered planning) but that does not measure outcomes. The current draft has hundreds of excellent goals but we need to focus our efforts on some very visible and public measures. A great example of this is found on page 34. The indicator – "Increase in percentage of persons on public funding who have a lease or own their own home." We agree that this is a great indicator to measure self determination and should be reviewed annually.
- On p. 49 in the second paragraph the second sentence reads "There are individuals with disabilities who are not able to participate in community life in ways that are personally meaningful, regardless of where they live and regardless of whether or not they receive publicly-funded services." This seems like an odd and inappropriate statement for an Olmstead Plan. We request that this sentence be deleted from the Plan.

Finally the Draft Plan emphasizes throughout the document self determination. The Arc Minnesota believes the most effective way to move towards a more self directed system is to implement this vision:

> *The Arc's vision for the future is that individuals with intellectual and developmental disabilities (I/DD) will have an annual budget allocation; will have clear guidelines about how they can spend it: will know how they will be held accountable; and, with appropriate support, will then be able to design their own services and supports to best meet their needs, goals, and dreams.*

3000 Minnesotans currently utilize Consumer Directed Community Supports which allows them to control their individual budgets. Minnesota is moving to a similar model for current PCA recipients when they implement Community First Services and Supports (CFSS). Let's accelerate self determination by developing a plan to make individual budgets available to all Minnesotans with disabilities who are on Medical Assistance and receive long term services and supports.

Thank you for your great work.

Sincerely,

Steve Larson
Senior Policy Director
651 604 8077
stevel@arcmn.org

Comment 154

From: Carol Rydell [mailto:crydell@kaposia.com]
Sent: Thursday, October 17, 2013 11:49 AM
To: *DHS_OPC Public
Cc: Carol Rydell
Subject: Comments on October Draft of Olmstead Plan

Joint Comments Submitted by the Employment First Coalition and Minnesota APSE Via Email on October 17, 2013

Dear Lieutenant Governor Prettner Solon and the Olmstead Plan Subcabinet:

The Employment First Coalition and Minnesota APSE appreciate the opportunity to comment on the employment sections of the October draft of the Olmstead Plan. Our comments can be summed up in two words – "Well done!" We are excited that Minnesota will join other states in the nation in developing an Employment First policy. Although Minnesota is not among the first states to adopt Employment First policies, we feel the state has "leap-frogged" over other Employment First states with some of the timelines and activities specified in the Plan. We look forward to partnering with you on moving the Plan forward and making "Employment First" a reality in Minnesota.

One addition we would suggest for the final Plan is to define "Employment First." We propose the following definition:

Employment First is the initiative to align vision, policies, resources, and practices to increase competitive employment in the general workforce, with or without supports, as the first and preferred outcome of working-age citizens with disabilities, regardless of the level of disability. It is employment in which the individual is employer-paid and receives minimum or prevailing wages and benefits or is self-employed, and offers ordinary opportunities for integration and interactions with co-workers without disabilities, with customers, and/or the general public.

We want to make one additional comment about the plan that impacts not only employment, but also the broader scope of the Plan. Peer support and self-advocacy are important components of support and service in Minnesota. Minnesota has a rich history of working with consumer advocates and consumer advocacy organizations. Self-advocacy and peer support are recognized as essential to improving quality of life outcomes and ensuring that individuals with disabilities are not just "recipients" of services but instead exercise choice and self-determination in their lives. As individuals with disabilities take on the role of "directing" their supports and services, they become less reliant on paid supports and better able to access peer networks and natural supports. We would recommend more

attention to self-advocacy and peer support networks in the final Plan and would suggest that they be included in the section on "Supports and Services" rather than in "Community Engagement."

We believe the employment section of the October draft of the Olmstead Plan has improved greatly over the June draft of the Plan. We appreciate the hard work of the Subcabinet and their colleagues to ensure that Minnesota is a leader in Employment First.

Submitted on behalf of the Employment First Coalition and Minnesota APSE

Carol Rydell
Kaposia, inc.
380 E. Lafayette Freeway South
St. Paul, Minnesota 55107
Phone: 651-789-2815

Steve Piekarski
President
Minnesota APSE

Comment 155

From: Scott Schifsky [mailto:scotts@arcmn.org]
Sent: Friday, October 18, 2013 10:04 AM
To: *DHS_OPC Public
Cc: Don Lavin; Steve Larson
Subject: Olmstead comments from Scott Schifsky The Arc Minnesota

Greetings,
I want to first of all thank the sub cabinet for your diligent work in preparing Minnesota's Olmstead plan. I have observed a great deal of good pieces written throughout the document. Below are just a few suggestions that I hope you will consider as you finish your work. You are operating on a tight work schedule and thanks so much for your efforts.

I have a particular interest in housing and your document points to a variety of options that move towards full integration. Here are my thoughts.

Page 32
There are additional energy programs that are available within power company coops throughout Minnesota that offer assistance with energy costs. Many people are not aware of them and it would be important to make this citation in effort to raise awareness and assure people know where to go and how to fill out the applications.

Page 33
"A note about measuring integration and choice in housing."
Could you consider a statement that would offer fully integrated housing presented as the first option for any person with a disability regardless of the severity of their disability? I would define fully integrated housing as: The person with a disability is the owner or has their own lease and that a

service provider does not control the housing. Also, the person would be living in a place that is not over concentrated with other people with disabilities. This would basically mean an apartment, duplex, etc. that is typically rented by people who do not have disabilities.

Page 33 10th bullet
"Unit is not in a building that also provides inpatient treatment, or is adjacent to……." Could you also consider adding that the building should not be controlled by a provider of direct service?

Page34 Primary indicators
May I ask that there be specific numbers and timelines rather than references to percentages? Could this be more specific please?
Also, could you define "community characteristics?"

Page 35 Action two
I think it is important to acknowledge that there are existing housing that people can rent from and the idea of building more housing specific for people with disabilities is a concern in my opinion. My work with Housing Access Services as a contractor for DHS has proven to show that landlords will rent to people with disabilities as they have stable public funding. If you would be so kind to view the following videos, you'll hear from some people who have rented directly from typical landlords. Moreover, to date Housing Access Services in partnership with counties, DHS, and other organizations have moved 841 people to homes of their own where they are on the lease and are in a typical apartment/lease arrangement that people without disabilities typically access.

HAS Movers: http://www.youtube.com/watch?v=1pVefy7_fKU
HAS Circles: http://www.youtube.com/watch?v=YPvHI0rvQtA

Page 36 GRH and MSA
MSA Housing assistance is a great program. I'm just not quite sure about the concept of combining both programs. My understanding is that MSA dollars come out of the GRH pool. However, as you are aware, MSA Housing Assistance has a specific criteria that is a more self directed service. I would suggest and recommend that the integrity of this state program continue to follow people into their own homes and that the program not saturate into a subsidy that moves in a direction that creates more segregated type housing options.

Lastly, I'd like to just point to a resource that may be helpful as you finalize your draft. Here is a link to a website that provides information on People 1st language. I noticed in the document that there is language that is not written in the person 1st context.
http://www.disabilityisnatural.com/explore/people-first-language

Again, thank you for taking the time to read my comments. I hope they reach you in time and I wish you luck in your efforts and wholeheartedly support your diligent work in moving Minnesota forward.

Best,

Scott Schifsky
Program Director
The Arc of Minnesota
651-604-8055

806 yes that's 806! people have moved to homes of their own with Housing Access Services! Mark your calendars for The Arc Minnesota State Conference November 1 and 2. Visit www.thearcofminnesota.org for details.

Achieve with us!

Comment 156

-----Original Message-----
From: *[Redacted text]*
Sent: Friday, October 18, 2013 12:01 PM
To: *DHS_OPC Public
Subject: my health care and disability problems

I was recently diagnosed with level 4 celiac disease. I have been sick all of my life with various problems that got worse instead of better. i went to various doctors over the years, none of them could figure it out. I finally got the diagnosis at age *[Redacted text]*.

so,for *[Redacted text]* years i was not digesting vitamins or minerals, years ago a scientist proved that all disease can be traced to a mineral deficiency

[Redacted text] years of undigested gluten in my stomach caused extrensive damage to my intestines,i can not eat real food,i can only eat food that has been cultured, such as yogart and sauerkraut, bone broths with very soft vegetables in them. these foods are basically predigested, my stomach can not tolerate regular foods at this point.

they have done a lot of research on celiac disease this past year. they have proven that it can effect any organ or system of your body, Current research says that it causes neurological problems more often then stomach problems.

some of my sympptoms which are common among celiacs:

i have periodic full vision loss, there is no warning, it just happens,it is temporary lasting maybe 10 to 20 minutes,sometimes longer

i also have seizures,usually get a little warning for them

i have significant hearing loss,i have learned to read lips

i have sensory problems, extremely sensitive to light and sound

palsy of the face
slurred speach
many signs of early onset dementia
night blindness
damaged optic nerve
cant gauge distance

vertigo
ataxia
i do not produce saliva or digestive fluids balance problems hypoglycemia

these symptoms are common among celiacs.

current research also states that if you are not diagnosed until over age 40 and there is significant damage to your intestines, your chance of healing the intestines is very slim.

i went to social services *[Redacted text]* MN. they gave me food stamps,but i was not using them, they asked me why i was not using them,i said well i need transportation to get to the grocery store. (i also needed assistance when in the grocery store.)

they said well why dont you just walk. (at the time i was pregnant)

i only live about *[Redacted text]* from the grocery store, but there are *[Redacted text]* train tracks that i have to cross to get to the grocery store.

can you imagine a pregnant lady who is struggling with seizures and vision loss and hearing loss and vertigo and ataxia and balance problems.....

is it realy a wise thing to be telling someone with those symptoms to be walking by themselves to a grocery store. especially when it involves crossing *[Redacted text]* train tracks!!

i was so upset when he told me that i didnt even know what to do. i cried after our conversation, i didnt sleep for days.

social services need to be updated on what celiac disease is. and the damage it does to the body.

they still have not offered me any advice on where to go to get help with my various health problems.

i do not have family in town.

Comment 157

-----Original Message-----
From: *[Redacted text]*
Sent: Friday, October 18, 2013 12:52 PM
To: *DHS_OPC Public
Subject: reworded

I was recently diagnosed with level 4 celiac disease. I have been sick all of my life with various problems that got worse instead of better. i went to various doctors over the years, none of them could figure it out. I finally got the diagnosis of celiac at age *[Redacted text]*.

[Redacted text] years of not being diagnosed, not being treated.... the disease did a lot of damage to my organs.

they have done a lot of research on celiac disease this past year. they have proven that it can effect any organ or system of your body, Current research shows that it causes neurological problems more often then stomach problems.

some of my symptoms which are common among celiacs:

i have periodic full vision loss, there is no warning, it just happens, it is temporary lasting maybe 10 to 20 minutes, sometimes longer

i also have seizures, i usually get a little warning for them

i have significant hearing loss,i have learned to read lips

i have sensory problems, extremely sensitive to light and sound

palsy of the face
slurred speach
many signs of early onset dementia
night blindness
damaged optic nerve
cant gauge distance
vertigo
ataxia
i do not produce saliva or digestive fluids balance problems
hypoglycemia

these symptoms are common among celiacs.

current research also shows that if you are not diagnosed until over age 40 and there is significant damage to your intestines, your chance of healing the intestines is very slim.

i went to social services *[Redacted text]* MN. they gave me food stamps, but i was not using them, they asked me why i was not using them ,i said well i need transportation to get to the grocery store. (i also needed assistance when in the grocery store.)

they said well why dont you just walk. (at the time i was pregnant)

i only live about *[Redacted text]* from the grocery store, but there are *[Redacted text]* train tracks that i have to cross to get to the grocery store.

can you imagine a pregnant lady who is struggling with seizures and vision loss and hearing loss and vertigo and ataxia and balance problems.....

is it really a wise thing to be telling someone with those symptoms to be walking by themselves to a grocery store. especially when it involves crossing *[Redacted text]* train tracks!!

i was so upset when he told me that i didnt even know what to do. i cried after our conversation, i didnt sleep for days.

social services needs to be updated on what celiac disease is. and the damage it does to the body.

they still have not offered me any advice on where to go to get help with my various health problems.

i do not have family in town.

celiacs all over are complaining of not getting assistance.

celiacs look normal on the outside, but the disease has done a lot of damage on the inside

---

Comment 158

From: *[Redacted text]*
Sent: Saturday, October 19, 2013 1:38 PM
To: *DHS_OPC Public
Subject: Thank you

Dear Members of the Olmstead Sub-Cabinet:

Thank you for posting the October, 2013, draft of the state's Olmstead Plan. My husband and I wanted to let you know how much we appreciated the housing topic plan.

We have a *[Redacted text]* year old developmentally disabled son. Our son has his own 1 bedroom apartment in a *[Redacted text]* apartment building in *[Redacted text]*, and has lived there since *[Redacted text]*. He enjoys his *[Redacted text]* apartment, which provides an attractive, safe environment for him, and where he is able to live quite independently. Our son has been employed, full time, in the laundry *[Redacted text]* hotel since *[Redacted text]*.

We applaud the Sub-Cabinet's focus on helping people with disabilities to live in the most integrated setting "of their choice." Each of us chooses housing based on a number of different factors, many of them based on personal preference. People with disabilities are no different. Thank you for not pigeonholing people with disabilities into just one or two types of housing.

We look forward to seeing the final plan later this fall. Thank you all for the time and effort you are putting into this important issue.

Sincerely,
[Redacted text]

Comment 159

From: *[Redacted text]*
Sent: Sunday, October 20, 2013 8:13 PM
To: *DHS_OPC Public
Subject: Response

Minnesota has been a leader in the development of the alternatives of housing for the developmentally disabled. In the Sixties and Seventies, communities began to develop Day Activity Centers and Sheltered Workshops that gave meaning to the daily lives of the disabled individual. Developmentally disabled individuals began to move from the state hospitals to the community. Housing began to be developed by community leaders, providers and families. Minnesota can be proud of the leadership we have shown, but now I believe the pendulum appears to be reaching the end of it?s swing.

I watched the pendulum begin to swing from the days in the sixties, when my wife was a nursing student working in the state hospitals. The nurses were told to wear their swimming suits on certain days because that was bath day. They brought the residents into the shower room, soaped them down and then hosed them off. Those were unfortunate times, and clearly not what our society was willing to tolerate. Minnesota responded. The pendulum has now swung to where today we are building $300,000 houses in neighborhoods, providing a vehicle and staffing it with employees who do the cooking, cleaning and supervision.

As the swing began, the keepers of the coin scrambled to insure both the efficiency as well as the effectiveness of these developments. But they were reacting to a rapidly changing system of service. The design of housing evolved swiftly. Apartment style housing, duplexes and four bed residential homes replaced fifteen bed group homes. What was important was to recognize the design of these living arrangements were driven by the growth of physical and social needs of the consumers themselves. The people who worked with them, providers, direct care staff, parents and county social workers watched as the individuals changed. The individuals became more capable, more independent and more able to live in a ?normal? lifestyle. The driving philosophy of this development was to provide as normal and supportive living arrangement as possible. The persons who were delivering the services were most aware of the needs of the individual with disabilities. Those were the people who took the risk and developed those alternatives.

The result of that growth was the development of many models of service. Unfortunately, in recent years, the kind of housing available was driven not by consumers, but by the changing sources of financing. Consumers were moved from housing they were satisfied and comfortable with into other models, only because counties were able to leverage dollars from the federal government. We are now beginning to recognize the keepers of the coin are limited in their ability to absorb the expense of some of these isolated models.

As noted by the editorial in Saturdays Minneapolis Tribune there are consumers for whom the most appropriate model is one that happens to provide the support and security for them. The concept of ?integration? should not be misinterpreted to be ?isolation? from the supports the individuals with disabilities are most comfortable with. There are many models of living available in our world. For those who are ?normal? we can choose a family home, dormitories, assisted living, apartments, nursing

homes, even communal living. Let?s not limit the alternatives available to the disabled because we know better.

[Redacted text]

Comment 160

-----Original Message-----
From: *[Redacted text]*
Sent: Monday, October 21, 2013 8:29 AM
To: *DHS_OPC Public
Subject: Olmstead Plan

Olmstead Sub-Cabinet Members:

We are writing in support of the October draft of the Olmstead Plan and the recent Editorial Page comments in the Star Tribune.

We have a daughter with a developmental disability. She lives in her own apartment in a small building. It looks like a lot of the other affordable and safe housing settings around town. The only difference is that her apartment building happens to serve only people with disabilities. Otherwise, she has the same rights as anyone else who rents an apartment in any other building. She has her own lease and keys, she is free to come and go as she pleases, and she can choose what types of services she wants and from which providers.

This type of independent living should be valued and preserved. Thank you for clarifying that Minnesota's Olmstead Plan will do this.

Thank you.

[Redacted text]

Comment 161

From: Nancy Hylden *[Redacted text]*
Sent: Thursday, October 24, 2013 11:07 AM
To: *DHS_OPC Public
Cc: Bibus, Beth (MMB); Kuhl, Luke (GOV)
Subject: FW: Coalition for Choice in Housing - feedback to OCTOBER 8 Olmstead Plan draft
Importance: High


Coalition for Choice in Housing October Le

Hi Beth:

Attached is what I believe is the coalition's final input to the Olmstead plan due out in final form in November. In a nutshell, the coalition encourages the subcabinet to be specific around the removal of the 25% cap to ensure that a clear signal is given to the legislature that an alternative to the cap she be sought that would retain choice and improve accountability.

Regards,

Nancy

Nancy Hylden
[Redacted text]

[full text of attached document]

Dear Lieutenant Governor Solon and Olmstead Subcabinet Members,

On behalf of the Coalition for Choice in Housing, a diverse and growing coalition of tenants, advocates, individuals, and providers who share the fundamental belief that all people, including people with disabilities should have meaningful choice in housing, thank you for your excellent work on the October draft of Minnesota's Olmstead Plan.

In reviewing this latest draft of the plan, we were pleased that choice in housing continues to be a principle housing goal of the Subcabinet. *See* "People with disabilities will choose where they live, with whom, and in what type of housing." Draft Minnesota's Olmstead Plan, October 8, 2013, page 34 of 83; *See also*, "The goal of this Olmstead plan is to reduce the barriers on both an individual and system-wide level that prohibit a person from being able to live in the most integrated setting *of their choice*." *Ibid*, page 33 of 83, *Emphasis in the original*.

We are also pleased that the Subcabinet remains committed to "increas[ing] the number of affordable housing opportunities created." *Ibid*, page 35 of 83. This is critical because as the State rightly increases the affordable housing options and choices available to people with disabilities, we also want to be sure to preserve the opportunities and honor the choices which people are availing themselves to today.

In addition, we are very supportive of the direction that the Subcabinet has taken with respect to acknowledging that "there are a number of characteristics that can be used to help gauge the level of integration and choice within a particular setting." *Ibid*. Specifically, the multiple characteristics that the Subcabinet enumerates, "person controls their own schedule and activities," "person has a lease or own their own home," "person has privacy in their living or sleeping area (no unwanted roommates)," etc. are excellent indicators that a person is not in fact institutionalized. *Ibid.* Moreover, we greatly appreciate and completely agree with your understanding that "[i]t is not necessary for every housing option to meet the above requirements at all times [as] [t]hese may not be appropriate for all persons in all settings." *Ibid.*

In moving towards Minnesota's final November Olmstead Plan, however, we continue to strongly encourage the Subcabinet to explicitly state in your final report that "caps and moratoriums regarding

housing options are inconsistent with Olmstead's promise of meaningful choice, which includes choices of living location and situation." In considering our proposed language, we hold that our suggestion is highly consistent with the Subcabinet's call for "[i]ncreas[ing] housing options that promote choice and access to integrated settings by reforming programs that provide housing and supports to allow greater flexibility." *Ibid*, page 36 of 83. And more specifically, your conclusion that "allowing income supplements to be used in a broader range of settings will result in greater levels of choice in housing for persons who are disabled." *Ibid.*

Finally, with regards to the stated metric of determining "how many people move from institutions or congregate settings to having their own lease" we respectfully ask the Olmstead Subcabinet to carefully delineate the differences between a congregate setting and an institution. *Ibid*, page 37 of 83. To wit, many individuals who have made informed choices to live in what may be considered a congregate setting already have their own leases, private apartments, and many features of integrated housing that do not at all resemble an institution.

Thank you again for your diligent work on our State's Olmstead Plan. As always, we are happy to serve as a resource to the Subcabinet and look forward to continuing to work with you in forging an Olmstead Plan which ensures that all Minnesotans have access to meaningful choice in housing.

Comment 162

From: Sue Abderholden [mailto:sabderholden@namimn.org]
Sent: Tuesday, October 29, 2013 6:45 PM
To: *DHS_OPC Public
Cc: *[Redacted text]*
Subject: NAMI Minnesota

Attached are our comments to the most recent draft of the Olmstead Plan.

Comments on Olmstead Plan - Octol

Sue Abderholden, MPH
Executive Director
NAMI Minnesota
800 Transfer Road, Suite 31
St. Paul, MN 55114
651-645-2948 Ext. 105
612-202-3595 Cell Phone
1-888-NAMI-HELPS
www.namihelps.org

[full text of attached document]

To Olmstead Subcabinet:

On behalf of the National Alliance on Mental Illness of Minnesota (NAMI Minnesota) we are submitting these comments regarding Minnesota's draft Olmstead Plan released October 22, 2013. NAMI Minnesota is a statewide grassroots organization dedicated to improving the lives of children and adults with mental illnesses and their families. Nearly 100% of our board and staff either live with a mental illness or have a family member with a mental illness.

While this latest draft represents a significant improvement over previous versions, it still demonstrates (with a few exceptions) a fundamental lack of understanding about people with mental illnesses, their needs, and the continuum of *mental health* services and supports needed to make the principles of Olmstead a reality for our community. We are exasperated that the very serious concerns of the mental health community are still not being addressed. As such, we once again urge you to create a separate section of the Olmstead Plan dedicated to people with mental illnesses that is based on input from and collaboration with the mental health community.

We find it ironic since the two women in the Olmstead case were in a state psychiatric hospital and were there due to the lack of community mental health services. We also find it odd that the report mentions the DOJ guidance regarding reductions in personal care services – which were reduced in Minnesota and this reduction largely affected people with mental illnesses from the African American community. The language used throughout the plan does not conform to our preferences, which would be use of the words "mental illnesses" or "a mental illness" in recognition that there are various types of mental illnesses and people cannot be lumped into one group.

We are also frustrated by the continued insistence on one-size-fits-all solutions. While the plan acknowledges this is a frequently cited concern (p. 7, 21-22), it does little to address it. As we have tried to illustrate in previous comments, there are important differences between the way people with mental illnesses and people with physical and developmental disabilities are affected by their conditions. People can recover from a mental illness to the point where it is no longer disabling, and if addressed early enough, the disabling effects of a mental illness can be prevented all-together. This important distinction directly relates to the types of services and supports needed to help people be independent and successful as well as the approaches and strategies these services utilize. Once again this is not reflected throughout the vast majority of the Olmstead Plan.

If a goal of the Olmstead Plan is truly to help people with mental illnesses maximize choice and integration, it should support expanding and improving our mental health system along with other appropriate services and supports that will help people recover from their illness and move on with their lives. The plan *should not* insist people with mental illnesses utilize systems and supports that are not appropriate for them nor seek to continue and expand policies that restrict their access to services altogether. These issues go beyond the Olmstead Plan and reflect a disturbing pattern of ignoring the unique needs of people with mental illnesses along with the promising and innovative strategies found within the mental health system. The Olmstead Plan as currently designed will simply reinforce and exacerbate these issues. For example, we support SAMHSA's definition of recovery and their list of the eight dimensions of recovery. Will the quality of life measurement include measuring those eight dimensions?

The mental health community has been striving for years to build a robust continuum and array of mental health services and community supports. Through several task forces and reports we have identified where gaps persist and how to address them. For all the gains we have made to improve and expand community mental health services, the mental health system is still woefully under-resourced and many people with mental illnesses are simply unable to access basic services and supports that they need. The mental health community knows what works for us and we have the evidence and data to support it. It's time to build on this knowledge and make the investments necessary to meet the need.

We also have a number of comments related to specific sections of the plan. To make them easier to follow, we have organized our comments to align with the relevant sections and have included page numbers wherever possible. Our comments for individual sections are as follows:

Employment

We support the goal of expanding Individual Placement and Support (IPS) to 17 additional counties and developing a plan for IPS to be available statewide (p.34). However, we would like clarification that the goal of expanding IPS to 17 additional counties would be above and beyond expansion already underway as a result of statutory changes and small funding increases in the 2013 Legislative Session. Part of this confusion stems from the fact that there is no mention of Extended Employment for People Serious Mental Illnesses (EE-SMI), which is the program that currently funds IPS programs in Minnesota.

We would also like to see that the plan go further with a goal of increasing the number of people with a serious mental illness who are competitively employed. We want to see the design and implementation of a 1915(i) Medicaid option that funds Individual Placement and Support (IPS) employment to support this goal.

In addition, we have concerns that the language being used here may be misinterpreted and run counter to the purpose of IPS. IPS does not seek to help people find *integrated* employment but rather *competitive* employment. Integrated employment has specific connotations in the world of vocational rehabilitation and disability employment and is just one of many examples where the approach to serving people with mental illnesses differs from the approach to serving people with other conditions. While the plan alludes to competitive employment earlier on, we want IPS to be tied directly to people with mental illnesses finding and maintaining competitive employment.

The goal to have students with disabilities have at least one paid job before graduation may not be appropriate for students with serious mental illnesses. Simply attending school full-time is sometimes all the stress that a student can handle. Additionally, the goal for many students with a mental illness should be post-secondary education, not necessarily a job.

We support the goal of adopting an Employment First policy in Minnesota (p. 35) as well. While we appreciate the intent of establishing common definitions for employment and employment-related services (p. 35), we want to caution you once again against one-size-fits all solutions and to be cognizant of different employment needs for different people.

Lastly, we are concerned that the sections Training, Technical Assistance, Public Information, and Outreach (p. 36-37), will have very little relevance for nor be adequate to meet the needs of people with mental illnesses; with the possible exception of cross-agency training on motivational interviewing. People with mental illnesses face unique barriers to employment, including for many people, involvement in the criminal justice system. Additionally, the stigma associated with mental illnesses is very different than for people with physical and development disabilities. We are worried that without specific steps to address the unique employment barriers facing people with mental illnesses, excessive unemployment rates for our community will persist. Very few employers know what accommodations can be made for people with a mental illness.

Housing

We support many of the goals of this section as well as many of the activities. In particular, Action Two: "Increase the number of affordable housing opportunities created" (p. 42) is something we clearly support but we believe that some key programs that assist people with mental illnesses to live in the community were not mentioned.

We have some concerns about the recommendation to combine GRH and MSA. GRH funds can be used in some cases to provide services aimed at serving people with mental illnesses and/or a chemical dependency. Some of the specialized services include secure central storage of medication, reminders and monitoring of medication for self-administration, support for developing an individual medical and social service plan, updating the plan, and monitoring compliance with the plan, and assistance with setting up meetings, appointments, and transportation to access medical, chemical health, and mental health service providers (Minnesota Statue 256i.05, subd. 1D). As we have mentioned in previous comments, the need to separate housing from services is far more relevant in the developmental disability community than to the mental health community as these are often temporary settings for many people. People also need choices about where they want to live and for some people who live with a mental illness having services available in their apartment building can make all the difference. It is also unclear how this recommendation would impact work already underway by the current GRH taskforce that is looking at updates to this program, including pieces related to serving people with chemical and mental health needs.

There are also several major omissions in this section and the plan needs to go much further in order to truly make an impact. While the plan notes the importance of rental assistance programs and the difficulty of accessing Section 8 due to lengthy waiting lists (p. 38), there is no mention of the Bridges Rental Assistance Program for people with serious mental illnesses. This program directly supports the principles of Olmstead by focusing on people who are not living in the most integrated settings, including people experiencing homelessness, people residing in a Regional Treatment Center (RTC), people residing in community-based residential treatment facilities and persons living in substandard or rent burdened units. We know this program is effective but it cannot even begin to serve the need without additional resources.

The plan also overlooks the Crisis Housing Fund. This is a state funded program available to adults with a serious mental illness who are in an in-patient setting for up to 90 days. It allows people to maintain

their housing while receiving treatment so they can return to their community as soon as they are well again. This too needs to be directly supported in the plan.

Additionally, the plan does not adequately address the issue of homelessness, particularly as it relates to people with mental illnesses. According to the most recent Wilder Survey more than 50% of people experiencing homelessness in Minnesota live with a serious mental illness (noted on p.16). The Olmstead plan needs to address this crisis and should support continued efforts to end long-term homelessness and expansion of the broad array of homelessness support services for both youth and adults, including housing first options.

Supportive housing is another area that needs more attention in the plan. Action Four to make information about supportive housing options more transparent and accessible (p. 44) as well as Action Five (p. 44-45) to increase the number of supportive housing providers meeting fidelity standards are important but do not go nearly far enough. To truly make a difference we need to continue to increase our capacity of supportive housing for people living with mental illnesses. Grants for Supportive Housing services through DHS to pay for the wrap-around services that aren't offered through other services such as ARMHS – tenancy support, independent living skills, etc. – were part of 2007 Mental Health Initiative. These services were supposed be sustained over time but funding has been scaled back in recent years due to budget cuts. Beyond this, the plan should include designing a 1915(i) program that funds supportive housing. The "Housing Stability Services" option (p. 43) sounds very similar but we question the need to create an entirely new paradigm when the evidenced-based practice of Permanent Supportive Housing is already widely known and serves this very purpose.

Finally, we support the intention of Action One, which aims to help people move out of inappropriate settings into more integrated settings (p. 41) but we worry about how this will work in practice for people with mental illnesses. This is a prime example of the need to work closely and directly with the mental health community and to create a specific section of the Olmstead Plan for people with mental illnesses. We worry that if new settings are created strictly from the perspective of serving people with physical disabilities or developmental disabilities, the same problems will persist. We would like to see a requirement that any group setting that serves people with a primary diagnosis of a mental illness either be operated by a mental health agency or have the mental health certification, and that it exclusively serve people who have a primary diagnosis of a mental illness. We would also like to measure not just how many people have their own lease, but housing stability. You need safe affordable stable housing to recover from a serious mental illness. It's also important to recognize that people with poor rental histories (such as having police called to a mental health crisis) and with criminal backgrounds will have an extremely difficult time obtaining housing in their name/their own lease.

<u>Transportation</u>

NAMI Minnesota serves on the NEMT task force. We want to make sure that DHS supports a single assessment tool that recognizes the impact of mental illnesses on taking regular public transportation (including being able to transfer multiple times, standing in extremely hot weather waiting for a bus) We also would like to see the development of protected transportation so that people with mental illnesses

are not transported by police or strapped in ambulances when being transported between treatment facilities.

Supports and Services

This section, more than any other, is where specific recommendations and activities for people with mental illnesses are sorely needed. The strategies proposed in this section will do very little to help achieve the goals of Olmstead for people living with mental illnesses and in many cases could have the opposite effect. We need to measure the number of people living in integrated settings AS WELL AS the number of people receiving the appropriate supports in a setting.

Action One (p.52-53), as with much of this section, is deeply rooted in the terminology of serving people with developmental disabilities. This leads us to believe that this initiative will be designed and implemented from that perspective leaving people with mental illnesses, once more, to fit into a system that was not designed with them in mind. There have been questions raised nationally about how person centered planning fits in with mental health treatment recommended by mental health professionals. Certainly it's a collaborative effort but there are different versions of person centered planning and we want to ensure that we use a process geared for people with mental illnesses.

We support the goals under Action Two of reducing the number of people at Anoka Metro Regional Treatment Center (AMRTC) and Minnesota Security Hospital (MSH) who no longer require such intensive care (p. 54). But the goals are targeted to the reduction of people at these facilities who no longer need to be there instead of the number of people who have found appropriate and quality services and supports in the community. Having experienced closings without the development of community services, we need to measure what we want to see happen. IF we build the system correctly, those numbers will be reduced. We are very concerned that without appropriate transitional settings in the community that are equipped to meet the needs of people living with serious mental illnesses, people leaving AMRTC and MSH will continue to be poorly served. One of the biggest issues we have now is that too often people leaving these settings are "dumped" in corporate adult foster care, assisted living, board and lodges or other facilities that are not designed to meet their needs and where the staff have little, if any, training about mental illnesses. We are concerned that without developing appropriate transitional settings, people with mental illnesses will continue to be placed in settings with people who have vastly different needs, where the opportunity for community engagement is extremely limited, and where the level of control over the person's life does not reflect their needs or abilities.

Action Three again speaks to the serious issues created by insisting on a one-size-fits-all approach, which invariably has a negative impact on people with mental illnesses. The first activity under this section is the implementation of 245D (p. 55), which will presents major problems for mental health providers. The language used throughout that law and the accompanying materials are firmly rooted in the terminology and practices of working with people with developmental disabilities; much of which has little applicability for working with people with mental illnesses. This action item also talks extensively about setting uniform definitions and compiling lists of policies and best practices for use across state agencies (p. 56) without recognizing that there are fundamental differences in the way people with

different conditions are served. We are very concerned this nuance will be lost in the process just as it has been with 245D.

We see no mention of the number of new people who should be served under the community services used by people with mental illnesses. This would include ACT, ARMHS, IRTS, crisis homes, or even ways to build our system such as the use of mental health peer specialists, or the use of evidence-based practices including IMR, family psychoeducation, or IDDT, .

Under Action Three, we support the plan to create a coordinated triage and "hand-off" process for crisis intervention (p. 56). However, the proposal related to the use of crisis services to reach people who are at risk of civil commitment (p. 56) is too limited. NAMI Minnesota and others in the mental health community are actively working on a similar proposal for the upcoming legislative session that seeks to provide services far before people are at risk of civil commitment or even hospitalization. Our proposal would would clarify the definition of a mental health crisis to ensure people can receive crisis services before a situation becomes an emergency; expand the scope of services mental health crisis teams provide, including engaging the person in voluntary treatment, more direct linkages to services, and when necessary connecting the person to more intensive services. It would also ensure that family pyschoeducation will be a part of mental health crisis response services. It is essential that we intervene well-before they are at risk of commitment. Considering the more extensive history of the use of crisis services in the mental health community we were surprised that these services received little mention.

The narrative section of Action Four (p. 56-57) is very much in line with our perspective – people need to be able to access the right service, at the right time. We are concerned, however, that the actions under this section will not accomplish the goals outlined in this narrative. The narrative points out that expanding state plan services can reduce pressure on services that have growth limits, such as waivers. In the realm of mental health, that is exactly what we've done. A wide range of community-based mental health services including Adult Rehabilitative Mental Health Services (ARMHS), Assertive Community Treatment (ACT) and crisis services (along with many others outlined in previously submitted comments) are covered under Medical Assistance and MinnesotaCare but these services are not available to everyone who needs them. The Olmstead Plan should support expanding the capacity of the community mental health system to offer these services and to ensure that they are available to people who are still uninsured and underinsured as well as to people in every part of the state.

The first activity is replacing the Personal Care Assistance (PCA) program with the Community First Services and Supports (CFSS) program (p. 57). Unfortunately, the eligibility criteria for CFSS will leave many people with mental illnesses unable to access this service, even though it could be immensely beneficial in helping them achieve recovery. Revising these criteria to ensure that people with mental illnesses can access the program should be part of this recommendation.

We also want to be sure that the second action - to look at home and community-based supports and services waiting lists and to prioritize based on urgency and needs (p. 57) – will not make it more difficult for people with mental illnesses to access home and community-based services when needed.

The mental health community has repeatedly expressed concern that changes to the Nursing Facility Level of Care criteria will disproportionately lead to people with mental illnesses losing waiver eligibility.

Lifelong Learning and Education

We support Action One (p.59) but it should also include collecting data on the use of police interventions and "reasonable force" (Minnesota Statute 121A.582) for students on an IEP in order to monitor and address unintended negative consequences due to the elimination of the use of prone restraints next year. Also, mental health crisis services should be made available to any student who needs them, not just students with complex disabilities. We also support Action Two (p. 60) for PBIS but dedicated state funding will be needed to make this a reality and should be included in the recommendation.

Action Three does not appear to be geared towards students with mental illnesses at all (p. 60). It also is unclear if youth with mental illnesses would be served by Action Four (p. 61) as it lacks specifics but it should include supported education for youth with mental illnesses at very least.

Action Five needs refinement and more specifics. Some students with mental illnesses enter residential or day treatment to address their mental health needs and it is unclear how this would impact those children.

This section also does not address several major issues facing children with mental illnesses in educational settings. The first is the extremely low graduation rates and high suspension rates for students with mental illnesses. Students in the "Emotional or Behavioral Disorders" category have the lowest graduation rate of any disability category. Secondly, students with mental illnesses are far too often truant as a result of their illness which leads to disciplinary issues and often unnecessary involvement with the juvenile justice system. These issues should be addressed in the plan as well. Our goal should be that students graduate. That is the most successful outcome that we could hope for. In addition, students in the EBD category often are never diagnosed by a mental health professional. The use of FBAs for students are not useful when there is no function to the behavior because it is a symptom – not a behavior. More attention should be paid to the EBD category since so many of these students end up in very segregated settings and have poor outcomes.

The plans should also support further expansion of school-linked mental health services which have been widely successful in improving outcomes for students with mental illnesses. The plan should also support more school support personnel (school social worker, school psychologists, etc.) and help ensure schools have the right balance of support personnel.

Healthcare and Healthy Living

This section covers an area that the mental health community has been focusing on for some time. People with serious mental illnesses have a life expectancy that is 25 years shorter than the general population, largely due to preventable medical conditions such as diabetes or cardiovascular, respiratory, or infectious diseases.

We greatly appreciate the item under Action One related to the development of behavioral health homes (p. 64). Not only does it address the particular needs of people with mental illnesses, it clearly articulates that the mental health community will be involved in the development and builds on innovation already underway. This should be a model for other elements of the Olmstead plan as they relate to people with mental illnesses.

We also agree with and support the item to expand access to dental services (p. 65). Access to dental care is a serious problem for many people with mental illnesses and we expect that the unique barriers facing our community in this regard will be included in the proposed study and subsequent recommendations. 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.

We are confused by the item under Action Two to conduct a needs assessment around access to specialty care providers, including mental health providers, for people with disabilities (p. 66). How does this relate to and impact people with a primary diagnosis of a mental illness who do not have co-occurring disabilities? This speaks directly to our broader concerns about the lack of attention to the unique needs of people with mental illnesses. Minnesota has a drastic shortage of mental health care professionals and it has reached crisis proportions. One of the biggest barriers to achieving the goals of Olmstead for people with mental illnesses is the lack of community services and the lack of a workforce to deliver those services. The Olmstead plan should address this issue head on and include support for expanding the mental health workforce. In addition, the term "mental health counselors" does not have any specific meaning in Minnesota.

Lastly one of the major health issues affecting people with serious mental illnesses is the high percentage of people who smoke. There are not targeted interventions specifically for them nor are there any efforts to help mental health professionals assist the people they treat to quit smoking.

Appendix A

As with the September draft, the demographic figures, in this appendix and throughout much of the plan, completely omit mental illnesses (aside from statistics on homelessness). We feel this reflects our broader frustration that the Olmstead Planning process, from the beginning, has failed to understand people with mental illnesses and their needs as well as the failure to meaningfully engage with the mental health community. If people with mental illnesses are to be included in this process, the extreme disparities in housing, employment, physical health, etc. faced by people with mental illnesses should be recognized, just as the unique services and supports to address those disparities need to be specifically supported by the plan itself.

Appendix B

We are disappointed that there were no subject matter experts who specialize in mental health and that the subcabinet did not consult with the numerous mental health experts from either here in Minnesota

or nationally. Going forward, this expertise is hugely important if the plan is to effectively serve people with mental illnesses.

Additional Comments

The June draft of the Olmstead Plan contained detailed recommendations related to Minnesota's criminal justice system. This section was exceptional in that it directly addressed the needs of people with serious mental illnesses and offered concrete activities, much of which aligned with the priorities of the mental health community. None of those recommendations have appeared in any of the subsequent drafts. This is very concerning given that far too often people with mental illnesses become unnecessarily involved with the criminal justice system. If people with mental illnesses are to be included in the Olmstead Plan, this is area that warrants careful attention and we would like to see the early recommendations revisited and expanded upon based on feedback from the mental health community.

Comments on Process

NAMI Minnesota has provided considerable input into the Olmstead planning process and we have repeatedly asked for more engagement with the mental health community. As the plan acknowledges, people impacted by this plan "expect to be involved and provide leadership in developing and implementing Minnesota's Olmstead Plan" (p. 22). While the plan alludes to more opportunities for public input (p. 29), we would like to know what *specific steps* will be taken to meaningfully involve the mental health community.

It would be also extremely helpful if future revisions to the plan could specifically highlight what has been changed, added or deleted. As it is, it can be very difficult to assess everything that has changed from one version to the next, especially for organizations with limited time and resources, much less individuals.

Lastly, we would like to note that it has been very difficult to provide meaningful input given the tight deadlines. We were preparing comments on the October 8 draft when the current draft was released. Three weeks between drafts does not leave much time for stakeholders to offer feedback, much less to integrate that feedback.

Conclusion

This concludes our comments. If you have questions or would like more information, please contact us.

Sue Abderholden, MPH
Executive Director

Matt Burdick
Grassroots Advocacy Coordinator

Comment 163

From: Hoopes, Pamela [mailto:phoopes@mylegalaid.org]
Sent: Thursday, October 31, 2013 4:16 PM
To: *DHS_OPC Public
Cc: Hoopes, Pamela
Subject: MDLC/MMLA Comments on October 22, 2013 Draft Olmstead Plan

Dear Olmstead Subcabinet,

Attached please find the Minnesota Disability Law Center's comments on the Olmstead Subcabinet October 22, 2013 Draft Olmstead Plan. Please contact me with any questions or concerns.


1180588.docx

Sincerely,

Pamela Hoopes

Pamela Hoopes
Legal Director
Mid-Minnesota Legal Aid
Minnesota Disability Law Center
430 First Avenue North, Suite 300
Minneapolis, MN 55401-1780

612-746-3711 (direct dial)
612-334-5755 (FAX)
phoopes@mylegalaid.org

[full text of attached document]

TO: Olmstead Subcabinet (opc.public@state.mn.us)
FROM: Pamela Hoopes, Minnesota Disability Law Center/Mid-Minnesota Legal Aid (MDLC)
RE: MDLC Comments on Olmstead Subcabinet October 22, 2013 Draft Olmstead Plan (third draft Plan)
DATE: October 31, 2013

Mid-Minnesota Legal Aid (MMLA) is designated by the Governor as the federally mandated Protection and Advocacy entity for Minnesota, and it carries out this function through its statewide program, the Minnesota Disability Law Center (MDLC). MDLC Legal Director Pamela Hoopes served on the Olmstead Planning Committee. On December 21, 2012, MDLC submitted comments on that Committee's Recommendations.

Following the publication of the Olmstead Subcabinet's June 2013 first draft of Minnesota's Olmstead Plan ("first draft Plan"), MDLC attended and testified at a number of the Olmstead Subcabinet's Listening Sessions around the state. We submitted comments on the first draft Plan on August 19, 2013. On October 8, 2013, we also submitted comments on the second draft Plan.

In this memo, we are submitting comments on the third draft Plan dated October 22, 2013 ("the Plan"). This memo augments our previous written comments, public hearing testimony, and the substantial oral critiques that we have provided in numerous meetings with state agency staff involved in the Plan process.

We commend the Subcabinet and the participating state agencies for the ambitious scope of the Plan and the collaborative effort that has gone into developing it. Minnesota's draft Plan is fairly comprehensive and, even at this stage, focused on key needs and issues of importance for individuals with disabilities.

However, the Plan's impressive scope is linked to its primary weakness: given the short timelines for producing it, the Plan is clearly still a work in progress, and lacks critical baseline data, specific goals, timelines, and benchmarks by which progress toward the goal of integration must be measured. In these comments, with some exceptions, we do not attempt to fill in the gaps by suggesting goals and timelines, beyond what we have already urged in previous submissions; but we look forward to reviewing and discussing such specifics based on data as the Plan evolves and implementation begins.

1. **The topic-specific plans are still disappointingly preliminary because they lack baseline quality data.**

    - The Plan still lacks sufficient quality data. While each topic-specific plan provides some general figures that are helpful for overall context, and the introductory sections of the Plan and the Appendices provide more, the data does not set a baseline from which goals can be set and progress measured. It is good that the State recognizes the critical need for data and makes getting it the first action step in some parts of the Plan. However, we think that data is now readily accessible to agencies in many instances.

    - For example, the Department of Human Services (DHS) recently conducted a Gaps-Analysis study gathering quantitative and qualitative data from nearly every county in Minnesota related to services available for persons with disabilities. These data sets include information on nearly every topic in the Olmstead Plan. Each topic-specific plan should carefully examine these and other available data sets as soon as possible. Each agency should then reassess the current timelines for establishing baseline figures, and where such data already exists, strive to move up timelines for meeting measureable objectives.

2. **The Quality Assurance mechanisms need additional careful review and revision.**

    - **The Quality of Life Measurement:** Some basic questions are raised by the Plan's description of this process. The Plan states that "it will apply to all people with disabilities." It appears that the state intends to survey all individuals in Minnesota who have disabilities—including those who do not receive disability-related services from the government. If so, this goes beyond the

scope of a manageable Olmstead Plan. It will be critical to tie any Quality of Life measurement to the specific goals of the Plan, both for usefulness and cost. Moreover, the question of how individuals with disabilities would be identified in the general population is troubling, as is the presumption that all individuals with disabilities will need or want government services. These issues need to be examined and discussed further as the Quality Assurance effort unrolls.

- **The Grievance/Dispute Resolution Process:** Our comments submitted on October 8, 2013 set out in detail our concerns about the barriers to due process that could result from new "Olmstead" review mechanisms. The Plan does not allay our concerns. Implementing a new mechanism to cover complaints about <u>any</u> issue mentioned in this ambitious Plan would not only be costly, but may create confusion and barriers to other appeal processes. At a minimum, any new dispute resolution process must be aligned with existing review processes, so that individuals do not miss appeal deadlines for administrative or court review of disputes because they have unsuccessfully engaged in the proposed new process. Legislative action should be taken to add tolling provisions to all statutory deadlines for filing appeals, so that individuals are not penalized for attempting to resolve their issue by using this new process before filing an administrative appeal or court action.

- **Oversight, Monitoring and Quality Improvement:** The proposed efforts are commendable and show an appreciation of the central importance of closely tracking progress. Ongoing review and input from people with disabilities, their families, advocates and others in the continued development and implementation of the Plan will be absolutely essential to its utility and success.

3. Employment:

- It is very encouraging that employment is a key aspect of the Plan. We are also pleased that Minnesota plans to adopt an Employment First policy and use these principles in service design and delivery. The stated general employment- related goals of the Plan are excellent and reflect the disability community's strong interest in and need for integrated, competitive wage employment.

- More information regarding baseline data is needed. The Plan indicates that baseline data will be available by June of 2014 for the goal of Expanded Integrated Employment opportunities (pages 23 and 24). The Plan should indicate how this data will be collected and, at a minimum, should include a county-by-county employment capacity and job development analysis.

- We are perturbed that, despite substantial input from MDLC and others, the Plan barely mentions a fundamental Olmstead problem in the employment arena: the continued use of segregated/center-based employment funded by the Medicaid waivers. Our understanding from discussions with state agency staff is that the billing records for Day Training and Habilitation activities under the waivers do not currently separate out work from other activities. As a result, the basic data about how many people are working in what settings paid for by the Medicaid waivers, and how much time people are spending at Day Training and Habilitation centers doing activities that are not work, is not available. Fixing this critical data lacuna should be a priority task in the employment area. Based on this data and county-specific job capacity data, specific goals to move toward integrated employment, with timelines—similar

to those we have proposed in earlier submissions and testimony—should be adopted in the Plan and implemented.

- The Plan does not acknowledge that a key step to increasing integrated employment for individuals with disabilities is to cease referring transition-aged students to center-based/segregated employment programs and other segregated settings. We strongly urge the Plan to adopt a clear statement that these referrals should be phased out and to add specific action steps with measurable outcomes to accomplish that goal.

4. Housing:

- The Plan's recognition of supportive housing as a best practice is an important step to ensuring meaningful integration. But supportive housing has a variety of models and best practices, and the Plan only indicates a few specific model/program of supportive housing (the Hennepin County Housing First program/model indicated on pages 36-37 and the Individual Housing Choice program on page 38). We strongly recommend that DHS and the Minnesota Housing Finance Agency (HFA) convene a supportive housing working group/stakeholder group to better meet goals 4 and 5 in this topic-specific plan and to adequately implement the various Supportive Housing models and best practices that best meet the integration mandate of Olmstead.

- Current integration efforts must be aligned with those indicated in the Plan. Significant programs such as Moving Home Minnesota and the Housing and Urban Development (HUD) 811 Project Rental Assistance (PRA) demonstration project, both of which have already received significant federal funding, are not mentioned in the Plan. Both DHS and the Minnesota Housing Finance Agency (MHFA) should ensure that all current and future programs involving housing opportunities incorporate the principals of Olmstead and the best practices developed through the working groups convened to carry out the action steps of the Plan.

- The Proposed Group Residential Housing (GRH)/Minnesota Supplemental Aid-Housing Assistance (MSA-HA) merger, as outlined on pages 36 and 37, signals a very important step towards integration. This process, however, should be rolled out in phases to adequately reform the programs while causing minimal disruption to the current housing supports already in place for individuals. This reform process will necessarily take time and careful planning and, at a minimum, we suggest that by the end of November 2013, DHS should convene a stakeholders planning committee to work on the complex transition.

- DHS should take actions for the 2014 legislative session that would advance the goal of reforming its housing assistance programs, including:
  - Increasing the monthly MSA-HA subsidy;
  - Scaling up existing pilot programs that already allow individuals to use GRH funds for independent housing in scattered-site and independent apartments; and
  - Examining other supportive housing best practices such as peer-networks and transition services that can be convened or leveraged now in order to more quickly effectuate GRH reform.

5. Transportation:

- The Plan should incorporate and build on data already gathered through the DHS Gaps Analysis. The Plan should specifically incorporate current multi-stakeholder efforts to expand non-emergency medical transportation benefits that can be paid for under waiver services.

6. Services and Supports:

- We are pleased to see that the Plan recognizes the dramatic increase in the diagnosis Autism Spectrum Disorder (ASD). As the Plan moves forward, action steps should include:

    - DHS will assure that all children in public health programs, including those getting health care through managed care plans, are periodically screened, provided full assessments when indicated and followed up with early intensive treatment to assure that these children reach developmental norms by age five. The opportunities to avoid lifelong segregation are clear if intensive early services are provided to young children with ASD. Our state could make a major difference in the long-term outcomes for these children in public programs, and we urge that this be accomplished expeditiously.

    - The Minnesota Department of Education (MDE) will take steps to assure that school districts implement intensive early intervention services for all children identified as having symptoms of ASD. With the new Medical Assistance benefit for young children with ASD, school districts should now either provide the early intensive services or refer children so that young children maximize their functioning by age five. Reducing the symptoms of ASD early will reduce school districts' use of segregated settings and aversive practices for children with ASD diagnoses and improve long-term outcomes.

- We commend the Plan for adopting aggressive timelines to move people at Anoka Metro Regional Treatment Center (AMRTC) and the Minnesota Security Hospital (MSH) into the community. However, the lack of data on individuals now living and receiving services in other segregated settings in this section is very disappointing, as DHS has much of this data readily available now. Residential segregation is at the heart of the *Olmstead* case and, although the introductory sections of the Plan recognize that residential desegregation should be given priority, the lack of data and specificity in this section's discussion of supports raises concerns.

- For persons with mental illnesses, the Plan should contain a basic discussion of recovery management that outlines available home care and community supports such as personal care assistance (PCA) and Community First Services and Supports (CFSS) and other supports that can be available under the Medicaid waivers, such as customized living, Independent Living Services (ILS) and personal supports. The Plan should also commit to fixing the serious problem with the current definition of dependency in the CFSS program, which, if left as is, will result in many people with mental illnesses being excluded from the CFSS program.

- The Plan does not refer to or examine the underlying assumption that everyone needing commitment has to be committed to the Commissioner of Human Services. The commitment statute does not require this. For example, about 60% of those committed to Anoka have schizophrenia, the treatment of which is well known and well documented; treatment efficacy is

higher than that of a lot of chronic illnesses. Many of the persons treated at Anoka could be treated elsewhere in the system and would not have to go to Anoka in the first place, if the payment system were more appropriately aligned. The Plan should acknowledge this as a factor in unnecessary institutionalization at Anoka that must be addressed to move toward the goal of integration.

7. Education:

- MDE's revision to its section of the Plan is improved. The revision includes a more comprehensive approach to the goal of having 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." We strongly agree with MDE's proposed actions to reduce restraint and seclusion and to increase the implementation of Positive Behavioral Interventions & Supports (PBIS) schools in Minnesota.

- For "Action One," (pages 59-60), relating to the reduction of restrictive procedures and the elimination of prone restraint, the data collected from school districts should be reported to the public on a school-by-school basis. Additionally, MDE should identify districts that have low rates of restrictive procedures or that have reduced the rate of use to serve as models for other districts. MDE should examine student populations, district/school size and location, status of the district/school's PBIS efforts, and other relevant factors to compare and contrast districts with higher and lower restrictive procedure use. By using effective models and success stories, MDE will be more effective in reducing restrictive procedure use and eliminating prone restraint.

- For "Action Two," relating to building staff capacity for positive behavior interventions and supports in schools, the Plan should emphasize data collection on the implementation of PBIS at its tertiary implementation level. The data collected should include discipline rates, referral of students to more restrictive placements, referral of students to less restrictive placements, and restrictive procedures use. PBIS can be very effective in meeting the overall goal of inclusion. However, the Plan should place more attention on implementation of PBIS' tertiary level, which focuses on effective approaches designed to integrate children with more challenging behaviors and needs.

- "Action Three's" discussion of supporting integrated employment options should contain a strong statement that the MDE is fully committed to the integrated employment goals contained in the employment section of the Plan. As a critical step toward achieving those goals, we urge the MDE to commit in the Plan, along with the collaborating agencies, to phasing out placements and referrals of transition-age students to segregated work and day programs. We also urge the MDE to adopt more aggressive goals for how many schools will adopt evidence-based practices that result in integrated competitive employment outcomes. The stated goals are unacceptably low. The Minnesota Post School Outcomes Survey as well as the State's Annual Performance Plan already includes data about competitive employment rates.

- "Action Four," which discusses increasing enrollment in postsecondary education and training programs, should also include data collection related to increasing the number of students in competitive employment. We strongly urge the MDE to include a statement and goal in the

Plan that, consistent with Olmstead, post-secondary programs should not be in segregated settings.

- "Action Five" discusses the re-integration of children with disabilities who are placed out of state or who are in juvenile correctional facilities. This is an important area of focus and can serve as a model for re-integration efforts with other student populations and we commend its inclusion in the Plan.

- A significant area that is missing from the Plan is an effort to re-integrate students who are currently in more restrictive, segregated school placements into mainstream settings. It is not sufficient for the state to rely on the framework of the Individuals with Disabilities Education Act (IDEA) to justify this continued segregation of young people with disabilities. We urge the MDE to address this issue as the Plan evolves.

- Students currently in or likely to be placed in more restrictive settings (e.g. Federal Instructional Setting Levels IV-XIII, which include educational services in public or private segregated sites, residential locations, and hospital-based or homebound services), often get put on a track towards center-based employment (also called facility-based employment, sheltered workshops, or segregated employment). MDE should use the Plan as an opportunity to take steps to reduce the numbers of students going from more restrictive school settings to less integrated employment options. MDE should add to the Plan an Action that would:

    - Ensure that students with disabilities who are placed in more restrictive settings (Federal Setting Levels IV-XIII) are able to return to more integrated settings when appropriate.
    - The timeline for this Action should include the following steps:

        - By June 30, 2014, a review of how many students have been and are in each of these settings over the past 10 years until the report date on these student populations.

        - By June 30, 2014, a review of how many students have returned from each of these settings into a mainstream or regular education setting (Federal Setting Levels I- III) for at least 60 consecutive school days.

        - By December 30, 2014, develop prototype reintegration plans to move students to more integrated settings.

        - By June 30, 2015, implement reintegration plan protocol statewide.

        - By June 30, 2016, and annually thereafter, continue monitoring data and publicly reporting on the number of students who are placed in Level IV-XIII settings and how many have been placed in Level I-III settings for at least 60 consecutive school days following a more restrictive placement.

Conclusion

We recognize the continuing strenuous efforts of the Subcabinet and state agencies to move the Olmstead Planning process forward toward completion and implementation. We have appreciated the opportunity to comment during the drafting process. We strongly encourage the Subcommittee to continue to accept feedback and comments from stakeholders after the submission of the draft Plan to the Court. We look forward to participating in the ongoing review and revision of the Plan and its implementation.

Please feel free to contact me with any questions regarding these comments at 612-746-3711 or phoopes@mylegalaid.org