UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, Guardians and next friends of Bradley J. Jensen, et al.,

Civil No. 09-1775 (DWF/FLN)

Plaintiffs,

v.

Minnesota Department of Human Services, an agency of the State of Minnesota, et al.,

Defendants.

Minnesota Olmstead Subcabinet Report to the Court

STATUS UPDATE
November 1, 2014 – December 31, 2014

Report Number 6

Contents

I. PURPOSE

On January 22, 2014 the Court provided the following direction for updating the status of the Olmstead Plan implementation:

"The State of Minnesota shall file its first update, including any amendment to the Olmstead Plan and a factual progress report that shall not exceed 20 pages, within 90 days of the date of this Order. The Court expects the parties to address the progress toward moving individuals from segregated to integrated settings, the number of people who have moved from waiting lists, and the results of any and all quality of life assessments. The Court needs to be in a better position to evaluate whether the Settlement Agreement is indeed improving the lives of individuals with disabilities, as promised and contemplated by the Settlement Agreement itself.

As the Court ordered on August 28, 2013, updates to the Olmstead Implementation Plan shall include activities undertaken pursuant to the Plan, documentation of such activities, and any requests for modification of the Plan's deadlines or other elements.

The State of Minnesota shall file a revised Olmstead Plan on or before July 15, 2014, after first providing a draft to the Court Monitor on or before July 5, 2014.

This Court respectfully directs that the Olmstead Subcabinet use all of its combined resources and talents to implement the Olmstead Plan. Further, the Court respectfully directs that the Olmstead Subcabinet cooperate, communicate, and work with the Court Monitor. The Court expects the Olmstead Subcabinet to discuss ongoing implementation with the Court Monitor, as well as the Executive Director of the Governor's Council on Developmental Disabilities and the Ombudsman for Mental Health and Developmental Disabilities, on a 60-day report system, with feedback and communication between all parties, so that true progress can be realized in the lives of the individuals with disabilities intended to benefit from the Settlement Agreement and so their lives can truly be significantly improved."

On September 18, 2014, the court ordered:

"Reports to the Court must be accurate, complete, and verifiable. The Court requires the State to report on the following: (1) the number of people who have moved from segregated settings into more integrated settings; (2) the number of people who are no longer on the waiting list; and (3) the quality of life measures. With respect to the first inquiry, any calculation must consider admissions, readmissions, discharges, and transfers—reflecting the dynamic movement of individuals through segregated settings—to determine the net number of people who have moved into more integrated settings. Regarding the second inquiry, the State must evaluate whether the movement is at a reasonable pace. Finally, with respect to the third inquiry, the State must summarize and submit to the Court any available data and highlight any gaps in information."

The bimonthly report to the court, court monitor, and the public provide the status of work being done by state agencies to implement the Plan. Each bimonthly report cover action items that were to be

completed for a two month period as noted on the cover page of each report. Additionally, a preview of activities associated with action items for the following four months is included to inform on progress and potential issues.

On December 31, 2014 the Court Monitor issued a report to the Court identifying specific items he found non-compliant with the Olmstead Plan. This bimonthly report provides status updates on Olmstead Plan action items with deadlines in November and December 2014 and items specifically found non-compliant by the Court Monitor. Additional information is provided in **Appendix 6-A** on action items with deadlines through April 30, 2015.

Proposed Modifications to the Olmstead Plan

In accordance with the August 28, 2013 and January 22, 2014 orders from the Court, proposed modifications were submitted to the Court Monitor for review and approval. On June 9, 2014, the subcabinet adopted the approved modifications and provisionally adopted six modifications pending approval of the Monitor. The Plan with approved modifications was submitted to the Court Monitor on June 30, 2014 and to the Court on July 10, 2014.

On August 6, 2014, the Court Monitor issued a report to the Court recommending that the Court approve the Plan. The Monitor further recommended that concerns raised in the report be addressed during the implementation process. "One area of serious deficiency is that both treatment in the facility and transition planning for discharges from Anoka Metro Regional Treatment Center and Minnesota Security Hospital significantly fail to adhere to the Olmstead-required person-centered planning standards." Additionally, the Monitor stated that "the Plan continues to require refinement with regard to its structure and specificity," in particular, the establishment of baselines and measurable goals.

On August 20, 2014 the Court issued an order directing that the State modify the Plan in compliance with the Court Monitor's Reports. On September 18, 2014 the Court directed that the State submit a revised Olmstead Plan to the Monitor by November 10, 2014. The revision is to include measurable goals and address accurate reporting on the number of people who have moved from segregated to more integrated settings; the number of people who are no longer on the waiting list; and the quality of life measures. Proposed measurable goals were submitted to the Court Monitor on November 10, 2014.

On January 9, 2015, the Court provisionally approved the proposed revision from November 10, 2014 subject to the review of the State's modifications and any submissions by Plaintiff's Counsel. The court directed a revised Olmstead Plan to be filed by March 20, 2015.

II. Olmstead Plan Impact on Lives of Individuals

On January 22, 2014 the Court directed the following: "*The Court expects the parties to address the progress toward moving individuals from segregated to integrated settings, the number of people who have moved from waiting lists and the results of any and all quality of life assessments.*"

This table indicates the cumulative number of individuals who moved from various segregated settings to integrated settings and the number of individuals who have moved from the home and community-based services waiting list. The data to calculate net number of individuals moving for each setting is included in **Exhibit 6-1**.

During November and December, the cumulative number of individuals who:	
• Moved from segregated to integrated settings	105
• Moved from the wait list	239

Movement from Segregated to Integrated Settings

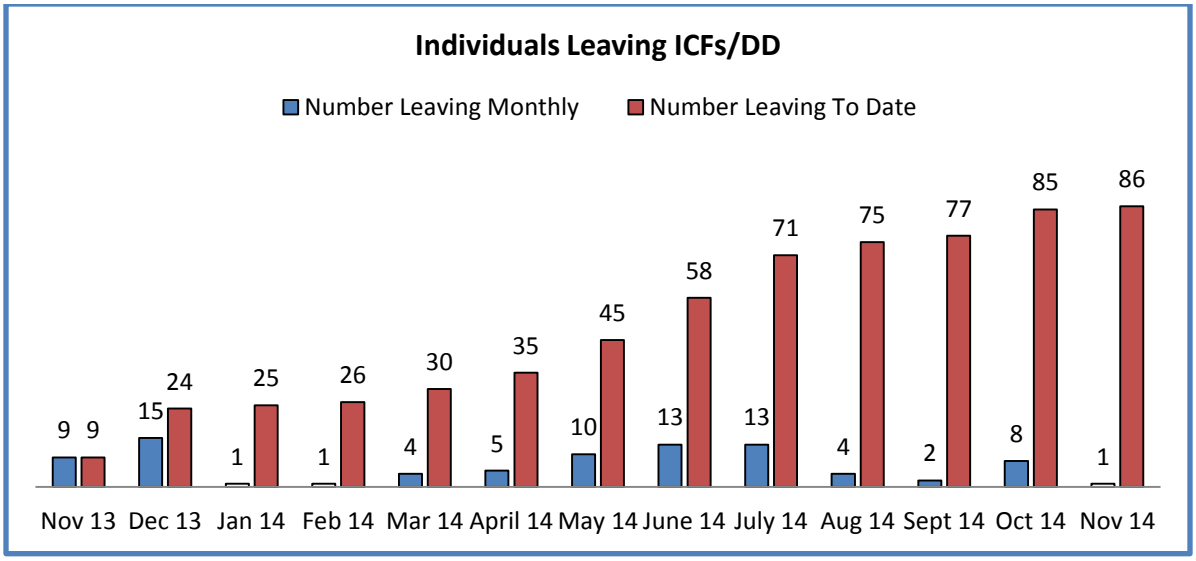
The Plan action items with movement goals are summarized in the graphs below. The action item is included to show progress toward the goal. A status update is provided for the current reporting period. The graphs are used to show progress over the last twelve months in the movement from segregated settings to integrated settings. In addition, **Exhibit 6-1** includes information on admissions, readmissions, discharges, and transfers to reflect the dynamic movement of individuals through segregated settings.

SS 2C - For individuals in Intermediate Care Facilities for Persons with Developmental Disabilities(ICFs/DD) and people under 65 who have been in nursing facilities longer than 90 days

- By December 31, 2014, 90 people will have transitioned to community services.

Status: During October and November the number of people who transitioned to community services from Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD) was 9.

Between November 2013 and November 2014, the total number of individuals leaving an ICF/DD for a community setting was 86. During the same timeframe there were 131 admissions or readmissions, 45 transfers and 3 deaths. The number of individuals receiving services in an ICF/DD is 1,646[1]. The data indicates that the population of ICFs/DD is static.



[1] 2015 projection

SS 2C - For individuals in Intermediate Care Facilities for Persons with Developmental Disabilities(ICFs/DD) and people under 65 who have been in nursing facilities longer than 90 days

- By December 31, 2014, 90 people will have transitioned to community services.

Status: During October and November 105 people under age 65 (in nursing facilities longer than 90 days) transitioned to community services. During the same timeframe there were 12 transfers and 13 deaths. The number of people in a nursing facility under the age of 65 who had been there for at least 90 days in August was 1,539 and September was 1,522.

A modification request will be submitted to establish new measurable goals for item SS 2C.

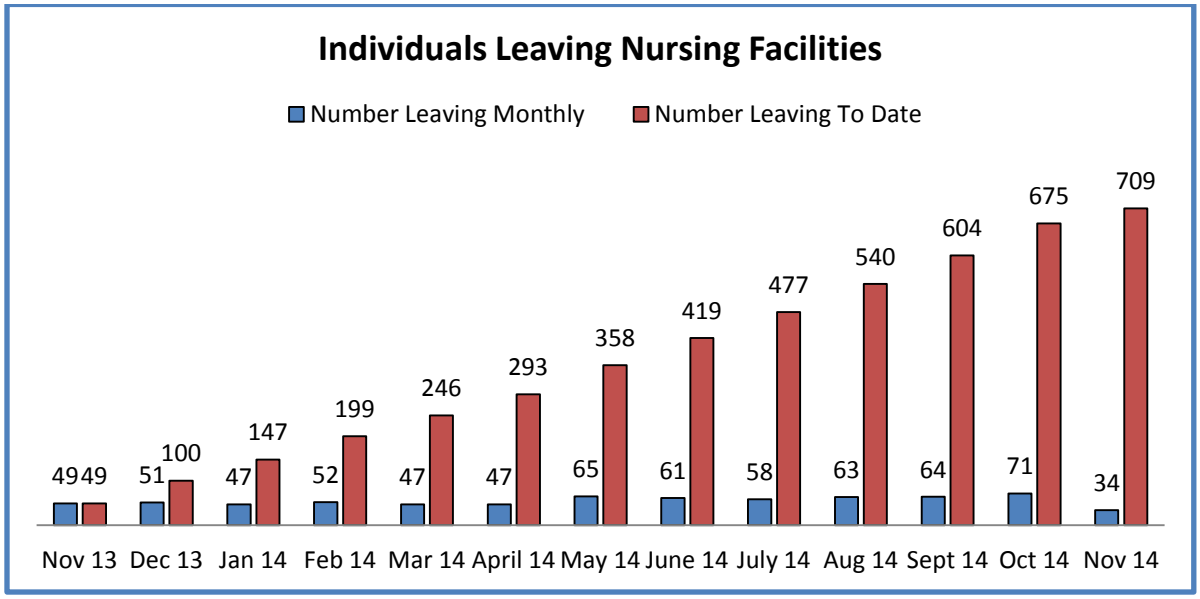


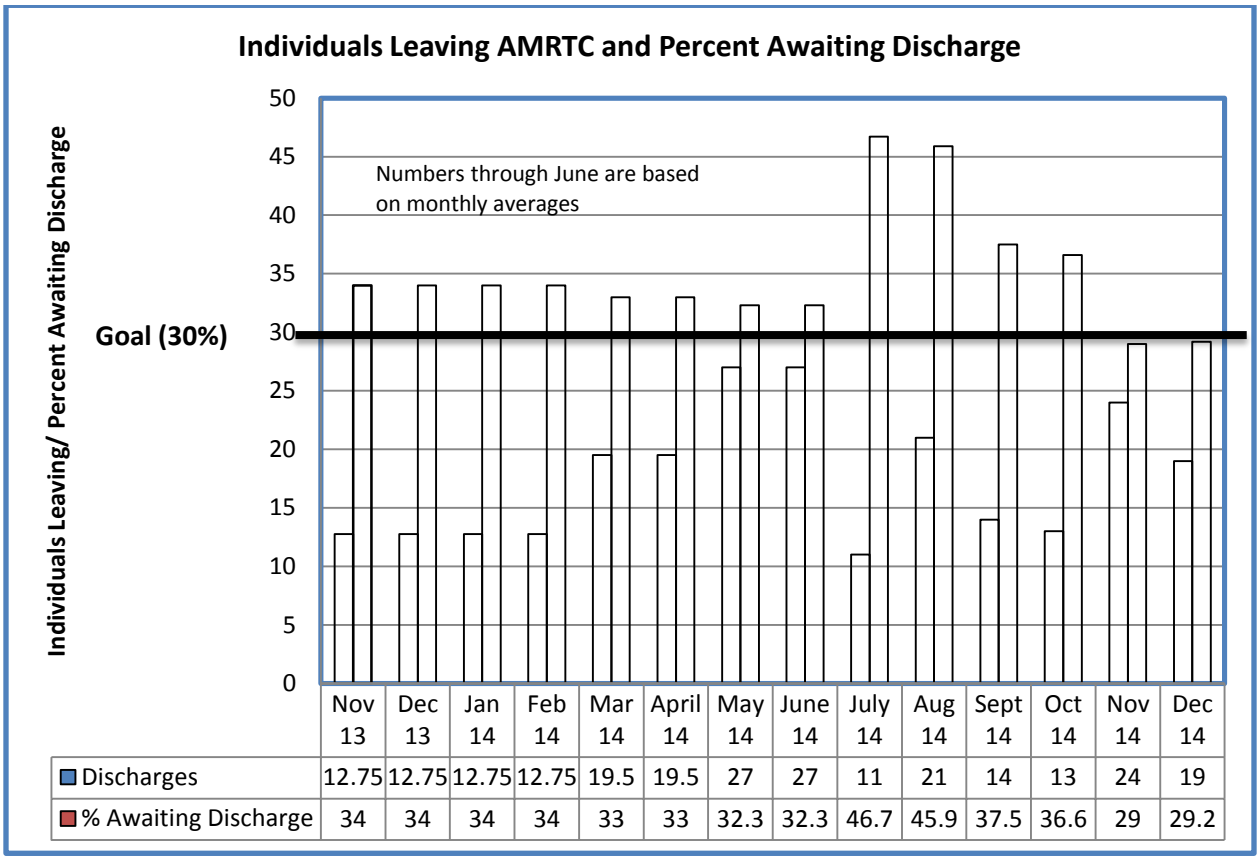
Exhibit 6-1 includes information on admissions, readmissions, discharges, and transfers to reflect the dynamic movement of individuals through segregated settings.

SS 2D - For individuals in Anoka Metro Regional Treatment Center (AMRTC):

Current daily average baseline of persons at AMRTC who do not require hospital level of care and are awaiting discharge to the most integrated setting is 40%.

- By December 31, 2014 the number of individuals who do not require hospital level of care and are awaiting discharge to the most integrated setting will be reduced to 30%.

Status: In November and December the percentages of individuals awaiting discharge was the lowest it has been in a year and has met the goal of 30%. In the same months there were 43 individuals discharged from AMRTC to most integrated settings. During that same timeframe there were 27 transfers, zero deaths, 41 admissions and 8 readmissions. The average daily census was 98.7 in November and 100.4 in December.



	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Discharges	12.75	12.75	12.75	12.75	19.5	19.5	27	27	11	21	14	13	24	19
% Awaiting Discharge	34	34	34	34	33	33	32.3	32.3	46.7	45.9	37.5	36.6	29	29.2

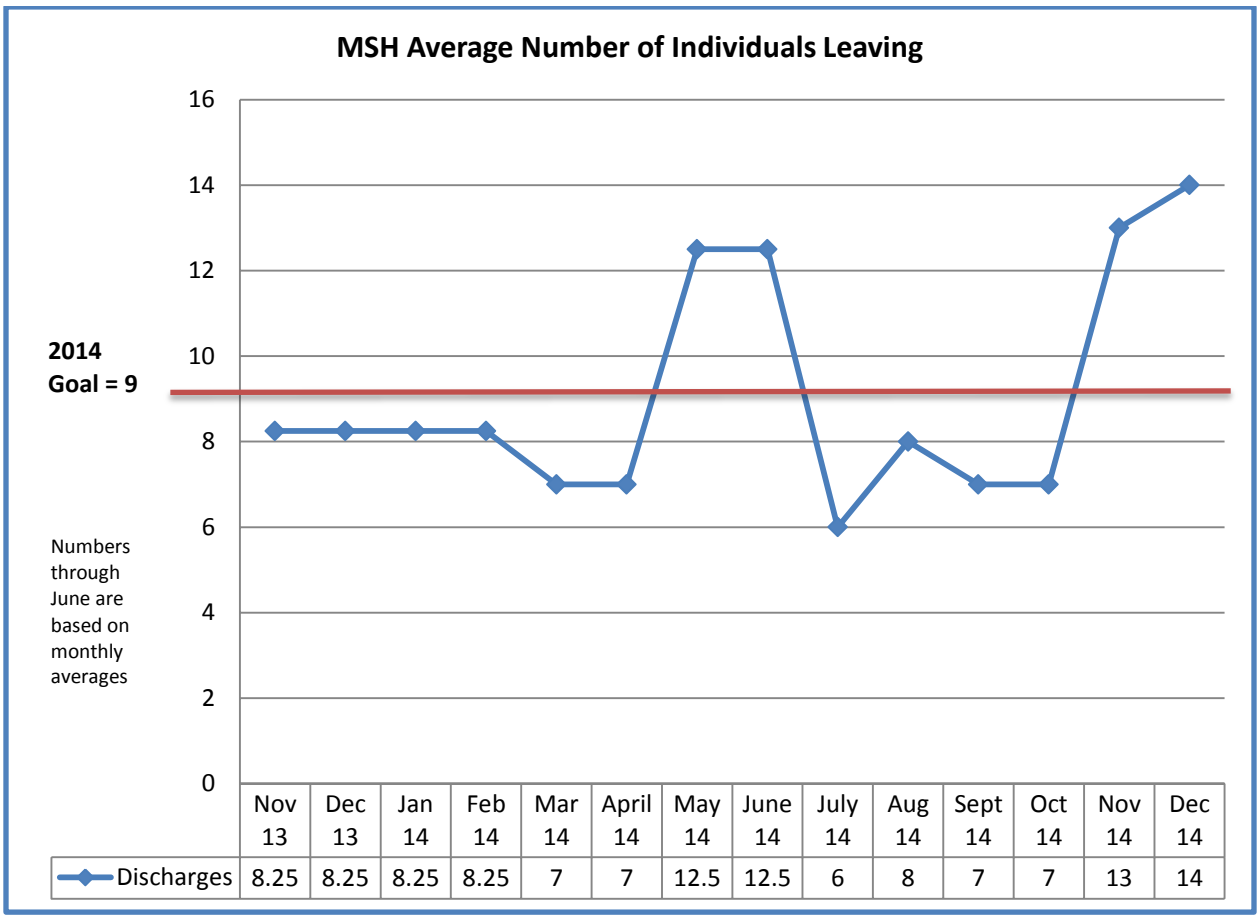
The spike in July and August was in part due to a new law that calls for people who are in jail to be admitted to Anoka within 48 hours. In many cases, that means on day one the individual does not meet hospital level of care criteria, so the influx of that population may have contributed to the increase of people who did not meet the criteria at the facility.

Exhibit 6-1 includes information on admissions, readmissions, discharges, and transfers to reflect the dynamic movement of individuals through segregated settings.

SS 2F - Minnesota Security Hospital (MSH) will increase the average monthly discharge rates according to the following timeline:

- By December 31, 2014, increase average monthly discharge rates from 8 individuals per month, to 9 individuals per month.

Status: As of December 31 2014 the average monthly discharge rate is 9.073. The goal of 9 has been met. In the months of November and December there were 27 discharges, 17 transfers and 1 death. During that same timeframe there were 27 admissions and 1 readmission. The average daily census was 375 in November and 375.6 in December.



	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Discharges	8.25	8.25	8.25	8.25	7	7	12.5	12.5	6	8	7	7	13	14

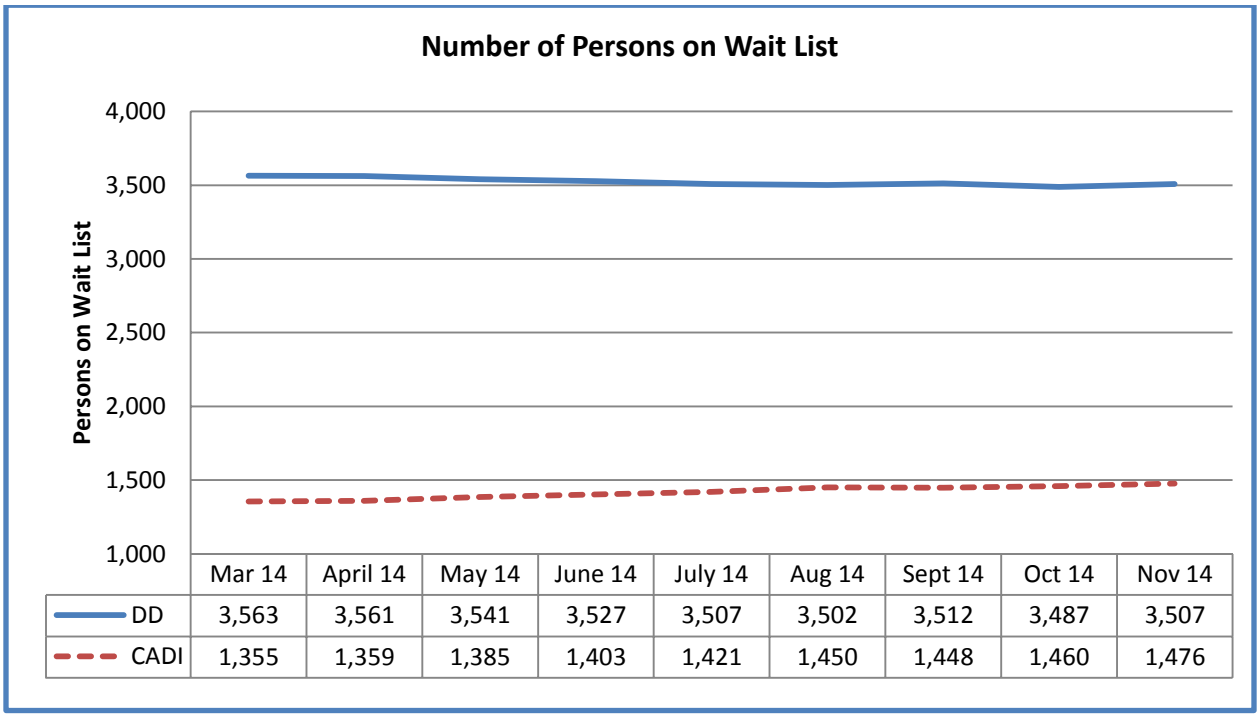
Exhibit 6-1 includes information on admissions, readmissions, discharges, and transfers to reflect the dynamic movement of individuals through segregated settings.

SS 4B: By September 30, 2014 DHS will report to the Olmstead Subcabinet, or its designee, recommendations on how to improve processes related to the home and community-based supports and services waiting list. The process will include the prioritization based on urgency and needs and describe how adopting these practices will result in the wait list moving at a reasonable pace.

Status: The graphs below provide the information that is currently available on the disability waivers wait list. It includes the number of individuals on wait lists for disability waivers[2], the number of individuals beginning waiver services and the number of individuals moving from the wait list.

This data does not include levels of urgency nor does it report the pace at which an individual moves off the wait list. A report submitted to the subcabinet included recommendations to establish urgency categories for waiting lists and parameters for measuring whether individuals are moving off the wait list at a reasonable pace.

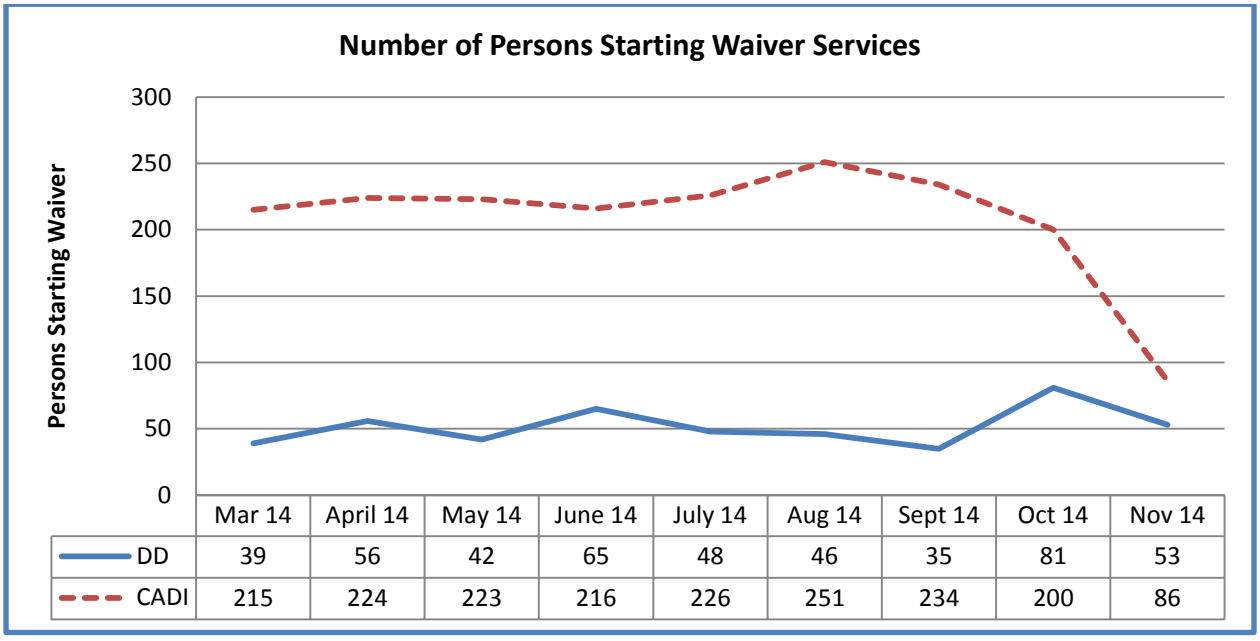
The first graph shows that the number of persons on the DD waiver wait list has remained at about the same level over the 9 month period, while the number of persons on the CADI waiver has increased over the same timeframe.



	Mar 14	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14
DD	3,563	3,561	3,541	3,527	3,507	3,502	3,512	3,487	3,507
CADI	1,355	1,359	1,385	1,403	1,421	1,450	1,448	1,460	1,476

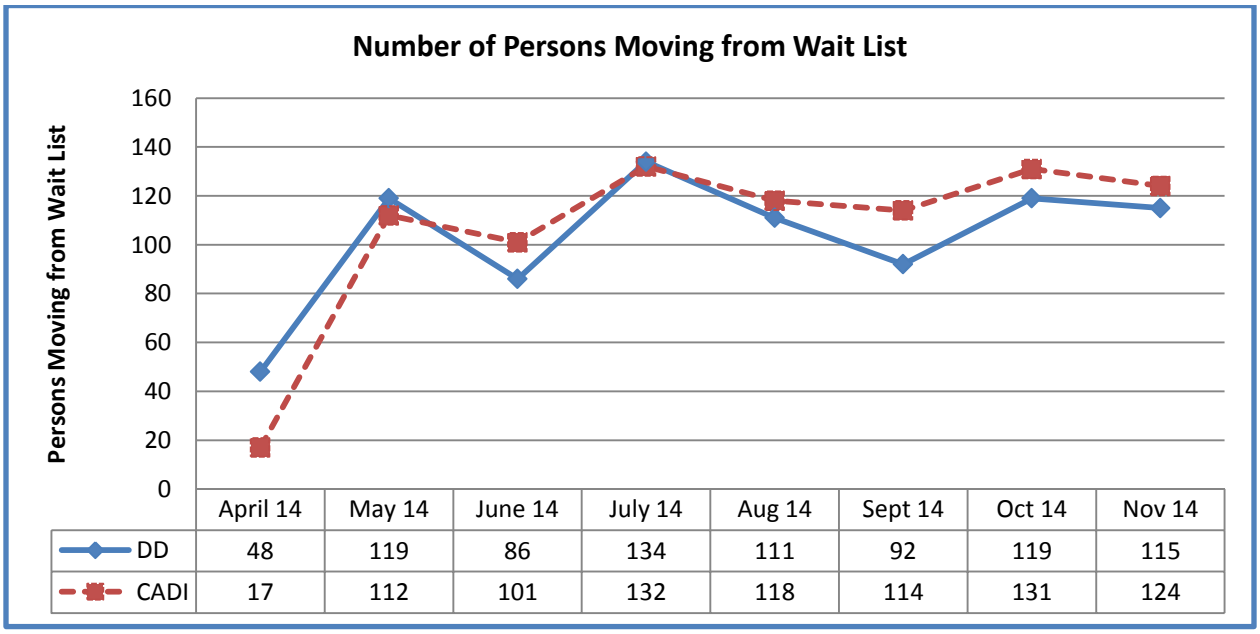
[2] Disability Waivers = Developmental Disabilities (DD) and Community Alternatives for Disabled Individuals (CADI)

The second graph shows the number of persons starting waiver services. This graph includes individuals on the wait list moving onto the waiver as well as those who were never on the wait list and has begun waiver services.



	Mar 14	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14
DD	39	56	42	65	48	46	35	81	53
CADI	215	224	223	216	226	251	234	200	86

The third graph shows that the number of persons moving from the wait list has increased since April and has been a similar amount since August. This graph includes persons moving from the wait list onto the waiver and individuals leaving the wait list for any other reason.

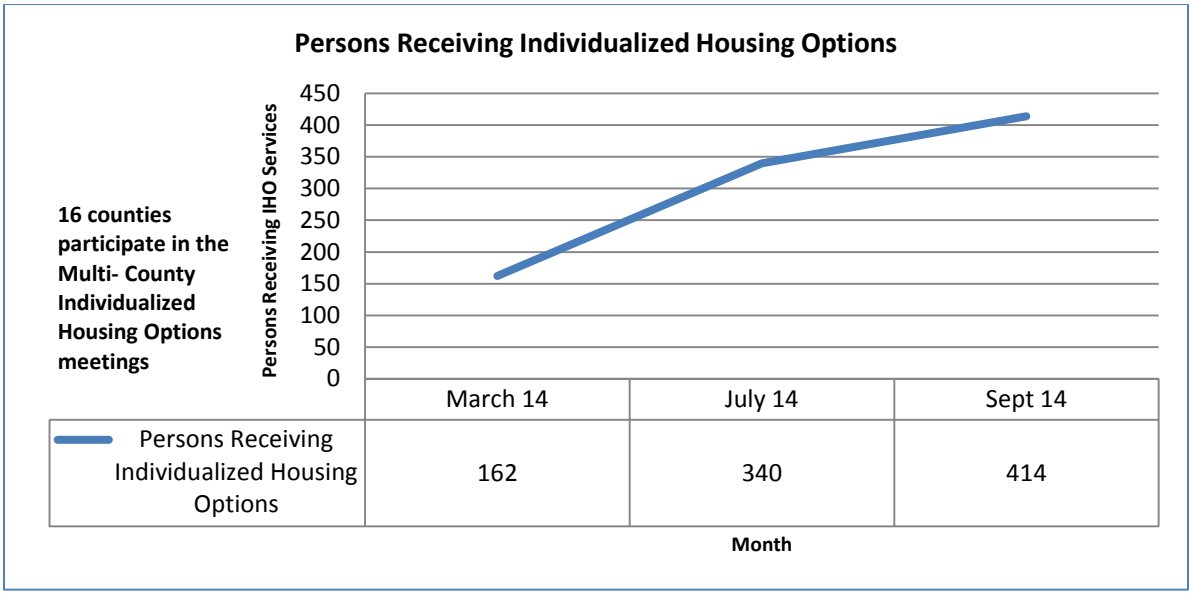


	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14
DD	48	119	86	134	111	92	119	115
CADI	17	112	101	132	118	114	131	124

HS 5B - By June 30, 2014, begin to measure the number of counties participating and the number of individuals receiving Individualized Housing Options services and report to the subcabinet every two months regarding progress on increasing the number of individuals receiving these services.

- By December 31, 2014 the number of counties participating will increase to 17.

Status: The number of counties participating is sixteen. Counties report the number of people that receive individualized housing options services. The number of individuals receiving services continues to increase over time.



Quality of Life Assessments

Quantitative Measure

The Quality of Life survey pilot was completed by December 31, 2014. The status update for action item QA 1C is included on page 12.

Qualitative Measure

Personal stories about individuals who moved to an integrated setting are not available for this report.

III. OLMSTEAD PLAN ACTION ITEMS STATUS UPDATE

The table below indicates the timeliness of the completion of action items due during the two month reporting period and any outstanding items needing approval by the subcabinet. More detailed information of the status of each action item is provided below.

Item	Deadline	Brief Description	On Time	Late	Subcabinet Action	
OV 1A	12/31/14	Individual planning service		X		March
OV 2B	12/31/14	Identify barriers to integration	X		February	
OV 3A	12/31/14	Leadership opportunities		X		March
QA 1C	12/31/14	Quality of life survey pilot	X		February	
QA 2A	6/30/14	Dispute resolution process		X		March
QA 3C.1	12/31/14	Annual report		X	February	
QA 3E	8/31/14	Olmstead Implementation Office Report		X	February	
QA 4A	9/30/14	Quality Improvement Plan		X		March
EM 3A	8/31/14	Person centered planning employment first		X		March
EM 3C	9/30/14	Federal contractor training	X		February	
EM 3D	9/30/14	Motivational interviewing training	X			March
EM 3J	12/31/14	Stories of contributions in the workplace	X		February	
HS 1A	9/30/14	Data on those in publicly funded housing	X		February	
HS 1E	12/31/14	Track individuals exiting corrections	X		February	
HS 2A	12/31/14	Affordable housing baselines/targets	X			March
HS 4B	9/30/14	Plan to educate public on HousingLink	X		February	
TR 1A	9/30/14	Transit spending baseline		X	February	
TR 1B	9/30/14	Review of administrative practices		X		March
TR 3A	8/31/14	MNDOT ADA Transition plan		X	February	
TR 4B	6/30/14	MCOTA alignment / recommendations		X	February	
SS 2G	9/30/14	Baselines/targets other segregated settings	X		February	
SS 3C	7/1/14	Analysis of policies on positive practices		X	February	
SS 3D	7/1/14	Statewide plan for positive practices		X	February	
SS 3E	8/1/14	Common incident reporting process		X	February	
SS 3I	8/1/14	Crisis triage and hand-off process		X		March
SS 3J	12/1/14	Technical assistance on positive practices		X		March
SS 4B	9/30/14	Improvements to the waiting list	X			March
SS 4C	12/31/14	Expand use of assistive technology		X		March

Item	Deadline	Brief Description	On Time	Late	Subcabinet Action	
SS 4D	9/30/14	FACT teams for those exiting corrections		X	February	
ED 1D	11/30/14	Stakeholder input on prohibition of prone restraint in schools	X			March
HC 1C	12/31/14	Framework for behavior health home	X			March
HC 2D	9/30/14	Identify data sources for health measures		X	February	
HC 2G	12/31/14	Baseline data for current care	X			March
HC 2I	9/30/14	Barriers in healthcare transitions for youth		X		March
HC 2J.1	12/31/14	50% of youth transition to adult health care	X			March
CE 1A	12/31/14	Increase opportunities in policy making		X		March
CE 1B	12/31/14	Peer support and self-advocacy programs		X		March
CE 2A	12/31/14	Involvement in public planning processes		X		March

- On Time = verified as completed on the due date
- Late = verified as completed after the due date
- Subcabinet Action = month subcabinet takes action on the item

ITEMS FOR REVIEW AT FEBRUARY SUBCABINET MEETING

The purpose of this section is to report the status of action items under each topic area that are due during this reporting period and items that need to be approved by the subcabinet.

OVERARCHING STRATEGIC ACTIONS

- **OV 2B -** By December 31, 2014 identify barriers to integration that are linked to federal legislation, regulation, or administrative procedures; identify options to address them.

  Status: The deadline was met. A contract was initiated with Management Analysis & Development (MAD) for assistance in survey and evaluation. A survey was sent to internal and external stakeholders to help identify barriers and disincentives to integration. A meeting to review survey submission was held with disability stakeholder groups comprised of representatives from the Governor appointed disability councils. **Exhibit 6-2** includes the survey results and recommendations for consideration by the subcabinet.

QUALITY ASSURANCE AND ACCOUNTABILITY

- **QA 1C -** By December 31, 2014 conduct a pilot of the (quality of life) survey.

  Status: The deadline was met. A contract was initiated with The Improve Group to conduct the pilot survey. The pilot study tested the survey tool to ensure that it was effective across all disabilities, age groups and settings. **Exhibit 6-3** includes the report which identifies and addresses

challenges in the survey administration process to assure that the survey process goes as smoothly as possible in future iterations.

- **QA 3C.1** – By December 31, 2014 an annual report will be issued by the subcabinet.

  Status: The deadline was not met. An annual report summarizing Olmstead Plan activities from November 2013 through December 2014 is included as **Exhibit 6-4**.

- **QA 3E** - By August 31, 2014 the subcabinet will issue a report on the staffing, funding and responsibilities of the Olmstead Implementation Office and on the oversight and monitoring structure described above, including timelines for completion of any outstanding action items.

  Status: The deadline was not met. The Olmstead Implementation Office report is included as **Exhibit 6-5.** The report summarizes activities for the timeframe of November 1, 2013 through December 31, 2014. The report covers the execution of the first and second Executive Orders and the transition process. The report also includes the structure of the office and the utilization of DHS Compliance team and an overview of the current status of outstanding action items.

EMPLOYMENT

- **EM 3C -** By September 30, 2014 Disability Employment Specialists will provide training and technical assistance to federal contractors regarding the 7 % workforce participation benchmark established in the revised regulations implementing Section 503 of the Rehabilitation Act of 1973.

  Status: The deadline was met. Training on Section 503 requirements is now a staple element of the training the Disability Employment Specialists provide. **Exhibit 6-6** includes the training handouts and curriculum that is used and the training calendar for 2014. The initial training calendar for 2015 is also included.

- **EM 3J -** By December 31, 2014 publicize statistics, research results and personal stories illustrating the contributions of persons with disabilities in the workplace.

  Status: The deadline was met. On December 1, 2014, a report to the Legislature was published on the status and evaluation of the Individual Placement and Support (IPS) approach to supported employment for people with serious mental illness. The report includes data, statistics, comments, and recommendations for expanding the program to comply with the *Olmstead* Plan and meet the needs of Minnesotans with mental illness who require employment services.

  In addition, the State Rehabilitation Council (SRC) published their annual report on January 28, 2015. The report contains statistics and results of the Vocational Rehabilitation program, including personal stories about individuals who have obtained employment. The reports are available online and in print. They are distributed in electronic or print format to legislators, mental health providers, advocacy organizations. **Exhibit 6-7** includes both publications.

HOUSING

- **HS 1A -** By September 30, 2014 data gathering and detailed analysis of the demographic data on people with disabilities who use public funding will be completed.

  Status: The deadline was met. This action item aligns with action item SS 2G. Refer to the status for that item in the Supports and Services section below.

- **HS 1E -** By December 31, 2014 develop a process to track the number of individuals with disabilities exiting state correctional facilities and their access to appropriate services and supports.

  Status: The deadline was met. Within the Department of Corrections' Facilities Division, business procedures exist within the intake and case management processes that can be used to identify inmates who meet the definition of "disability". An information systems change will need to be made in order to compile those processes for purposes of reporting and for tracking services received following release. Criteria within the current business process that would identify individuals with disabilities are: health care screening, health services release planning, medical exam, health profile, ADA access plan, and education assessment. **Exhibit 6-8** maps out the business process.

- **HS 4B -** By September 30, 2014 a plan to inform and educate people with disabilities, case workers, providers and advocates about HousingLink will be developed.

  Status: The deadline was met. HousingLink used a combination of web-based and in-person strategies to inform and educate people with disabilities, case workers, providers and advocates about HousingLink. This included 18 feedback sessions throughout the state and 10 additional events for the specific purpose of educating and informing communities. Minnesota Housing used the ideas and concepts generated during the consultation sessions to develop a work plan which is included in **Exhibit 6-9**. The plan will:

  1. Create a "test environment" website based on feedback received during the listening session
  2. Seek potential users (i.e. persons with disabilities and other relevant individuals) to "test" the website
  3. Collect feedback and suggestions on the usability of the test site; modifying as necessary
  4. Continue informing and educating persons with disabilities, their case workers, providers, advocates, family members, etc. about HousingLink and its resources

  Although access to computers was not an identified barrier for persons with disabilities, Disability Linkage Line and Senior Linkage Line staff are trained in the use of HousingLink to help those who call in. Access to quality internet was an identified barrier. HousingLink is responding to this concern by creating a mobile friendly HousingLink app which requires less bandwidth resulting in a stronger interface quality.

TRANSPORTATION

- **TR 1A -** By September 30, 2014 the Dept. of Human Services, MnDOT and Metropolitan Council will establish a baseline of services and transit spending across public programs they administer.

  Status: The deadline was not met. The Center for Transportation Studies (CTS) has been working with DOT and DHS to obtain data on transportation expenditures of both agencies. A schematic of funding and a detailed table of funding sources were developed. The final report is attached in **Exhibit 6-10**.

- **TR 3A** - By August 31, 2014 complete MnDOT ADA Transition Plan.

  Status: The deadline was not met. The transition plan was open for public comment until August 26, 2014. Comments were taken into consideration and changes were made accordingly. The final plan is available online and is included as **Exhibit 6-11**.

- **TR 4B-** By June 30, 2014 report to the Olmstead Subcabinet on MCOTA's alignment with the Olmstead Plan actions and timelines, and include recommendations for any necessary changes.

  Status: The deadline was not met. The Department of Transportation (DOT) submitted a report to the subcabinet on August 11, 2014 that determined that because MCOTA's role is advisory in nature, they are not in the position to implement the action items. A follow up report is attached as **Exhibit 6-12**. DOT is requesting a modification of the Plan. Once the subcabinet approves the modification, it will be submitted to the Court Monitor.

SUPPORTS AND SERVICES

- **SS 2G -** By September 30, 2014, DHS will identify a list of other segregated settings, how many people are served in those settings, and how many people can be supported in more integrated settings.

  Status: The deadline was met. A report that details the demographic analysis, setting counts, targets and timelines was submitted to the subcabinet on December 15, 2014 and is included as **Exhibit 6-13.** Baselines and measurable goals were approved by the subcabinet on November 3, 2014. They were submitted to the Court Monitor for consideration on November 10, 2014.

- **SS 3C** - By July 1, 2014 the state will create an inventory and analysis of policies and best practices across state agencies related to positive practices and use of restraint, seclusion or other practices which may cause physical, emotional, or psychological pain or distress.

  Status: The deadline was not met. A facilitated conversation between DHS and MDE took place to identify policies and best practices related to positive practices and use of restraint, seclusion and other practices which may cause physical, emotional, or psychological pain or distress. **Exhibit 6-14**

includes “Minnesota’s Statewide Plan” which was submitted to the Subcabinet on October 22, 2014. The report identifies areas where gaps exist with plans and timelines to address the gaps. The report anticipates routine reporting to the subcabinet on the status of implementation of the plan.

- **SS 3D** - By July 1, 2014 a report outlining recommendations for a statewide plan to increase positive practices and eliminate use of restraint or seclusion will be delivered to the Olmstead Subcabinet or their designee by an assigned team of representatives from Olmstead Subcabinet agencies.

  Status: The deadline was not met. This action item was done in coordination with SS 3C and SS 3E. See the status update for SS 3C above.
- **SS 3E** - By August 1, 2014 the state will develop, across state agencies, a common definition of incidents, including emergency use of manual restraint, that are to be reported, and create common data collection and incident reporting processes.

  Status: The deadline was not met. This action item was done in coordination with SS 3C and SS 3D. See the status update for SS 3C above.

- **SS 4D -** By September 30, 2014, Department of Corrections (DOC) and Department of Human Services (DHS) will analyze the need for a FACT and/or ACT team with high fidelity and a forensics component and establish measurable goals for actual services to benefit individuals.

  Status: The deadline was not met. A needs analysis identified 110 individuals who would be eligible for FACT services. The FACT model is an adaptation of the evidence-based model of Assertive Community Treatment. It is a program that provides treatment, rehabilitation, and support services to individuals who have schizophrenia, schizoaffective disorder, bipolar disorder and who have significant and persistent functional impairments (homelessness, repeated hospitalizations, unemployment) coupled with significant involvement in the corrections system. **Exhibit 6-15** provides information on the needs analysis and the FACT model.

  The governor’s budget proposal includes funding for this item. An update will be provided after the legislative session is over and actual funding appropriations are known. This item was submitted to the Court Monitor for consideration on November 10, 2014.

HEALTHCARE AND HEALTHY LIVING

- **HC 2D -** By September 30, 2014 identify data sources; establish data sharing agreements between state agencies, local agencies and service organizations, and the academic community; identify any necessary legislative changes.

  Status: The deadline was not met. The data sources to be analyzed were identified. The analysis plan was completed and is included as **Exhibit 6-16**. No data sharing agreements are currently necessary, but they will be developed in the future if needed.

ITEMS FOR REVIEW AT MARCH SUBCABINET MEETING

The subcabinet has scheduled a special meeting on March 10, 2015 to complete the review of action items for the reporting period and any outstanding items needing approval by the subcabinet.

Overarching Strategic Actions

- **OV 1A -** By December 31, 2014, Define an individual planning service that is available to people with disabilities to assist them in expressing their needs and preferences about quality of life. (This service may be an expansion of an existing practices or development of new practices.); Make funds available for this purpose.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

- **OV 3A -** By December 31, 2014 leadership opportunities will be identified and implemented.

  Status: The December 31, 2014 deadline was not met. This item will be reviewed at the March subcabinet meeting.

Quality Assurance and Accountability

- **QA 2A** – By June 30, 2014 the state will establish a dispute resolution process.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

- **QA 4A -** By September 30, 2014 the subcabinet will adopt an Olmstead Quality Improvement plan to be administered by the Olmstead implementation office.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

Employment

- **EM 3A** - By August 31, 2014 enhanced Person Centered Planning training components will be offered to assure employment-planning strategies and Employment First principles are understood and incorporated into the tools and planning process.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

- **EM 3D -** By September 30, 2014 establish plan to provide cross-agency training on motivational interviewing.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

Housing

- **HS 2A -** By December 31, 2014 a baseline will be established and targets for future years determined addressing: The number of new affordable housing opportunities created compared to the previous 5 years' average; the number of people with disabilities accessing affordable housing opportunities in the community; the number of people with disabilities with their own lease; and for people who

move to more integrated settings, track measures related to housing stability such as duration of residence and transitional moves within the system.

Status: The deadline was met. This item will be reviewed at the March subcabinet meeting.

Transportation

- **TR 1B -** By September 30, 2014 review administrative practices and implement necessary changes to encourage broad cross state agency coordination, including non-emergency protected transportation.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

Supports and Services

- **SS 3I** - By August 1, 2014 a coordinated triage and "hand-off" process for crisis intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation. Report will be delivered to the Olmstead Subcabinet.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

- **SS 3J -** By December 1, 2014 an assigned team of representatives from state agencies, community organizations, community corrections and people with disabilities who have used the crisis system will: identify best practices, including use of technology; set service standards; and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions (e.g. person-centered planning, positive practices, available resources). Progress toward goal will be reported to the Olmstead Subcabinet or their designee.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

- **SS 4B -** By September 30, 2014 DHS will report to the Olmstead Subcabinet, or its designee, recommendations on how to improve processes related to the home and community-based supports and services waiting list. The process will include prioritization based on urgency and needs and describe how adopting these practices will result in the wait list moving at a reasonable pace.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

- **SS 4C -** By December 31, 2014, develop a plan to expand the use of assistive and other technology in Minnesota to increase access to integrated settings. The plan will specifically include an evaluation of Medicaid funding possibilities, a plan for agency collaboration regarding assistive technology, and a plan for coordinated refurbishment/reuse of assistive technology. The plan will include forecasts, goals, and timelines for expanding the use of technology that increases access to integrated settings.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

Lifelong Learning and Education

- **ED 1D -** By November 30, 2014 the restrictive procedure stakeholder workgroup will meet to discuss and recommend revisions to Minnesota Statutes §125A.0942 subd. 3 (8) to clarify that prone restraint will be prohibited by August 1, 2015 in Minnesota school districts and will apply to children of all ages.

  Status: The deadline was met. This item will be reviewed at the March subcabinet meeting.

Healthcare and Healthy Living

- **HC 1C -** By December 31, 2014 engage consumers of services to inform the design of the first framework to serve adults and children; design the model; obtain approval to implement the framework and develop contingency plan for moving work forward if approval is not obtained; and, determine the fiscal effects of statewide implementation in near-term.

  Status: The deadline was met. This item will be reviewed at the March subcabinet meeting.

- **HC 2G -** By December 31, 2014 establish baseline data for current care (medical, dental, chiropractic and mental health) of people with disability; develop an implementation plan to further assess, develop, and respond.

  Status: The deadline was met. This item will be reviewed at the March subcabinet meeting.

- **HC 2I -** By September 30, 2014 complete a system analysis describing barriers that need resolution; develop a plan for addressing these barriers.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

- **HC 2J.1 -** By December 31, 2014 50% of Minnesota's transition age youth with disabilities will receive the services necessary to make transitions to adult health care. Biannually thereafter, there will be a 5% increase in the proportion of transition age youth with disabilities who receive the services necessary to make transitions to adult health care.

  Status: The deadline was met. This item will be reviewed at the March subcabinet meeting.

Community Engagement

- **CE 1A-** By December 31, 2014 the state will develop a plan to increase opportunities for people with disabilities to meaningfully participate in policy development and provide the plan to the Olmstead Subcabinet.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

- **CE 1B -** By December 31, 2014 in consultation with people with disabilities, family members, and diverse community groups, the state will assess the size and scope of peer support and self-advocacy programs; based on this information the state will set annual goals for progress. Recommendations, including funding and any necessary legislative changes, will be made to the subcabinet.

Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

- **CE 2A -** By December 31, 2014 the state will evaluate, revise as necessary, and disseminate guidelines and criteria when public dollars are used for ensuring that people with disabilities are incorporated in public planning processes, and that plans for public facilities and events are informed by attention to inclusion of people with disabilities. The guidelines and plans for incorporating them in public processes will be reported to the Olmstead Subcabinet or their designee.

  Status: The deadline was not met. This item will be reviewed at the March subcabinet meeting.

PREVIEW OF ITEMS DUE IN NEXT FOUR MONTHS

A preview of Olmstead Plan action items that are due from January 1, 2015 through April 30, 2015 are included in **Appendix 6-A**.

IV. ACTIONS TAKEN BY SUBCABINET

1. The subcabinet approved items due for review at February meeting (page 12 – 16)
2. The subcabinet approved moving review of action items to March meeting (page 17 – 20)
3. The subcabinet approved the February Bimonthly report
4. The subcabinet approved the formation of a Quality of Life workgroup
5. The subcabinet approved designating QA 4B.1 to DHS and MDH
6. The subcabinet approved modification of the plan based on the recommendations report for action item TR 4B

INDEX OF APPENDICES AND EXHIBITS

APPENDIX 6-A: PREVIEW OF JANUARY–APRIL ACTION ITEMS

Key to abbreviations used in Grid:

TOPIC AREAS

CE = Community Engagement

ED = Lifelong Learning and Education

EM = Employment

HC = Healthcare and Healthy Living

HS = Housing

OV = Overarching Strategic Actions

QA = Quality Assurance and Accountability

SS = Supports and Services

TR = Transportation

RESPONSIBLE AGENCY

DEED = Department of Employment and Economic Development

DHS = Department of Human Services

DOC = Department of Corrections

MDE = Minnesota Department of Education

MDH = Minnesota Department of Health

MDHR = Minnesota Department of Human Rights

MHFA = Minnesota Housing Finance Agency

MnDOT = Minnesota Department of Transportation

OIO = Olmstead Implementation Office

SC = Subcabinet

Appendix 6-A - Preview of Action items for January – April 2015 (in alphabetical order)

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
EM	2G	1/1/2015	Clarify cross-agency employment service planning and coordination to expand competitive employment in the most integrated setting.	43	DHS, DEED, MDE	The Interagency Employment Panel identified program, planning and funding priorities for the 2015 legislative session. These recommended activities leverage existing funding streams and support innovation and interagency coordination.
EM	3F	1/1/2015	Provide technical assistance and support to non-integrated/facility-based employment programs to develop and design new business models that lead to competitive employment in the most integrated setting	44	DHS, DEED, MDE, MDHR	Currently 18 agencies and 62 individuals have completed the ACRE training in Customized Employment. Additional training is scheduled in January. A leadership strategy workshop is scheduled in January and will focus on developing recommendations on structuring agency resources to improve supported (customized) employment implementation.
EM	3L.1	1/1/2015	Distribute findings, policy interpretations and recommendations from Interagency Employment Panel (annual)	45	DHS, DEED, MDE, MDHR	Interagency Employment Panel continues to meet on a regular basis. The report will be completed in January 2015.
HC	1A	1/1/2015	Establish baselines and targets to increase number of teams that are able to provide integrated, person-centered primary care for persons with disabilities	76	DHS, MDH	There are 735 eligible clinics in the State. In October 2013 the number of clinics certified as Health Care Homes (HCH) was 252, or 35% of primary care clinics in the state. Currently, the number of clinics that are certified as HCHs is 356, or 56% of primary care clinics in the state. Goal for 2016 is 67%. This information is due for submission to the Court Monitor.
SS	1B	1/1/2015	Establish characteristics and criteria that define best practices in person-centered planning and the Olmstead requirements, to be used by state agencies to evaluate and revise their assessment and plan content	62	SC	Reviewing the work done on person-centered planning when completing the July draft of the Plan. Working with agency staff and stakeholder to define criteria.

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
SS	2A.2	1/1/2015	For all individuals leaving certain settings for the most integrated settings, designated protocols and processes to support individuals will be used	63	DHS	Anoka Metro Regional Treatment Center (AMRTC), MSH-St. Peter and LifeBridge have begun implementing transition protocols. These protocols consist of the use of a defined transitioning summary tool and the policies/ procedures that surround the use of that tool. Work continues on the tool for Persons with Developmental Disabilities (ICF/DD) and people under 65 in nursing homes for more than 90 days and its implementation.
HS	3A	1/6/2015	Prepare proposals for legislative proposals for the 2015 session, giving priority to changes that promote choice and access to integrated housing settings	52	DHS	Group Residential Housing (GRH)/Minnesota Supplemental Aid (MSA) legislative proposal is complete and is currently being reviewed through the Governor's budget process.
OV	2C	1/6/2015	Prepare proposals for legislative and fiscal changes for the 2015 session to reduce barriers to integration	32	SC	Proposals were prepared for 2015 session.
SS	2J	1/6/2015	Develop a legislative initiative to fund an electronic health record system to assist with release of individuals from corrections facilities to community settings with appropriate levels of support	65	DHS, DOC	A legislative request for funding for electronic health records has been completed, and is currently being reviewed through the Governor's budget process.
SS	4E	1/6/2015	Develop a legislative initiative to build capacity and/or expand services for an assertive community treatment team for individuals leaving corrections facilities	69	DHS, DOC	A legislative proposal for the 2015 session has been drafted and is currently being reviewed within the Governor's budget process.
TR	1D	1/6/2015	Prepare proposals for legislative proposals for the 2015 session; priority to changes that will increase funding flexibility to support increased access to integrated transportation	57	DHS	Legislative proposals have been drafted relating to non-emergency protected transportation and increasing transportation outstate. They are currently being reviewed within the Governor's budget process.

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
SS	3J.1	1/15/2015	Complete the necessary analysis and planning to expand crisis services, diversion, and early intervention services to persons at risk of experiencing a crisis situation; set dates for implementation	67	DHS	Legislative proposals have been developed to expand mobile mental health crisis services to serve persons with disabilities and to develop regional Positive Behavior Supports and Person-Centered Planning communities of practice to develop system-wide capacity for early intervention services. They are currently being reviewed within the Governor's budget process.
HS	1B	1/30/2015	Develop timeframe for completing individual assessments and facilitating moves into more integrated housing settings	50	DHS	This action item relates to the demographics report completed in SS 2G. Work is underway to design individual assessments. A review of transition protocols is underway. This includes looking at housing within the various assessment processes that are planned or currently in place.
SS	2A.3	1/31/2015	Develop a method to measure and track individuals transitioning from certain settings to assess transition success and stability and to identify problems.	63	DHS	Work continues on a tool to track and measure individuals transitioning to the community.
SS	2H	1/31/2015	Make a legislative request in support of the movement of the individuals in other segregated settings within established timelines	64	DHS	A number of legislative proposals for the 2015 session have been drafted and are currently They are currently being reviewed within the Governor's budget process.
ED	1E	2/1/2015	Report to the legislature on districts' progress in reducing the using of restrictive procedures in Minnesota schools and on stakeholder recommendations regarding Minnesota Statutes §125A.0942 subd. 3 (8)	72	MDE	Restrictive procedures workgroup meeting schedule has been set for the 2014/2015 school year. The workgroup will provide recommendations related to the prohibition of prone restraint and work plan activities to be included in the February 1, 2015 legislative report.
OV	1B	3/31/2015	Initiate new individual planning service to assist people with disabilities in expressing their needs and preferences about quality of life	31	SC	Subcabinet needs to assign to appropriate agencies

EXHIBIT 6-1: OLMSTEAD PLAN IMPACT ON LIVES OF INDIVIDUALS

INDIVIDUALS MOVING FROM SEGREGATED TO INTEGRATED SETTINGS

SS 2C - ICFs/DD and Nursing Facilities (for persons under 65 in facility longer than 90 days)

The tables below contain information about the movement of individuals through the segregated settings of ICFs and Nursing Facilities (NF). It includes Medicaid recipients only and is based on Medical Assistance billing databases. Revisions may be made in subsequent months due to billing and accounting practices.

Intermediate Care Facilities for Persons with Developmental Disabilities

Month	Moved to community[1]	Admissions	Readmits	Transfers	Deaths
November 13	9	9	0	2	0
December 13	15	16	0	4	0
January 14	1	9	0	3	1
February 14	1	8	0	3	0
March 14	4	17	0	7	0
April 14	5	23	1	12	0
May 14	10	14	0	6	2
June 14	13	11	0	1	0
July 14	13	7	0	2	0
August 14	4	8	0	2	0
September 14	2	1	0	1	0
October 14*	8	6	0	1	0
November 14*	1	1	0	1	0
Totals	86	130	1	45	3

Nursing Facilities (for persons under 65 in facility longer than 90 days)

Month	Moved to community[2]	Admissions	Readmits	Transfers	Deaths
November 13	49	81	0	8	1
December 13	51	83	0	14	2
January 14	47	85	0	19	5
February 14	52	80	0	11	3
March 14	47	61	0	10	6
April 14	47	86	0	15	9
May 14	65	72	0	15	8
June 14	61	55	0	7	5
July 14	58	57	0	11	7
August 14	63	23	0	7	5
September 14	64	24	0	10	6
October 14*	71	11	0	7	7
November 14*	34	4	0	5	6
Totals	**709**	**722**	**0**	**139**	**70**

*Data source problems were reported for months of October and November 2014

[1] Community includes private home/apartment, board/care, group home and adult foster home

[2] Community includes private home/apartment, board/care, group home and adult foster home, and assisted living

SS 2D - Anoka Metro Regional Treatment Center (AMRTC)

The table below contains information about the number of individuals at AMRTC who have been discharged to community settings and the percent of individuals who do not meet hospital level of care and are awaiting discharge. Readmissions include individuals returning whose Provisional Discharge has been revoked. Transfers are also reported as a discharge as they are not counted on the AMRTC census. Individuals who are transferred have a transition plan in place which includes a community service option and not a return to AMRTC.

Month	Discharges	% Awaiting discharge	Deaths	Admissions	Readmits*	Avg. Daily census	Transfers*
Nov 13-Feb 14	51	34%					
March-April 14	39	33%	0	62		108	
May-June 14	54	32.3%	0	61		106	
July 14	11	46.7%*	0	23		108	
August 14	21	45.9%*	0	33		108	
September 14	14	37.5%	0	27	2	104.7	16
October 14	13	36.6%	0	19	2	102.3	12
November 14	24	29.0%	0	24	3	98.7	15
December 14	19	29.2%	0	17	5	100.4	12

*The spike in July and August was in part due to a new law that calls for people who are in jail to be admitted to Anoka within 48 hours. In many cases, that means on day one the individual does not meet hospital level of care criteria, so the influx of that population may have contributed to the increase of people who did not meet the criteria at the facility.

SS 2F - Minnesota Security Hospital (MSH)

The table below contains information about individuals from MSH being discharged to more integrated settings. Information is also provided regarding the number of discharges in progress and the timeliness of the discharge process. Readmissions include individuals who were readmitted into a psychiatric treatment setting or jail within 3-6 months of discharge.

Month	Dis-charge	D/C in progress	< 180 days	> 180 days	Readmit	Deaths	Trans-fers*	Admits	Avg Daily census
Nov 13 - Feb 14	33	41	76%	24%	0				
Mar-April 14	14	60	77%	23%	0	0		26	365
May-June 14	25	56	79%	21%	0	1		27	369
July 14	6	56	37%	63%	1	1		10	367
Aug 14	8	64	55%	45%	0	0		14	371
Sept 14	7	72	48%	52%	0	1	1	14	374.3
Oct 14	7	77	54%	46%	0	0	0	11	373.5
Nov 14	13	67	31%	36%	0	1	10	12	375
Dec 14	14	73	36%	37%	1	0	7	15	375.6

*As of September 2014, the State began reporting readmissions and transfers in response to the September 18, 2014 Court order which stated, "Any calculation must consider admissions, readmissions, discharges, and transfers—reflecting the dynamic movement of individuals through segregated settings—to determine the net number of people who have moved into more integrated settings."

SS 4B - WAIT LIST INFORMATION

Below is the information that is currently available on the disability waivers wait list. It includes the number of individuals on wait lists for disability waivers, the number of individuals beginning waiver services and the number of individuals moving from the wait list. This data does not include levels of urgency nor does it report the pace at which an individual moves off the wait list.

A report submitted to the subcabinet included recommendations to establish urgency categories for waiting lists and parameters for measuring whether individuals are moving off the wait list at a reasonable pace.

Disability Waiver[3]	**March 2014**	**April 2014**
	Recipients on waivers	
DD	15,279	14,206
CADI	18,930	17,668

	March 14	**April 14**	**May 14**	**June 14**	**July 14**	**Aug 14**	**Sept 14**	**Oct 14**	**Nov 14**
	Number of persons on wait lists for disability waivers								
DD	3,563	3,561	3,541	3,527	3,507	3,502	3,512	3,487	3,507
CADI	1,355	1359	1,385	1,403	1,421	1,450	1,448	1,460	1,476
	Number of persons beginning waiver services								
DD	39	56	42	65	48	46	35	81	53
CADI	215	224	223	216	226	251	234	200	86
	Number of persons moving from wait list[4]								
DD		48	119	86	134	111	92	119	115
CADI		17	112	101	132	118	114	131	124

Medical Assistance billing databases are being used to track these items. Variations from month to month may be due to billing and accounting practices. To reflect changes, monthly figures may be updated in future reports.

[3] Disability Waivers= Developmental Disabilities (DD) and Community Alternatives for Disabled Individuals (CADI)
[4] A person with urgent need does not go on a waiting list but goes directly to receiving waiver services.

RECEIVING INDIVIDUALIZED HOUSING OPTION SERVICES (HS 5B)

Baseline information from March 2014

- Counties participating in Individualized Housing Options = 14
- Counties who have issued RFP/RFI related to Individualized Housing Options = 6
- People receiving specialized Individualized Housing Options services as a direct result of one of the RFPs/RFIs = 162

People receiving specialized Individualized Housing Options services as a direct result of RFP/RFI

County	March 2014	July 2014	September 2014	Total
Anoka	-	50	3	**53**
Dakota	-	10	12	**22**
Hennepin	82	53	23	**158**
Olmsted	40	5	5	**50**
Ramsey	-	48	29	**77**
Stearns	-	6	-	**6**
Washington	40	6	2	**48**
	162	**178**	**74**	**414**

As of December 31, 2014

- 16 counties are participating
- The number of individuals receiving services is not available

EXHIBIT 6-2: OV 2B – OLMSTEAD BARRIERS AND DISINCENTIVES SURVEY RESULTS

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Olmstead Barriers and Disincentives Identification Survey Results

Author: Olmstead Implementation Office in collaboration with Management Analysis & Development (MAD)

Date submitted to subcabinet: 02/02/2015 Date approved by Subcabinet: 2/9/2015

12/31/2014

Contents

Introduction

Addressing the needs of Minnesotans with disabilities has never been simply a matter of more money. The state already spends a significant amount of federal and state funds. A crucial issue is how well those funds are used.

During the next biennium, funds will be allocated to meet the concerns of today. However, those funds are directed by the flow and use of laws, statutes, rules, regulations, policies, procedures, and program manuals generated over several decades. Minnesota has many regulations and processes that were considered innovative back when they were created 30 or 40 years ago, or even 70 or 80 years ago. Yet not only are they archaic today, but they may inadvertently help lead to new policies that maintain out-of-date policy and funding approaches. The best of intentions can be mired in the procedures of the past.

The 2013 Minnesota Olmstead Plan calls for a transformation, a rethinking of how the State addresses disability. As legislative proposals move forward, it becomes important to ask some basic questions. For examples, do proposals:

- Help people live, learn and work in the most integrated setting?
- Develop a robust system of supports?
- Ensure individual choice and self-direction?
- Keep people in, or let them return to, their home communities?
- Safeguard each person's respect and dignity?

This document does not propose new statutes or allocations. Rather, it begins a re-look at what Minnesota already has, in order to identify existing barriers and disincentives that may not be the most effective use of money while inhibiting the transformative promise of Olmstead.

Background

In order to achieve the vision and goals identified in the 2013 Minnesota Olmstead Plan, the State adopted a set of overarching strategic actions, intended to be the foundation of the transformation that is needed to increase integration and inclusion of individuals with disabilities. One of these actions is to instill an Olmstead perspective in state action. Specifically, the Olmstead Plan action is to:

> *"Review **all** policies, procedures, laws, and funding through the perspective of the Olmstead decision (including related case law and guidance), identifying where and how current systems unintentionally create barriers to integration or create disincentives to development and use of integrated settings.*
>
> *Wherever such a barrier or disincentive exists, develop a concrete plan for change, through administrative alignment and collaboration, legislative action, policy and rule changes, and funding changes and prioritization. This action includes other agencies and departments in Minnesota (not only subcabinet agencies.)"* *Pages 31-32 of the Olmstead Plan*

The state has identified immediate actions that have been taken administratively in 2014. State agencies (and other stakeholders) are preparing legislative proposals for the 2015 legislative session.

Timeline elements in the strategic action include: "By December 31, 2014, identify barriers to integration that are linked to federal legislation, regulation, or administrative procedures; identify options to address them" OV 2B; and "By January 6, 2015, prepare proposals for legislative and fiscal changes for the 2015 legislative session." OV 2C Page 32 of the Olmstead Plan

Document development

To initiate action items OV 2B and OV 2C of the Plan, the Olmstead Implementation Office sent a survey to a wide array of stakeholders (listed on pages 28 and 29 of this document): self-advocates, advocacy organizations, service providers, research and education groups, and local and state government agencies. The survey listed each of the Olmstead Plan's seven topical goals:

> *Employment:* People with disabilities will have choices for competitive, meaningful, and sustained employment in the most integrated setting.
>
> *Housing:* People with disabilities will choose where they live, with whom, and in what type of housing.
>
> *Transportation:* People with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections.
>
> *Support and Services:* People with disabilities of all ages will experience meaningful, inclusive, and integrated lives in their communities, supported by an array of services and supports appropriate to their needs and that they choose.
>
> *Lifelong Learning and Education:* People with disabilities will experience an inclusive education system at all levels and lifelong learning opportunities that enable the full development of individual talents, interests, creativity, and mental and physical abilities.
>
> *Healthcare and Healthy Living:* People with disabilities, regardless of their age, type of disability, or place of residence, will have access to a coordinated system of health services that meets individual needs, supports good health, prevents secondary conditions, and ensures the opportunity for a satisfying and meaningful life.
>
> *Community Engagement:* People with disabilities will have the opportunity to fully engage in their community and connect with others in ways that are meaningful and aligned with their personal choices and desires.

For each of these topical goals, the questionnaire asked people to list barriers or disincentives that prevent each goal from happening. For each barrier or disincentive, people were asked to list the federal or state policies, procedures, laws or funding that created the barrier or disincentive.

The results were compiled, and then discussed in meetings with groups of stakeholders (listed on page 28 and 29 of this document).[1] Through the multiple steps, the raw results of the questionnaire were improved in terms of clarity and consistency. (Some responses were removed if they noted only that current funding levels were too low, or if they noted only that societal attitudes needed to change. While valid, the responses were outside the framework of what was requested.) The results, however, were not edited in terms of acceptability. The results are similar, in a sense, to an opinion survey in that they reflect perspectives articulated by some involved stakeholders, but do not represent the formal positions of any organizations or agencies. There is no presumption that all organizations and agencies find all the results to be acceptable, or even accurate in their assertions. All of the results, however, do have some support among stakeholders and require further consideration.

Purpose

The process and results provided in this document are an inaugural effort to identify Olmstead barriers and disincentives in existing laws, regulations and policy statements. The results are being shared with stakeholders as they develop and advance legislative proposals for the 2015 legislative session to use as appropriate to their work. This is being given to agencies and advocates to use as a tool as they review proposals. The intent is to use this and subsequent survey results to help develop an Olmstead perspective.

Before the 2016 legislative session, the Olmstead Implementation Office will work with state agencies in determining priority requests to the governor's office and the legislature for changes in law and policy to eliminate Olmstead perspective barriers and disincentives.

[1] For example, one group (the Governor's Council on Developmental Disabilities) spent their council meeting time answering survey questions. After the meeting a national literature review of barriers and disincentives was conducted and supplemented the member input. At the following meeting, the input was refined and edited.

Survey Results

The grid included here is the compilation of the unedited responses received from survey respondents. The responses were reviewed with stakeholders but were not necessarily verified in terms of accuracy. While all responses have some stakeholder support, this compilation does not represent the formal position of any agency or organization.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
A. EMPLOYMENT		
A.1 Employment: labor statistics Confusion in the measurement, reporting and definitions about Labor Force Participation—unemployment, underemployment, employment.	*FEDERAL:* • Social Security definition 42 U.S.C. 423(a)(1)(E) *STATE:* • State disability definitions in statute (partial list in the barrier description) • Governor's executive order re: state employment • M.S.256C.26	• There is confusion in understanding disability in the context of unemployment statistics. It is unclear which disabilities types are included. Unemployment and employment are measured, but not underemployment. The available data is not presented in a way that clearly describes the disability-related employment situation. • One root cause may be multiple definitions of disabilities in both state and federal laws. And the definition of under-employment needs to be clarified, and separated out, in a disability context. Another issue is that Department of Employment and Economic Development DEED is required to report labor statistics but that requirement does not require disability data. For more background, see: http://www.house.leg.state.mn.us/hrd/pubs/ss/ssdisdetr.pdf • M.S.256C.26, passed in 1980, requires DEED to develop a plan on underemployment of deaf, deafblind and hard of hearing people, has yet to be implemented. State disability definitions include: Human Rights Act, 363A.03 Judges retirement plan, 490.121 Local relief association benefit plans, 353B.02 Minneapolis Police Relief Association, 423B.01 Property Tax Refund Act, 290A.03 Teachers retirement, Saint Paul and Duluth, 354A.011 Uniform Probate Code, 524.1-201 Commitment and Treatment Act, 253B.02 Developmentally disabled persons, support services, 245B.02, 245B.06 Facility, abuse and maltreatment, reporting, 626.556 Health threat procedures, 144.4172 Housing Finance Agency, 462A.03 Long-term care consultation services, 256B.0911 Missing Children's Act, 299C.52 Public Guardianship for Adults with Developmental Disability Act, 252A.02 State institutions, 246.51

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
A.2 Employment: benefits loss Disincentives to employment include fear of benefits loss due to Social Security practices and multi-law confusion of benefits	*FEDERAL:* • Social Security Administration practices with Substantial Gainful Activity and asset limits. • Affordable Care Act *STATE:* • Asset limit in statute ($3K household of 1; $6K household of 2)	• Disincentives include possible loss of social security, health insurance and living situations. Social Security still creates disincentives. Fear of loss of benefits – fear of losing health insurance or Medicaid or Social Security Insurance (SSI) or Social Security Disability Insurance (SSDI) or loss of housing, especially if one works fulltime. • The Social Security Administration uses Substantial Gainful Activity and asset limits. There are benefits counselors and an online disability benefits calculator; however, there is a firm belief among many that you don't want to work. • The Affordable Care Act allows people to enter through a MAGI (Modified Adjusted Gross Income) door but most people with disabilities still enter through SSI participation. • There are asset limits in Minnesota Statute ($3 thousand, household of one; $ 6 thousand, household of two). • The federal Department of Labor allows for payment of subminimum wages under 16C exemptions for businesses and providers/vendors.
A.3 Employment: training limits Training and Postsecondary Education—there are limits imposed on hours and options.	*FEDERAL:* • 22014 Reauthorized Workforce Investment and Opportunity Act (WIOA) • There are federal limits on training and postsecondary education.	• Skills for competitive employment: there are hard skills (academic and vocational) and there are soft skills (work experience and grooming for competitive jobs). Minnesota is lagging behind in creation of post-secondary opportunities for persons with disabilities. Training for a job (if it exists) is not enough—it could be two hours a day. Federal limits in terms of what can be put into this training so need to set expectations. If the person is employable then how will training occur? • There is a perception that Vocational Rehabilitation Services (VRS) policy and practice is biased against higher education options, preferring any employment. WIOA provides an existing opportunity to address training limits.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
A.4 Employment: transition quality Transition programs are not structured to promote quality outcomes. Students are not leaving school and entering employment.	*FEDERAL:* • Individuals with Disabilities Education Act (IDEA) legislation has the most detail about transition policy. • Workforce Innovation and Opportunity Act (WIOA) • Rehabilitation Act, Section 101(a)(11)(D), 34 C.F.R. 261.22; C.F.R. 300.154; 34 C.F.R. 300.348 *STATE:* • MN special education law describes regional committees: M.S.125A.22. The 2014 Legislature deleted the statute's required yearly summary and follow-up report. • Transition service plan documents • DEED program manuals • Memorandum of Agreement between DEED and MDE	• People get stuck in transition programs and cannot transition to actual employment before their Individual Education Plan (IEP) eligibility ends. There is a need to get opportunities earlier to move toward integrated competitive employment. • During high school, get students into employment and work evaluation so they can get employment after high school. Students with disabilities may not be experiencing paid employment, unpaid employment, volunteer work or internships. • Transition Service Plans (and CSSP) are not structured to prompt creation of an employment plan. • Supported Employment Services funding should be available to students before they leave a transition program. • WIOA requires 15% of Vocational Rehabilitation (VR) funding to provide pre-employment transition services. To this opportunity, the barrier is a lack of engagement of stakeholders in the implementation planning process. • The Rehabilitation Act requires Minnesota Department of Education (MDE) and DEED (VRS, State Services for the Blind (SSB)) to establish a coordinated delivery system to improve transition planning. A barrier is vagueness in the Memorandum of Agreement (MoA. It should support Olmstead goals.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
A.5 Employment: work segregation There is a lack of available options and choice in education and employment.	*FEDERAL:* • Centers for Medicare and Medicaid Services (CMS) Medicaid policy *STATE:* • Department of Human Services (DHS) policy • County funding policy	• Medicaid and county funding policies have a bias toward segregated services (Day Treatment & Habilitation (DTH) & sheltered); policy needs to shift this funding to fully integrated services.
A.6 Employment: state marketing State website lacks important information.	*STATE:* • DHS website	• DHS website does not have any mention of employment in the section describing day training and habilitation. No mention of employment as part of licensure.
A.7 Employment: discriminatory hiring Job application systems, position descriptions and hiring decisions may be discriminatory.	*FEDERAL:* • Americans with Disability Act (ADA) *STATE:* • M.S.43A.191 • M.S.363A.36 • Governor's employment executive order	• Online applications and interview processes may be screening people out and may limit employment and may be discriminatory and illegal. • Public and private businesses need to look at people with disabilities as a talent pool. There is abundant talent. • Knowledge and support people who want to work. This is similar to the situation affecting other diverse populations. • Position descriptions may be discriminatory. Affirmative Action (AA) plans are not in place in a timely fashion in state government (see M.S. 43A.191) and there must be AA plans in place for state contractors (see M.S. 363A.36). • In Minnesota, no one ensures that employers have ADA-compliant application and hiring processes, or workplaces.
A.8 Employment: waiver policies Federal and state waiver policies include employment barriers.	*FEDERAL:* • CMS waiver policies *STATE:* • DHS waiver policies	• Federal and state waiver compensation policies for hourly services don't allow for service-related time with employers, social workers, other team members, and family, integral to people finding and maintaining competitive employment; or related to getting to work like setting up Metro Mobility rides. Also, work options are limited by staffing patterns in living arrangements. Risk assessments state people must have staff on premises to work, but rates limit options.
A.9 Employment: contradictory policy AbilityOne contracting contradicts ADA and Olmstead rulings.	*FEDERAL:* • 41 CFR Ch. 51 • FAR Part 8 Subpart 8.7 • FAR Part 6.3022-5	• Providers with SourceAmerica or AbilityOne contracts are required to complete all with a workforce that is non-integrated; 75% of the work must be completed by individuals with disabilities. This is a contradiction of ADA and Olmstead rulings.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
A.10 Employment: rehab categories Vocational rehab categories are too limiting.	*FEDERAL:* • Vocational Rehabilitation policy	• VR categories are limiting. It is a selective process, and some categories get closed. Also, since the law says those with most severe disabilities get served first, there are no resources left for those needing minimal help. This can lead to more people being homeless or in the criminal justice system. • VR pushes some people to DTH but don't provide interpreters or staff who sign, keeping people out of needed courses.
A.11 Employment: rural areas DHS waiver services rate framework discriminates against rural areas	*STATE::* • Medical Assistance (MA) statute • DHS policy and practices • County policy and practices	• The MN DHS rate framework for waivered services discriminates against Minnesotans with disabilities living in rural areas. For example the rate framework for Supportive Employment Services and look at the Client programming and supports section http://mn.gov/dhs/partners-and-providers/continuing-care/reform-initiatives/rate-setting/rate-setting-frameworks.jsp -- 8.6% of the reimbursement rate is expected to be utilized for participation costs, reinforcers and mileage. This equated to approximately $1. Per service hour allocated for mileage - or less than 2 miles. In rural Minnesota there may be 50 miles one way to get to the nearest clinic or shopping area. Basic tier 3 mileage reimbursement non-commercial transportation – i.e.: mileage may be reimbursed at the IRS rate of $.56 per mile when program participants require transportation and there is no public or free transportation available - County staff are told they may not authorize mileage although there is a mechanism for it - they are told it is in the reimbursement rate.
A.12 Employment: supports policy State support focuses on getting a job, but not on keeping a job.	*FEDERAL:* • VRS law, rule • WIOA *STATE:* • M.S. 268A.16 • DEED policy • DEED program procedures	• Vocational Rehabilitation and State Services for the Blind assist people in finding work, but shortly after they do, their needed employment supports end. People, after a period of time, have their cases closed and they have to go through the process of having it reopened if they need even a small piece of assistive technology to remain employed. • A new federal set-aside for transition (in WIOA) needs implementation. • State law requires employment transition support for some disabilities, but others only if an appropriation is made by DEED. Workers who quality should be able to obtain services in American Sign Language.
A.13 Employment: health costs MAEPD copayment rates are a barrier to employment	*STATE:* • MAEPD policy	• Medical Assistance for Employed Persons with Disabilities (MAEPD) copayment rates need to change in order to increase employment of people with disabilities.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
A.14 Employment: state accommodation A lack of a centralized accommodation fund is a disincentive to MN state employment policy.	*STATE:* • FY 14 Session Law Chapter 312 Article 4 Section 26 • Governor's executive order on employment	• All public agencies are expected to employ people with disabilities but only the largest agencies absorb accommodation expenses. Not providing resources that are enterprise-wide, rather than agency-specific, is a barrier to public employment.
A.15 Employment: workforce centers Workforce centers are not accessible in their equipment and training opportunities.	*STATE:* • DEED workforce policies and standards	• Workforce centers are intended to be accessible, but only 1 of 50 offers training classes in American Sign Language (ASL). Some equipment is not accessible. Work Force Centers (WFCs) often refer people to VRS instead of making their services accessible. The problem isn't policy, but the program application of policy.
B. HOUSING		
B.1 Housing: Section 8 vouchers Potential disconnect between federal and state policy decisions.	*FEDERAL:* • Housing Act of 1937 (42U.S.C.§1437f) • HUD Section 8 Voucher policy *STATE:* • State participation policy	• Housing and Urban Development (HUD) sets policies for its money but the state participation can be designated for people with disabilities. There is a waiting list for Section 8 vouchers; it is virtually closed in most counties. Bonding funds dictate the terms and how many units are designated for low income. IRS & HUD determine rents in tax credit programs so rent can be higher than what Section 8 allows.
B.2 Housing: GRH & MSA segregation State program has negative restrictions.	*STATE:* • State GRH, MSA statutes • DHS GRH, MSA policies • County MSA policies	• Group Residential Housing (GRH) is a state program that congregates and segregates people. Funds can only be used in licensed settings and not in independent living. MN Supplemental Aid (MSA) Shelter Needy program results in county-created segregated housing. • GRH doesn't fully address personal choice and results in little roommate selection. Affordable options outside of GRH tend to be in unsafe areas for vulnerable adults.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
B.3 Housing: policy alignment Federal, state, county policies not aligned.	*FEDERAL:* • Federal housing policies *STATE:* • State housing policies • County housing policies	• There is no alignment across federal, state, county funded housing programs in terms of how funds are used and who can live there. Example: Minnesota Housing Finance Agency (MHFA) issues bonds with restrictions on how buildings are used, who lives there, who pays what. Not all units pay the same rent. Another example: Minn. Stat. § 245D policy limits staff pay, in turn limiting housing options.
B.4 Housing: asset limits Caps result in requiring perpetual poverty.	*FEDERAL:* • Federal housing policies *STATE:* • State housing policies	• Subsidies and spend-downs leave people in perpetual poverty (Note: people with disabilities experience poverty at twice the national average level.) People with disabilities cannot earn or save money because of asset limits. • M.S.256B.0658 has the Housing Access Services grant, which has successfully placed over 1,000 in homes or their own or homes they control.
B.5 Housing: visitability Current statute lacks standards.	*STATE:* • State statute • State rule, policy (lacking)	• Visitability refers to single-family or owner-occupied housing designed so that it can be lived in or visited by people who have trouble with steps. MN does have a statute covering visitability for new construction, but no standards are in place. • MN law makes it impossible for individual communities to institute changes that would be helpful.
B.6 Housing: affordable accessibility Not all cities require affordable, accessible housing in new developments.	*STATE:* • State statute • City ordinances, policies	• Cities should require all new housing developments to include accessible affordable housing. Much “affordable” housing is not affordable to low income families. State standards are not in place. • Requirements are met by one bedroom units to the exclusion of multi-bedroom or family units which are needed.
B.7 Housing: transition practices Case managers impeded from transition planning.	*STATE:* • State policy • County policy	• High caseload numbers impede and discourage case managers from intensive planning to transition out of corporate foster care into their own homes. Housing options are not available.
B.8 Housing: neighborhood accessibility Pedestrian access limited in some communities.	*STATE:* • State statute, policy • Municipal ordinance, policy	• There is a lack of pedestrian access to services such as grocery stores, pharmacies, banks, etc. For blind, deaf/blind and deaf people in particular, there are few non-urban alternatives.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
B.9 Housing: rural areas DHS waiver service rate framework discriminates against rural areas.	*STATE:* • DHS policy	• The MN DHS rate framework for waivered services discriminates against Minnesotans with disabilities living in rural areas. For example if you look at the rate framework for Independent Living Skills Training or Supportive Living Services and look at the Client programming and supports section http://mn.gov/dhs/partners-and-providers/continuing-care/reform-initiatives/rate-setting/rate-setting-frameworks.jsp you will see that 8.6% of the reimbursement rate is expected to be utilized for participation costs, reinforcers and mileage. This equated to approximately $1. per service hour allocated for mileage - or less than 2 miles. In rural Minnesota there may be 50 miles one way to get to the nearest clinic or shopping area. • Also: People with disabilities in rural Minnesota could continue to remain independent if chore services had a better rate structure. The reimbursement rate is $14.88 per hour. If someone lives in rural Minnesota and they need a person to come out and remove snow for example, the person doing the snow removal needs to cover their time and gas to get to the home and then be paid for their time. People could remain independent in their homes if the payment mechanism would allow for travel costs.
B.10 Housing: fire safety State law could be used to assist with visual fire alarms.	*STATE:* • M.S.237.51 telecommunications	• Smoke detectors and carbon monoxide detectors with flashing strobe lights should be made part of the Telecommunication Equipment Distribution Program as they are in other states to ensure people with hearing loss are safe in their homes.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
C. TRANSPORTATION		
C.1 Transportation: Greater MN Much of the state lacks a coordinated local system	*FEDERAL:* • FTA: Section 5310 Enhanced Mobility of Seniors and Individuals with Disabilities Program. STATE: • M.S.174.24 • State transit policies • Regional or local policies	• 5310 program provides vehicles and buses can be made available on weekends and evenings, but that rarely happens. M.S.174.24 requires MnDOT to meet 80% of needs by 7-1-15. Insurance and maintenance also are barriers. • School buses for students with disabilities operate separately, not full day, and are not available for after-hours activities. • The local nature of system design means there is no uniform approach to coordination and suggests state legislation is not likely to assist in improving coordination. • In rural areas, transportation systems cannot cross county lines for employment or medical services. Other systems have too-restrictive mile limits or time limits.
C.2 Transportation: paratransit systems Metro Mobility is unreliable for employment	*STATE:* • Statutes regarding accessibility of paratransit systems. • Metro Mobility policies, procedures	• Para-transit systems lack flexibility and their lack of on-time performance affects employment of people with disabilities. Metro Mobility gives priority to people with medical appointments. Metro Mobility follows mainline bus schedule for start and end times but has no standards for waiting times, which are excessive and makes it unreliable. Driver training is inconsistent. Other alternatives should be explored: hour cars, car coops, etc. Asset limits means cars for people with disabilities must be junkers. Off-hour employment not feasible without transit. • The Metro Mobility model is not sustainable due to capacity limits. • Metro Transit (MTC) should hire transportation coaches to move people from paratransit to mainline systems.
C.3 Transportation: mainline systems	*STATE:* • State policies on transit safety, snow removal, curb cuts. • Local laws and policies on snow removal, curb cuts. • State service animal policy	• Lack of safety on mainline transit makes people feel vulnerable waiting for a bus. • There is a lack of snow removal and curb cuts. The transit system includes streets, sidewalks, crosswalks, curb ramps and crossing signals. • Workers are not required to have adequate training regarding service animals, or other disability concerns.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
C.4 Transportation: funding streams Allow individuals to combine funding streams.	*FEDERAL:* • Transportation laws, policies *STATE:* • Transportation statutes, policies	• People with disabilities sometimes have access to multiple transportation funding streams: from vocational providers, residential programs, etc. Let them combine the funds to best fit their needs.
C.5 Transportation: MA policy Medical Assistance can favor institutional over community settings	*STATE:* • M.S.256B.69, subd.4(b)	• Medical Assistance recipients may have access to better coordinated transportation services in institutional care settings than in the community. In a documented case, a person had a care coordinator through a managed care plan when the client lived in an institutional care setting and then transitioned the community. When moved to the community, the person was deemed ineligible for managed care. In theory, the client's access to transportation services should have been the same. In practice, the client missed a number of medical appointments due to deficiencies in coordination of transportation. • Minn. Stat. § 256B.69, subd. 4(b) is the authority cited for why some Medical Assistance recipients, specifically those with medical spenddowns, are ineligible for managed care. • 2014 Session created a non-emergency medical transit advisory committee. Recommendations should be considered.
C.6 Transportation: accessibility Transportation, including planes and trains, is not fully accessible	*FEDERAL:* • ADA	• Although ADA requires accessibility, airlines and trains continue to have accessibility problems. Poor enforcement mechanisms for existing law are a barrier.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
D. SUPPORTS & SERVICES		
D.1 Supports & services: availability Needed services aren't available	*STATE:* • M.S.256A.0656 (CDHC repeal 2014) • M.S.256B.0657 (self-directed supports) • M.S.256B.0659 (PCA change) • M.S.256B.0711 (SEIU)	• While change is happening, too many services are too limited. Issues include: high Personal Care Attendant (PCA)turnover; crisis homes not available; no group home or day program options in some counties; limited housing options; waiting lists for waivers and unspent funds; some counties don't keep waiting lists; some people need but don't get 24 hour help; caregivers don't get respite. There are few options between family homes and group homes. The system is complex and people don't know what to do. • Different settings such as Anoka and St Peter have different barriers. Need specialty courts. Counties have inconsistent civil commitment practices and prosecution. There are poor reintegration practices from county to county. • The services that are available often are not coordinated by full team planning. Policy should not require this, but should encourage it when in order.
D.2 Supports & services: self-determination CDCS still is not person-centered	*STATE:* • State CDCS policy and practice • County CDCS policies and practices	• Consumer Directed Community Supports (CDCS) is still not person-centered. Counties still make the decisions; there are county differences with no universal approach to individual planning. Some counties say they don't do CDCS; they protect funds. They don't trust families with public funds. They don't listen to individuals who have guardians. This is contrary to Olmstead, which is about shifting from a service model to a supports model. Policies should be rewritten to be person-centered. • A separate but related concern is that Child Protection is called when children with disabilities exhibit behaviors. Counties try to remove the child rather than support the family.
D.3 Supports & services: training Inadequate training for professionals and support people.	*STATE:* • State policy	• Lack of quality training programs for personal care attendants, job coaches and other support people. Lack of training (and low wages) leads to staff turnover. • Professionals need consistent, continuous training on the employment first concept. Actions indicate that segregated employment is still considered an appropriate starting point. • State regulations don't assume provider competence, resulting in resources going to testing and paperwork. • Policies don't support adequate parent training.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
D.4 Supports & services: MA policy Medical Assistance provides less service coordination for people with fee-for-service than with managed care.	*STATE:* • M.S.256B.69, subd.4(b)	• Medical Assistance enrollees whose care is paid through fee-for-service should have access to the same supports and services as those whose care is through managed care plans. In practice, enrollees in fee-for-service experience less connection and coordination in their services. • Managed care is not currently available for Medical Assistance recipients with a medical spend down. Minn. Stat. § 256B.69, subd. 4(b): Under this policy's application, a person may be eligible for managed care while in an institutional care setting but then lose eligibility by moving to the community if he/she has an income above 100% of federal poverty guidelines. The person is eligible for Medical Assistance--because of his or her age or disability—in both the institutional and the community-based setting, but the option of services through managed care are not available if he or she elects to live in the community, precisely where the loss of integration and coordination in the provision of care through managed care may be most acutely felt.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
D.5 Supports & services: rural areas DHS waiver service rate framework discriminates against rural areas.	*STATE:* • DHS waiver policy, procedures • DHS 245D rules, practices	• The MN DHS rate framework for waivered services discriminates against Minnesotans with disabilities living in rural areas. For example if you look at the rate framework for Independent Living Skills Training or Supportive Living Services and look at the Client programming and supports section http://mn.gov/dhs/partners-and-providers/continuing-care/reform-initiatives/rate-setting/rate-setting-frameworks.jsp you will see that 8.6% of the reimbursement rate is expected to be utilized for participation costs, reinforcers and mileage. This equated to approximately $1. per service hour allocated for mileage - or less than 2 miles. In rural Minnesota there may be 50 miles one way to get to the nearest clinic or shopping area. Basic tier 3 mileage reimbursement non-commercial transportation - ie: mileage may be reimbursed at the IRS rate of $.56 per mile when program participants require transportation and there is no public or free transportation available - County staff are told they may not authorize mileage although there is a mechanism for it - they are told it is in the reimbursement rate. • The 245D rules for basic services require far too much documentation and their requirements are overkill. Many people with disabilities require a few hours of homemaking per week to remain independent - if a person receives 2 hours per week to get help to wash their floor, change their bed linens etc. their staff person may work 104 hours per year. If they live in rural Minnesota that staff person will only work for one person - but they are required to have 10 hours of orientation, and 12 hours of annual training, a great deal of documentation, etc. Providers have difficulty finding staff willing to do the work and the Minn. Stat. § 245D requirements force providers to refuse people who have low hours because they can't afford to serve them. A typical provider makes $1,896.96 for 104 hours of homemaking service, the wages are $1,060.80, taxes and insurance are $159.12, this leaves $677.04 per year for the provider to cover office overhead costs, payroll administration, staff education, home visits with the corresponding staff time and mileage, service coordination, case manager reporting, licensing and audits.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
E. LIFELONG LEARNING & EDUCATION		
E.1 Lifelong learning: segregation Replace segregation with inclusion	*FEDERAL:* • Federal education laws including IDEA • Federal transition laws STATE: • M.S.125A.62 (Academies; includes LRE language) • State education laws • State charter school laws • School district policies	• Embedded in state and federal laws are the concepts of Least Restrictive Environment (LRE). In many cases, LRE should be replaced with the concept of most integrated setting. Among the exceptions are situations where a full continuum of alternative placements needs to consider communication needs. • Transition programs can be segregated. It seems easier to build a segregated school building than make funds available for inclusion. This is regressive and the opposite of inclusion. • There is confusion about transition and learning. There is inconsistency with lots of funding going to Transition Plus. • Charter schools may lead to more segregation. • School choice has led to new tensions. On one block, 20 students can attend 8 different schools. This trend means neighborhood school is a historical concept. • There tends to be a separation of students especially in testing. In order to drive test scores up, students with disabilities are excluded from the test pool.
E.2 Lifelong learning: measurement Data is not adequate.	*STATE:* • M.S.120B.11	• Education data could be clearer. Graduation rates can be confusing since students can graduate as late as age 21, but most published rates are at age 18, missing the older students. It is unclear how we measure retention beyond a short period. Graduation data for IEP vs. state standards is lacking. There is a disability data hole-disaggregate data to show tracking • M.S. 120B.11 describes a process for a school district to review its curriculum, instruction and student achievement. Within that section is a requirement for customer satisfaction. It would be possible to add a requirement that satisfaction with special education be disaggregated.
E.3 Lifelong learning: positive behavior supports Gaps in positive behavior supports lead to restrictive placement.	*STATE:* • M.S.125A.62 • M.S.125A.0942 • M.S.245D	• In terms of Positive Behavior Support (PBS)—there are gaps in capacity, training, expertise and supports which lead to restrictive placements. • Cultural issues can be a barrier. If a student is not English speaking and in special education and has behavior issues then what is the school staff to do? It can take four adults to assure safety and 911 is called. Staff members need support through training and development. • PBS is too vague in state law. It is mentioned in the Academies legislation (MS. 125A.62) and in 125A.0942 (standards for restrictive procedures). PBS is mentioned in 245D (Human Services).

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
E.4 Lifelong learning: self-determination Clarify student self-determination in state law.	*FEDERAL:* • IDEA 2004 *STATE:* • State education law	• Strengthen student self-determination and self-advocacy to state law. Students should be able to learn at their own pace and still graduate on time. • All people want to learn no matter the age. Funding should allow taking classes as an adult.
E.5 Lifelong learning: transition Transition services should be available to all students with disabilities.	*STATE:* • M.S. 268A.16 • State transition policies and practices	• Work skills, volunteering, internships and paid job experiences should be made available to students with disabilities. Employment begins too late for students with disabilities. Schools are not engaged with Work Force Centers. Transition programs shift from academics back to functional skills. Federal 15% budget allocation 268A and independent living training should be taken into consideration. • M.S.268A.16 requires DEED to provide support for deaf, deafblind and hard of hearing people in transition, and a grant program for school-based services, once an appropriation is made. No appropriation has been made.
E.6 Lifelong learning: funding formula Funding formula can drive segregation.	*FEDERAL:* • IDEA STATE: • State education law, funding formula	• Funding formula can drive segregation but the formula is changing and getting more complicated. • Congress has never fully funded IDEA. • Some districts recruit students to get more money but at the same time special education is marginalized. • Inadequate funding to add teachers into general education classrooms; inadequate funding for teacher development.
E.7 Lifelong learning: teacher training Teacher training should not be segregated	*STATE* • Teacher training policy.	• Teacher training is separated for special education and general education, but some could be integrated. • Technology barriers include access, training, support and consistency for all students.
E.8 Lifelong learning: accessibility Modifications needed: buildings, technology, materials.	*STATE:* • M.S. 16E.03 subd.9 & subd.10 • State education regulations • School district policies, practices	• Modifications must be made: buildings, technology, learner materials. The field shifts from standards and access to academic curriculum to individual needs. Schools waive course work to avoid addressing accessibility issues. • Some students are not receiving appropriate help because they fly below the radar. • Many district use “flipped” classrooms with posted video lessons; they are not captioned. • Standardized tests are administered with voice instructions. Contracts for future upgrades should include captioned instructions.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
E.9 Lifelong learning: cognitive disability There is a lack of college programs for people with cognitive disabilities	*STATE:* • State, Minnesota State College and University System (MnSCU) policy	• There is a lack of college programs for people with cognitive disabilities. There are some tech programs, but only ones with certificates.
E.10 Lifelong learning: lifelong skills Adult Basic Education (ABE) and community education can provide ongoing skills training	*STATE:* • M.S. 268A.11 • Education policy • State ABE policy, practices	• Rather than rely on independent living centers, people with disabilities should receive money management, cooking, etc. classes through adult basic education and community education. Universal design and community integration should be elements. • The State doesn't reimburse ABE programs for teaching ASL a necessary prerequisite for many (especially immigrants) who are deaf. At the same time, Independent Learning Center (ILCs) don't provide training in ASL. This is a barrier for some people with disabilities. State policy doesn't recognize second language ASL.
E.11 Lifelong learning: preschool Early education programs can better address disability considerations.	*STATE:* • Education policy • School district policy	• Training for early learning programs needs to include disability awareness and related topics. School districts need to adequately staff integrated preschool programs with a more appropriate staffing ratio.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
E.12 Lifelong learning: school segregation Segregation instead of integration in schools is discriminatory.	*FEDERAL:* • Laws reference least restrictive settings rather than most integrated settings. *STATE:* • M.S.245.487 Children's Mental Health Act (least restrictive environment) • M.S.125A.0942 • State education policies • State juvenile justice policies • Local school district policies • Funding formulas and bonding bills allow new segregated options. • Local school district policies and practices can separate and segregate students. (Note: M.S.125A.12 allows student attendance in other school districts; this can be a positive.)	• Segregation in school hurts students with disabilities and prevents an expectation of lifelong integration. With segregation, many never experience students with disabilities. As students enter junior high school then segregation begins and extends to graduation. • Federal law allows discrimination because individuals interpret "least restrictive setting" to mean it is okay to segregate and you don't have to do inclusion. • Federal contradictions—the term LRE works at the margins but does not get to the heart of the issue—inclusion. • One root cause may be that segregation is built into federal and state laws that continue to use least restrictive environment and least restrictive alternative rather than most integrated setting. • Another issue is financial incentives in funding formulas and bonding bills that allow for construction and financing of segregated options. • Another root cause may be local policy and practice that separates and segregates students. • Environments are segregated including school buildings: "exceptional education" means segregation. Schools have emotional disturbance immersion programs; some behaviors send students to juvenile facilities. Students must connect with the community. (As new terminology, emotional disturbance immersion needs greater understanding in public policy.)

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
F. HEALTHCARE AND HEALTHY LIVING		
F.1 Healthcare: access & funding limits Low Medicaid rates and policies can hamper health	*FEDERAL:* • Medicaid law and policy *STATE:* • MDH policy	• Dental/oral health care: there is limited access because of low reimbursement rates (Medicaid), few providers and those who do provide cannot break even. MA covers only certain procedures. Preventative care coverage is limited. Appointments may take longer. Some people need anesthesia. Baseline capacity of dentists, and the actual number needed, is unclear. • Other limits: facilities provide least costly food; preventative care not emphasized; limits on needed equipment; slow equipment deliveries; exams missed; and lack of coverage for some forms of care. Disparities are not studied.
F.2 Healthcare: accessibility Accessibility issues in health facilities	*FEDERAL:* • ADA	• Care clinics: there are accessibility issues (no automatic door openers, narrow aisles, no Hoyer scales for weighing a person, too much furniture, small exam rooms, and inaccessible equipment) which contribute to lack of proper medical exams. • Policies and procedures create barriers such as inaccessible forms and communication • Pharmacies often lack audible bottles; or information in braille, large print. Eye exams are inaccessible because of the set-up of the office and equipment. There is often a lack of interpreters, signage and path finding. • There is a lack of compliance with 508 – patient portals. • ADA lapses result in traumatic emergency room visits for people with disabilities.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
F.3 Healthcare: attitudes Medical bias exists and hampers care.	*STATE:* • M.S.145.986 • M.S.144.661-665 • M.S.62U.02	• Medical professional bias exists against people with disabilities. Assume all people live in group homes. Attitude and culture affect health care. Nursing and professional bias exist about quality of life. If the State pays for performance quality data then some people will be screened out and that could be a person with complex health situations. Being read questions without privacy. • Cultural competence. Professional training is absent. • HRSA has not identified people with disabilities as an underserved group. Accreditation of health care does not cover disability topics. Campaigns about smoking, drinking not aimed at people with disabilities. Some fields like psychiatry have few professionals specializing in helping people with disabilities. Also: doctors often do not make SSB referrals for patients who are blind. • There are disparities in health care and health outcomes for people with disabilities. While there is an Office of Health Equity it is difficult to find disability included in these efforts. There is no statutory reference. The State Health Improvement Program Grants are authorized under M.S. 145.986 and disability is mentioned. There is a statutory section for people with traumatic brain injury and spinal cord injuries (M.S. 144.661 – 144.665). There is a statutory section called community health measures at M.S. 62U.02.
F.4 Healthcare: abuse	*STATE:* • M.S.299C.06	• Vulnerable adult issues: people with disabilities are not trained to know what is appropriate and what is not. Screeners, investigators and first responders need training to judge validity of a claim. Emergency Medical Technicians (EMTS)/Emergency Room (ER) professionals need training; otherwise the default is to do nothing. The transition from a pediatrician to an adult practitioner is difficult. There may not be a transition process or plan in place. • The Department of Public Safety has two sections about crime statistics (M.S. 299C.06 which references using the FBI form; another references bias crimes where disability status is mentioned).
F.5 Healthcare: Medical Assistance standards State standards discriminate against those elderly or with disabilities	*STATE:* • M.A. statute • M.A. policy and practices	• For those elderly or with disability, MN has different qualifying standards for MA. Current MA limit without disability: 138% poverty or $1,342 per month. With disability or elderly, 100% poverty or $973 per month. Also, with disability or elderly is a $3 thousand asset limit; no asset limit for others.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
F.6: Healthcare: health care homes Enforcement and accountability measures are unclear for providers not meeting legislated standards,	*STATE:* • M.S.256B.0751, subd. 2 • M.S.2256B.0757	• For Medical Assistance enrollees not provided the option of managed care enrollment, health care homes are promoted as resources for care coordination. However, list providers are not fulfilling the legislated standards, and measures for enforcement and accountability are unclear. M.S. §256B.0751, subd.2, identifies the services to be coordinated, and M.S. §256B.0757 provides even more detail. However among health care homes listed under the Minnesota Department of Health (MDH) Health Care Home website, at least two health care clinics have directly stated that they do not offer health care home services or offer only a limited spectrum of those services excluding care or services to home-bound patients.
G. COMMUNITY ENGAGEMENT		
G.1 Community: accessibility	*FEDERAL:* • ADA *STATE:* • Olmstead Plan • Local building codes	• There continue to be accessibility issues with public buildings even after renovation. Acoustic standards are not included. Inclusive, universal design needs to be an Olmstead Plan component. • Other accessibility issues include inadequate transportation options and a lack of broadband and internet accessibility in much of the state. Also, communications of state-sponsored events do not meet ADA standards. • Include in the Olmstead Plan the ADA definitions of auxiliary aids and effective communication.
G.2 Community: inclusion Lack of exclusion does not mean full inclusion.	*FEDERAL:* • ADA • CMS guidelines	• The lack of exclusion does not mean full inclusion. Communities need to practice inclusion in order to get used to inclusion. Separate is not equal. Children's community programs are not inclusive but segregated including: sports, church, park and recreation, music, theater and arts.
G.3 Community: staffing Inadequate staff funding limits community engagement.	*STATE:* • Staff funding levels • School district practices • County policies	• Lack of staffing means that a group home does everything together; there is no independent activity in the community. A single staff member cannot accommodate 3-4 people with disabilities when there are no natural supports. • Give more respect to those on the front lines. A school will say that the staff ratio is 1:1 when it is really 1:4. There is an overall staff shortage and high staff turnover. County staffing policies inhibit personal choice.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
G.4 Community: self-determination System is still too top-down	*STATE:* • CDCS policy and manual • Voting laws	• If funding follows the person then there will be better options and more flexibility. The system is top-down and dictating how money is spent and how time is spent. CDCS must be improved. Funds have been reduced. • Disability rights are not taught. People are told what they want to do and what they can do. Adults are treated as 10-year-olds with a curfew. • Lack of understanding of person centered planning and thinking. Some staff members are told that they cannot be friends because of boundary issues. Paid staff members consume a person's life. • Self-determination requires training for people with disabilities on public safety and emergency preparedness. • Voting issues: there are still accessibility problems at polling places; election judges need training about voter assistance and rights; there are still attitudinal barriers; and same day registration has problems for people with disabilities. In the event of challenges, court judges and county attorneys also need relevant accessibility training.

Barrier or disincentive	Relevant document	Survey Participant Responses (unedited)
G.5 Community: choice State policy limits choice.	*STATE:* • MN Constitution Article VII (Elective Franchise) • Statutes (c.f. Description column)	• Very few people have choice. Barriers exist because of how the system is set up. Risk management limits people. We all manage risk but people with disabilities are held to a different standard. There is a need to know what is available and be able to get to community activities. • Technology will continue to drive access which in turns allows greater participation by people with disabilities (and they are recognized as a market or customer segment). • The State Constitution sets barriers on the right to vote for persons with disabilities, using antiquated, flawed constructs. • Service providers are not trained on how to offer informed choice. • Statutes: There is state legislation about peer support (M.S. 256B.0615 and 245.462) but there is no comparable legislation about self-advocacy. Marriage: M.S. 517.03 prohibits marriages and M.S. 246.01 limits choice in the duties of the commissioner. Note limits in Sterilization (M.S. 524.5-310) and Electroconvulsive Therapy (ECT) (M.S. 253B.04). • Informed choice appears in M.S. 256B.49 subdivision 12 and for the consumer support grant in 256.476. Informed consent appears in 253B.03 and informed decision appears in the Health Care Bill of Rights (144.651). • The PCA limited hours appears in 256B.0659 which was amended in 2015 by Chapter 291, Article 8, Section 6, and subdivision 11. The Human Rights Act does prohibit discrimination based on disability (M.S. 363A.) Person centered planning exists in M.S. 245D.07. The Quality Council exists in 256B.097. The Commitment Act mentions least restrictive alternatives (253B.185). Emergency Use of Manual Restraints appears in 125A.0941.

Limitations

The initial timeframe set for the analysis of *all policies, procedures, laws, and funding,* was not sufficient given the magnitude of the action required in the plan. Through the process of the initial survey it was determined that the scope of the initial survey was quite large and overwhelming for a number of the recipients.

Recommendations

There are some recommendations going forward.

- Conduct a survey going forward to review policies, procedures, laws, and funding.
- Develop a series of smaller surveys that are targeted to particular topic areas.
- Send out smaller surveys annually (schedule to be determined).

Each of the subcabinet agencies is in the process of developing their 2015 legislative proposals. The results of 2014 survey will be disseminated to the subcabinet agencies to aid them in their legislative agendas. Once information is available related to the agency requests it will be paired with the survey results and shared with the public so that they have the opportunity to speak to their legislators and potentially influence policy.

Stakeholder List and Survey Participants

Survey participant list

The following agencies, groups and/or individuals were sent a request to respond to the survey developed in consultation with Management Analysis & Development (MAD). Many groups combined input from several individuals into one response document. Others shared the request with other interested parties who responded on their own or in combination with the initial group.

Disability Organizations including:

Advocating Change Together

MN Centers for Independent Living

MN Governor's Council on Developmental Disabilities

MN State Council on Disability

Arc of the Greater Twin Cities

Other Organizations including:

MN Disability Law Center

Substitute Decision Making Network

State Agencies including:

Department of Human Services

Department of Transportation

Department of Human Rights

Health Department

Department of Corrections

Department of Employment and Economic Development

Minnesota Housing Finance Agency

Department of Education

Survey Review Group

Olmstead Implementation Office Advisory Group – Composed of representatives of the 23 Governor appointed disability councils, groups and boards.

EXHIBIT 6-3: QA 1C – QUALITY OF LIFE SURVEY PILOT STUDY REPORT

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Minnesota's Olmstead Plan Quality of Life Survey Pilot Study Report

Contents

Quality of Life Survey Pilot Study Executive Summary

Purpose of the Study

Since June 2014, the Improve Group has supported the Olmstead Implementation Office in piloting the Center for Outcome Analysis Quality of Life Survey tool. The purpose of the pilot study is twofold. First, we tested the survey tool to ensure that it was effective a number of different settings, and across diverse groups of people with disabilities. Second, we identified and addressed challenges in the survey administration process so that the survey process goes as smoothly as possible in future iterations.

Survey tool

The Center for Outcome Analysis Quality of Life survey tool was selected because it is reliable, valid, low-cost, and repeatable, and it applies to all people with disabilities. In early 2014, Olmstead Implementation Office staff reviewed seven tools used locally and nationally to examine how well they would measure participant quality of life over time for the Olmstead Plan. The criteria used to judge the tools include applicability across multiple disability groups and ages, validity and reliability, ability to measure changes over time, and whether integration is included as an indicator in the survey. The Center for Outcome Analysis Quality of Life survey tool was the only tool to fully meet all the requirements listed. Studies about the reliability and validity of the tool are found in Appendix D. Olmstead Implementation Office staff presented the survey options to the Olmstead Sub-Cabinet at the April 22, 2014 meeting. At that time, the Sub-Cabinet voted to approve the Center for Outcome Analysis Quality of Life survey tool.

Methodology

Samples and Settings

The Improve Group worked with the Minnesota Department of Employment and Economic Development, the Department of Human Services and the Department of Education to obtain survey samples. We sampled over 400 people and conducted 105 surveys in nine settings. This includes Adult Foster Care, Boarding Care, Board and Lodging, Center-Based Employment, Day Training and Habilitation, Intermediate Care Facilities for Persons with Developmental Disabilities, School Settings, Nursing Home, Assisted Living and Supervised Living Facilities.

Disability populations

Through the pilot process, the survey was tested with people with physical disabilities, people with intellectual disabilities, people with mental illness, people with brain injuries, people who are Blind, and people who are Deaf. The majority of the surveys were administered by interviewers with disabilities recruited by the Improve Group for this project.

Pilot Results

A rigorous analysis of quantitative and qualitative data shows that the Center for Outcome Analysis Quality of Life Survey tool worked well across disability groups and across settings. We recommend a few adjustments to the tool, and all recommended adjustments to the tool have been approved by the developer.

Key Recommendations

A complete list of recommendations for survey administration is available in the body of the report, starting on page 47.

1. Use the Center for Outcome Analysis Quality of Life Survey tool, with the modifications listed in the body of the report, to conduct the Olmstead Quality of Life baseline survey. By surveying approximately 3,000 individuals in the settings selected each year, the State will be able to extrapolate the results to the general population with a 95% confidence level and a 5% confidence interval. The survey developer has proposed a follow-up strategy in which 500 participants are surveyed each subsequent year to measure changes over time.

2. Plan for a three- to six-month design phase for the study followed by a survey period of at least four to five months.

3. The Olmstead Implementation Office should work to secure access to participant data through the support of the Sub-Cabinet, by using legislation, a court order, or other means. Establish a plan or structure for each agency to share data (survey samples) with the Olmstead Implementation Office and the Survey Administrator.

4. The Survey Administrator should work with liaisons in each agency to draw the survey sample. It is recommended that the sample be a stratified random sample, with stratification by setting. The data request should include disability and demographic information for each person included in the sample.

5. The Survey Administrator should have the state agencies select a sample four times larger than the number of individuals the State hopes to interview. For example, to achieve 3,000 participants, the sample should include 12,000 people.

6. They survey should be arranged the survey so that the sections of greatest interest for the Olmstead Plan are at the beginning of the survey. This will ensure that the most important sections have the highest response rate.

7. Future trainings with survey interviewers should include more depth about survey content, methods for recording responses, and how the results will be used. State agencies should also provide tools for training interviewers about programs and services. This will prepare interviewers to respond to questions from survey participants and their loved ones.

8. The Olmstead Implementation Office should develop a marketing strategy for the survey so that participants and providers are familiar with the survey efforts before they are asked to participate. Take advantage of existing communication channels to market the survey to providers and potential survey respondents.

Background

About Olmstead

The Olmstead Decision

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

The Jensen Settlement

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

Minnesota's Olmstead Plan

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

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

About the Olmstead Quality of Life Project

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

The project is a longitudinal study. In the first year, people with disabilities from across the state will be surveyed to collect a baseline. Throughout the report, this is referred to as the baseline survey. In the following years, it has been recommended by the survey developer that a smaller sample will be selected from the baseline participants to complete the survey again. The results will be used to track Minnesota's progress on the Olmstead Plan.

About Quality of Life Survey Tool

The Quality of Life survey was created by the Center for Outcome Analysis to measure changes in quality of life as people with disabilities move to more integrated settings. The tool was selected because it is reliable, valid, low-cost, and repeatable, and it applies to all people with disabilities. In early 2014, Olmstead Implementation Office staff reviewed seven tools used locally and nationally to examine how well they would measure participant quality of life over time for the Olmstead Plan. The criteria used to judge the tools include applicability across multiple disability groups and ages, validity and reliability, ability to measure changes over time, and whether integration is included as an indicator in the survey. The Center for Outcome Analysis Quality of Life survey tool was the only tool to fully meet all the requirements listed. Studies about the reliability and validity of the tool are found in Appendix D. Olmstead Implementation Office staff presented the survey options to the Olmstead Sub-Cabinet at the April 22, 2014 meeting. At that time, the Sub-Cabinet voted to approve the Center for Outcome Analysis Quality of Life survey tool.

The Quality of Life survey will measure:

- How well people with disabilities are integrated into and engaged with their community;
- How much autonomy people with disabilities have in day to day decision making; and
- Whether people with disabilities are working and living in the most integrated setting that they choose.

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

The Quality of Life survey is only one way in which the experiences of people with disabilities will be gathered. The survey is intended to a tool for providing oversight and accountability for the plan. Minnesota will use additional methods including collecting individual stories to enhance the survey data.

About the Pilot

The purpose of the pilot survey is to learn how best to administer the baseline and follow-up surveys, including identifying challenges that may arise from conducting the survey in a variety of settings. The data collected during the pilot study will be used to evaluate the project and will not be publicly available.

The primary goal of the pilot is to test the tool in a variety of settings and with people with a range of disability types. In addition, the pilot is an opportunity to test and reflect on elements of the project in order to plan for the baseline study including:

- Recruitment plan
- Sampling strategy
- Sample size
- Survey locations

- Interviewer recruitment and training

Key Players in the Olmstead Quality of Life Survey Pilot Study

In June 2014, the Improve Group was selected to conduct the pilot study through a contract with Minnesota Management Analysis & Development (MAD). The work has been guided by the Olmstead Implementation Office, with support by individuals listed below. Collectively, this group is referred to as the "Olmstead Team" throughout the report.

Olmstead Implementation Office

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

The Improve Group

The Improve Group, an independent research and evaluation consulting firm located in St. Paul, is responsible for administering the pilot survey, as well as drafting recommendations for administering the baseline survey. The Improve Group has expertise in evaluating health and human services programs, with significant experience in the area of home and community-based programs and mental health service delivery systems in Minnesota.

The Olmstead Team

Improve Group staff worked closed with the Olmstead Implementation Office throughout the study. In addition, individuals from multiple agencies contributed to the study by providing information about Minnesota's systems that serve people with disabilities. Collectively, this group is referred to the "Olmstead Team" throughout the report.

Funder

The study was funded by the Minnesota Housing Finance Agency.

About the Report

The purpose of this report is to evaluate the process of administering the Olmstead Quality of Life Survey. The report is divided into sections depending on the phase of the project. Each section of the report includes the steps taken in the phase. Each step has the original plan (either based on the contract or scope of work or early decisions made by the Olmstead Team), what actually happened, and the recommendations for future surveys based on the pilot.

Planning Phase includes selecting the survey instrument, the settings, identifying the population of interest, the timeline, and selecting the contractor.

Design Phase includes the steps taken before individuals are invited to participate in the survey such as working with agencies, selecting the sample, provider outreach, and interviewer training.

Administration Phase includes working with providers, scheduling interviews, and data collection.

Analysis Phase includes reviewing the data, analyzing response patterns, identifying problematic questions and terms, and recommendations for the baseline.

Planning Phase

Selecting the Survey Tool

The Olmstead Implementation Office contracted with the Center for Outcome Analysis to use a Quality Of Life (QOL) assessment tool that is specific to the Minnesota Olmstead Plan's requirements. The Center for Outcome Analysis has previously developed QOL scales that can be used across multiple disabilities, ages, and setting types. The tool was delivered to Minnesota on March 31, 2014.

The Quality of Life tool was selected from a small number of survey instruments that met the rigorous requirements of the Olmstead Plan, including being a valid and reliable tool that has been tested with people with a wide range of disabilities. The contract includes survey development, administration instructions, documentation of validity and reliability studies, and the authorization to use the tool through December 2018. This agreement providing authorization to use the tool could be renewed beyond December 2018. The author of the tool, Jim Conroy, was the content expert for Minnesota's Olmstead Plan.

Population

The population of interest for the Quality of Life survey is people with disabilities who are living, working, or going to school in segregated settings. While the level of segregation varies person to person, the intent is to survey people who will be most impacted by the state's efforts to provide services in the most integrated setting appropriate to the individual.

The sample should also reflect the diversity of Minnesota's population including: disability type, culture, race and ethnicity, location within the state, and other demographics. The primary disability types included in the sample are:

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

Settings

Participants were selected from nine different settings where people with disabilities receive services. The setting list represents the most segregated settings where people receive services.

The settings included in the pilot were:

- Center Based Employment, a Minnesota Department of Employment and Economic Development (DEED) setting
- Children in segregated school settings, a Minnesota Department of Education (MDE) setting
- Day Training & Habilitation, a Minnesota Department of Human Services (DHS) setting
- Board and Lodging, a DHS setting

- Supervised Living Facilities, a DHS setting
- Boarding Care, a DHS setting
- Nursing Homes and Assisted Living, a DHS setting
- Adult Foster Care, a DHS setting
- Intermediate Care Facilities for Persons with Developmental Disabilities (ICF-DD), a DHS setting

Timeline

Original Plan

Table 1 below shows the original timeline for the study at the initial proposal from the Improve Group, the modified proposal at contract execution, and the actual timeline for the four phases of the study.

TABLE 1: PILOT STUDY TIMELINE

Phase	Original Timeline at Initial Proposal	Modified Timeline at Contract Execution	Actual Timeline
Kick-off	April 2014	June 2014	June 2014
Design Phase	May – July	June – July	June – September
Data Collection	July – October	Late July – October	October – November
Analysis Phase	November – December	November – December	November - December

What Really Happened

Getting access to participant data in order to contact people to take the survey took significantly longer than expected, resulting in a longer design phase and a truncated data collection period. In order to have access to the names of people receiving services in Center Based Employment and Segregated School Settings, each agency had to obtain consent to release information from participants and, if applicable, their guardians. For participants in other settings, the Improve Group was able to secure a data sharing agreement with DHS that allowed for access to participant data without an additional consent to release information.

The invitation process also impacted the time available for conducting surveys. For everyone except participants living in Adult Foster Care and Supervised Living Facilities, the process was to send a packet to the provider about the survey, and request the provider's help with inviting people to participate and scheduling interviews. This process, including initial and follow up phone calls, provider follow up with clients, and scheduling an interview time, took no less than 2 weeks. If we needed to obtain a consent to release information or guardian consent, it could take more than a month to schedule an interview.

Turnaround time was calculated from the date the initial invitation was mailed to the date interviews were scheduled and to the date the interviews were completed. If all of the participants at location declined to participate, the date the provider informed us of this was record as the interview scheduled date. Providers that did not respond to outreach efforts or refused to participate are not included in the calculations.

TABLE 2: TIME TO SCHEDULE AND COMPLETE INTERVIEWS BY SETTING

Setting	Average days to schedule interviews after first invitation	Average days to complete interviews after first invitation	Minimum number of days to schedule interviews after first invitation	Maximum number of days to schedule interviews after first invitation
Adult Foster Care	33	39	30	44
Boarding Care	13	25	20	33
Board And Lodge With Special Services	8	18	7	29
Center-Based Employment	26	36	24	56
Day Training and Habilitation	18	29	23	36
Intermediate Care Facility for Persons with Developmental Disabilities	43	49	43	60
Segregated School Settings	16	16	12	19
Nursing Homes and Assisted Living	12	26	14	34
Supervised Living Facilities	2	6	2	6

Because it took so long to get access to participant data, the data collection phase was 8 weeks long instead of 13-16 weeks. In order to conduct as many interviews as possible during the shortened timeframe, most of the providers we selected were in the Minneapolis-St. Paul metro area. In addition, interviews were conducted in St. Louis County, Stearns County, Goodhue County, and Renville County. Because not all of the settings or populations of interest were reached during the data collection phase, additional interviews were scheduled in December with deaf individuals and individuals receiving services in greater Minnesota.

See recommendations for the planning phase in future survey administration on page 46 of this report.

Design Phase

Research Approvals and Human Subjects Protection

Original Plan

The Improve Group's original proposed approach was to determine whether the study required approval from an Institutional Review Board (IRB). If IRB approval was deemed necessary, the plan was to work with an independent IRB to get research approval. At contract execution with the Improve Group, the plan for obtaining consent from individuals had not been finalized.

What Really Happened

It was determined that the Olmstead Quality of Life Survey is exempt from IRB approval under Federal regulation §46.101, available at http://www2.ed.gov/policy/fund/guid/humansub/overview.html.

Before it was determined that this study was exempt from IRB approval, the Improve Group completed an application for the Heartland Institutional Review Board. This application was ultimately not submitted. However, the application outlined steps for protection of human subjects and data security that were incorporated the study's data security plan.

Additionally, the Improve Group used an internal review process for project materials. The team also required active consent from all survey participants and obtained guardian consent for participants who are unable to give informed consent.

Internal Review

All project materials, including surveys, consent forms, communication materials, and questionnaires, were reviewed by the Olmstead Team. Additional review was provided by the Advisory Group and Improve Group Directors that were involved in the study.

Informed Consent

Participants were asked to give informed consent at the time of the interview. If the individual did not give consent, or if they did not understand the consent form, they were not interviewed. Alternate documentation of consent, such as a witness observing a participant's verbal or visual consent, was used with individuals with disabilities that limited their ability to sign a consent form. Participants who were not able to give informed consent, such as people under 18 and individuals under guardianship, were asked to provide assent at the time of the interview, and were only contacted after the guardian gave consent.

Data Security

The Improve Group developed a project-specific data security plan, and the Olmstead Team reviewed the plan. Protections include:

- storing project materials in locked cabinets

- encrypting files and folders with personal or protected data
- limiting access to encrypted files to project staff
- training staff and contractors in data security, confidentiality, and human subjects protections

See recommendations for Human Subjects Protections in future survey administration on page 46 of this report.

Preparing the tool

Original Plan

Consult with Jim Conroy to finalize the survey instrument with the Minnesota context in mind (with particular attention to demographic questions) and make sure we collect the data in a way that can be compared to national results.

Prepare the survey for administration using a laptop or tablet as well as a web-based version of the survey for people who would prefer to take the survey on their own or without an interviewer present.

What Really Happened

Finalizing the survey was an ongoing process that extended into the administration phase. There were no major changes to the structure or content of the survey after the interviews started. However, there were minor changes to language and question routing in reaction to notes from survey administrators. Question routing allows interviewers to skip questions that are not relevant to the participant. These changes were made to improve the interview flow and to clarify the meaning of questions or response options.

Changes to the survey

The biggest change to the survey was adding response options to make the survey more inclusive or better suited to the current context. For example, “something else” was added as a response option for questions about gender or race and ethnicity. A “Don’t Know” option was added to the questions that did not already have that option. In addition, scripts were added to smooth the transition between sections and to help interviewers explain the survey. Finally, question routing and question piping was added. Question piping customizes each survey for participants by taking a response from one question and automatically inserting it into a future question.

A complete list of changes to the survey, including the rationale for each change, can be found in Appendix A.

Preparing the tool for administration

The survey was prepared for administration using laptops or tablets using SNAP Survey software, which has the capability of creating surveys for the web or for paper and pencil administration. Question routing, piping and scripts for interviewers were added to the survey to streamline administration and make the survey more consistent across interviewers.

In addition to routing and piping, a question was added to end of each page or section about any items or terminology the primary respondent had difficulty with. The responses to these questions were used to identify questions that were difficult for participants and to make technical changes to the survey. Interviewers also used these questions to make notes about technical problems with the survey.

A modified web-based version of the survey was created for people who would prefer to take the survey on their own. The modified survey was the same as the interview version except that some of the scripts and interviewer instructions were removed. The feedback questions at the end of each section were reworded to address the participant. The web version of the survey was made it available to people who requested it.

Accessibility

The survey tools and communication materials were used by Improve Group staff and interviewers. The materials were read to participants. Neither the survey nor the communication materials were tested for accessibility. A plain text version of the survey was created; however that version was not used or tested. None of the pilot participants requested a version of the survey for screen readers or large print versions of the survey; however only a small number of individuals who are blind or visually impaired were surveyed.

See recommendations for Preparing the Tool for future survey administration on pages 47 of this report.

Translation and Interpretation

Original Plan

Translation and interpretation were not included in the original pilot plan or scope of work. As a result, no funds were available for providing alternate versions of the survey for the deaf or hard of hearing, blind or visually impaired, or non-English speakers.

What Really Happened?

The Improve Group entered into an agreement with an American Sign Language (ASL) interpretation provider for individuals who requested an interpreter. For other non-English speakers, the Improve Group provided an interpreter if one was needed and requested. All materials, including consent forms and recruitment materials, were only available in English and were interpreted onsite. Two interviews were conducted in ASL and one was conducted in Amharic.

We asked providers when we scheduled interviews if any of the participants needed any accommodations, including if any of the participants would need an interpreter. However, the providers did not always have this information. Some participants completed the survey even though their primary language was something other than English. One interview had to be stopped early because the participant requested a Mandarin interpreter during the survey. We were not able to reschedule that interview.

One set of ASL interviews and the Mandarin interview had to be cancelled because we were unable to schedule interpreters. We attempted to reschedule the Mandarin interview twice and interpreters were not available either time.

See recommendations for Translation and Interpretation on page 47 of this report.

Sampling Strategy

Original Plan

Randomly select 200-250 people to participate in the survey using setting as the primary selection criteria, disability type as a secondary selection criteria, and demographic and other characteristics as tertiary selection criteria.

The nine settings to be included in the sample were:

- Center-based employment
- Children in segregated school settings
- Day Training & Habilitation (DT&H)
- Board & Lodging
- Supervised Living Facilities
- Nursing Home / Assisted Living
- Adult Foster Care
- Intermediate Care Facilities for Persons with Developmental Disabilities (ICF / DD)

The proposed secondary selection criteria were:

- Physical Disabilities
- Developmental Disabilities
- Mental Health Needs
- Brain Injury
- Deaf or Hearing Impaired
- Blind or Visually Impaired

Demographic and other characteristics tertiary selection criteria included:

- Geographic location
- Race / ethnicity
- Age
- Make extra efforts to include culturally diverse populations

What Really Happened

An initial sample of 455 individuals in eight of the settings was selected to take the survey. In addition, volunteers were recruited in order to ensure the survey was tested in all of the settings and with all of the populations of interest.

With input from the Olmstead Team, the Improve Group selected five to ten providers per setting to participate in the pilot. Providers were selected that represent diverse disability groups and some providers were selected for the diverse demographic populations they serve. Once the providers were selected, the secondary selection criteria were only used to identify individuals with hearing or vision needs in DHS settings. Because the data structure and information maintained about individuals receiving services varies by agency and provider, demographic information was not used as a selection criterion for individual participants after the providers were selected.

Setting

The Olmstead Team used licensing information and agency guidance to identify organizations that provide services in each of the setting types. The agencies then helped to select a sample of individuals from each provider to invite to the survey. Forty-nine providers were selected as pilot sites. In all, we conducted interviews with participants from 29 providers. Of the 20 providers for which we did not conduct interviews:

- Six providers declined to participate.
- We were unable to schedule interviews with the other nine providers for which we had a sample.
- Additionally, we were not able to get a sample for nine providers, but four of those providers allowed us to interview volunteers.

Identifying providers to select a sample from was more complicated than expected, especially for DHS providers. The biggest challenge is that the different settings are not clearly defined, and providers may offer services for multiple setting types at the same location. It is also possible that providers may also provide services for participants through multiple funding streams. This complexity poses a challenge for ensuring the setting types are well represented without looking at the participant's funding source.

Disability Type

During the early planning stages, the Improve Group created a grid of settings and disability types with the impression that the Olmstead Team would be able to identify which settings would have a greater number of individuals with certain disability types.

Each of the state agencies collects and report disability type differently, which made it difficult to consistently use disability type as a selection criteria. Disability type was not included in the sampling criteria for DEED or MDE participants because the Improve Group did not have access to participant data. For participants in DHS-funded settings, we attempted to capture variety in disability type by selecting providers that specialize in working with certain disabilities. In addition, the houses in the adult foster care and supported living services sample were selected because one or more individuals in the home had hearing or vision needs.

The number of people with vision or hearing disabilities in the initial sample was not large enough to provide reliable feedback about the survey. In order to reach enough people to test the survey, organizations that provide services that do not fall into the 9 survey settings were approached to serve

as pilot locations. Individuals who were surveyed in these locations were asked to provide additional feedback about accessibility and interpretation.

Demographic and Other Characteristics

Selecting the sample required working with state agencies to define setting types and to select appropriate providers. A different approach was used to select the sample from each state agency. The approaches reflect the different data structures and level of data access for each agency.

See recommendations for Sampling Strategy on page 47 of this report.

Working with State Agencies

The settings included in the sample are funded by three different agencies: Minnesota Department of Human Services (DHS), Minnesota Department of Education (MDE), and Minnesota Department of Employment and Economic Development (DEED). The Olmstead Team worked with the agencies to find liaisons to help access data and generate the survey sample. Each agency has different data structures and different data sharing requirements. The process for working with each agency follows.

Department of Employment and Economic Development

DEED holds the data for people who receive services through Center Based Employment. In order to share participant data with the Improve Group, DEED required Consent to Release Information Form from each program participant or their guardian. DEED maintains data on participant's legal representatives, but the Improve Group could not access that information to contact guardians directly.

The process for selecting and inviting DEED participants to the survey was as follows:

- The Olmstead Team, with guidance from DEED about appropriate providers, identified 5 metro area center-based employment providers from which to select the sample;
- DEED selected the sample using guidance from the Improve Group;
- The Improve Group prepared a provider packet that included project information, consent to release information forms, and guardian consent forms for participants with legal guardians. The packet included instructions on completing and returning the forms as well as contact information for the Improve Group. DEED sent the packets along with a cover letter from DEED employee John Sherman encouraging providers to participate to the sites;
- Providers were asked to manage collecting first consent, including obtaining consent from participants' guardians; and
- Interviews were scheduled at the providers' offices to make it easier for participants to take the survey during the workday.

Challenges

- Staff turnover at DEED caused a delay in selecting the sample and sending information to providers.

- The arrangement with DEED required obtaining consent to release information from participants and guardians before the Improve Group could contact them about the survey. This meant that significant "leg work" for the survey had to be completed by DEED staff.

Department of Human Services

DHS holds the data for individuals in seven of the nine settings. The Improve Group was able to secure a data sharing agreement with DHS, which gave the Improve Group permission to contact individuals directly. The Olmstead Team selected providers to sample from, and DHS provided the sample of individuals within each setting if that information was available. However, the data for several settings was limited, and the lack of participant information in Supervised Living Facilities, Boarding Care, and Board and Lodge with Special Services presented an additional challenge. DHS maintains information guardianship status for some participants. However, guardian contact information for people receiving DHS services is held at the county level.

The process for selecting the DHS sample is as follows:

- The Olmstead Team, with guidance from DHS, selected 5-10 providers from which to select the sample. The number of providers depended on the type of service, with smaller settings having more providers.

- DHS data liaisons selected a sample from each provider. If the provider had fewer than 15 participants, all of the people receiving services at that setting were included in the sample.

- DHS transmitted the sample directly to the Improve Group, and the Improve Group obtained first consent.

- The Improve Group requested support from providers with obtaining guardian consent to contact individuals to participate. Providers also helped to facilitate the survey by encouraging individuals to participate and arranging interview times.

Challenges

- DHS uses multiple systems to manage data for individuals in different settings, which caused a delay in getting data for multiple settings. Determining which system to use to pull data for each setting, creating the code, and searching for providers within the system was also time consuming.

- There is no plain language definition of settings, and many of the providers hold multiple licenses. This made selecting providers and the sample difficult. In addition, not all of the providers we selected were in the databases, particularly Board and Lodging and Boarding Care providers.

Minnesota Department of Education

MDE oversees programs for students with disabilities up to age 22. However, each district maintains information on students and their guardians, and neither MDE nor the Improve Group had access to the data.

The Improve Group worked with MDE to identify metro-area schools to include in the pilot. The schools were selected based on the number of students in segregated school settings over age 7 and geographic location. Two schools, one in the south metro and one in the west metro, were selected to participate in the pilot. MDE contacted district superintendents about the project, and the Special Services office of each school worked with the Improve Group to recruit participants.

The process for selecting the MDE sample was as follows:

- Two school districts were selected to participate based on student population and geographic location. The schools were selected because MDE data showed they had 30-50 students in segregated school settings;
- MDE contacted the School Superintendent in each district, requesting their participation in the project;
- The Improve Group worked with the Special Services Offices to send invitations to all families with students receiving services in Federal Special Education Settings 3 and 4. The invitations included background information about the project and guardian consent forms;
- Parents and guardians returned consent forms to the Improve Group; and
- Interviews were scheduled with the families in their homes or at a neutral location.

Challenges

- Both school districts had nearly 90 students in segregated settings, not the 30-50 we expected based on the information from MDE.
- Not having access to student data limited the options for follow up. Both school districts provided additional support with encouraging families to participate, but only 11% of families returned a consent form.
- Both schools used their resources to encourage families to participate in the project, but the relationship between the schools and the families was not as conducive to getting people to participate as the other providers. There are some fundamental differences in education programs and residential or vocational programs.

See recommendations for Working with State Agencies on page 47 of this report.

Advisory Group

Original Plan

The Improve Group recommended engaging an advisory group to provide insights about recruiting, administration, and interpretation of data. The advisory group would have 6-10 members and would meet up to four times during the project. The advisory group would help the Olmstead team to make sure that the concerns and needs of the community were heard throughout the process. The advisory group would provide feedback on surveys and communication tools to make sure the Olmstead Team was "speaking the language" of the community.

The ideal advisory group member would:

- Have a disability or be an advocate for people with disabilities
- Be close to the survey experience
- Be from the community rather than a government agency
- Be an advocate for the Olmstead Quality of Life Survey

What Really Happened

The Olmstead Team identified members of the community and advocates for people with disabilities to invite to the advisory group. Five people from a range of backgrounds and experience agreed to join the group. Extra effort was made to help ensure the advisory group was inclusive of people from multiple disability groups.

The advisory group met once, in early November. Several attempts were made to schedule an in-person meeting in August or September, but it was difficult to find a time when everyone could meet. In order to get advisory group feedback before starting surveys, the Olmstead Team asked group members to review documents and provide feedback individually. Advisory group members provided feedback on the pilot review questionnaire, interview topics, and lessons learned from other initiatives.

At the November meeting, the Olmstead Team shared how the project was working so far, and asked for feedback about the project. It was a time for members to meet, here progress about the survey and share feedback about the process. The Advisory Group members shared that it is important that individuals with disabilities and individuals that represent the diverse communities of Minnesota conduct the survey as much as possible. Racial, ethnic, and cultural diversity were shared as being particularly important.

The plan was to meet with the Advisory Group in December to share initial findings. The condensed time of the study did not allow for this meeting. The Olmstead Team will share a summary of findings with Advisory Group members and invite their participation in future discussion about the study in the baseline year.

See recommendations on the Advisory Group on page 48 of this report.

Reporting Abuse and Neglect

The Olmstead Team identified the need to develop a protocol for documenting interviews in which people threaten to hurt themselves or others or incidents of reported or suggested abuse or neglect. The Improve Group developed a protocol for reporting suspected abuse or neglect using DHS resources for mandated reporters. This protocol required that all incidents or self-reported, observed, or suspected abuse or neglect be reported to the common entry point within 24 hours of the interview. If the participant was in immediate danger, the interviewer was to call 911 immediately. The Improve Group created a form for internally documenting reports of abuse or neglect.

In all, there were three incidents of suspected abuse or neglect. Of these cases, one resulted in a report to the common entry point, and the other two were cases that were previously reported and resolved.

See recommendations on Reporting Abuse and Neglect on page 48 of this report.

Administration Phase

Working with Providers and School Districts

Original Plan

Send at least two letters to providers to let them know about the survey and their role as well as to help get information to participants about the survey and encourage them to participate.

What Really Happened

Providers had an active role in supporting the survey, including helping to obtain first consent from participants and their guardians, scheduling appointments, and arranging space for interviews. Providers also played a huge role in getting people to participate in the survey. For all of the settings except schools, most of the interviews were conducted on-site. The school districts helped with outreach and provided space to conduct surveys; however, families of school-aged children generally preferred to be interviewed at home or in a neutral location.

In residential and vocational settings, the close relationship between the providers and participants also helped to prepare interviewers for the appointment. Staff members shared tips for communicating with individuals, provided context about participant's situation, and supported participants during the survey when requested. Many of the providers played the dual role of advocating for the project and their clients.

While most of the providers were supportive of the project, some were hesitant to get involved and a few refused to participate. Providers that were hesitant cited multiple surveys from different agencies, demands on staff, or the likelihood that their participants would not be interested in the project. Providers were surprised they had not heard about the Olmstead Quality of Life survey prior to receiving the provider packet, and some were concerned that DHS might not sanction the project. Reasons some providers gave for opting out of the survey included: clients would not be interested, lack of time, or lack of information. Other providers did not return phone calls.

The letter providers received from the state agency inviting them to participate was often the first they had heard of the project. If the provider did not receive the letter or if the packet got shuffled around and lost, the phone call was the first they heard of it. Because the project was a surprise, it was hard to find the appropriate contact, which sometimes ended up leading to calling in circles. Also, because the packets were sent to the individual homes for ICF / DD and foster care settings, sometimes we had guardian consent forms before the provider had figured out what the next steps were.

Because the providers were the primary method of reaching potential participants, gaining their support was essential to the project. To gain this support, someone from the Improve Group contacted each provider at least twice before attempting to schedule interviews. While the letters sent by agency liaisons helped to establish credibility and authority with the providers, many of the providers required additional evidence that their participants' rights and privacy would be protected.

On the whole, the providers we talked to were aware of the Olmstead Plan and supported efforts to improve services for their participants. Many of them said they thought the project was important, and

that they were encouraging people to participate. Several providers rescheduled interviews to make sure that everyone who had agreed to take part in the survey was available.

See recommendations on Working with Providers and School Districts on page 48 of this report.

Recruitment and Communication Strategies

Original Plan

Develop recruitment and communication tools for providers and survey respondents. Two letters to providers and facilities about the survey letting them know that we would be contacting them and participants.

What Really Happened

The Improve Group worked with state agencies to reach out to providers about the survey. The Improve Group prepared packet of materials to the providers or school districts that included information about the survey, provider roles, guardian consent forms, and, if available, a list of participants. For every setting except Adult Foster Care and ICF / DD, materials were sent from the state agency. The Improve Group contacted ICF / DD providers and adult foster care participants directly.

After the packet was sent, the Improve Group called providers to give them more information and answer questions. As soon as the providers were onboard, we began coordinating guardian consent and scheduling interviews. Scheduling and coordination was also done via email. Depending on the setting and provider, the turnaround time ranged from a couple of days to over a month. Recruitment efforts took much longer in Adult Foster Care and ICF / DD because the packets were sent directly to homes instead of to the provider's main office. This approach made tracking down the right person to talk to much more difficult.

Some providers contacted the Improve Group as soon as they got the packet to ask questions and coordinate scheduling, while others never received the packet. The contact information and mailing addresses for some providers were out of date or incorrect.

See recommendations on Recruitment and Communication Tools on page 49 of this report.

Consent Process

Original Plan

Obtain informed consent from all participants before starting the survey. For participants with guardians, obtain guardian consent and participant assent. Allow for alternate documentation of consent for participants with disabilities that keep them from signing their name.

What Really Happened

All participants were given the option to opt out of the survey before an interview was scheduled and at the time of the appointment. Even if the person agreed to participate, the survey was not conducted if the interviewer did not think the person understood the consent form. Some individuals who agreed to participate declined at the time of the interview, either by not showing up for the appointment or by

declining to answer questions. People were most likely to decline at the time of the interview in residential settings, especially Boarding Care and Nursing Homes / Assisted Living. In several cases the contact person could not find the person at the time of the interview, and the contact person felt those individuals were passively opting out of the survey. In other cases the guardian had given permission to contact the individual but the person was not interested in participating.

The Improve Group obtained guardian consent before contacting individuals to participate in the survey. However, the Improve Group did not have access to guardian information, so providers were asked to help obtain guardian consent either by contacting guardians directly or by providing contact information.

If a person who could not consent had a guardian present, the guardian was given the option to complete the survey. Seventeen guardians were present for the survey, and in seven cases the guardian was the primary respondent. In all of the cases where guardian was the primary respondent, the focus person was a student in segregated school settings.

See recommendations on the Consent Process on page 49 of this report.

Survey Administration

Original Plan

The Improve Group will administer 85 surveys. We hope to administer 40-45 surveys among our staff and then reflect on and document lessons learned. At that point will recruit and train people with disabilities to administer the surveys, and then co-administer the remaining 40-45 surveys as training and coaching opportunities. Each survey administrator would then administer up to 30-40 additional surveys. In total, we anticipate that 205-245 surveys will be administered.

What Really Happened

The shortened survey timeline and longer design phase meant that Improve Group staff did not administer the first group of surveys. Instead, the first round of interviews were used for training and coaching purposes, and Improve Group staff administered surveys when other interviewers were not available. Having interviewers conduct the surveys instead of Improve Group staff allowed for conducting more surveys because of budget constraints that resulted in more time spent during the design phase gathering samples than was originally anticipated.

At the end of the administration phase 105 surveys were attempted or completed. Because some of the target populations were not reached during the administration period, an additional four surveys were completed in December. In addition, six partial surveys were conducted at Vision Loss Resources to get feedback from people with vision loss about the survey.

The original plan estimated 3 hours per survey including scheduling, travel, meeting and greeting participants, and survey administration. In practice, it took an average of 4 hours to schedule and complete each survey. This estimate includes 2 hours for coordinating with providers and scheduling interviews, an hour to conduct the interview, and one hour for travel, setup and breakdown. The coordination time includes time spent explaining the survey to providers and family.

Most of the surveys were conducted using laptops and an internet-based survey program. Each interviewer had a password-protected hotspot to bring with them to survey participants rather than relying on the survey location for internet access. We chose this administration method because we were able record participant responses and transmit data securely to the Improve Group servers. In most cases this administration mode worked well; however, there are some limitations to using computers to administer the survey.

First, there were many settings where the hotspot did not work or it worked intermittently. This meant interviewers had to move rooms to complete the survey or switch to paper part of the way through the interview. In addition, sometimes the hotspot worked, but the signal was not strong enough to move fluidly through the survey. The problems with internet access were disruptive enough that we do not recommend using an internet-based survey.

Second, many of the interviews were conducted in small spaces such as the participant's bedroom or a small office. The interviewers had a hard time navigating the small spaces with the laptop while trying to be respectful of the participant's space. If the interviewer had several interviews in one day they would have to find a place to plug in the computer during the survey, limiting the where the survey could be administered.

When we were not able to use a computer because of internet access or other barriers, the survey was conducted on paper. This allowed for the interviewer to take notes about the responses and made it easier to go back to sections if the participant provided more information during the interview. However, paper surveys did require extra time for data entry after the interview.

See recommendations on Survey Administration on page 49 of this report.

Special Populations

Survey Administration in Greater Minnesota

Original Plan

We will chose three additional locations in greater Minnesota to provide some geographic representation, including one rural area with few services or resources and an "outstate hub" with more services and resources.

What Really Happened

A total of 15 interviews were conducted in greater Minnesota. Eleven during the survey administration period and four after the administration phase ended. The interviews were conducted in St. Louis County, Stearns County, Goodhue County, and Renville County. The St. Cloud provider was selected because it is a service provider for several rural counties. In addition, we contacted providers in Pope and Faribault Counties, but were unable to schedule interviews.

A Center-Based Employment provider in Goodhue County and two providers in Duluth, an ICF / DD and a Board and Lodge with Special Services, were included in the original sample. Six people at the Center-

Based Employment provider and one person at the ICF / DD agreed to participate and were interviewed. The Board and Lodge declined to participate.

We sent information to six foster care houses and a DT&H in Pope County. The notification inadvertently was delayed for Pope County and providers were asked to participate at the end of the survey administration period. The DT&H declined because of the tight timeline for getting guardian consent and scheduling interviews. No one from the foster care houses agreed to participate.

In order to include more individuals receiving services in rural areas in the survey, the Improve Group reached out to providers in greater Minnesota. In order to schedule interviews quickly, we selected settings where participants were less likely to have guardians based on our experiences in the metro area.

When confirming the appointment time with one provider, we found out that all of the participants would require guardian consent. The contact person said it was a common practice in rural areas to obtain guardian consent over the phone. However, we felt the guardian consent form was too complicated to administer over the phone and rescheduled the interviews in order to allow more time to obtain guardian consent.

In general, the challenges with scheduling and conducting interviews in greater Minnesota were similar to the challenges in the metro area. However, the process was complicated by travel time and interviewer travel limitations. For example, it was difficult to find interviewers who were available to travel outside of the metro area at the times that worked for the participants. This challenge was even greater for interviews that required overnight travel.

See recommendations on Survey Administration in Greater Minnesota on page 50 of this report.

Blind or Visually Impaired or Deaf and Hard of Hearing

We attempted to include people who are blind or deaf in the sample by using vision and hearing needs as a sampling criteria. The Adult Foster Care and Supported Living Services houses that were selected as survey locations were selected because at least one resident had vision or hearing needs. However, approach was not successful in recruiting blind participants. Some providers declined to participate because of the resident's vision or hearing needs, particularly in homes where participants were receiving Supported Living Services

DEED was not able to use hearing or vision needs as a sampling criteria because there are very few individuals with these needs in Center-Based Employment, particularly in the metro area. We also attempted to survey students at the Minnesota Academies, but were not able to schedule interviews.

One boarding care provider was selected as a survey location because they have a program that specializes in deaf services. However, only two interviews were conducted at that provider. In order to test the survey with more individuals who required ASL interpretation, we scheduled interviews with

participants receiving services from the Minnesota Employment Center (MEC) for People Who are Deaf or Hard of Hearing, but were not able to conduct the interviews.

In order to reach more people with vision loss, we tested the survey at a peer counseling meeting at Vision Loss Resources. Due to time limitations, we divided the survey into two sections and had volunteers provide feedback on those sections.

See recommendations on Blind or Visually Impaired and Deaf or Hard of Hearing Participants on page 50 of this report.

Analysis and Reporting

Pilot Results

A rigorous analysis of quantitative and qualitative data shows that the Center for Outcome Analysis Quality of Life Survey tool worked well across disability groups and across settings. We recommend a few adjustments to the tool, and have consulted with the tool's developer about making those adjustments.

Qualitative Analysis

There were three main sources of data for the qualitative analysis of the pilot: the Pilot Review Questionnaire, interviewer notes recorded during the survey, and interviewer reflections. These sources were analyzed to evaluate the survey instrument and the administration process.

Survey Tool Questions

A question was added to the end of each section of the survey for interviewers to note any problems the participant had with the survey. This question was also used to report technical problems with the survey and to make notes about the participant's behavior. These responses were analyzed for trends related to questions and terminology that caused problems for the participant.

Pilot Review Questionnaire

For each survey the interviewers completed a Pilot Review Questionnaire that included information about the participant, the setting, and the survey process. These responses were compared to the survey results to identify patterns survey non-completion and problem areas.

The questionnaire also allowed the interviewer to share successful interview techniques or unusual situations. These responses were used to provide ongoing coaching to interviewers and to make adjustments to the administration process. The responses were also used to make recommendations for the baseline survey.

Interviewer Reflections

As the people working in the field, the interviewers had the most extensive knowledge of what worked well during the pilot and what needed to be changed. In order to share this experience, the interviewers regularly debriefed staff about their experiences in the field. These conversations were used to improve processes throughout the administration phase. Because the interviewers had time to reflect more on their experiences before debriefing, these reflections were often more in depth than the pilot review questionnaire allowed. Interviewers also provided feedback about the pilot project at the end of the survey administration period. Their feedback was used reinforce findings and recommendations**.**

Quantitative Analysis

The survey responses were analyzed for response rate, survey completion rates, and survey length. Participant's responses to race and ethnic identity and disability type and perceived significance questions were also compiled.

Response Rate

Approximately 450 individuals from 9 settings were invited to take the survey, and 105 individuals agreed to participate for an overall response rate of approximately 22%. A handful of providers volunteered to ask everyone they serve to participate in the study. Because the number of people these providers serve is unknown, it is not possible to calculate survey response rate. This includes an estimate of the number of people who were invited to participate during community meetings at the Anoka Metro Regional Treatment Center. Volunteers were recruited in Board and Lodging but were not used to calculate the response rate.

Two settings, Adult Foster Care and School Settings, had response rates around 10%. However, these settings had unique recruitment issues that may have depressed the response rate. The Adult Foster Care response rate includes participants receiving Supported Living Services, and no interviews were conducted in those homes. Of the participants receiving funding through the CADI, CAC, and BI waivers the response rate was 18%. For school settings, the response rate was likely affected by the fact that there was no way for the Improve Group to follow up with families after the initial letter.

At each setting there were individuals who agreed to take the survey but who declined at the time of the interview. In some settings, most notably Boarding Care and Nursing Homes, there were people who agreed to take the survey but did not show up for their appointment. Other people agreed to the survey but were unable to participate because of scheduling conflicts. A longer survey administration period would give these individuals more opportunities to participate.

TABLE 3: RESPONSE RATE BY SETTING

Setting	Number of Invitations	Number of Surveys	Response Rate
Adult Foster Care	57	5	9%
Boarding Care	28	12	42%
Board and Lodge with Special Services (participants were recruited at the time of the interview)	0	10	-
Center-Based Employment	60	22	35%
Day Training and Habilitation	47	9	19%
Intermediate Care Facilities for Persons with Developmental Disabilities	25	8	32%
School Settings	166	18	11%
Nursing Homes and Assisted Living	50	15	30%
Supervised Living Facilities	30	6	20%
Total	455	105	22%

Survey Completion

Overall, 88% of participants completed the required sections of the survey, and 60% completed all but the last section. Only 34% of participants completed all the survey sections. This is in part due to

participant fatigue and in part because interviewers were told to give the participant the option to stop the survey after 60 minutes. At least 80% of participants completed the required sections in every setting except DT&H and Boarding Care. The low completion rate (56%) in DT&H is because many of the participants had barriers to completing the survey that are related to their disabilities. The completion rate was also lower (67%) in Boarding Care. This is due to people who agreed to take the survey but who decided to stop during the first section. Survey completion rates by setting are shown in Table 4. The four surveys conducted after the survey administration period are not included in the results.

Most of the participants who stopped at the end of the required sections or after the Person-Centered Planning section stopped because of fatigue or because of other appointments. However, some participants declined to complete the Close Relationships Inventory because they were concerned the section would be too personal. In Segregated School Settings, only one participant completed the Close Relationship Inventory. Several parents declined to complete the section because their child "didn't have any friends." We recommend adding more training around framing this section to increase completion rates.

TABLE 4: SURVEY COMPLETION BY SETTING (PERCENT COMPLETED)

Setting	Attempted Surveys	Did Not Complete Required Sections	Completed Required Sections	Person-Centered Planning	All Sections
Adult Foster Care	5	0%	100%	40%	40%
Boarding Care	12	33%	67%	50%	17%
Board and Lodging	6	0%	100%	67%	67%
Center-Based Employment	22	5%	95%	68%	64%
Day Training and Habilitation	9	44%	56%	56%	33%
Intermediate Care Facilities for Persons with Developmental Disabilities	8	0%	100%	13%	13%
Segregated School Settings	18	0%	100%	94%	6%
Nursing Home / Assisted Living	19	16%	84%	42%	26%
Supervised Living Facility	6	0%	100%	67%	17%
All Settings	**105**	**11%**	**90%**	**59%**	**32%**

Survey Completion Time

The total time needed to complete the survey varied by setting. Across all settings, the average survey length was 42 minutes with a maximum length of 91 minutes. Average, minimum, and maximum survey length by setting is shown in Table 5. The minimum survey length includes surveys that were started but not completed. Unless noted, this calculation does not include interviews that were recorded using paper and pencil.

An important consideration in survey length time is the relationship between survey length and survey completion. Overall, the higher the survey completion rate the longer the survey took to finish. This is of particular importance in settings where participants have higher barriers to participation or communication needs that will lead to longer surveys such as DT&H. Also, interviews that took place at a provider were scheduled for 60 minutes and most surveys were stopped if they lasted over an hour. Participants were also reminded of their option to end the survey after the required sections or when they showed signs of fatigue.

TABLE 5: SURVEY LENGTH BY SETTING (MINUTES)

Setting	Average Survey Length	Minimum Survey Length	Maximum Survey Length
Adult Foster Care	46.7	34.6	60.7
Boarding Care	27.8	4.1	54.8
Board and Lodging	36.7	29	48.2
Center-Based Employment	46.5	30.8	70.4
Day Training and Habilitation	20.3	2.4	45
Intermediate Care Facilities for Developmental Disabilities	34.5	26.4	40.8
School Settings	54.3	29.9	90.7
Nursing Homes and Assisted Living	45.2	7.9	89.8
Supervised Living Facility (includes paper surveys)	32.2	22.5	46.7
All Settings	**41.8**	**2.4**	**90.7**

Respondent Characteristics

Participants were asked to provide their race and ethnic identity followed by primary ethnic identity. Participants could select more than one response for race and ethnic identity, but only one primary ethnic identity. If the participant only selected one race or ethnic identity, the interviewer chose the same response for primary ethnic identity.

When asked to choose their primary ethnic identity, 63% of participants identified as Caucasian or White, and 12% identified as African American or Black. Ten percent responded “Something Else” and 8% of participants refused or did not understand the questions. Respondent’s primary ethnicity identity is shown in Table 6.

TABLE 6: PRIMARY RACE AND ETHNICITY

Race and Ethnicity	Number	Percent
African American / Black	13	12%
American Indian or Alaskan Native	4	4%
Asian	1	1%

Race and Ethnicity	Number	Percent
Native Hawaiian or Other Pacific Islander	0	0.0
Hispanic or Latino	2	2%
Caucasian or White	67	63%
Something Else	11	10%
Refused, left blank	8	8%

The Quality of Life tool includes a list of disabilities. For each item on the list, participants were asked if that disability applied to them and, if yes, if they perceived the disability to be of "Major" or "Some" significance. At least one participant reported a "Major" disability for all of the items except Dementia. Some participants responded "None" for all of the items on the list.

People from all five of the disability types included in the sampling guidelines were interviewed during the pilot. The most frequently mentioned disabilities were Mental Illness (49%), Intellectual Disability (43%), Major Health Problems (38%), and Communication (36%). Walking (38%) was not included as on option on all of the surveys, as it was inadvertently left out of the first surveys administered. Four participants reported a "major" hearing disability and seven reported a "major" vision disability. These numbers reflect the difficulty we had with recruiting deaf and blind participants.

TABLE 7: DISABILITIES AND PERCEIVED SIGNIFICANCE

Disability	Major	Some	None	Percent Major / Some
Autism	10	7	83	17%
Behavior: Aggressive or Destructive	5	15	80	20%
Behavior: Self-Abusive	2	14	85	16%
Brain Injury	8	13	75	21%
Cerebral Palsy	4	4	90	8%
Communication	20	17	50	37%
Dementia (Including Alzheimer's Disease)	0	4	91	4%
Health Problems (Major)	20	18	50	38%
Hearing	4	20	74	25%
Intellectual Disability	21	21	55	42%
Mental Illness	26	22	50	57%
Physical Disability Other Than Ambulation (walking)	12	15	72	27%
Seizures	4	14	81	18%
Substance Abuse	8	8	82	16%
Swallowing: Inability to swallow independently	2	9	87	11%
Vision	7	19	74	26%
Walking (this item was not asked of everyone)	17	14	52	37%
Other	15	12	60	30%

Lessons learned by setting

Working in Different Settings

Initially, 46 providers were selected as pilot sites, and additional providers were added throughout the administration phase in order to reach all of the target populations. In total, we contacted 51 providers about the project, and interviewed participants from 29 providers. Reasons interviews were not conducted at the other providers include scheduling problems, lack of participant interest, and because the providers refused to participate. In addition, some of the providers were not appropriate settings for the Quality of Life Survey because they do not provide services to people with disabilities.

The process for working with providers in each setting follows.

Adult Foster Care

Invitations to participate in the pilot were sent from the Improve Group to participants that live in Adult Foster Care and receive services from the Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI) or Community Alternative Care (CAC) waiver programs. A separate letter was sent to the provider explaining the survey and asking for help in obtaining guardian consent when needed. Interviews were either scheduled with the focus person or through a house manager depending on the number of people in the home who agreed to participate. All the residents of the home, including people who were not a part of the sample, were given the opportunity to participate in the pilot. Three of the four providers participated in the survey. The interviews were conducted in common rooms and resident's bedrooms.

Invitations for participants in living in Supported Living Services homes and receiving services from the Developmental Disabilities (DD) waiver were sent to the provider and to individual homes. The Improve Group then reached out to the providers and individual houses to recruit participants, but no interviews were scheduled. Two providers contacted us to discuss the project and to address concerns about the pilot and the baseline survey.

Scheduling interviews with foster care residents was complicated by the different schedules of the people living in the home. We tried to schedule multiple interviews for a single visit, but it was difficult to find times that worked for multiple residents. Many of the interviews had to be rescheduled or cancelled on short notice because the participant was not available. This happened both when the interview was scheduled through house staff or with the individual. For many of the participants work opportunities, leisure activities, and sleep took priority over participating in the survey.

Boarding Care

A packet of information, including a list of participants if available, was sent from DHS to Boarding Care providers. DHS was only able to pull a sample for two of the five providers that were selected as pilot sites. The other providers were not found in MAXIS. Although we were not able to get a sample for the provider, we reached out to a third Boarding Care provider that has a deaf services program. All the participants in that program were invited to participate.

We worked with providers to schedule a time when most of the participants would be available for interviews. Most of the interviews were conducted in a semi-public space such as a dining hall or multi-purpose room. Staff helped to coordinate interviews by finding participants and escorting them to the interview.

Getting individuals to start and to complete the survey was more difficult than at other settings. Although most of the people selected initially agreed to the survey, many participants could not be located when it was time for their interview. Based on feedback from providers we believe that at least some of those people did not feel comfortable declining to participate. Several participants consented to the survey, but stopped during the first section because they were uncomfortable with the questions and how their responses would be used. At one provider we recruited volunteers to complete the survey.

Board & Lodge with Special Services

A packet of information was sent from DHS to Board & Lodge providers. However, DHS was not able to select a sample for any of the providers. Instead of selecting a sample, we contacted the providers and asked for volunteer participants. One provider agreed, two declined, and we were unable to reach the contact person at the other two. The Improve Group reached out to an additional Board and Lodge provider greater Minnesota, and we were able to conduct interviews at that provider. The interviews were conducted in offices or semi-private spaces at the providers.

The biggest problem with selecting Board and Lodge participants was identifying appropriate providers. The lack of plain language definitions compounded this problem. All of the providers we selected were listed as receiving Group Residential Housing funding, but four of the providers could not be found in the eligibility databases. One provider we selected did not provide services based on participant's disabilities. The residents at one provider opted out of the survey because of concerns related to their disabilities, specifically mental health concerns. We were not able to make contact with the appropriate person at the other providers.

Center-Based Employment

A packet of information, including a list of participants, was sent from DEED to Center-Based Employment providers. The providers helped with obtaining consent to release information to the Improve Group from participants and their guardians. When applicable, the providers also obtained guardian consent to survey participants. The providers also scheduled interview times and reserved space in their offices to conduct the interviews during the participant's work day. Everyone who was available during the interview time was given the chance to participate. Some of the providers paid the survey participants for missed work time.

We were able to schedule interviews at four providers. The fifth provider agreed to participate, but no interviews were scheduled. Two of the providers rescheduled interviews to make sure most of the people who agreed to take the survey were available. One provider requested the web version of the survey, and two of their participants completed the survey online.

Some of the people in the Center-Based Employment sample work offsite in an enclave or job crew. It was difficult to schedule interviews with those individuals without either extending their work day or disrupting programming. Because of transportation limitations, it was not possible to move people from their worksite back to the interview location. The providers suggested trying to interview people at the end of the work day, but warned that most of the individuals would be ready to go home and likely not have enough energy to complete the survey. In addition, people who were interviewed at the end of the day were concerned about missing their ride home.

One solution to these problems is to schedule interviews with people in Center-Based Employment outside of work hours. These interviews could be scheduled at the person's home or at a location of the person's choice. However, the providers played a significant role in encouraging people to participate, including reminding them that they had made a commitment and needed to follow through. If interviews are scheduled outside of the work day, this support will be lost. Based on our experiences in other settings, it may be more difficult to schedule interviews without the provider support. Interviews could also be scheduled at the participant's work site.

Finally, the Decision Control Inventory scale was not relevant to people who live independently or with family. When interviewing people who do not have paid staff, we recommend using the alternate scale for people without staff to capture whether the participant feels like they have control over the choices that are being made. The alternate scale is explained on page 42 of this report in the "Decision Control Inventory" section.

Day Training and Habilitation

A packet of information, including a list of participants, was sent from DHS to Day Training and Habilitation (DT&H) providers. The providers managed obtaining guardian consent to survey participants. The providers also scheduled interviews, reserved space in their offices to conduct the interviews while the participant was on site, and served as a support person during interviews.

We were able to schedule interviews at four of the six providers we contacted. One provider declined to participate because of the short timeline for obtaining guardian consent. The other provider obtained guardian consent for several participants, but we were unable to connect with the contact person to schedule interviews.

All of the DT&H participants had barriers to completing the survey that were related to their disability. This included non-verbal participants, individuals who were deaf and had no way of communicating beyond communicating their basic needs, and deaf-blind participants. In addition, staff shared that the participants with Autism had difficulty participating in the survey because of the disruption to their normal routine. All of the DT&H participants required a support person to help complete the survey.

As with Center-Based Employment participants, some DT&H participants work offsite which makes it difficult to conduct those interviews at the provider. During the pilot at least one person who wanted to participate in the survey was not interviewed because he was not able to make the appointment. Because people who work offsite rely on the provider for transportation, there is a short window to

interview them at the provider. Interviews with those individuals should be scheduled at a time and place that is convenient for the person.

Intermediate Care Facilities for Persons with Developmental Disabilities

A packet of information, including a list of participants, was sent from the Improve Group to Intermediate Care Facilities for Persons with Developmental Disabilities (ICF / DD) providers. The providers managed obtaining guardian consent to survey participants. Provider staff also scheduled interviews and served as support people during interviews.

We were able to schedule interviews at four of the five ICF / DD homes, although all of the providers agreed to participate. Interviews were not scheduled at the fifth home because the participants' behavior issues were a safety concern. However, there were challenges to scheduling and conducting interviews at all of the ICF / DDs. In some cases difficult relationships with guardians were a barrier to obtaining consent.

We encountered challenges when administering the survey at ICF / DD providers. Many of the participants were non-verbal or had other barriers to participation related to their disability. For those individuals it was important to have a support person present, and a staff person was often the most appropriate person to help with the interview. For many participants, their support staff has the most experience communicating with them and knows most about their activities. This does cause a problem if the person wants to but does not feel comfortable providing negative feedback. We also had problems obtaining guardian consent and making contact with providers.

Nursing Homes and Assisted Living

A packet of information, including a list of participants, was sent from DHS to Nursing Home and Assisted Living providers. The providers managed obtaining guardian consent, scheduled interviews, and coordinated appointments.

Ten Nursing Home or Assisted Living providers were originally selected for the pilot. We conducted interviews at only four of the 10 providers due to time constraints and because there was a large enough sample at the four facilities for the needs of the pilot. We were not able to conduct surveys with any participants who had guardians. One provider did not reach out to guardians, and a second provider's sample included several individuals in a persistent vegetative state. The guardians of those individuals were not contacted for the pilot.

One provider scheduled appointments for each of the participants, and we were able to interview everyone who agreed to take the survey. The other providers scheduled a block of time during which to conduct interviewers. At those providers, many of the participants chose to attend other activities or appointments during the interview time.

Most of the interviews were conducted in an office or a semi-public space in the facility. In some cases the interviews were conducted in the person's bedroom. In those situations, the small bedrooms made it hard to use the laptop and for interviewers with mobility limitations to get around.

Segregated School Settings

The individual school districts managed invitations and initial consent. The school districts sent letters to the families and guardians of students receiving services in Federal Special Education Settings 3 and 4 inviting them to participate in the survey. All students were invited to participate in the pilot. The mailings included background information about the project and a guardian consent form. The student's guardian was asked to complete and return the consent form to the Improve Group. An interviewer then contacted the parent or guardian to schedule an interview.

Because the initial mailing had a low response rate, the school districts provided additional support by attempting to recruit families during parent / teacher conferences and calling parents to encourage them to participate. Eighteen students and their guardians participated in the pilot. Most of the interviews were conducted at the student's home; one student was interviewed at school.

The biggest challenges with administering the survey to students in segregated school settings were scheduling appointments and interviewing students. Another concern is that the Decision Control Inventory is not appropriate for students who live with their family.

Almost all of the parents or guardians wanted to be present for the interviews, and some said they would prefer for their child to not be present. In addition, many of the parents wanted to complete the survey for their child, either because they felt the student was not capable of responding to a survey or because the student did not have the attention span for participating in the survey. Our policy was to allow parents or guardians to participate in the survey, but to ask to have the child present. In many cases, the student only answered a few questions or did not participate at all. Only one student completed the survey without a parent or guardian present. Because of the way the interviews were conducted, it is uncertain if the students would have been able to participate if their parents were not present.

A second consideration when scheduling interviews with students in segregated school settings is that interviews had to be scheduled in the evening or on weekends. This meant that many of the surveys were scheduled close to dinner time or at another time that was disruptive to the student's schedule. One parent did asked for the survey to be scheduled during the school day, and the interview was conducted in a school office. However, scheduling surveys during the school day requires coordination with the school and requires the student's service providers to be present.

Finally, the Decision Control Inventory scale was not relevant to children living in their parent's home because most of the decisions are made by parents. For this, we recommend using the alternate scale for people without staff to capture whether the participant feels like they have control over the choices that are being made. The alternate scale is explained on page 42 of this report in the "Decision Control Inventory" section.

Supervised Living Facilities

Supervised Living Facilities are various treatment and rehabilitation programs licensed by the Minnesota Department of Health. They include:

- Detoxification Programs
- Chemical Dependency Treatment Program
- Residential Facilities for Adults with Mental Illness
- Residential Services for People with Developmental Disabilities, not certified as ICF / DD
- Residential Services for People with Developmental Disabilities, certified as ICF / DD

It was very challenging to select a sample of Supervised Living Facilities for this study. As described above, ICF / DD facilities are licensed as a Supervised Living Facility, but they are already included in the sample. The Olmstead Team did not believe that it was the intent to include Detoxification Programs, Chemical Dependency Treatment Programs, or Intensive Residential Treatment Services (IRTS) as they are all limited-term treatment programs and not residential settings. The only program included in this sample is the Anoka Metro Regional Treatment Center. DHS did not have access to the names of people in the Supervised Living Facility, so the DHS liaison reached out to the provider for a list of people receiving services in the Anoka Metro Regional Treatment Center. The Anoka leadership team was not comfortable with DHS selecting a random sample, primarily due to treatment and safety concerns. They proposed inviting the residents to participate in the survey during a community meeting. The Olmstead Team agreed to this approach. The residents of two units were invited to participate in the survey. A representative from the leadership team presented the project to residents and collected interest forms. The interviews were scheduled through the nurses' station in each unit.

The team had three main concerns about selecting a sample of residents. The concerns were:

- Involuntary clients: people who are in Anoka are there by court order. Leadership felt that asking a sample to participate in the study would feel coercive, but making it a volunteer opportunity would be better.

- Safety: Leadership suggested it was not always safe to interview clients.

- Length of stay: The average length of stay is 90 days, so creating a sample using our guidance was not feasible. They suggested it would be easier to contact discharged patients.

We were not able to get a list of providers to contact. Based on the pilot experiences, the Olmstead Team should gather more information about Supervised Living Facilities to determine whether they should be included in the baseline sample.

Recommendations to Tweak the Survey Tool

After the completion of the pilot surveys, Improve Group researchers analyzed the completed surveys and the completed pilot review questionnaire to identify trends in problem questions or sections in the Olmstead Quality of Life survey tool. We analyzed trends in problem areas for all participants as well as by setting type. Overall, the tool performed well and consistently across settings. Therefore, it is the Improve Group's recommendation to that the Olmstead Implementation Office use the Center for Outcome Analysis Quality of Life Survey for the baseline and follow-up surveys, with the modifications listed below. These recommendations have been discussed with and approved by the survey author.

Survey respondents had the biggest challenges were with the demographic and housing questions at the beginning of the survey. For that reason, we are recommending creating a "prescreening" process to gather information that is particularly difficult for participants to share. There are also a few areas where survey questions need to be reviewed for content in order to reflect the experiences of the participants. Finally, there were instances where interviewers require more training and content knowledge, and / or the survey prompts are needed to ensure the questions are asked consistently across interviewers.

The complete list of questions that need to be tweaked, including the problem that needs to be addressed and our recommended approach can be found in Appendix A.

Prescreening

A prescreening process should be developed to collect demographic, disability, and housing information about the participant. These questions were consistently the most difficult for participants to answer, and it is more important to have accurate information than to get the response from the participant. The answers to these questions can be obtained from other sources, including agency records, providers, and the county from which the participant receives services. The only exception is housing information for people who live independently or with family. For those individuals, the information may be obtained from the focus person or someone providing support.

Collecting disability information during a prescreening process would change how the perceived significance scale works. If the person is eligible for services because of a disability, then that disability would be recorded as "major." If a person has other disabilities, but is not eligible for services because of that disability, the disability would be recorded as "some." This method does not allow for capturing the person's perception.

According to Jim Conroy, the perceived significance of the person's disability is not an outcome measure, meaning significance is not expected to change greatly over time. However, it is possible that as people move into the community they will perceive their disabilities to be less significant. We recommend omitting these questions from the survey as they were was such difficult questions for participants to answer. However, if it is decided to gather this information, disability information could

be collected before the interview so that the focus person was only asked about the significance of disabilities that pertain to them.

Content

Because the survey is designed to be modular, the order of the sections is not important. Therefore, the Olmstead Implementation Office should arrange the survey so that the sections greatest interest for the Olmstead Plan are at the beginning of the survey. This will ensure that the most important sections have the highest response rate.

Community Integration and Engagement: Time, Money & Integration – During the Day

State agencies should provide plain language definition of work settings and programs that reflect the participant's understanding of the services they are receiving. The Olmstead Implementation Office should work with an advisory group to ensure the plain language definitions provided by the agencies matches the participants' understanding of how they spend their time. Interviewers should also be given guidance on how to rephrase questions and explain terms to help participants answer questions, while still maintaining the integrity of the survey.

Community Integration and Engagement: Integrative Activities Scale

Some of the activities listed may not match the participant's experiences, either because common activities are not included or because some activities have become less common over time. After the baseline survey the list may need to be updated to include activities reflect the activities people are engaging in. This means adding "other" responses with a high frequency and removing activities that may be becoming less common such as going to the bank or the post office.

The scale for this question was difficult for interviewers and participants. Participants were asked "Do you normally have interactions with community members during this kind of trip or outing?" If they said yes, they were then asked if they had a little, some, much, or very much interaction with community members. Participants and interviewers had a hard time with the difference between much and very much. We could not find a way to phrase the question that was not awkward, and it took so long to explain the scale that the question had to be asked several times.

We propose changing the scale to a four-point scale: none, little, some, a lot. Simplifying the scale would reduce the burden on participants. Although changing the scale would mean the results from this section would not be comparable to those in other states, we believe the change would lead to higher quality data. If this change is made, Jim Conroy would work with the Olmstead Implementation Office and the survey administrator to validate the approach.

Decision Control Inventory

Overall, the Decision Control Inventory scale works well across settings with the exception of people who live independently or with family. For those participants, there was no way to differentiate between decisions that were being made for them by unpaid caretakers and decisions the person was making for themselves. The Center for Outcome Analysis created an alternate scale for people without paid staff that asks if decisions are made by the person or by relatives, friends, or advocates. The scores

for both scales measure how much power the focus person is able to exert in making choices, and the two scales can be analyzed together.

Elements of Person-Centered Planning

Each question in this section has an element of the person-centered planning process, a plain language statement about that element, and a definition of the term that uses technical language and jargon. The jargon was included in case the participant needed more explanation about the statement. Although some participants asked for more information about some of the terms, especially person-centered planning, the interviewers did not use the jargon. In addition, some of the interviewers found the jargon distracting. Therefore, we recommend removing the jargon from the survey.

Interviewer Training

The abbreviated training period did not allow enough time for thoroughly training interviewers on the survey content and context. While the interviewers had enough information to conduct the survey, they would have benefited from additional training in survey content and context to answer questions from participants. Future trainings with survey interviewers should include more depth about survey content, methods for recording responses, and how the results will be used. State agencies should also provide tools for training interviewers about programs and services.

In practice, the tool more closely resembles a supported interview than a survey, and learning how to best conduct the interview in the field was difficult for survey administrators. More time should be dedicated to breaking down and administering the scales and for recording “out of range” responses. Interviewers should be trained both in administering the survey as written and supporting participants through the survey. Trainings should also include an overview of how section scores will be calculated and compared over time. This training will help interviewers become more comfortable with using the scales and increase consistency across interviewers.

In order to feel comfortable explaining settings and terminology to participants, interviewers should have training on the services offered to people with disabilities. This training should include information about the different settings they will be visiting and programs in the Community Integration section. Interviewers should also have some training around person-centered planning and the types of planning groups participants may have. This training will provide content knowledge for supporting participants during the interview and increase the accuracy of recorded responses.

The list of questions that will need particular attention for interviewer trainings and recommendations for training is provided in Appendix A.

First Steps for the Baseline Survey Planning Phase

Access to Data

One of the largest delays during the pilot project was securing access to data. These delays led to a shorter survey administration period because of the time it took to secure multiple releases or data sharing agreements. In addition, because we did not have access to guardian information, we had to rely on providers to communicate with guardians about the survey.

The Olmstead Implementation Office should work to secure access to participant data through legislation or court order. The legislation or court order should include access to data for contractors. If needed, state agency liaisons should make sure data sharing agreements are in place early in the process.

Finalize Sampling Strategy

The project budget and timeline are dependent on the number of interviews to be conducted during the baseline. The Olmstead Sub-Cabinet and Olmstead Implementation Office will need to determine a final sample size and sampling guidelines.

As demonstrated in Appendix B, by surveying just under 3,000 individuals in the settings selected, you will be able to extrapolate your results to the general population with a 95% confidence level plus or minus 5%. The survey developer has proposed a follow-up strategy in which 500 participants are surveyed each subsequent year to measure changes over time. The agencies should select a sample four times larger than the number of individuals you hope to interview. For example, to achieve 3,000 participants, the sample should include 12,000 people.

Plain Language Definitions of Settings

State agencies should provide plain language definition of work settings and programs that reflect the participant's understanding of the services they are receiving. The Olmstead Implementation Office should work with an advisory group to ensure the plain language definitions provided by the agencies matches the participants' understanding of how they spend their time.

Translation of Survey Materials

Survey materials, including the Quality of Life tool, consent forms, and communication materials should be translated for non-English speaking participants. The materials should be translated into the languages spoken by a substantial number of people eligible for the survey, including American Sign Language.

Lead Agency Roles

In past projects, DHS has reached out to county and tribal case managers for help with obtaining guardian consent for survey participants. In most cases, DHS is able to identify if a particular participant has a guardian or conservator, but DHS does not hold information on the guardian name or contact information. The information is maintained at the county or tribal government level. Through the pilot study, this information was gathered through providers. In the baseline survey, the Olmstead

Implementation Office and Survey Administrator should consider working with DHS to contact county case managers for this information.

Recommendations for Baseline and Follow-Up Survey Administration

The recommendations below represent lessons learned from the pilot study. Many of the following recommendations are practical, technical recommendations for the Survey Administrator of the baseline and follow-up Olmstead Quality of Life surveys. Some recommendations are for the Olmstead Sub-Cabinet, the Olmstead Implementation Office, or others, and are labeled accordingly.

Recommendations for the Planning Phase

- The Olmstead Team should use the Center for Outcome Analysis Quality of Life Survey tool to conduct the Olmstead Quality of Life baseline survey. The Olmstead Sub-Cabinet and Olmstead Implementation Office will need to determine a final sample size. As demonstrated in Appendix B, by surveying approximate 3,000 individuals in the settings selected, you will be able to extrapolate your results to the general population with a 95% confidence level and a 5% confidence interval. The survey developer has proposed a follow-up strategy in which 500 participants are surveyed each subsequent year to measure changes over time.

- The Olmstead Sub-Cabinet and Olmstead Implementation Office should create a survey timeline for the baseline study, including a three to six month design phase for the study, followed by a survey period of at least four to five months, and a reporting period of two to three months. The design phase should include up to four weeks to obtain participant data from state agencies after the request is submitted.

- The Olmstead Implementation Office should work to secure access to participant data through the support of the Sub-Cabinet, by using legislation, a court order, or other means. If using legislation or court order, it should include access to data for contractors. If needed, state agency liaisons should make sure data sharing agreements are in place early in the process.

- The Olmstead Implementation Office should ensure sufficient budget is included for translating project materials, providing interpreters, and interviewer training.

Recommendations on Human Subjects Protections

- The Olmstead Team should use multiple levels of review for documents, forms, and communication material, including obtaining feedback from advocates and self-advocates.

- The Survey Administrator should develop and institute a robust data protection plan and include several layers of human subjects protections for future surveys. The Olmstead Implementation Office and agency liaisons should review and approve the data protection plan.

- The Survey Administrator should empower individuals with disabilities to make their own decisions about whether or not to participate through a transparent consent / assent process that centers on protecting the rights and safety of the participants.

- The Olmstead Implementation Office and stage agencies should include language about the Institutional Review Board exempt status of the project in communication materials with providers.

Recommendations on Preparing the Tool

- Questions and response options should reflect Minnesota programs and offerings, especially in employment settings and housing questions. DEED, DHS, and MDE should provide the Olmstead Implementation Office with plain language definitions of these settings and programs for the survey.

- The Survey Administrator should prepare accessible and large print versions of the survey.

- A self-administered web-based version of the survey has limited appeal to participants. The Survey Administrator should provider other alternatives for interviewing people who might find an in-person interview disruptive should be explored, such as offering a Skype or video chat option.

Recommendations on Translation and Interpretation

- The Survey Administrator should include translation and interpretation costs in the project budget. This includes project materials, recruitment tools, communication tools, marketing and outreach materials, as well as the survey itself.

- The Survey Administrator should recruit interviewers who speak target languages, including American Sign Language, to help address potential issues with scheduling interpreters.

- The Survey Administrator should plan on additional time to schedule interviews with interpreters. The Survey Administrator should also consider working with multiple interpretation providers.

Recommendations on Sampling Strategy

- The Survey Administrator should work with liaisons in each agency to draw the survey sample. It is recommended that the sample be a stratified random sample, with stratification by setting. The data request should include disability and demographic information.

- The Survey Administrator should have the state agencies select a sample four times larger than the number of individuals you hope to interview. For example, to achieve 3,000 participants, the sample should include 12,000 people.

Recommendations on Working with State Agencies

- As stated above, securing access to data through legislation or court order will eliminate the need for obtaining consent to release information to the Olmstead Implementation Office or the contractor responsible for the survey.

- The Survey Administrator should engage agency liaisons early in the planning process to streamline access to data and selecting the sample.

- The Survey Administrator should be aware of and plan for needing time to engage agency liaisons and bringing them up to speed on the project and survey. Be aware that this is another item on the liaisons' and the data person's to do list.

Recommendations on the Advisory Group

- The Olmstead Implementation Office and Survey Administrator should collaborate on recruiting members for an advisory group. The advisory group should be engaged early in the planning process. The sooner the advisory group can provide ongoing feedback about outreach, communication, and recruitment, the more effective the group will be. Consider using Advisory Group members from the Pilot Study period.

- To gain legitimacy and to ensure that all voices are heard, the advisory group should include members from multiple disability. Members should be dedicated to gaining community support for the project and promoting transparency.

- Be creative about getting input from the advisory group. In person meetings are ideal, but not always feasible. Use technological solutions such as surveys, online discussion boards, and skype to convene virtual meetings and allow the group members to collaborate on their own schedule.

- Be honest and transparent about what can and cannot change as a result of the advisory group feedback. The details that are set in stone and the reasons for those decisions should be addressed from the beginning.

Recommendations on Reporting Abuse or Neglect

- The Survey Administrator should develop a protocol for documenting and reporting suspected abuse and / or neglect to the common entry point and to the Olmstead Implementation Office.

- The Survey Administrator should include a module on mandated reporting during interviewer training.

- Communications to providers should include notification that the interviewers are required to report suspected abuse and or neglect to the appropriate agency.

Recommendations on Working with Providers and School Districts

- The Survey Administrator should work with Agency Liaisons to identify the appropriate person at each provider to contact about the survey. This should be someone at the director level who is empowered to make decisions about the project.

- Many providers, especially providers receiving funding from DHS, are asked to support the administration of multiple surveys throughout the year. The Survey Administrator should be mindful of the various requests the providers are balancing.

- Communications to providers should include information about how the Survey Administrator and Olmstead Implementation Office will protect participants' privacy and rights during and after the survey.

Recommendations on Recruitment and Communication Strategies

- The Olmstead Implementation Office should develop a marketing strategy for the survey so that participants and providers are familiar with the survey efforts before they are asked to participate. Take advantage of existing communication channels to market the survey to providers and potential survey respondents.

- Establish credibility and authority with providers by having agency liaisons make first contact with directors about the Olmstead Quality of Life Survey. This shows that the state agency supports the project and the administration team. This outreach should start early in the planning phase of the baseline study, and can build on outreach efforts during the pilot study.

- The Olmstead Implementation Office should work with agency liaisons develop a strategy for gaining provider support for the baseline survey. Regardless of how the participants are invited to take the survey, having the providers support will increase response rates.

- The Survey Administrator should engage the advisory group in developing an outreach and marketing strategy for participants. The strategy should include reaching participants and their families through community programs and online communities such as Facebook groups.

Recommendations on the Consent Process

- The Survey Administrator should work with county case managers to collect guardian information for participants selected through DHS. Case managers could also be asked to help obtain guardian consent. Guardian information should be included in the data request to DEED and to districts through MDE.

- When it is not possible to work with case managers, the Survey Administrator should reach out to providers for help with obtaining guardian consent. The relationships providers have with participants and guardians added credibility to the pilot project, and that relationship could also be helpful for the baseline survey.

- The recruitment strategy should give participants time to formulate their response about whether they would like to take the survey. People may not feel comfortable saying no to a person in an authority position when they are first approached.

Recommendations on Survey Administration

- The Survey Administrator should plan for 4 hours per survey for coordination, travel, and survey administration in the Metro area. Travel in Greater Minnesota will be higher.

- The Survey Administrator should be prepared for no-shows and cancelled interviewers. A protocol for following up with participants who miss, cancel, or reschedule interviewers should be developed that ensures everyone has the opportunity to take the survey while respecting the right to decline in their own way.

- The Survey Administrator should select a survey administration mode that balances the need for data security and efficient data collection. The administrator should take into account the limitations of paper and computer administered surveys discussed in the report. We do not recommend administering the survey using an Internet-based platform because of unreliable wireless access in rural areas and buildings.

Recommendations on Survey Administration in Greater Minnesota

- Hire interviewers from greater Minnesota to reduce the travel time needed for surveys conducted outside of the metro area. In addition, interviewers from outside of the metro area may offer regional expertise that will add to the value of the survey.

Recommendations on Blind or Visually Impaired or Deaf and Hard of Hearing Participants

- The Advisory Group should help develop strategies for outreach and recruiting participants who are deaf or blind.

- The Survey Administrator should prepare the Quality of Life tool for administration with screen readers.

- The Survey Administrator should work with an American Sign Language interpreter to translate consent forms and the Quality of Life tool. The translation help to standardize interpreted interviews.

- The Survey Administrator should include modules on working with individuals who are blind, deaf, and deafblind in the interviewer training.

Appendix A: Recommended changes to the survey

Prescreening Questions

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

TABLE 8: PRESCREENING QUESTIONS AND RECOMMENDED SOURCES

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

Content

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

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

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

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

TABLE 10: COMMUNITY INTEGRATION AND ENGAGEMENT: INTEGRATIVE ACTIVITIES SCALE

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

TABLE 11: DECISION CONTROL INVENTORY

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

TABLE 12: PERCEIVED QUALITIES OF LIFE

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

TABLE 13: ELEMENTS OF PERSON-CENTERED PLANNING

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

Interviewer Training

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

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

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

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

TABLE 15: COMMUNITY INTEGRATION AND ENGAGEMENT: INTEGRATIVE ACTIVITIES SCALE

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

TABLE 16: DECISION CONTROL INVENTORY

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

TABLE 17: ELEMENTS OF PERSON-CENTERED PLANNING

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

TABLE 18: CLOSE RELATIONSHIPS INVENTORY

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

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

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

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

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

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

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

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

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

Participant consent form language

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

The purpose of the work

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

What we're going to ask you to do

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

The risks to you

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

The benefits to you

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

The benefits to other people

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

You can refuse, and that's no problem

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

We will protect your privacy

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

Contacts and Questions

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

The Improve Group:

700 Raymond Ave., Suite 140

St. Paul, MN 55114

Phone: (651) 315-8922.

Email: lizf@theimprovegroup.com

Tennessen Warning:

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

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

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

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

Guardian consent form language

Background

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

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

Procedures

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

Risk

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

Benefits

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

Confidentiality

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

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

Costs and Payment

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

Voluntary Participation & Disclosure of Health and Private Information

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

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

Abuse and Neglect

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

Contacts and Questions

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

The Improve Group:

700 Raymond Ave., Suite 140

St. Paul, MN 55114

Phone: (651) 315-8922.

Email: lizf@theimprovegroup.com

Tennessen Warning:

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

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

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

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

Participant Name (please print)

Parent / Guardian Name (please print)

Parent / Guardian Signature

Date

Please return signed consent forms to:

The Improve Group

700 Raymond Ave., Suite 700

St. Paul, MN 55114

Accommodations

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

My child or ward requires the following accommodations:

Introductory script about the survey for participants

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

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

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

Introductory script about the survey for providers and families

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

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

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

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

Any questions about the study can be directed to:

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

And / or

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

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

Hello,

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

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

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

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

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

Sincerely,

Elizabeth Radel Freeman
Research and Evaluation Director
The Improve Group

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

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

First Name:

Last Name:

Street Address:

City:

Zip code:

Phone number:

Email:

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

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

Letter about the survey to guardians

Dear [Guardian name],

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

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

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

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

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

Sincerely,

Elizabeth Radel Freeman
Research and Evaluation Director
The Improve Group

Letter about the survey to providers

Dear [Provider name or contact]

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

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

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

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

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

Sincerely,

Elizabeth Radel Freeman
Research and Evaluation Director
The Improve Group

Olmstead Quality of Life Pilot Survey Interviewer Training Agenda

Interviewer Training

Day 1

Friday September 19, 2014

9 am – 1 pm

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

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

Interviewer Training

Day 2

Monday September 22, 2014

8 am – 12 pm

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

Olmstead Quality of Life Pilot Survey Background Information

What is the Olmstead Plan?

The Olmstead Decision

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

The Jensen Settlement

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

Minnesota's Olmstead Plan

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

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

What is the Quality of Life Survey?

Quality of Life Survey

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

The Quality of Life survey will measure:

- How well people with disabilities are integrated into and engaged with their community;
- How much autonomy people with disabilities have in day to day decision making; and
- Whether people with disabilities are working and living in the most integrated setting that they choose.

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

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

Quality Of Life Assessment Tool

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

Who will be surveyed?

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

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

How many surveys will be conducted?

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

What settings are included?

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

- Center Based Employment

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

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

Where will surveys be conducted?

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

How long will the survey take?

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

When will people be surveyed?

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

Who is conducting the survey?

Olmstead Sub-Cabinet

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

Olmstead Implementation Office

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

The Improve Group

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

Appendix D: Center for Outcome Analysis Survey Studies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXHIBIT 6-4: QA 3C.1 – OLMSTEAD PLAN ANNUAL REPORT

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Minnesota's Olmstead Plan: Annual Report 2014

This report summarizes activities during the period from Nov. 1, 2013 – Dec. 31, 2014.

Adopted by Subcabinet on: February 9, 2015

Contents

Executive Introduction

The vision of the Minnesota Olmstead Plan is to transform our state's communities to welcome, engage and respect people with disabilities more than ever before. This means people with disabilities will have opportunities to live where and with whom they choose, choose what services and supports are best for them, have good jobs with fair wages and benefits, and be a part of their community – opportunities that are just like everyone else in Minnesota. To transform our communities in this way, we must build, remodel and enhance state services. It's a process that will take time, but it's worth it.

This report is a review of Olmstead work that has happened between Nov. 1, 2013, and Dec. 31, 2014. During this timeframe, activities were focused in large part on administrative and operational processes. These are critical structures that the State will rely upon as it transforms our communities through implementation of the Plan. These processes continue to evolve and improve.

As these processes become formalized, we will focus more of our efforts on the outcomes that most directly affect people. Our goal is to bring the promise of Olmstead to life by improving the options for Minnesotans with disabilities.

Report summary

- The promise of Olmstead can only be achieved with cross-agency collaboration and dedication. Staff roles were formalized and clarified for the Olmstead Subcabinet, Olmstead Implementation Office, Agency Leads and Compliance function.
- Plan activities were focused in these five primary areas: implementation, reporting, modification, community engagement and quality improvement.
- The Subcabinet and Olmstead staff engaged members of the disability community in order to learn from their perspective as well as build partnerships for Plan implementation.
- Financial activities by, or on behalf of, the Olmstead Implementation Office took place throughout the reporting period. A summary is provided.

Section 1: Who we are

Subcabinet

Governor Mark Dayton established an Olmstead Subcabinet in January 2013. This is the group of state agency leaders who are charged with developing and implementing Minnesota's Olmstead Plan.

The Olmstead Subcabinet has ten members and a chair. They include:

- A Chair appointed by the governor
- One representative from each of eight state agencies with responsibilities to implement the Plan
    - Department of Corrections
    - Department of Education
    - Department of Employment and Economic Development
    - Department of Health
    - Department of Human Rights
    - Department of Human Services
    - Department of Transportation
    - Minnesota Housing Finance Agency
- Two ex-officio members from the Governor's Council on Developmental Disabilities and the Office of the Ombudsman for Mental Health and Developmental Disabilities

Olmstead Implementation Office

As defined in the Olmstead Plan, the primary responsibilities of the Olmstead Implementation Office (OIO) are:

- Develop communication tools to explain Minnesota's Olmstead Plan, including a fully-accessible overview of the Plan itself
- Monitor the quality of life and process measures
- Convene regular meetings to update the Subcabinet on implementation
- Draft an annual report to be issued by the Subcabinet
- Maintain social media and website presence to keep the public aware of progress on the Plan
- Monitor audit and performance reports from all public agencies on issues relevant to the Olmstead Plan
- Develop and implement the Olmstead Quality Improvement Plan
- Collaborate across all relevant departments

Olmstead Implementation Office staff

Staff members from the OIO work on behalf of the Subcabinet to help coordinate and carry out the Plan goals.

The OIO began on interim basis beginning in December 2013. It was transitioned to a permanent office in June 2014, when the Executive Director came on board.

Executive Director
The Executive Director provides managerial leadership for all aspects of the OIO. Her primary objective is to successfully lead the OIO in support of the Subcabinet's goal to fully implement the Plan.
The OIO Executive Director is a 1.0 position. She was appointed in May 2014.

Assistant Director
The Assistant Director focuses on Plan compliance, interagency coordination, quality assurance and community relations. She also manages certain office operational tasks. These will be reassigned when additional staff members are added to the OIO.
The OIO Assistant Director is a 1.0 position. She was appointed in August 2014.

Communications Manager
The Olmstead Communications Manager focuses on planning, development and delivery of Olmstead messaging. This includes building communications infrastructure, executive presentations and media relations.
The Communications Manager is a .5 position. She began work with the OIO in October 2014.

Agency Leads
Each Subcabinet agency named a staff member to serve as its agency lead. The lead is a point-person who monitors agency progress towards the Plan's goals. They advise agency Subcabinet representatives on goal progress. The lead represents the agency at various cross-government meetings and events.

Compliance
The Department of Human Services was assigned the lead for monitoring compliance of Plan activities. This work began with the onset of the interim office and continued through the reporting period. There are two full-time staff members working on compliance.

Section 2: Plan activities
This report summarizes Minnesota's Olmstead Plan activities between Nov. 1, 2013 – Dec. 31, 2014. During this time frame, action was taken in these areas:

- Plan implementation
- Plan reporting
- Plan modification
- Community engagement
- Quality improvement

Plan implementation
In 2013, the Subcabinet established structures to better facilitate collaboration among state agencies. This work focused on three primary areas:

1. Agency lead meetings
   Agency leads meet monthly (originally, they met bi-monthly) to report on their agency's progress, discuss current issues and potential collaborations. The leads use this information to update and advise their Subcabinet member. Leads also hold additional meetings on an issue-by-issue basis and as needed.

2. Working groups
   Multiple cross-agency working groups were established to focus on goals within specific sections of the Plan. These working groups grew out of agencies collaborating on specific action items.

3. Governor's appointed councils
   Representatives from the agencies and the OIO began conversations with the 23 Governor-appointed councils, committees, commissions and boards on best ways to engage these groups to help monitor and implement the Plan. A full list of these groups is available on page 133 of the Olmstead Plan in appendix E.

Plan reporting

Bimonthly Reports

The bimonthly reports outline the progress and compliance on Plan implementation. The reports are reviewed and approved by the Subcabinet at their bimonthly meetings. Once approved, the report is submitted to the Court by the 22nd day of even-numbered months. These are public documents and can be viewed on Minnesota's Olmstead website.

Subcabinet Meetings

The Subcabinet meets every other month to conduct business, review and approve status reports to the Court and review other reports and action items in a timely manner. All approved Plan documents and meeting minutes are published on the website. The Subcabinet also held three special meetings, to deal with time sensitive items that required action by the Subcabinet.

Plan revisions and modifications

Revisions

In January 2014, the Court provisionally accepted the Olmstead Plan, but required certain revisions. These were filed with the Court in July 2014. The Court, however, initially declined to accept the revised Plan, instead requiring the Subcabinet to submit "measurable" goals in November 2014.

Modifications

In addition to the revisions, the Court ordered a separate process for the Subcabinet to seek modifications to the Plan through requests to the Court Monitor. Through this process, the Court Monitor can approve proposed modifications if there is "good cause." In the summer of 2014, the Subcabinet submitted a number of modification requests through this process. Many of these requests were approved by the Court Monitor.

Community engagement

Initial community engagement activities focused around a few key activities.

- Public listening sessions
  Members of the state's disability community were invited to attend public listening sessions to discuss Olmstead issues with members of the Subcabinet and the OIO. These meetings were held in the spring and fall in multiple locations across the state through a combination of in-person and a virtual venue.

- Website
  Information about the Olmstead Plan is available on Minnesota's Olmstead website. In addition, community information, concerns or comments are welcome through the website or by email.

- Individual communications
  Incoming calls and emails made directly to OIO are archived. Complaints are forwarded to relevant agencies and followed up to determine disposition.

Quality improvement

- Engaged Governor's appointed councils and advisory committees
  OIO has engaged the Governor's appointed disability councils and advisory committees in monitoring Minnesota's Olmstead Plan.

- Quality of Life survey
  One of the cornerstones of the Plan is the implementation of a quantitative Quality of Life survey that will measure changes in the lives of people with disabilities over time. The pilot Quality of Life assessment was concluded on December 31.

  Results from the pilot survey process provided useful operational information, including:

  - The survey works successfully across all disabilities, all ages and all settings.
  - Better understanding of the survey application, which will help with future surveys.
  - Many of the surveyors hired to work on the pilot were people with disabilities. This approach was successful.

  The Quality of Life survey will begin implementation in 2015.

Section 3: Partnerships

The promise of Olmstead can only be achieved with collaboration throughout the disability community. In 2014, we talked to a number of community groups to share information about the Plan, get input and build partnerships for future Plan implementation. The list of groups included:

- Disability rights advocates
- Disability policy experts and researchers
- Courts
- Faith communities
- Federal government agencies
- Higher education institutions
- Health insurers
- Housing developers
- Law enforcement organizations
- Legislature
- Local communities
- Local government
- Social Service Providers
- Regional development commissions and planning groups
- School districts
- Self-advocacy organizations
- State agencies, boards, councils, and ombudsman offices
- Technical assistance/accommodation experts
- Tribal governments

Section 4: Financial activities

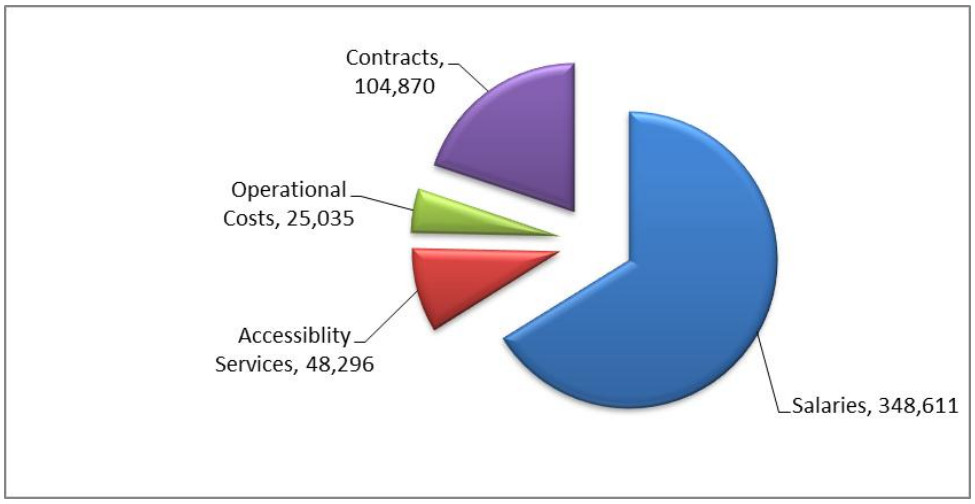
For the reporting period of November 1, 2013, through December 31, 2014, $526,812 has been expended by, or on behalf of, the Olmstead Implementation Office.

The Departments of Human Services (DHS), Employment and Economic Development (DEED), Transportation (DOT) and the Minnesota Housing Finance Agency (MHFA) made direct financial contributions totaling $364,919 during this timeframe.

In addition to these contributions, the 2014 Legislature allocated $500,000 for FY2015 in its supplemental budget for the Olmstead Implementation Office. Of that FY2015 appropriation, $161,893 has been expended to date.

DEED serves as the fiscal agent in support of the Olmstead Implementation Office.

Total funds expended November 2013 thru December 2014 = $526,812



Contracts were established to secure specialized services to accomplish Olmstead Plan's action items, i.e. the Quality of Life Pilot Assessment Report and the Disincentives and Barriers Report.

Appendix

Chronology of Court Orders, Court Monitor Reports and Olmstead Plan revisions through Dec. 31, 2014

Date	Item	Description
1/28/2013	Executive Order	Governor established Olmstead Subcabinet to develop and implement MN's Olmstead Plan
8/28/2013	Court Order	Olmstead Plan due November 1, 2013 shall include chronological timetable of tasks and deadlines to facilitate tracking and reporting. Requests for modification shall be in writing and for good cause
11/1/2013	Olmstead Plan to the Court	Olmstead Plan submitted to Court for approval
12/31/2013	Court Monitor Report	Court Monitor recommends provisional approval of the Plan with suggested modifications
1/22/2014	Court Order	• Court provisionally accepts and approves the Olmstead Plan subject to review after revisions based on Court Monitor, Plaintiffs' Counsel, Executive Director of Minnesota Governor's Council on Developmental Disabilities and Ombudsman for Mental Health and Developmental Disabilities • Orders the State to file bimonthly report by April 22, 2014 to address the progress toward moving individuals from segregated to integrated settings; the number of people who have moved from waiting lists; and the results of any and all quality of life assessments. • Orders the State to file revised Olmstead Plan by July 5, 2014 to Court Monitor and July 15, 2014 to Court
5/14/2014	Court Monitor report	Court Monitor provides feedback on modification requests
6/18/2014	Court Monitor report	Court Monitor provides feedback on modification requests
7/10/2014	Olmstead Plan revisions	Olmstead Plan revisions as approved by the Court Monitor is filed with the Court
8/20/2014	Court Order	Court adopts modifications as previously approved by Court Monitor
9/18/2014	Court Order	• Court declines to adopt the Proposed Olmstead Plan filed on July 10, 2014. • Orders a revised Olmstead Plan that establishes measurable goals be submitted to the Court Monitor by November 10, 2014 • Court requires the State to report on: the number of people who have moved from segregated settings into more integrated settings; the number of people who are no longer on the waiting list; and the quality of life measures.
11/10/2014	Olmstead Plan Revisions	Olmstead Plan revisions submitted to the Court Monitor in response to September 18, 2014 order
12/31/2014	Court Monitor report	Court Monitor issues report on Olmstead Plan: Completion of Deliverables. Court Monitor finds Defendants in Non-compliance with the Olmstead Plan due to failed completion of required action items within required timelines.

EXHIBIT 6-5: QA 3E – OLMSTEAD IMPLEMENTATION OFFICE REPORT

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Olmstead Implementation Office Report

Author: Olmstead Implementation Office

Date submitted to subcabinet: 02/02/2015 Date approved by subcabinet: 2/09/2015

Olmstead Implementation Office Report

By August 31, 2014 the subcabinet will issue a report on the staffing, funding and responsibilities of the Olmstead Implementation Office and on the oversight and monitoring structure described above, including timelines for completion of any outstanding action items. [Olmstead Plan QA 3E page 36]

An Overview of the Olmstead Implementation Office

This report addresses the staffing, funding and responsibilities defined for the Olmstead Implementation Office (OIO). The Olmstead Implementation Office has undergone numerous changes to create an office with existing resources and opportunities. The flexibility and viability of OIO was necessary to manage the multiple systemic challenges, realities, and necessary partnerships.

Staffing

The Olmstead Implementation Office is currently comprised of an Executive Director, Assistant Director and a part time Communications Manager. The Executive Assistant/Interpreter position description has been drafted and currently being prepared for recruitment and hiring. This will result in 3.5 Full Time Equivalents.

The Executive Director began her position on May 5, 2014. The Executive Director was immediately integrated and immersed into the operations and leadership responsibilities for the Olmstead Implementation Plan. The Executive Director along with the subcabinet assumed the tasks of implementing two objectives simultaneously: the implementation of the Office and implementation of the Plan.

Administrative support has been provided by Department of Employment and Economic Development (DEED), Department of Human Services (DHS), Department of Transportation (DOT) and Minnesota Housing Finance Agency (MHFA) and includes support related to Human Resources, Fiscal Management, and Compliance. Compliance support included compiling data, coordinating of bimonthly reports and providing collaborative compliance review of action plans.

The office also maintained contractual services. The Improve Group was contracted to conduct the Pilot Quality of Life survey; Management Analysis and Development (MAD) consultants were contracted to support the collection and analysis of current rules, regulations, and laws impacting lives of people with disabilities. The Olmstead Implementation Office also contracts with various accessibility services vendors, i.e., sign language interpreters, captioning, accessibility language, and other services.

The office was originally located within Department of Employment and Economic Development and relocated in September 2014 to Minnesota Housing Finance Agency.

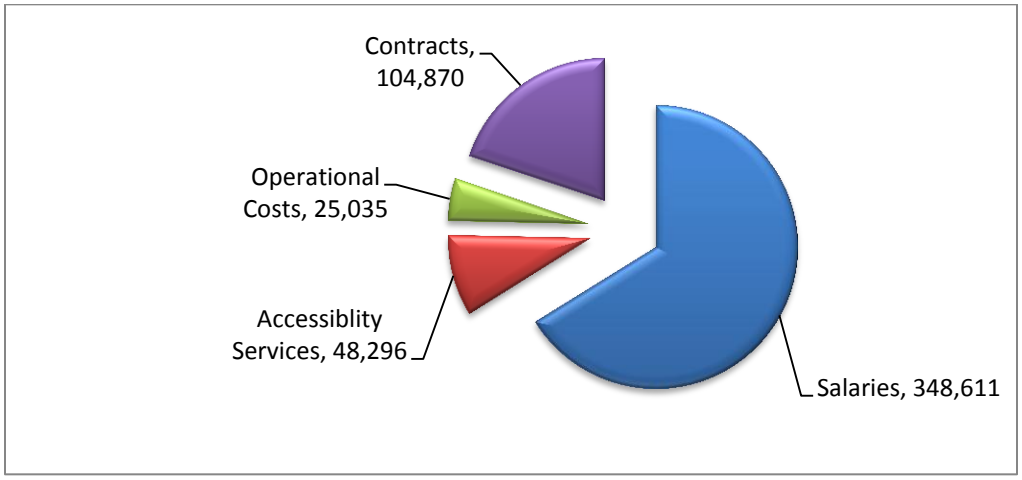
Funding

During the non-budget Legislative session in 2014, the state allocated $500,000 for fiscal year 2015 for the Olmstead Implementation Office as well as securing $875,000 per year in the base budgets for fiscal years 2016 and 2017 as base funding. It was acknowledged that these amounts were not adequate to support the entirety of the Plan. In January 2015, the Governor included a recommendation for additional $850,000 for the FY16-17 biennium. This legislature will complete its session in May 2015 and will determine the budget allocations for the state for the next biennium.

With current limited fiscal resources for FY2015, the state agencies DEED, DHS and MHFA have provided monetary and in-kind support for the Olmstead Implementation Office. The remaining state agencies have assumed financial responsibility for their own identified action items for 2015 in order to remain in compliance with the Olmstead Plan. Several state agencies have also assisted with the costs for accessibility services. The appropriation of funds will be transmitted through DEED. DEED will execute an interagency agreement with MHFA to assume administrative duties.

Financial Information for November 1, 2013 – December 31, 2014

Direct financial contributions were from Department of Human Services (DHS), Department of Employment and Economic Development (DEED), Department of Transportation (DOT) and Minnesota Housing and Finance Agency (MHFA) with totals of $364,919 during the report timeframe. In addition, during the non-budget Legislative session in July 2014, the state allocated $500,000 for fiscal year 2015 for the Olmstead Implementation Office. $161,893 of $500,000 has been expended to date. DEED serves as the fiscal agent in support of the Olmstead Implementation Office.



Total funds expended = $526,812

The contracts were established to secure specialized services to accomplish Olmstead Plan's action items, i.e., Quality of Life Pilot Assessment Report and Disincentives and Barriers Report.

Oversight and Monitoring

Governor Dayton issued Executive Order 13-01 on January 28, 2013 which ordered the creation of a subcabinet to develop and implement a comprehensive Minnesota Olmstead Plan.

> *"1. A Sub-Cabinet, appointed by the Governor, consisting of the Commissioner, or Commissioner's designees, of the following state agencies, shall develop and implement a comprehensive Minnesota Olmstead Plan: (i) that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the most integrated setting, and (ii) that is consistent with and in accord with the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999):*
>
> *Department of Human Services;*
>
> *Minnesota Housing Finance Agency;*
>
> *Department of Employment and Economic Development;*
>
> *Department of Transportation;*
>
> *Department of Corrections;*
>
> *Department of Health;*
>
> *Department of Human Rights; and*
>
> *Department of Education*
>
> *The Sub-Cabinet shall be chaired by Lieutenant Governor Yvonne Prettner Solon.*
>
> *The Ombudsman for the State of Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities shall be ex officio members of the Sub-Cabinet.*
>
> *The Sub-Cabinet shall allocate such resources as are reasonably necessary, including retention of expert consultant(s), and consult with other entities and State agencies, when appropriate, to carry out its work.*
>
> *2. Each Commissioner, or Commissioner's designee, shall evaluate policies, programs, statutes, and regulations of his/her respective agency against the standards set forth in the Olmstead decision to determine whether any should be revised or modified to improve the availability of community-based services for individuals with disabilities, together with the administrative and/or legislative action and resource allocation that may be required to achieve such results.*

3. The Sub-Cabinet shall work together and with the Governor's Office to seek input from consumers, families of consumers, advocacy organizations, service providers, and relevant agency representatives.

4. The Sub-Cabinet shall promptly develop and implement a comprehensive Minnesota Olmstead Plan."

In addition to the Executive Order, the Minnesota Olmstead Plan (page 36) states;

"By December 1, 2013 the subcabinet to establish an Olmstead Implementation Office that will report to the subcabinet. The purpose of the office will be to:

- *Develop communication tools to explain Minnesota's Olmstead Plan, including a fully accessible overview of the plan itself.*
- *Monitor the quality of life and process measures.*
- *Convene regular meetings to update the subcabinet on implementation.*
- *Draft an annual report to be issued by the subcabinet.*
- *Maintain social media and web site presence to keep the public aware of progress on the plan.*
- *Monitor audit and performance reports from all public agencies on issues relevant to the Olmstead Plan.*
- *Develop and implement the Olmstead Quality Improvement Plan.*
- *Collaborate across all relevant departments.*

The status of the required elements is below:

1. **Develop communication tools to explain Minnesota's Olmstead Plan, including a fully accessible overview of the plan itself**

   All subcabinet documents and minutes are published on the website www.mn.gov/olmstead. Contact information for the office staff is also available on the website for those needing an alternative format or more information.

2. **Monitor the quality of life and process measures:**

   The Olmstead Plan directs that a Quality of Life tool be utilized to measure progress across all disabilities on the impact of the plan on the lives of people with disabilities.
   - This data will be used to determine what components of the Plan are successful in improving the quality of life for people with disabilities.
   - The assessment will be conducted as a longitudinal study. This approach will provide a long-view on progress and success. Rather than showing a point-in-time snapshot of state services, it will tell a rich story of how the lives of Minnesotans with disabilities are changed.
   - The pilot quantitative Quality of Life survey was concluded on December 31, 2014 with recommendations for action to be submitted to the subcabinet.

3. **Convene regular meetings to update the subcabinet on implementation:**
   The subcabinet has convened regular bi-monthly meetings and Special meetings to conduct business in accordance with the Plan. The Olmstead Implementation Office provides support for the subcabinet and carries out duties as assigned.

4. **Draft an annual report to be issued by the subcabinet:**
   The annual report has been drafted and will be submitted to the subcabinet for review and approval at the February 9, 2015 meeting.

5. **Maintain social media and web site presence to keep the public aware of progress on the plan:**
   The Communications Manager started work on October 8, 2014. The overall communications goals and strategy for Olmstead are in process. Improving the social media and web presence for OIO is currently in progress. Content will be published or reworked when foundational communications elements are in place, specifically, an approved Olmstead logo/brand, program key messaging and overall communications goals. Communications support for these Olmstead work has been requested from all Olmstead subcabinet agencies. To date, support has been provided by DHS, DEED, DOT and Department of Health.

6. **Monitor audit and performance reports from all public agencies on issues relevant to the Olmstead Plan:**
   The Olmstead Implementation Office collaborates with DHS compliance staff in monitoring audit and performance reports from the agencies. They are also involved in drafting the bimonthly reports and communicate any issues to relevant agency staff.

7. **Develop and implement the Olmstead Quality Improvement Plan:**
   The first edition of Quality Improvement Plan includes the key components identified in the Olmstead Plan will be presented to the subcabinet for review and consideration for approval at the March 10, 2015 subcabinet meeting.

8. **Collaborate across all relevant departments:**
   Implementation of the Olmstead Plan requires strong interagency coordination and collaboration. The OIO established monthly meetings with Agency leads to assist in facilitating these relationships. The Olmstead Implementation Office participates in and supports regular state agency legislative liaisons and/or policy directors meetings, and agency finance meetings. The objective for these meetings is to effectively strategize priorities for the legislative impacts for 2015 Legislative session.

Changes to Structure

Executive Order 15-03

Executive Order 15-03 was issued on January 28, 2015. It further defines the role and duties of the subcabinet as well as their authority. The Sub-Cabinet shall adopt procedures to execute its duties, establish a clear decision making process, and to further define and clarify the role of the OIO. The Chair

is responsible for the drafting of these procedures, and will present them for review at the first Sub-Cabinet meeting of 2015 and approval at the second Sub-Cabinet meeting of 2015. Governor Dayton has appointed Commissioner Mary Tingerthal, Minnesota Housing Finance Agency to chair the subcabinet.

The key responsibilities and oversight elements from the Executive Order 15-03 includes:

> "The Sub-Cabinet shall allocate such resources as are reasonably necessary, including retention of expert consultant(s), and consult with other entities and State agencies, when appropriate, to carry out its work.
>
> 2. The duties of the Sub-Cabinet are:
>
> a. Provide oversight for and monitor the implementation and modification of the Olmstead Plan, and the impact of the Plan on the lives of people with disabilities.
>
> b. To provide ongoing recommendations for further modification of the Olmstead Plan.
>
> c. Ensure interagency coordination of the Olmstead Plan implementation and modification process.
>
> d. Convene periodic public meetings to engage the public regarding Olmstead Plan implementation and modification.
>
> e. Engage persons with disabilities and other interested parties in Olmstead Plan implementation and modification and develop tools to keep these individuals aware of the progress on the Plan.
>
> f. Develop a quality improvement plan that details methods the Sub-Cabinet must use to conduct ongoing quality of life measurement and needs assessments and implement quality improvement structures.
>
> g. Establish a process to review existing state policies, procedures, laws and funding, and any proposed legislation, to ensure compliance with the Olmstead Plan, and advise state agencies, the legislature, and the Governor's Office on the policy's effect on the plan.
>
> h. Establish a process to more efficiently and effectively respond to reports from the Court and the Court Monitor. 1. Convene, as appropriate, workgroups consisting of consumers, families of consumers, advocacy organizations, service providers, and/or governmental entities of all levels that are both members, and non-members, of the Sub-Cabinet.
>
> 3. The Sub-Cabinet shall appoint an Executive Director of the Olmstead Implementation Office (OIO), who will report to the Chair of the Sub-Cabinet. The OIO shall carry out the responsibilities assigned to the Sub-Cabinet, as directed by the Chair of the Sub-Cabinet.

4. The Sub-Cabinet shall adopt procedures to execute its duties, establish a clear decision making process, and to further define and clarify the role of the OIO. The Chair is responsible for the drafting of these procedures, and will present them for review at the first Sub-Cabinet meeting of 2015 and approval at the second Sub-Cabinet meeting of 2015."

Additional changes not in the Executive Order 15-03 include securing a Memorandum of Agreement with the Department of Human Services for two full time compliance staff to continue monitoring and reporting of the Olmstead Plan Implementation. DHS Compliance staff will identify and track risks of non-compliance, analyze performance, and provide other compliance services to the subcabinet. The staff will report directly to the Chair of the subcabinet

Timelines for Outstanding Action Items

The attached document contains a table of all items with deadlines through December 31, 2014 that have not been completed. The table indicates whether the item will be on the agenda for review and action at the February or March subcabinet meeting.

Outstanding Items and Month of Subcabinet Review

Topic	Item	Deadline	Brief Description	Lead	Monitor Comments from 12 31 14 Report	Feb	March
SS	3C	7/1/14	Create an inventory and analysis of policies and best practices across state agencies related to positive practices and use of restraint, seclusion or other practices which may cause physical, emotional, or psychological pain or distress	DHS	Item #02 (Page 3) After an initial long delay in initiating action, a non-final plan was created by September-October 2014. The final report will not be submitted for approval until February 2015, 7 months after the deadline.	X	
SS	3D	7/1/14	Report outlining recommendations for a statewide plan to increase positive practices and eliminate use of restraint or seclusion	DHS	Item #03 (Page 5) After an initial long delay in initiating action, a non-final plan was created by September-October 2014. The final report will not be submitted for approval until February 2015, 7 months after the deadline.	*X with SS3C, SS3E	
SS	3E	8/1/14	Statewide, develop a common definition of incidents (including emergency use of manual restraint); create common data collection and incident reporting process.	DHS	Item #04 (Page 7) After an initial long delay in initiating action, a non-final plan was created by September-October 2014. The final report will not be submitted for approval until February 2015, 6 months after the deadline.	*X with SS3D, SS3E	
QA	3E	8/31/14	Report on the staffing, funding and responsibilities of the Olmstead Implementation Office and on oversight and monitoring structures	SC	Item #06 (Page 11) The OIO structure and timeline are crucial to implementation of the Olmstead Plan. That this report is not to be submitted to the subcabinet until February 2015 is very problematic. The Update reports do not explain the reasons for this lengthy delay in finalizing the office which is responsible for overseeing the entire Plan.	X	
TR	3A	8/31/14	Complete MnDOT ADA Transition Plan, including Olmstead principles	DOT	Item #08 (Page 15) The State's Update 4 states that "pending approval, the plan will be finalized." There is no new information in Update No. 5. There is no indication that the approval and finalization have occurred. Therefore, this item is rated "not completed." This item has an 8/31/14 deadline.	X	

Topic	Item	Deadline	Brief Description	Lead	Monitor Comments from 12 31 14 Report	Feb	March
EM	3C	9/30/14	Provide training and technical assistance to federal contractors on federal employment goal for people with disabilities	DEED	Item #15 (Page 29) The requirement is that specified training and technical assistance will be "provided." The status reports state that training materials and curriculum are prepared. It does not state that any training or technical assistance has been provided to anyone. It speaks in the future tense about delivering, and only on "request" by an employer who appears at certain general events. This passive approach equates to failure to fulfill this requirement. Although there is preparation, nothing has been provided.	X	
HS	1A	9/30/14	Complete data gathering & analysis on demographic data (related to housing) on people with disabilities who use public funding	DHS	Item #17 (Page 33) Early planning and attention to the requirement, resulted in a report submitted to the subcabinet during the deadline time range. However the subcabinet will not be asked to approve the report until its February 2015 meeting. This is a very important report on movement of individuals to integrated settings. Therefore, while it is positive that the subcabinet approved "baselines and measureable goals" November 3, 2014, the Monitor observes that those goals are not at this point approved by the Court and, more importantly in this context, the contemplated report is not approved by the subcabinet. Therefore, a "not completed" rating is given.	X with SS2G	
HS	4B	9/30/14	Develop a plan to inform and educate people with disabilities, case workers, providers and advocates about HousingLink	MHFA	Item #18 (Page 35) Meetings do not constitute a plan by themselves. HS 4A and 4B are not the same activity. HS 4A (which was completed) is listening to improve HousingLink's resources and 4B requires a plan to educate people about HousingLink. The last Update indicates that the same sessions were used to satisfy both action items but 4B has a larger mission. The requirement is a "plan." Submission of information on listening sessions, a survey copy, and recommendations does not constitute submission and approval of a plan.	X	

Topic	Item	Deadline	Brief Description	Lead	Monitor Comments from 12 31 14 Report	Feb	March
TR	1A	9/30/14	Establish a baseline of services and transit spending across public programs	DOT	Item #19 (Page 37) A baseline with information on both funding and services is required. The State's updates indicate that funding may be been attended to, but not services. The involvement of the Metropolitan Council (named in the requirement) drops out of activities reported. In any event, no final draft has been submitted and none is expected until the February 2015 Update report. There is no indication that this draft (which is not attached to the most recent Update) is ready.	X	
SS	2G	9/30/14	Identify a list of other segregated settings; establish baselines, targets, and timelines for moving individuals who can be supported in more integrated settings.	DHS	Item #21 (Page 41) This topic addresses need for integrated settings, among other things. While the subcabinet approved baselines and measureable goals on November 3, 2014, these are pending before the Court. The subcabinet has not yet approved the report which it received; that approval will not be before the February 2015 meeting. Because there is no approved report, this item is rated "not completed."	*X with HS 1A	
SS	4D	9/30/14	Analyze the need for assertive community treatment team for individuals with disabilities who are transitioning from prison to community; establish measurable goals for actual services to benefit individuals	DOC/ DHS	Item #23 (Page 45) No model of service or needs analysis is provided. The Status Update No. 4 states that a model will be "finalized" but no finalized document is provided in the 5th Update. The referenced Exhibit 5-2 states a baseline of zero, and provides no measureable goals; the exhibit promises more information in June 2015. (Doc. 371 at p. 60 of docketed document). This item is "not completed."	X	
HC	2D	9/30/14	Identify data needed to measure health outcomes; establish data sharing agreements	MDH	Item #24 (Page 47) The State has determined that "no data sharing agreements will be needed to complete the analysis," as stated in Status Update No. 5. However there is no indication that the analysis is completed or when it will be completed. What Status Update No. 4 calls an "analysis plan" is needed but none is provided. Therefore, this item is rated "not completed."	X	
EM	3J	12/31/14	Publicize statistics, research results and personal stories illustrating the contributions of persons with disabilities in the workplace	DEED	Not included in Monitor's report	X	

Topic	Item	Deadline	Brief Description	Lead	Monitor Comments from 12 31 14 Report	Feb	March
HS	1E	12/31/14	Develop a process to track the number of individuals with disabilities exiting state correctional facilities and their access to appropriate services and supports.	DOC	Not included in Monitor's report	X	
HS	5B.1	12/31/14	The number of counties participating in individualized Housing Options will increase to 17	DHS	Not included in Monitor's report	X DATA	
OV	2B	12/31/14	Identify barriers to integration that are linked to federal legislation, regulation, or administrative procedures; identity options to address them	SC	Not included in Monitor's report	X	
QA	1C	12/31/14	Conduct a pilot of the quality of life survey	SC	Not included in Monitor's report	X	
QA	3C.1	12/31/14	Subcabinet annual report issued	SC	Not included in Monitor's report	X	
SS	2C	12/31/14	For individuals in Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs) and people under 65 who have been in nursing facilities longer than 90 days: 90 people will have transitioned to community services	DHS	Not included in Monitor's report	X DATA	
SS	2D.1	12/31/14	Reduce % of people at Anoka Metro Regional Treatment Center who do not require hospital-level of care and are awaiting discharge to 30%	DHS	Not included in Monitor's report	X DATA	
SS	2F.2	12/31/14	Increase average monthly discharge rates at Minnesota State Security Hospital from 8 individuals per month to 9 individuals per month	DHS	Not included in Monitor's report	X DATA	

Topic	Item	Deadline	Brief Description	Lead	Monitor Comments from 12 31 14 Report	Feb	March
SS	2G.1	9/30/14	Review data on other segregated settings and other states' plans for plans for developing most integrated settings for where people work and live. Set goals and timelines for moving individuals in these settings to most integrated settings	DHS	Not included in Monitor's report	*X with HS 1A	
TR	4B	6/30/14	Report to subcabinet on MCOTA's workplan alignment with Olmstead plan	DOT	Not included in Monitor's report	X	
SS	3I	8/1/14	Develop and implement a coordinated triage and hand off process across mental health services and home and community based long term supports and services	DHS	Item #05 (Page 9) Even after the fifth status update, work is still being done on this report. It will not be submitted for approval until February 2015, 7 months after the deadline.		X
EM	3A	8/31/14	Offer enhanced training on person-centered planning to ensure Employment First and employment planning strategies are incorporated	DHS	Item #07 (Page 13) Training was to have been offered August 31, 2014 but is not "expected" to happen until March 31, 2015, 9 months later. That training is described as incomplete, expected to be offered by only "several" counties.		X
QA	4A	9/30/14	Adopt an overall Olmstead Quality Improvement Plan	SC	Item #10 (Page 19) This is a fundamental requirement. It is an element of accountability and a means for the Olmstead Implementation Office, for the State, to have measures of progress. Months after the deadline, there is no plan in place to complete the item. There is no projection of when it will be completed. That a "proposal for completing" this requirement will be presented is not a satisfactory situation. This situation is a cause of deep concern.		X
EM	3D	9/30/14	Establish plan to provide cross-agency training on motivational interviewing.	DEED	Item #16 (Page 31) Status Update No.5 itself states that motivational interview training will not occur until beginning June 30, 2015. The requirement is that there be a "plan" for this training. The Status Updates do not describe or include a plan, nor do they state that the subcabinet has approved such a plan. The absence of a documented plan, together with the vague implementation 2015 time range, merits a "not completed" rating.		X

Topic	Item	Deadline	Brief Description	Lead	Monitor Comments from 12 31 14 Report	Feb	March
TR	1B	9/30/14	Review administrative practices and implement necessary changes to encourage broad cross state agency coordination in transportation, including non- emergency protected transportation.	DOT	Item #20 (Page 39) More than four months to "determine each agency's scope and responsibility and identify resources necessary for completion" seems unnecessary. In any event, no document will be submitted until the February Update; the draft is not attached to the most recent update. This item is "not complete."		X
SS	4B	9/30/14	Report and recommendations on how to improve processes related to the home and community-based supports and services waiting list.	DHS	Item #22 (Page 43) That the Court has addressed waiting list issues a number of times highlights the importance of this requirement. Status Update No. 5 states that the report was accepted but is not yet approved by the subcabinet. Exhibit 5-12 (the report) is problematic. It outlines several actions to be completed from December 2014 through 2017. None of the actions is shown to directly affect waiting list pace. The report does not persuasively "describe how adopting these practices will result in the wait list moving at a reasonable pace," as is explicitly required. The report does not account for many variables affecting the waitlist and it appears to be based on speculation that a new need categorization system will, of itself, reduce the waiting list.		X
HC	2I	9/30/14	Complete a system analysis and develop a plan to address barriers in healthcare transitions from youth to adult	MDH	Item #25 (Page 49) What is described as a "report" in the Status Report No. 5 (Exhibit 5-13, at pp. 167ff of Doc. 371) is titled "Olmstead Benchmark Report," authored by Barb Lundeen. There is no indication that this document was submitted to or approved by the subcabinet. The Olmstead Plan requirement for this item is a "plan" developed after a "system analysis" which describes barriers. Ms. Lundeen's document lists a number of group meetings held, and discusses several "gaps." Strategies are listed but with no dates, persons responsible, implementation mechanisms, or other elements of a "plan." This Benchmark Report, which does not self-identify as a "plan," does not demonstrate completion of the requirement.		X
CE	1A	12/31/14	Develop a plan to increase opportunities for people with disabilities to meaningfully participate in policy development	SC	Not included in Monitor's report		X with CE1B, CE 2A, OV3A

Topic	Item	Deadline	Brief Description	Lead	Monitor Comments from 12 31 14 Report	Feb	March
CE	1B	12/31/14	Assess the size and scope of peer support and self-advocacy programs; set annual goals for progress.	SC	Not included in Monitor's report		*X with CE1A, CE2A, OV3A
CE	2A	12/31/14	Evaluate, revise as necessary, and disseminate guidelines and criteria when public dollars are used for ensuring that people with disabilities are incorporated in public planning processes.	SC	Not included in Monitor's report		*X with CE1A, CE1B, OV3A
ED	1D	11/30/14	Stakeholders will discuss and recommend revisions to Minnesota Statutes §125A.0942 subd. 3(8) to clarify that prone restraint will be prohibited by August 1, 2015 in Minnesota school districts and will apply to children of all ages.	MDE	Not included in Monitor's report		X
HC	1C	12/31/14	Design framework and develop implementation plan for healthcare for adults and children with serious mental illness	DHS	Not included in Monitor's report		X
HC	2G	12/31/14	Establish baseline data for current care (medical, dental, chiropractic and mental health) of people with disability; develop an implementation plan to further assess, develop, and respond.	DHS	Not included in Monitor's report		X
HC	2J.1	12/31/14	50% of Minnesota's transition age youth with disabilities will receive the services necessary to make transitions to adult health care.	MDH	Not included in Monitor's report		X

Topic	Item	Deadline	Brief Description	Lead	Monitor Comments from 12 31 14 Report	Feb	March
HS	2A	12/31/14	Baseline and targets established for number of new affordable housing opportunities created, the number of people with disabilities accessing affordable housing opportunities in the community, and the number of people with disabilities with their own lease	DHS	Not included in Monitor's report		X
OV	1A	12/31/14	Define an individual planning service to assist people with disabilities in expressing their needs and preferences about quality of life; establish plan to initiate service	SC	Not included in Monitor's report		X
OV	3A	12/31/14	Leadership opportunities for people with disabilities to be involved in leadership capacities in all government programs that affect them will be identified and implemented	SC	Not included in Monitor's report		*X with CE1A, CE1B, CE2A
QA	2A	6/30/14	Establish Olmstead dispute resolution process	SC	Not included in Monitor's report		X
SS	3J	12/1/14	Identify best practices, set service standards, and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions	DHS	Not included in Monitor's report		X
SS	4C	12/31/14	Develop a plan to expand the use of assistive technology and other technology in Minnesota to increase access to integrated settings; set goals and timelines for expanding the use of technology that increases access to integrated settings.	SC	Not included in Monitor's report		X

EXHIBIT 6-6: EM 3C – SECTION 503 TRAINING MATERIALS AND TRAINING SCHEDULE

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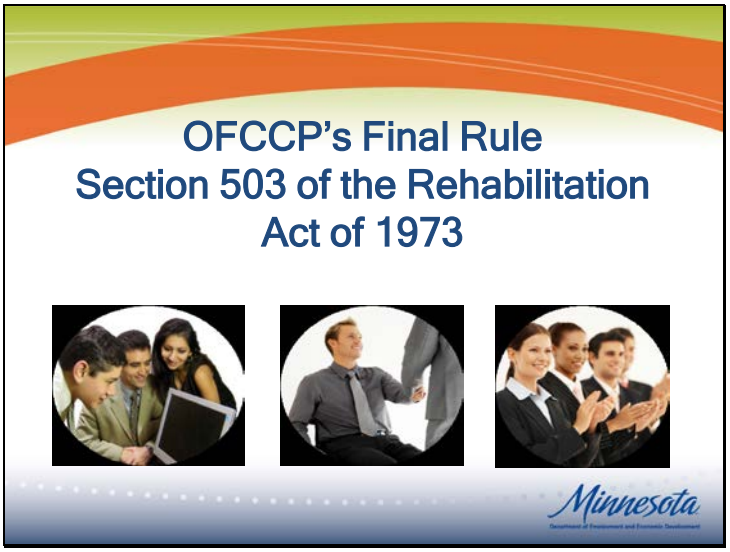
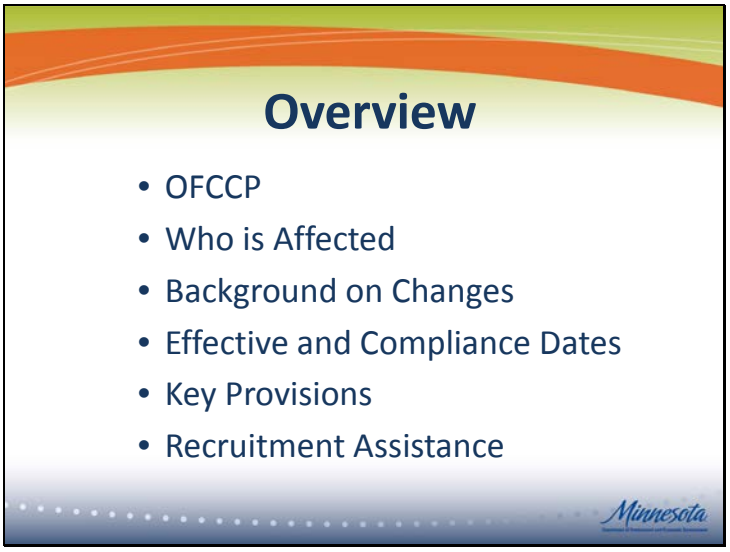
EM 3C – Training Curriculum and Power Point



Source of the information in this presentation is from the Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor.

Today we will discuss the changes in the Final Rules on Section 503 of the Rehabilitation Act of 1973.



What is OFCCP?

OFFICE OF FEDERAL CONTRACT COMPLIANCE PROGRAMS
OFCCP
U.S. DEPARTMENT OF LABOR

Minnesota

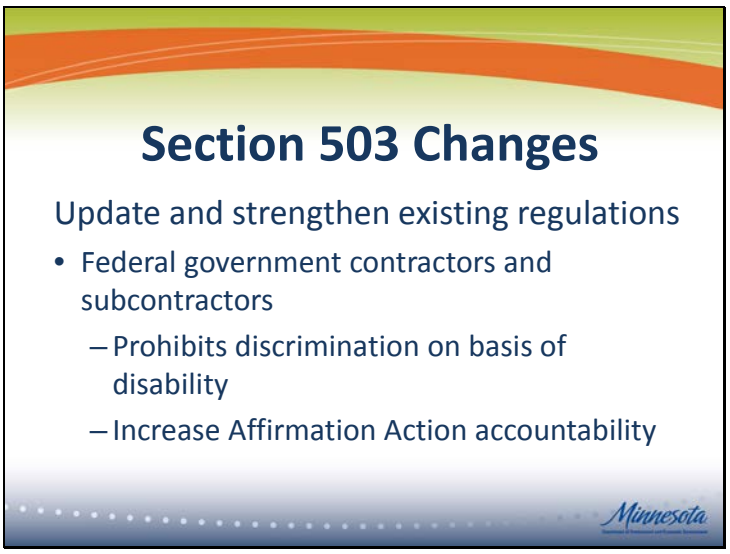
- Federal civil rights enforcement agency
- To enforce, for the benefit of job seekers and wage earners, the contractual promise of Affirmative Action and Equal Employment Opportunity required of those who do business with the Federal govt.
- Jurisdiction over federal contractors and subcontractors
    - Nondiscrimination
    - Affirmative Action
- Conducts compliance evaluations
- Conducts complaint investigations
- Provides technical assistance
- Engages in outreach and public education

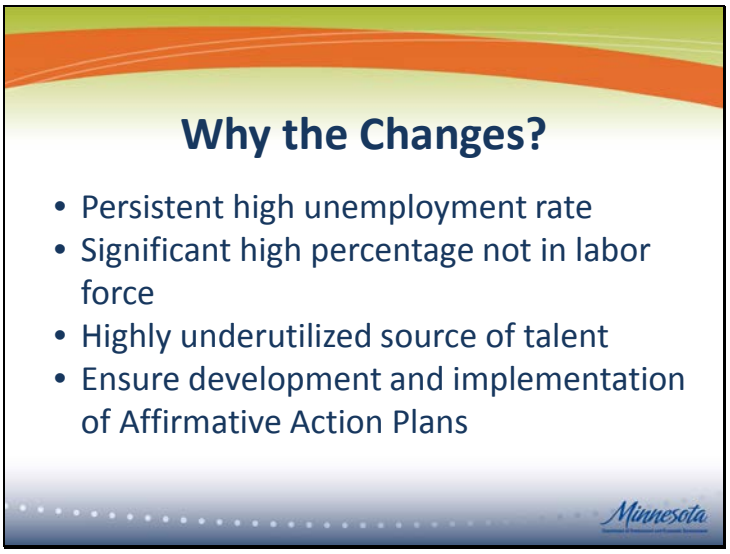
Who is affected?

Generally speaking, any business or organization that:

- (1) holds a single Federal contract, subcontract, or Federally assisted contract in excess of $10,000 or
- (2) has Federal contracts or subcontracts that combined total in excess of $10,000 in any 12-month period

Minnesota





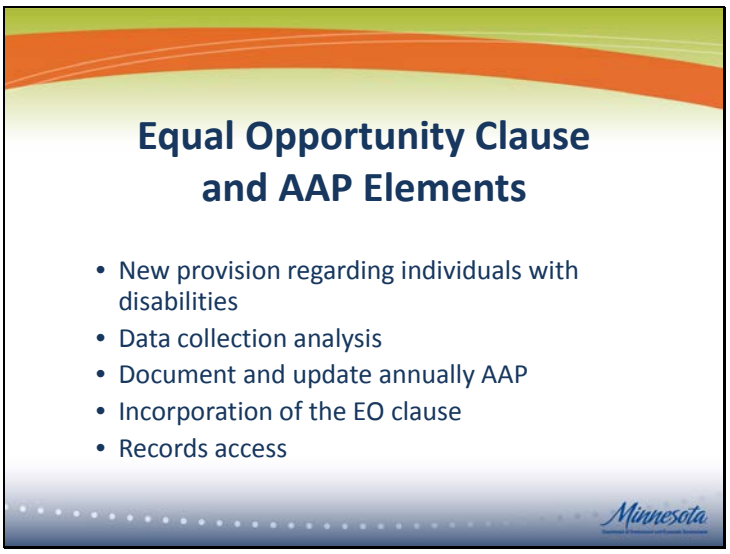
- The framework articulating contractors' Section 503 responsibilities has been in place since the 1970's. However,
  - The unemployment rate of working age individuals with disabilities is still significantly higher than those without a disability. Bureau of Labor Statistics, 2012, 15% vs 8%
  - The percentage of working age individuals with disabilities that are not in the labor force remains significantly higher versus those without disabilities. Bureau of Labor Statistics, 2012, workforce participation rate of 31.6% for working age people with disabilities compared with 76.5% of working age individuals without such disabilities.
  - Highly underutilized source of talent despite years of technological advancements that have made it possible for people with disabilities to apply for and successfully perform a broad array of jobs.
  - OFCCP compliance investigators found more Section 503 violations that seems to indicate that the current compliance framework is not as effective as hoped.

- The new regulations became effective on March 24, 2014.
- Contractors should be in compliance with the nondiscrimination provisions of the new regulations as of this effective date.
- However, OFCCP is providing contractors with an extended compliance date for the Affirmative Action Program requirements. During this extended period, OFCCP will provide technical assistance to facilitate the transition for contractors.
- Contractors with an AAP in place as of the effective date of the new regulations may maintain that AAP until the end of their AAP cycle. Contractors are nevertheless encourage to begin updating their employment practices and IT systems to come into compliance with the revised requirements as soon as possible.

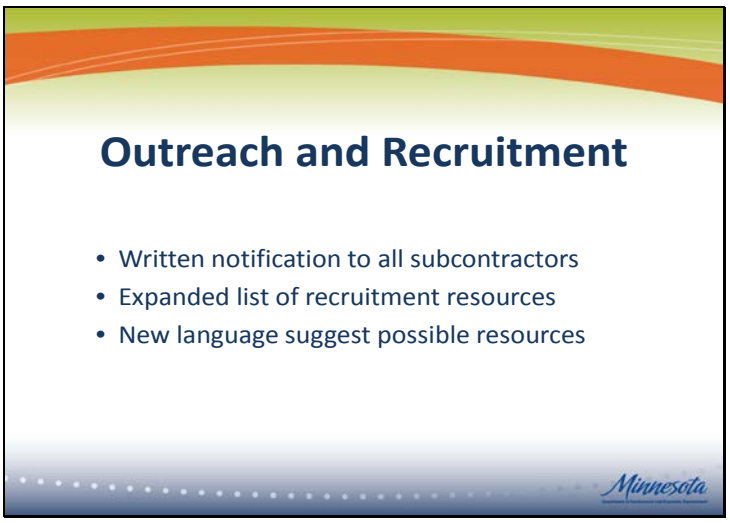
- The new regulations include an aspirational goal of 7%.
- OFCCP created this goal to give contractors a yardstick against which they can measure the success of their efforts in outreach to and recruitment of individuals with disabilities.
- More specifically, contractors should use the goal to measure the change in the representation of individuals with disabilities in their workforce.
- It's a goal. Failure to meet the goal in NOT a violation. It is also not a ceiling that limits or restricts the employment of individuals with disabilities.

- The new Section 503 regulations require contractors to invite applicants to self-identify at the pre-offer stage. It permits contractors to invite applicants to self-identify as an individual with a disability at the same time that the contractor collects demographic data regarding race, gender and ethnicity. The pre-offer invitation to self-identify may be included in the contractors' application materials for a position, but must be separate from the application.
- This is in addition to the already required post-offer self-identification invitation.
- OFCCP added this requirement so that contractors can track the number of individuals with disabilities who apply for jobs.
- Contractors can use this information to assess the effectiveness of their outreach and recruitment efforts. OFCCP has developed a form for contractors to use to invite self-identification of disability. The form is available on the OFCCP Website, in English and Spanish, and in both Word and .pdf formats at www.dol.gov/ofccp/regs/compliance/section503.htm.

- There is now a requirement that contractors also regularly invite all of their employees to voluntarily self-identify with a disability using the self-identification form provided by OFCCP.
- Contractors must invite their employees to self-identify every five years, beginning the first year that they become subject to the Section 503 voluntary self-identification requirements.
- In addition, at least once during the years between these invitations, contractors must remind their employees that they may voluntarily update their disability status at any time.
- Through the new invitation and reminder to employees to self-identify, contractors can capture data on employees who acquire a disability while employed, as well as those with existing disabilities who may feel more comfortable self-identifying once they have been employed for some time.
- It also allows contractors to monitor and improve their practices regarding placement, retention and promotion of individuals with disabilities.



- A new provision is added to the EO clause to be consistent with a comparable requirement regarding race and sex. The paragraph requires that contractors state in solicitations and advertisements that they are equal employment opportunity employers of individuals with disabilities.
- AAP (Affirmative Action Policy) The new regulations require that contractors document and update several quantitative comparisons for the number of IWDs who apply for jobs and the number of IWDs they hire.
- The data must be maintained for three years to be used to spot trends.
- The new regulations require that specific language be used when incorporating the equal opportunity clause into a subcontract by reference. The mandated language, though brief, will alert subcontractors to their responsibilities as Federal contractors.
- The new regulations clarify that contractors must allow OFCCP to review documents related to a compliance check or focused review, either on-site or off-site, at OFCCP's option. In addition, contractors are required, upon request, to inform OFCCP of all formats in which it maintains its records and provide them to OFCCP in whichever of those formats OFCCP requests.



- New rules requires that contractors send written notification of company policy related to its Affirmative Action efforts to all subcontractors and request their cooperation.
- New rules provides expanded list of recruitment resources.
- Adds language to include as possible recruitment resources “placement or career offices of educational institutions” and private recruitment sources, such as professional organizations or employment placement resources.”

We are Vocational Rehabilitation Services – or VRS – and we will share with you how we might be of assistance. Our mission is primarily to serve individuals with disabilities and empower them to achieve their career goals and live as independently as possible in the community of their choice.
Employers are the focus of one of our 4 Strategic State Goals and Priorities – the goal is centered on the importance of Employer Engagement, serving employers as key customers in addition to serving individuals with disabilities.

Bottom line – we are a vocational service, assisting individuals with their career choices and helping employers find talented workers.

Our core mission is employment. It's all about jobs
That's why VRS places great importance on our relationship with businesses, organizations, and employers.

We provide expert, professional employment services to help businesses find skilled and qualified candidates who have a disability. Our broad network of public and private sector agencies have decades of success in recruiting, hiring, supporting, and retaining diverse candidates for employment.

We can offer access to hundreds of prescreened, skilled, and qualified applicants to meet your needs – allowing you to select from candidates who offer skills in all career fields and have educational attainments ranging from GED to PhD. Our role is to introduce you to a candidate who fits your needs and to assist however we can during the recruitment and hiring process.

And throughout the state you can get in touch with our network of employment specialists with just one phone call. We have a growing network of partnerships around Minnesota with a focus on serving business needs.

Vocational Rehabilitation Services is part of a statewide system. We want emphasize the importance of this statewide network of partnerships and the collaborative nature of our work in meeting business needs.

The partnerships take many forms and involve dozens of public and private organizations – all of them working together toward the same goals of employment and greater independence for people with disabilities and assisting employers.

These partnerships began in Minneapolis in 2012 and have since been replicated in communities around the state – offering hiring and recruiting solutions for businesses. Collectively, they bring decades of experience and success in bringing together talented candidates for employment and the businesses that seek to employ them.

2014 Calendar for EM 3C – Section 503 Trainings for Employers and Multiple Stakeholders
PAGE 1

- August 7, 2014: Albert Lea Human Resources Peer Group: Presentation by Evie Wold, VRS Program Specialist in Placement to Human Resources Managers representing Albert Lea employers
- September 25, 2014: VRS Statewide Placement Advisory Group: 503 PowerPoint handout, training and overview. The VRS Statewide Placement Advisory Group consists of nineteen Placement Professionals across Minnesota who assist individuals with disabilities in obtaining and maintaining employment AND meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities;
- September 9, 2014: South Metro Placement Partnership: Presentation on how to engage with employers with federal contracts, Section 503 Overview. The South Metro Placement Partnership consists of eighteen Community Rehabilitation Providers as well as Dakota, Scott and Carver County staff who assist individuals with disabilities in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.
- October 14, 2014: Faribault Chamber of Commerce Peer Group presentation by Evie Wold, VRS Disability Employment Specialist to Member Businesses in the Faribault area)
- October 17, 2014: Dakota/Scott Workforce Investment Board: Kimberly Peck, Director of Vocational Rehabilitation Services and Maureen McAvoy, VRS Disability Employment Specialist presented on VRS Employer Engagement materials and 503 overview and resources. The Dakota County Workforce Investment Board consists of business, government, education leaders providing strategic focus and support of workforce investment.
- December 3, 2014: Southeast Minnesota Placement Partnership (SEMPP): Presentation by Evie Wold, VRS Disability Employment Specialists on 503 Overview and presentation. SEMPP consists of Placement professionals who assist individuals with disabilities in the Winona and Rochester areas in obtaining and maintaining employment. They additionally meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.
- December 12, 2014: East Metro Placement Partnership (EMPP) - Presentation by Maureen McAvoy, VRS Disability Employment Specialist with an overview of 503 with plans to do a more formal presentation in January, 2015. EMPP consists of Placement Professionals including VRS, Community Partner staff and Veterans Administration and who assist individuals with disabilities in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.
- December 17, 2014: VRS Statewide Placement Advisory Group; Continued discussion on sharing 503 requirements for employers holding federal contracts and utilizing VRS as a quality recruitment and hiring resource.
- Other Employer Section 503 Training and Technical Assistance – Calendar Year 2014: VRS Disability Employment Specialists provided Overview and Information Resources to the following employers on Section 503: Quad Graphics; MN Freezer Warehouse; St. John's Lutheran Community; Viracon; Doherty; Manpower; Mayo Clinic Health System; Cargill; Carleton College; St. Olaf College; Foth Companies; Mortenson Construction.

2015 Planning Calendar for EM 3C – Section 503 Trainings

PAGE 2:

- January 9, 2015: MaxAbility Employment Taskforce, part of the SE MN Workforce Investment Board) Presentation by Evie Wold, VRS Disability Employment Specialist to Max Ability Employment Task Force to member businesses on 503.
- January 20, 2015: USDA National Forest Service, Chippewa National Forest 503 presentation to Human Resources staff and Hiring Managers by VRS Disability Employment Specialist Marci Jasper and Steve Kuntz.
- January 23, 2015: East Metro Placement Partnership (EMPP) Presentation by Maureen McAvoy, VRS Disability Employment Specialist on 503.
- January 28, 2015: North Metro Placement Partnership (NMPP) Presentation by Marci Jasper, VRS Disability Employment Specialist on 503 presentation. NMPP consists of VRS, CRP and Veterans Administration who assist individuals with disabilities in the Anoka and northern Hennepin counties in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.
- February 10, 2015: South Metro Placement Partnership (SMPP) VRS Program Specialist in Placement Marci Jasper will present on 503 to SMPP staff.
- February 26, 2015: Minneapolis Placement Partnership (MPP) VRS Disability Employment Specialists Marci Jasper and Steve Kuntz will present on 503 to more than 15 VRS, CRP and Veterans Administration Placement Professionals who assist individuals with disabilities in the inner city of Minneapolis in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.
- March 17, 2015: South Central Minnesota Placement Partnership (SCMPP) VRS Program Specialist in Placement Evie Wold will present on 503 to more than ten VRS, CRP Placement Professionals who assist individuals with disabilities in the Faribault & Albert Lea areas in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.
- April, 2015 (date to be established) Medtronic World Headquarters Disability Employment Specialists Maureen McAvoy and Marci Jasper will present on 503 and other Employer Engagement activities to the Medtronic World Headquarters Talent Acquisition Group.
- April, 2015 (date to be established): Southeast Minnesota Workforce Investment Board event for Federal Contractors. VRS Disability Employment Specialist Evie Wold will present to Federal Contractors on 503.
- April, 2015 (date to be established): Cambridge Placement Partnership (CPP): Marci Jasper, VRS Disability Employment Specialist will present on 503 to more than 10 VRS, CRP and Pine County Placement Professionals who assist individuals with disabilities in Chisago, Pine and Isanti counties in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.

2015 Planning Calendar for EM 3C – Section 503 Trainings
PAGE 3:

- April, 2015 (date to be established): West Central Placement Collaborative (WCPC) VRS Placement Coordinator Paulette Liestmann will present on 503 to more than 5 VRS and CRP Placement Professionals who assist individuals with disabilities in the Willmar and Hutchinson area in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.
- May, 2015 – Marshall Area Placement Partnership (MAPP) Doreen Hoffman, VRS Placement Coordinator will present on 503 to VRS and CRP who assist individuals with disabilities in 11 counties in SW Minnesota in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.
- May 7, 2015: South Metro Placement Partnership Career Fair (SMPP) SMPP is having its 2nd Annual Career Fair and plans to sponsor thirty employers. The SMPP Career Fair will offer these employers the opportunity to learn more about 503 and connect with all of the SMPP members and over 200 qualified job seekers with disabilities.

Additional Section 503 Training Events to be developed for 2015

- Spring, 2015: Monticello Partners in Placement will present on 503 to more than 15 VRS, CRP and Veterans Administration Placement Professionals who assist individuals with disabilities in the Monticello area in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.
- Spring, 2015: St. Cloud Job Developer's Networking Group will present on 503 to VRS and CRP Placement Professionals who assist individuals with disabilities in the St. Cloud area in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.
- Spring, 2015: Moorhead Area Placement Partnership will present on 503 to VRS and CRP Placement Professionals who assist individuals with disabilities in the Fargo Moorhead area in obtaining and maintaining employment and meet with employers at a local and regional level, providing employer training, resources and assistance recruiting and hiring individuals with disabilities.

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EXHIBIT 6-7: EM 3J – IPS AND SRC REPORTS

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Individual Placement and Support (formerly known as EE-SMI)

Report to the Legislature as required by Minn. Stat. §268A.15

December 1, 2014

Author: Claire Courtney
Minnesota Department of Employment and Economic Development

Total cost of salaries, printing, and supplies in developing/preparing this report is $7,271.46 (reported as required by Minn. Stat. 3.197)

Minnesota
Department of Employment and Economic Development

"I am not a mental illness. I am a person with a mental illness…When a person with mental illness is employed, whether it's full-time, part-time, or volunteer, your self-esteem goes up, your confidence goes up, and you get happy again. It's a step to recovery. It might not be a recovery, but it's a step to recovery."

— A participant with a long history of mental illness, commenting on her "road to recovery"
June 2014 at a public forum on Individual Placement and Support

Introduction

Since 1987, the Department of Employment and Economic Development (DEED)'s Vocational Rehabilitation Services (VRS) Division has addressed workforce issues for persons living with serious mental illness. Investing in targeted employment services and supports for persons living with mental illness reduces unemployment, increases social inclusion and saves millions of dollars in public assistance while increasing productivity and tax revenues.

Historically, DEED administered these services through a program referred to as Extended Employment for Persons with Serious Mental Illness (EE-SMI), a unique collaborative service model intended to meet the specific employment needs of people living with serious mental illness. While the EE-SMI service model was considered "state of the art" at the time it was developed, it did not fully reflect the emerging principles of the evidence based practice of supported employment known as Individual Placement and Support (IPS). In particular, employment services were not integrated with mental health treatment services and there was no quantifiable measurement of how well the programs conformed to evidence based principles and research based criteria (fidelity scales).

Beginning in 2014, these EE-SMI programs, funded by grants from DEED to employment providers, are being transformed into the Individual Placement and Support approach to supported employment. This report focuses on the status and evaluation of grants that fund Individual Placement and Support employment services for persons with serious mental illness. It also includes recommendations for expanding the program to comply with the Olmstead Plan and meet the needs of all Minnesotans with mental illness who require employment services.

What is Individual Placement and Support?

Individual Placement and Support is a practice of supported employment for persons with serious mental illness. Supported employment — also called long-term job supports or ongoing supports — typically provides help in finding work, training or retraining on job tasks and managing changes in non-work environments or life activities that affect work performance. Supported employment is typically for people who have not had success in competitive employment or whose access to competitive employment is limited because of disability.

Nationwide evidence from more than 20 randomized controlled trials shows that IPS is the most effective way to provide employment services for persons with serious mental illness. IPS is different from other types of supported employment because employment services and supports are provided within mental health treatment services. Individual Placement and Support rests on a foundation of eight core principles:

1. Individual Placement and Support employment services are integrated with mental health treatment services.
2. Eligibility is based upon participant choice.
3. Participant preferences are honored.
4. Employer contact begins rapidly after participants enter the program.
5. Employment specialists build relationships with employers based upon participant job interests.
6. Competitive jobs are the goal.
7. Benefits planning (work incentives planning) is offered to all participants who receive entitlements.
8. Job supports are continuous.

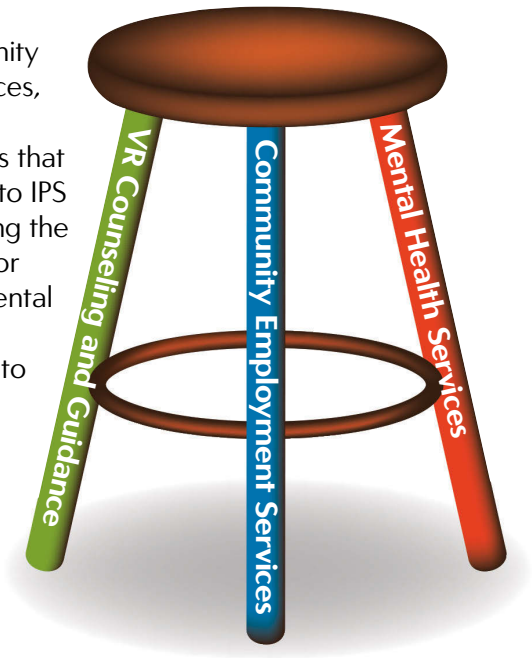
The IPS model is a Three-Legged Stool

The IPS team is sometimes described as a three-legged stool. The three legs include a Vocational Rehabilitation (VR) counselor, an employment services provider, and a mental health treatment services provider. Each of these team members is necessary to provide support for the IPS participant.

Several research studies have shown that individuals with serious mental illnesses achieve greater success when they are served by an IPS team that includes VR counselors along with employment services providers and mental health providers. All three bring different resources to the table and share resources and expertise to help each individual to develop an employment plan that focuses on the person's interests and skills.

Minnesota VR liaison counselors are embedded on the IPS teams and bring specialized training that helps IPS team members and job seekers think about a broad range of employment opportunities. VR counselors are knowledgeable about long-term illnesses and disabilities that affect the ability to find and keep a job; and they often have relationships with employers who might have job openings that would be appropriate for IPS participants.

This three-legged stool model — VR counseling and guidance, community employment services, and mental health services — ensures that the team adheres to IPS principles, providing the best opportunity for individuals with mental illness to not only find a job but also to continue receiving the job supports that help them to keep the job.



How does Individual Placement and Support Work?

Programs that use the Individual Placement and Support approach provide direct employment services and supports. Individual staff who provide these services are often referred to as employment specialists, and they work as members of multidisciplinary mental health treatment teams.

In general terms, employment services are provided to participants before employment. Such services might include:

- Assisting with preparation and conducting a job search
- Identifying job openings
- Contacting potential employers
- Completing applications
- Preparing for job interviews
- Coordinating employment services with mental health treatment providers

Support services typically are provided after a participant is employed, and are often geared toward job retention and advancement. Such services might include:

- Determining job accommodations
- Identifying and implementing strategies for addressing mental health symptoms on the job
- Planning for the impact of new income on receipt of public benefits (including Social Security, Medical Assistance or housing subsidies)
- Providing on-site job training or off-site face-to-face job coaching to assist participants in retaining or advancing in employment
- Offering direct support to employers

To be eligible to receive IPS supports an individual must meet the following criteria:

- Have a serious — or serious and persistent — mental illness.
- Be of working age.
- Want to work.
- Be referred by a mental health provider to an employment specialist who works on a team with the mental health service provider.

He [the participant] came to me with the business idea. We helped with a business proposal, but he really jumped into it and did a lot of work. His motivation to work impressed me. I feel sure that he is going to be successful.

— VR counselor, Northwest Minnesota

IPS project services in SFY 13

- **$755,000:** Total funding for IPS ($470,000 in VR Title 110 grants plus $285,000 in Serious Mental Illness grants)
- **160:** Number of individuals working in integrated competitive employment
- **$9.88:** Average hourly wage
- **29:** Average weeks worked
- **14:** Average hours worked per week
- **$1,000,000:** Total wages earned by participants

IPS project services in SFY 14

- **$1,700,000:** Total IPS transformation grants, including expansion of previously established Individual Placement and Support projects into additional counties and the transformation of all former EE SMI projects to IPS.
- **639:** Number of individuals working in integrated competitive employment
- **$10.27:** Average hourly wage
- **17:** Average weeks worked
- **16:** Average hours worked per week
- **$1,500,000:** Total wages earned by participants

I'm still choked up that they would help me. It's uplifting that people I don't even know care about somebody with mental health problems. This just doesn't happen to people like me. I'm so very lucky to have such a wonderful employer who supports mental health in the workplace. — IPS participant, West Central Minnesota

What is the current unmet need for IPS?

In 2013 the Legislature appropriated funds to transform existing EE-SMI projects to the Individual Placement and Support approach. Grant funds totaled $2.05 million, including $500,000 in one-time funds for SFY 14-15. Of that amount, nine proposals were funded totaling $475,000 (with the remainder designated for administrative costs of the grant program). This funding allowed all existing EE-SMI projects to be transformed to the Individual Placement and Support model in SFY14 and also funded several expansion projects. All DEED grant funds in this area are now dedicated to Individual Placement and Support.

While the transformation to a statewide, comprehensive Individual Placement and Support model is well underway, there is still much work to do — particularly to meet the huge demand for services. DEED's focus must turn now to building capacity throughout the state.

Of Minnesota's 87 counties, 47 have no Individual Placement and Support grant funding while 40 only have some access. The metro region, for instance, has extremely limited capacity: Hennepin County has just one Individual Placement and Support project serving 43 people; Ramsey County has directly funded Individual Placement and Support, but there is a significant waiting list; and Dakota County has one small grant.

Minnesota's Olmstead Plan specifically requires the State to expand Individual Placement and Support employment services in 17 counties for 200 individuals by June 2015, in addition to establishing a plan to expand IPS statewide. Aside from the one-time appropriation in SFY14-15, DEED has accomplished all transformation work thus far with existing funding streams (and no additional resources or staff support). Current funding and staffing will not allow statewide expansion of Individual Placement and Support services as required under Minnesota's Olmstead Plan.

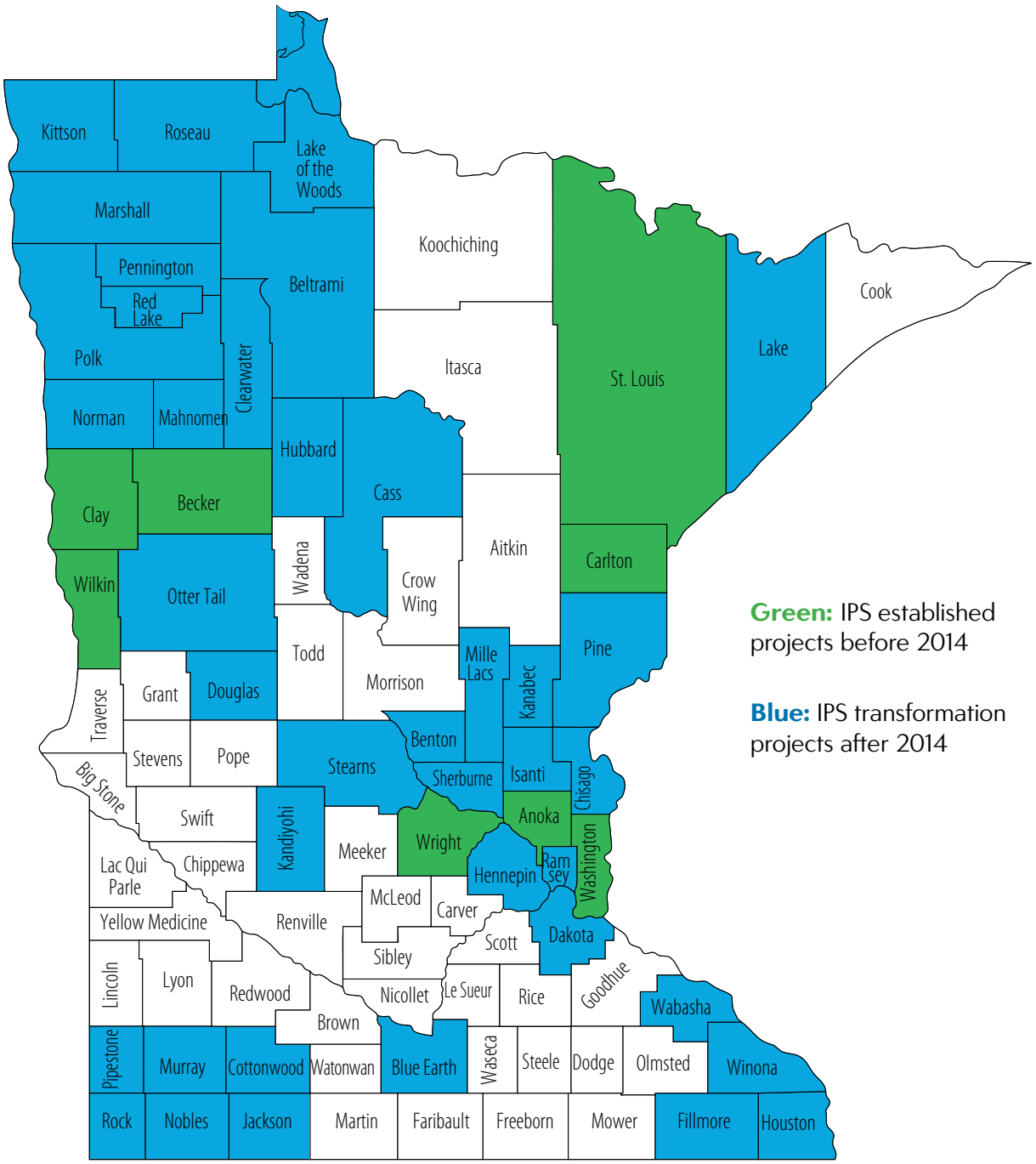
New funding for SFY 16-17 would allow for the creation of 10 new Individual Placement and Support projects serving a total of 400 new customers. This would be in addition to the customers served by continuing the one-time Individual Placement and Support funding from SFY14-15. Those funds are necessary for DEED to continue serving 300 customers who would otherwise lose access to services.

There is no registry of persons with mental illness as there is for cancer, spinal cord injury, or traumatic brain injury. Likewise we don't know how many people with mental illness are currently employed.

There are various definitions of serious mental illness across state and federal government sources. The most recent estimate is 5.4 percent of Minnesota's adult population, about 203,540 adults, have serious mental illness.

It is widely accepted that the majority of people with serious mental illness are not working and that people with SMI experience the highest unemployment rate and the lowest workforce participation rate of any disability group. The recent NAMI report Road to Recovery (2014) indicates the employment rate of persons with serious mental illness has declined over the last 10 years. NAMI estimates that less than 2 percent of people with SMI who want to work are receiving IPS supported employment.

IPS Grant-Funded Projects



Green: IPS established projects before 2014

Blue: IPS transformation projects after 2014

Impact on Minnesotans

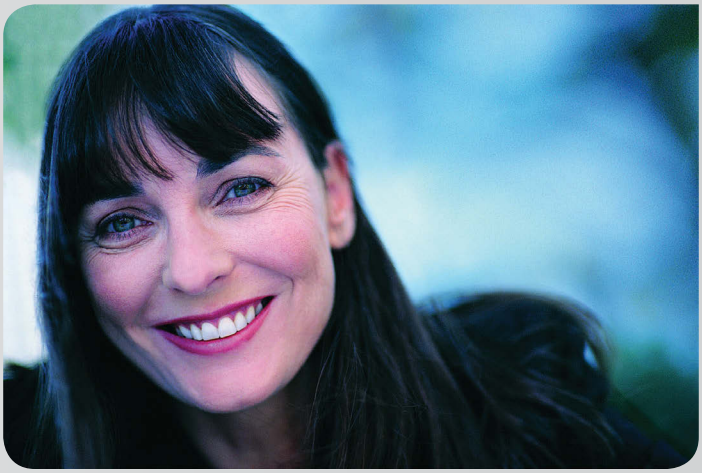
There's a huge difference in the way I feel, the way I act now. Having a job I love makes me feel like I'm contributing to society and not just a burden. I feel normal.... I don't feel like an outsider. It means a lot to come home from work, and be able to pay the bills and pay things off so I can further my life eventually. My kids are very proud of me. — IPS participant, North Metro

What is most important to me is having something to do every day. Sometimes the job is less stressful than being at home. When I am having problems with depression, mornings are the worst time. But I am scheduled to work in the afternoon and early evening, so this job is a good fit. It's not always easy, but I work hard at living a good life because I don't want to go back to where I was before. I'm proud of the progress that I've made.

— IPS participant, North Metro

I'm hopeful that someday I can employ other people like myself, people who need a hand up. I feel 10 feet tall!

— IPS participant, Northwest Minnesota



What people like the most is that they've been so inundated with "this is your diagnosis, this what your diagnosis says, these are the symptoms." We get to focus on hopes. It's like a hope machine. You're not just whatever your diagnosis is. There's a whole person, and I get to acknowledge that.

— Community service provider, Northeast Minnesota

Minnesota

State Rehabilitation Council — General

2014 ANNUAL REPORT OCTOBER 1, 2013 — SEPTEMBER 30, 2014

Welcome to the State Rehabilitation Council — General 201 2014 Annual Report

Welcome to the State Rehabilitation Council-General's 2014 Annual Report on Minnesota's Vocational Rehabilitation (VR) program.

The State Rehabilitation Council-General is a governor-appointed council charged with partnering and advising Minnesota's Vocational Rehabilitation Program. One of our responsibilities is to report to the governor and the citizens of Minnesota on Vocational Rehabilitation's annual performance.

This year we will provide a special focus on an important VR partner — Minnesota's employers. Of course you will still find VR performance data, features on innovations and client stories.

We hope you enjoy this report.

Bob Wagner, LP
Chair, State Rehabilitation Council
Ramsey County Community Human Services
Disability Services Supervisor
Representing Former Vocational Rehabilitation Participants

Employer Resources Offered by Vocational Rehabilitation Services:

Vocational Rehabilitation Services' (VRS) Employment Specialists offer employers creative strategies to recruit and retain skilled workers with disabilities. Their goal is to connect businesses with qualified job seekers, saving them time and money. Employers can tap into the following services free of charge:

- **Recruitment:** Access to a prescreened and qualified talent pool that ranges from entry-level to professional.
- **Education and training:** Assistance in creating a disability-inclusive work environment through VRS customized training on disability recruitment, employment and retention.
- **Consultation and technical assistance:** Resources to answer complex disability employment questions on topics such as the Americans with Disabilities Act and affirmative action for federal contractors.
- **Follow-up:** Create success for new employees through close communication between the VRS Employment Specialist and your business.
- **Job Coaching:** Assistance with individualized training to maximize the skill development of employees recruited through VRS.
- **Accessibility:** Information about job accommodations, job restructuring and worksite modifications.
- **Financial Incentives:** Information about tax credits, deductions, and cost reimbursements that are available to businesses that hire people with disabilities.

To find the VR Employment Specialist in your area, go to **www.mn.gov/deed/vrstalent** or call 1-800-328-9095.

VR's Partnership With Medtronic, Indrotec Leads to Jobs for People With Disabilities

Jacob Branum

Jacob Branum started working in August 2014 at Medtronic Perfusion Systems

Val Nauth, production manager for Medtronic Perfusion Systems in Brooklyn Park, is an enthusiastic proponent of diversity and inclusion in the workplace. "My philosophy," he says, "is that anyone and everyone can do the job — until they show me they can't." It's a philosophy that has led to the hiring of several individuals with disabilities—sometimes as student interns, sometimes as contract employees, and sometimes as full-time regular employees assembling perfusion devices used for blood management during surgery.

Jacob Branum, a 21-year-old from East Bethel, is one of them. He's a contract employee who started at Medtronic Perfusion Systems in September 2014 and has a realistic expectation of working his way into a permanent full-time career there. His story showcases a unique partnership model that matches the goals and skills of job candidates with the recruiting and hiring needs of an employer. In this instance, the partnership includes counselors and employment specialists from Vocational Rehabilitation Services, HR professionals and plant managers at Medtronic, and a Minneapolis staffing consultancy called Indrotec.

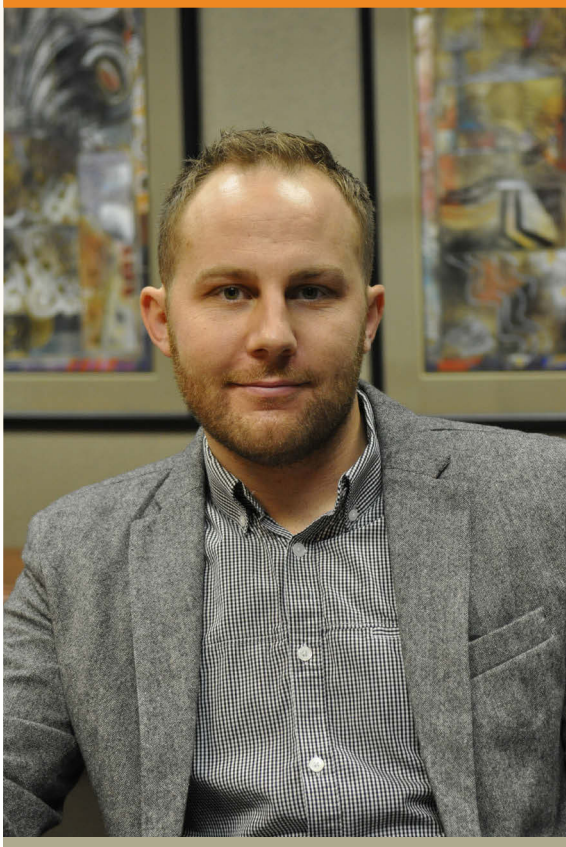
Jacob, whose disabilities affect his ability to find and keep work, was laid off from a previous job. He came to VRS and worked with Sara Wolf, placement coordinator in Blaine, who assisted him with his resume, mock interviewing, and finding job leads. Jacob also worked with Michelle Chmielewski, VRS placement coordinator in Brooklyn Park, who is the primary point of contact with Medtronic and Indrotec for recruiting and screening VRS candidates. "They helped me plan what I wanted to do, and they kept me moving really quickly," Jacob recalls. "And what I really wanted to do was to work with my hands, to have a hands-on job."

Soon the VRS partnership with Medtronic Perfusion Systems and Indrotec began to pay dividends. Sara suggested that Jacob might consider applying for an assembly position at Perfusion Systems. Meanwhile, Michelle contacted Patrick Lange, an account manager at Indrotec, who has a strong working relationship with the Medtronic human resources department. Together they were able to introduce Jacob to the workplace, assess his interest and skill set for the job, and establish that it would be a suitable fit for him. "Everybody wants to help people get a foot in the door," Patrick says. "These are quality jobs and career positions… and we want to be sure to put candidates in a position where they can succeed."

Jacob started his new job last September, and if his career path follows the anticipated trajectory, he'll work as a contractor through Indrotec for about a year, and then make the conversion to becoming a full-time permanent employee with a pay increase and full benefits. "It's a great job," he says. "I like it a lot and hopefully it's going to turn into a career."

The VRS relationship with Medtronic and Indrotec ensures that there's a regular and formal process for recruiting, interviewing and hiring people with disabilities — and that there will continue to be opportunities for VRS clients to begin their careers at the global medical technology company. Val Nauth, Perfusion's production manager, says he anticipates hiring several more employees like Jacob. "I have an appetite for this," he says. "Give us the candidates… there is no limit to what we can do."

Val Nauth, production manager for Medtronic Perfusion Systems



Patrick Lange, account manager for Indrotec staffing consultancy

Kwik Trip Convenience Stores: A Successful Partnership[205] with Vocational Rehabilitation

Russ Swain was hired at the Owatonna Kwik Trip store in January 2014

In August 2013 Joalyn Torgerson placed what proved to be a productive phone call to the Vocational Rehabilitation Services office in Mankato. She was calling from the human resources department at the Kwik Trip convenience store headquarters in La Crosse, WI, and she had a question: Would VRS have any interest in a partnership with Kwik Trip to fill retail helper positions in the chain's rapidly growing network of Minnesota stores?

Kwik Trip had been hiring people in Wisconsin stores through its retail helper program for more than 20 years — but until Torgerson placed that phone call the chain had never made a particular commitment in Minnesota to hiring people with disabilities. "That call, and the resulting partnership with VRS, is what really moved it forward," she says.

A year later, Kwik Trip has hired more than 40 people with disabilities, nearly all of them customers of Minnesota's VR program. "Partnering with Joalyn has been very successful in providing more employment opportunities for people with disabilities" says Roberta Johnson, the Mankato-based VRS program specialist who works most closely with Kwik Trip. Marci Jasper, a Twin cities VRS

Bobbi Moore, store leader; Russ Swain, Peggy Zinniel, former store leader

program specialist, also worked closely with Kwik Trip in the metro area and elsewhere throughout the state.

Russ Swain is one of many VR customers who have benefited from the partnership. In January 2014 he started his job at Kwik Trip in Owatonna, where he now works 15 hours a week making coffee, cleaning up, unloading trucks, stocking shelves. "I just come and do my job, whatever I'm told," he says, showing off the list that he carries to remind him what needs doing.

The list is a useful and necessary prompt, a simple accommodation that makes it possible for him to do his job. Swain has a form of diabetes, which in 2012 led to a severe drop in his blood sugar, resulting in a seizure that left him unconscious and hospitalized for 10 days. The episode caused significant brain damage and short-term memory loss, and forced him to leave a supervisory position at a business management consultancy. He worried that he might never work again.

For more than a year after his hospitalization, Swain received a variety of intensive services — counseling and guidance, home supports, assessment, job search assistance, job coaching, and transportation — from VRS and Straight River Enterprises, a day training and habilitation program that provides specialized vocational and skill building supports.

When the Owatonna Kwik Trip store posted an opening for a retail helper position, Swain was screened by Johnson, applied and interviewed for the job, and ultimately was hired by Peggy Zinniel, who was then the store leader. Her successor, Bobbi Moore, is now Swain's supervisor. Both contend that Kwik Trip's retail helper program works extremely well because of the strong relationship with VRS.

"It's great to have the relationship," Zinniel says. "Our working relationship is really good and extremely productive. I'm just honored and thankful that we have this program." And Moore adds that the program focus on hiring people with disabilities has been a huge benefit to the convenience store chain: "I've never seen people work harder than the retail helpers we've hired through this partnership. They're irreplaceable, in my opinion."

And the future looks bright. The company has a policy of promoting from within, so people who have been hired as retail helpers will likely have a good opportunity to advance in their careers. Additionally, Kwik Trip is rapidly expanding its presence in Minnesota, and on pace to open dozens of new stores in the coming years. Most of the stores will have retail helper positions to fill — and many will be filled because of the partnership with VRS.

Vocational Rehabilitation Outcomes

VR Outcomes

- This year, **2,869 Vocational Rehabilitation participants obtained employment**, up 131 from 2013.
- 25 percent of those finding employment utilized ongoing supports, up from 18 percent in 2012 and 20 percent in 2013.
- The average hourly wage for participants earning above minimum wage without long-term job supports is $11.46. Hourly wages ranged from $7.25 to above $99.00.

Return on Investment

- For every $1.00 VR spends on services, case management and administration, $8.90 goes back into Minnesota's economy through wages earned by VRS participants. The $8.90 has a broader impact on the economy, resulting in an additional $17.80 of economic activity. For more information, go to **http://mn.gov/deed/job-seekers/disabilities/research/general.jsp**.
- This year, the 2,869 people finding employment through Vocational Rehabilitation average earnings increased from $28 per week to $326 dollars per week. Individuals employed after receiving VR services earned a combined total of $935,000 per week.

Who VR Serves

- 18,459 people with disabilities received services from the Vocational Rehabilitation Program in FFY 2014, down 1,076 from FFY 2013.
- 4,381 applicants developed employment plans this year.
- 76 percent of participants of Vocational Rehabilitation had three or more serious functional limitations. An additional 18 percent of the VR caseload had two serious functional limitations.
- 34 percent of all VR participants report a serious mental illness.
- 42 percent of those accepted for service in 2014 were transition-aged youth, age 16 through 24 (see page 14).
- At application, 33 percent of VR participants were receiving Supplemental Security Income, Social Security Disability Insurance or a combination of both.

Placements by Type of Employment 2014

	2012	2013	2014	Percent of 2014 Placements	Average Weekly Wage
Competitive Employment	2,023	2,183	2,125	74%	$345.00
Self-employment	21	16	44	1.5%	$459.00
Employment With Supports	446	539	700	24.5%	$232.00
Total	2,490	2,738	**2,869**	100%	

VR Participants by Cultural/Ethnic Groups 2014

Percent of MN Population, ages 18-24[1]	Cultural/Ethnic Group	Percent of Caseload	Percent Obtaining Employment
1.00%	American Indian	2.5%	1.8%
4.40%	Asian	2.3%	1.9%
5.20%	Black or African American	12.9%	12.1%
4.90%	Hispanic/Latino[2]	3.8%	3.4%
0.00%	Pacific Islander	0.5%	0.2%

[1]Source: U.S. Census Bureau, ACS 2012
[2]Duplicate Count

The VR Caseload: What are the Major Categories of Disability?

Primary Disability Group	2014 Participants	2014 % of Caseload	2014 % of Total Placements
Serious Mental Illness	6,299	34.0%	31.0%
Learning Disability	3,655	20.0%	21.0%
Autism Spectrum Disorder	1,875	10.0%	9.0%
Developmental Cognitive Disabilities	1,304	7.0%	8.0%
Orthopedic/ Neurological Impairments	909	5.0%	5.0%
Deaf/Hearing Loss	748	4.0%	5.0%
Traumatic Brain Injury/Stroke	681	4.0%	4.0%
Cerebral Palsy	277	1.5%	1.5%
Arthritis & Rheumatism	245	1.5%	1.5%
Chemical Dependency	243	1.5%	1.5%
Epilepsy	155	1.0%	1.0%
Spinal Cord Injury	148	1.0%	0.5%

Vocational Rehabilitation at a Glance

Competitive Employment* Placements 2014

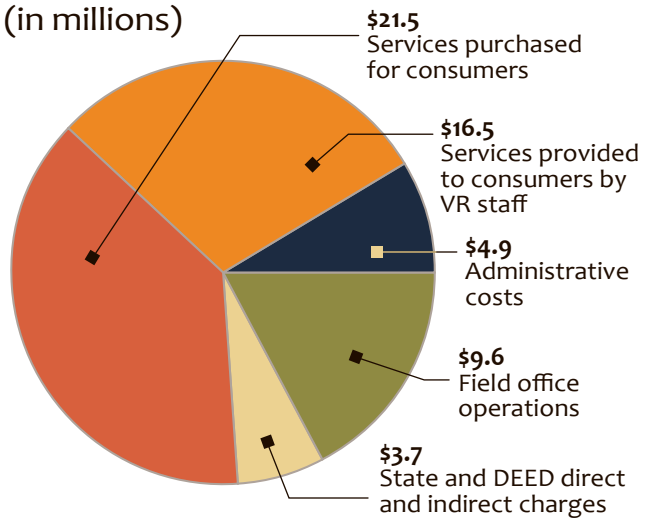
Occupation	Number of Consumers	Average Hourly Wage	Average Hours per Week	Average Weekly Wage
Clerical/Sales	777	$9.71	28	$275
Healthcare: support and service	304	$10.80	30	$324
Industrial Trades	382	$11.87	34	$413
Misc. Occupations	247	$10.78	30	$342
Professional/Technical/Managerial	394	$16.60	31	$516
Service	763	$9.03	25	$232
Total	**2,867**	$10.97	29	$326

Competitive employment is defined as work typically found in the community with wages and benefits commensurate to other employees.
*Two participants found employment below minimum wage, but are working towards commensurate wages.

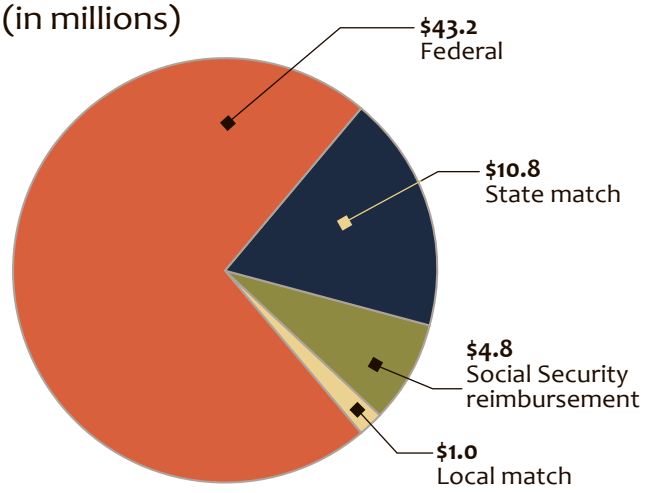
Top Six 2014 Vocational Rehabilitation Referral Sources

Educational Institutions	36.0%
Self Referral	23.0%
Workforce Centers	7.0%
Community Rehabilitation Program	7.0%
State or Local Government	5.0%
Health Care	4.0%

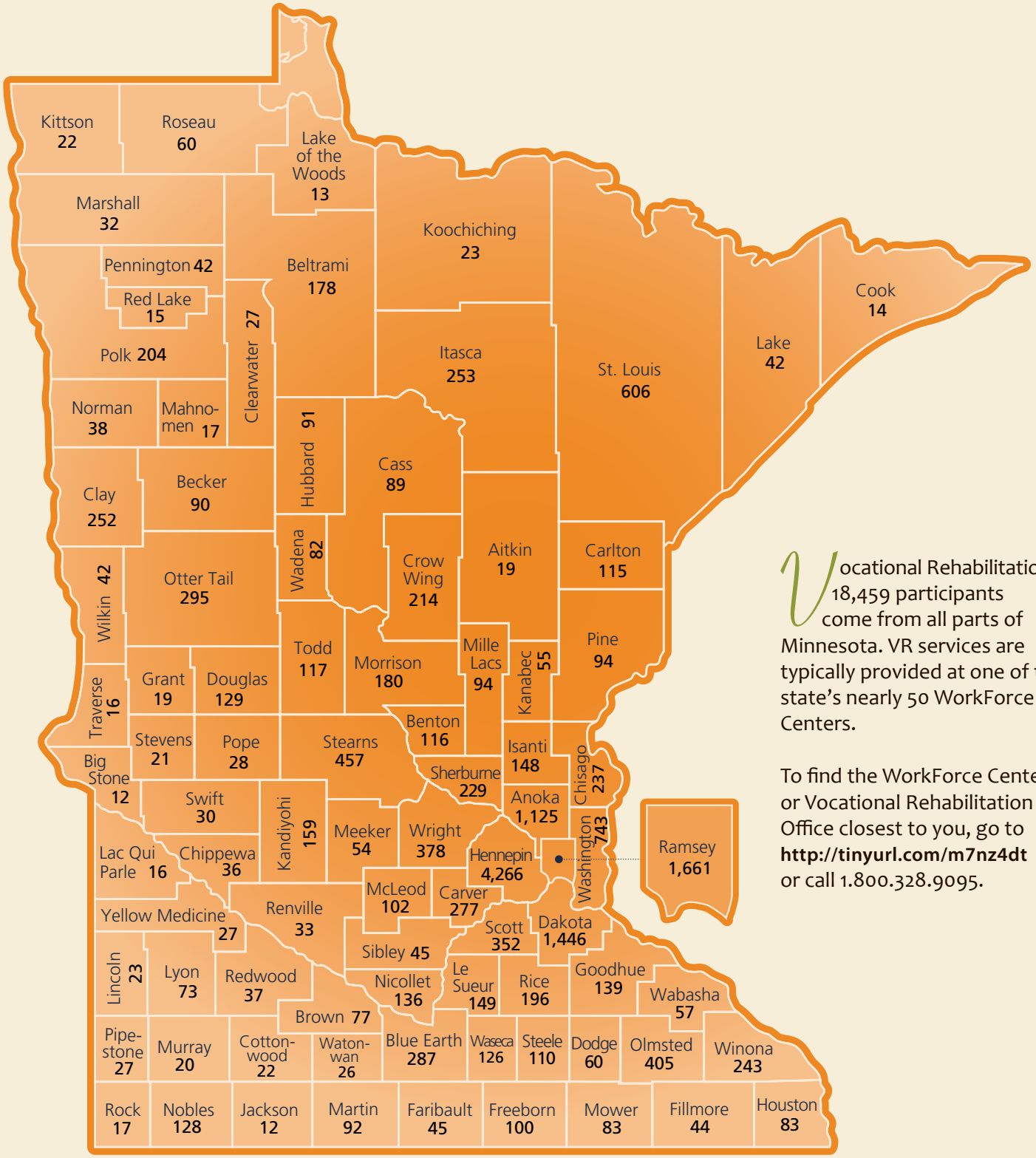
VR Expenditures (in millions)



VR Funding Sources (in millions)



Vocational Rehabilitation Participants by County



Out of State 65

State Total 18,459

Vocational Rehabilitation's 18,459 participants come from all parts of Minnesota. VR services are typically provided at one of the state's nearly 50 WorkForce Centers.

To find the WorkForce Center or Vocational Rehabilitation Office closest to you, go to **http://tinyurl.com/m7nz4dt** or call 1.800.328.9095.

Public Forum: Individual Placement and Support

The State Rehabilitation Council holds public forums to gather information on statewide employment need and to better prepare themselves to give advice to Vocational Rehabilitation Services. In June 2014, the council sponsored a day-long forum in Duluth focusing on the topic of Individual Placement and Support (IPS).

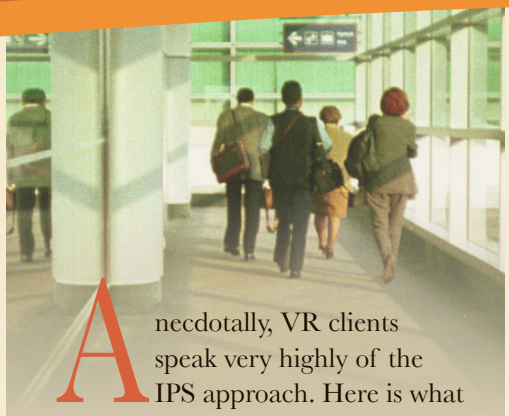
Why this forum?

Work is a vitally important part of recovery for people with mental illness. That was the clear message at the SRC's public forum, which focused on an innovative approach to supporting people with mental illnesses as they move toward employment and economic self-sufficiency.

Vocational Rehabilitation Services has long invested in targeted employment services and supports for persons living with mental illness. The IPS approach to supported employment turns on its head the idea that work is too stressful to handle for people with mental illness. Instead, the IPS approach draws on evidence that suggests people with mental illness not only can be successful at work, but also that employment can help them in their recovery process.

In fact, a growing body of rigorous studies has shown IPS to be the most effective way to provide employment services for people with serious mental illness. IPS is unique because employment services and supports are provided by a team that includes VR counselors, employment service providers and mental health providers.

The IPS practice of supported employment for persons with serious mental illness will be expanding in Minnesota. The Olmstead Plan, Minnesota's response to a court settlement that requires people with disabilities be served in the most integrated environment, requires the state to devise a plan by June 2015 to expand IPS supported employment services statewide. The SRC must be prepared to advise Vocational Rehabilitation on how to meet the requirements of the Olmstead Plan.



Anecdotally, VR clients speak very highly of the IPS approach. Here is what some of the participants had to say about their experiences with IPS:

I am not a mental illness. I am a person with a mental illness… When a person with mental illness is employed, whether it's full-time, part-time, or volunteer, your self-esteem goes up, your confidence goes up, and you get happy again. It's a step to recovery. It might not be a recovery, but it's a step to recovery.

What people like the most is that they've been so inundated with, "This is your diagnosis, this is what your diagnosis says, these are the symptoms." We get to focus on hopes. It's like a hope machine. You're not just whatever your diagnosis is. There's a whole person, and I get to acknowledge that.

I was always told "You can't do that…you don't want to do that… you don't want to work with those kinds of people"… Laura and Sam, they said, "Try it, go for it." To hear that, someone giving you encouragement and support like that, … just hearing that, my confidence went up and I started saying to myself "you can do this".

What is Individual Placement and Support?

The approach rests on principles that aim to integrate employment services with mental health treatment services, assure client choice and consumer preferences, achieve competitive employment and provide continuous, ongoing job supports.

Individual Placement and Support rests on a foundation of eight core principles:

1. Individual Placement and Support employment services are integrated with mental health treatment services.
2. Eligibility is based upon participant choice.
3. Participant preferences are honored.
4. Employer contact begins rapidly after participants enter the program.
5. Employment specialists build relationships with employers based upon participant job interests.
6. Competitive jobs are the goal.
7. Benefits planning (work incentives planning) is offered to all participants who receive entitlements.
8. Job supports are continuous.

Alec Erickson: VR Partners Help With a Successful Transition From School to Work

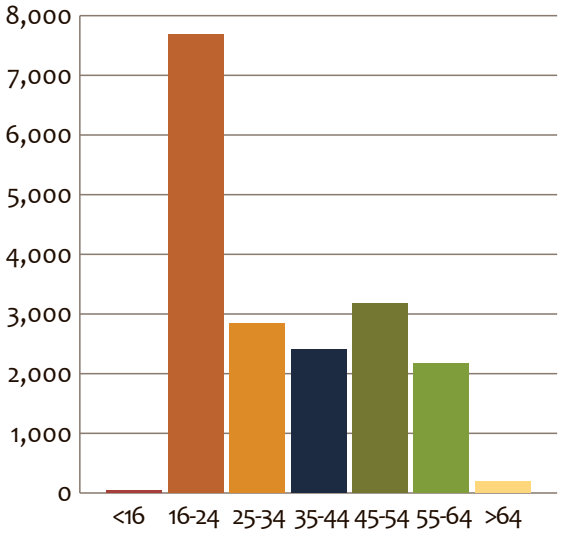
Alec Erickson, who is now 23 years old, came to VRS in November 2011 with a diagnosed developmental cognitive disorder. He was in his second year at the VECTOR South Transition Program in Richfield, and beginning to think about a career in the food industry. On his own, he had applied at a Byerly's grocery store and obtained a job as a bagger, working 15-20 hours a week. He loved working at Bylery's and they loved him there, but it wasn't clear that the job was his best long-term option. Alec wanted to work more hours and earn more money.

Alec's VR counselor offered to help him explore other aspects of the food industry as well as related fields and other career paths. Together they chose to work with Autism Works, a service provider that uses the Discovery Process, an intensive form of vocational assessment. Autism Works set up a meeting with Alec's supervisor, who offered training that might allow Alec to take on inventory and ordering duties in the dairy department. Autism Works provided emotional support and encouragement and Alec made the transition smoothly and now works 30-plus hours a week making more than $10 an hour.

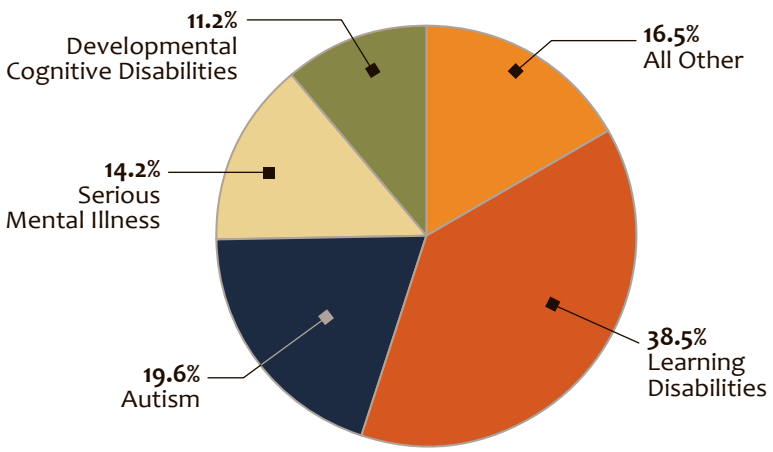
Next up was obtaining a driver's license. Alec lived with his mother in an area without reliable bus routes, and he didn't want to rely on others to get him to and from work. VRS agreed to do driver's assessment and driving lessons through Courage Center, where Alec is currently working to complete his licensing course.

Alec and his brother recently moved to a shared townhome with access to a good bus route. He received bus training through the Metropolitan Center for Independent Living, quickly learned to ride independently, and now takes the Metro Transit bus to and from work. And in a nice little development, Alec has joined Bridging Hearts, an online social network that connects young adults with learning disabilities, and will be going on their Caribbean Cruise this winter.

Number Served by Age Group



Transition Age Group by Type of Disability



Looking Forward: The 2015 SRC Public Forum Will Discuss Transition-Age Services

The Workforce Innovation and Opportunity Act (WIOA), authorized in July of 2014, will have far-reaching effect on the work of Vocational Rehabilitation Services. Among many other changes, WIOA places increased emphasis on services to transition-age youth and will require VRS, in conjunction with the Department of Education, to provide prevocational services to younger students with disabilities. The State Rehabilitation Council will host a public forum to discuss how to best implement this requirement. Watch for more information about the time and location of this forum at **http://tinyurl.com/k5y735b**

The State Rehabilitation Council Seeks Public Input

The SRC is the citizen's voice for VR. We are appointed by the governor, represent many walks of life and come from across the state.

We work with VRS to conduct statewide needs assessments, shape VR policy, develop a strategic plan and write the state plan. We are responsible for conducting customer satisfaction studies, assessing program effectiveness and writing this annual report.

We value citizen input. Our meetings are always open to the public. We have time set aside at every meeting to take public comment.

In 2015, we are seeking representation from the following categories.

- advocates
- vocational rehabilitation counselors
- community rehabilitation providers
- current or former vocational rehabilitation participants
- business, industry or labor.

Applications can be obtained at: **www.sos.state.mn.us/**

For more information about the State Rehabilitation Council, go to **http://tinyurl.com/k5y735b** or call Gail Lundeen at 651-259-7364.

State Rehabilitation Council Members

JEFF BANGSBERG — New Hope
Advocate

CHRISTINE BAUMAN — Mankato
VR Counselor

SCOTT BERSCHEID — Saint Michael
Business, Industry and Labor

EMMA CORRIE — Saint Paul
Business, Industry and Labor

STEVEN DITSCHLER — Eagan
Governor's Workforce Development Council

AL HAUGE — Owatonna
Department of Education

MICKEY KYLER — Crookston
Statewide Independent Living Council

GLORIA LAFRINIERE — Naytahwaush
White Earth Vocational Rehabilitation

CLAYTON LIEND — Keewatin
Community Rehabilitation Provider

ANDIE (ANDREA) MOORE — Bloomington
PACER

ANITA OLSON — Fertile
Former VR participant

KIMBERLEY PECK — Saint Paul
VRS Director

SHERRI RADEMACHER — Melrose
Former VR Participant

CLAIRE REEVE — Rochester
Business, Industry and Labor

ANNE (ANDREA) REDETZKE — St. Joseph
Advocate

ANNE ROBERTSON — Minneapolis
Client Assistance Project

CHUCK RYAN — Saint Michael
Business, Industry and Labor

BOB (ROBERT) WAGNER — Saint Paul
Former VR participant

NICK (NICHOLAS) WILKIE — Saint Paul
Advocate

EXHIBIT 6-8: HS 1E – PROCESS TO TRACK INDIVIDUALS EXITING CORRECTIONS

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OLMSTEAD PLAN: ADDITIONAL INFORMATON (January 27, 2015)

HS 1E: Develop a process to track the number of individuals with disabilities exiting state correctional facilities and their access to appropriate services and supports. (pg. 50)

Lead Contact Person(s): Deb Kerschner, DOC, 651-361-7366

Within the Minnesota Department of Corrections' Facilities Division, business procedures exist within the intake and case management processes that can be used to identify inmates who meet the definition of "disability". An information systems change will need to be made in order to compile those processes for purposes of reporting and for tracking services received following release. Criteria within the current business process that would identify individuals with disabilities are: health care screening, health services release planning, medical exam, health profile, ADA access plan, and education assessment.

Process Flow Chart

Facility Services Business Process ***Olmstead Reporting Process***

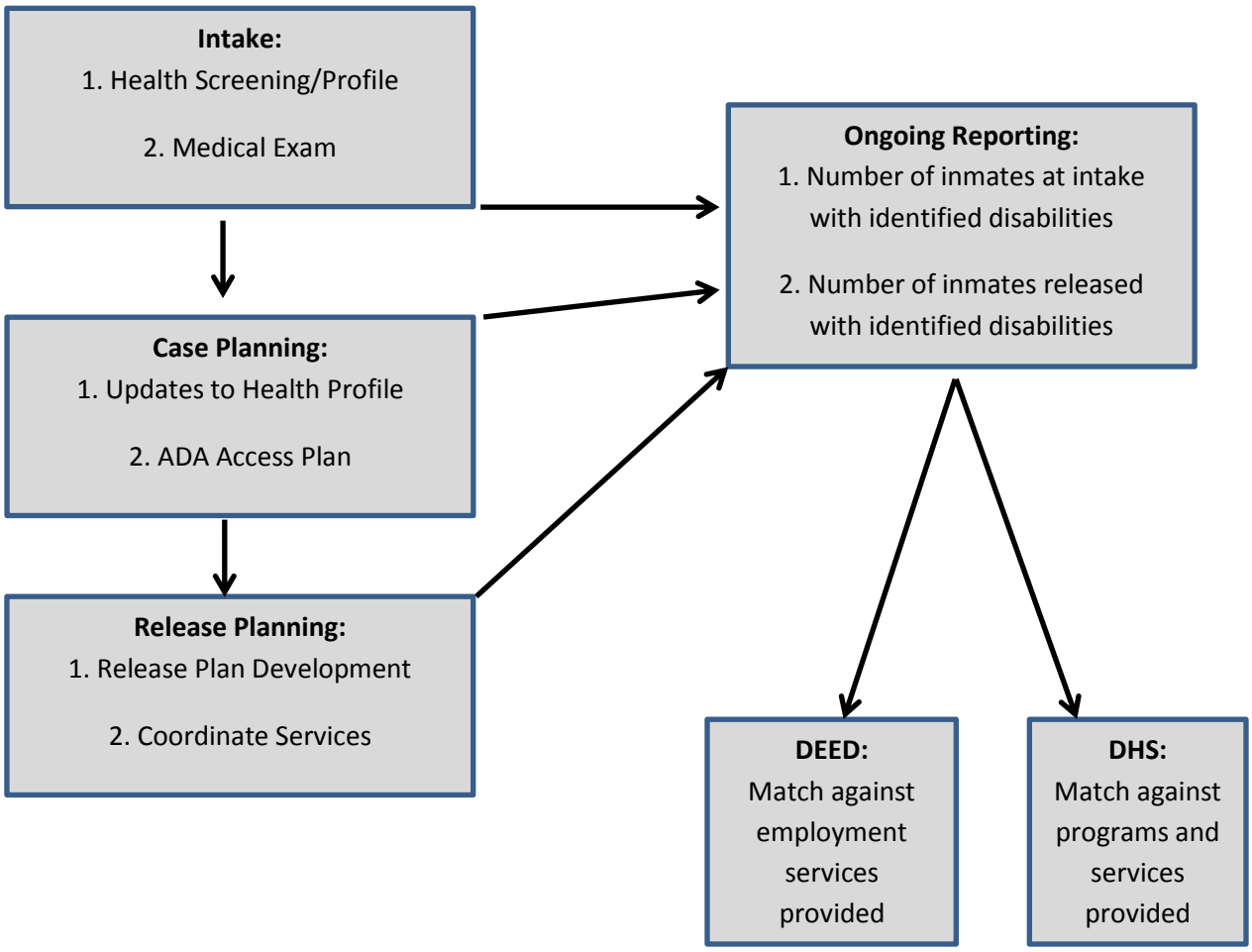

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EXHIBIT 6-9: HS 4B – HOUSINGLINK IMPROVEMENTS WORKPLAN

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HousingLink Olmstead Housing Goal
Implementation Plan: Phase II

The Olmstead Plan clearly states the housing goal as, "People with disabilities will choose where they live, with whom, and in what type of housing." Action Four in the plan focuses specifically on "Increase access to information about housing options." In Phase I of our work HousingLink engaged the disability community in conversation about using our website to access housing and identify what improvements need to be made to expand our website to include more depth of information about affordable rental housing options that meet the needs of persons with disabilities. Now that HousingLink successfully completed the initial phase of its work, the following is the proposal to take those learnings and implement the changes to the www.housinglink.org website. Throughout Phase II HousingLink will also inform and educate people with disabilities, case workers, providers and advocates throughout Minnesota about our website and using it to locate rental housing options.

Phase II: hList Enhancements and Statewide Promotion
During this phase of the Olmstead Plan implementation HousingLink will have two focus areas.

1.**hList Enhancements:** HousingLink will implement the changes identified in the Requirements Definition submitted to Minnesota Housing as a deliverable for Phase I of the project. This includes increased mobile device friendliness of the website and providing expanded accessible feature search capability in hList. Throughout the development process HousingLink will meet with key stakeholders for their input and feedback on the changes we are implementing.

2.**Statewide Promotion:** HousingLink will actively promote our resources throughout the state of Minnesota targeting persons with disabilities, case workers, providers and advocates. In addition to promoting our existing resources a new "Accessibility" webpage will be added to the Housing Resources section of our website that focuses on educational content for renters, landlords, and social service professionals so all can better understand the rights and responsibilities they have when living in rental housing with a disability. Also, HousingLink is taking all content offered in PDFs and converting it to text on a webpage so individuals who are visually impaired can access the educational content using a screen reader.

Timeline for Phase II:
There will be overlap among the steps in the process, all work to be completed by September 30, 2015. The detailed activities are in the attached Olmstead Phase II Work Plan.

Payment Schedule:
The payment schedule will be 50% at contract execution, 25% at the point where wireframes are shared, and 25% at project completion.

Olmstead Phase II Work Plan

This phase is focused implementing changes to hList and website functionality and promotion of our resources statewide.

Outcomes:

1. hList enhancements and website navigation improvements developed and implemented.
2. Promotion of HousingLink throughout Minnesota to relevant stakeholders.

Olmstead Phase II			
Task	**Start Date**	**End Date**	**Primary Staff**
Deliverable: hList enhancements implemented	11/1/2014	9/30/2015	Don, Sue, Rick, Josh
Select designer for new layout			Don, Sue, Josh
Select developer			Don, Rick, Sue
Approve Design			Team
Share final design with key stakeholders			Josh, Sue
Share wireframes with key stakeholders			**Team**
Review feedback, share with developer as needed			Don
Test enhancements			Team
Launch enhancements on website			Don
Resolve bugs			Don
Deliverable: Statewide Promotion of HousingLink	11/1/2014	9/30/2015	Josh, Sue
Promote HousingLink to landlords in Greater MN			Josh, Sue
Promote HousingLink to human service providers in Greater MN			Josh, Sue
Present about HousingLink to statewide audience via conferences			Josh, Sue
Promote HousingLink to disability community			Josh, Sue
Deign Accessibility webpage			Josh
Share Accessibility pager with key stakeholders			Josh
Move content from PDF documents to web pages			Josh
Publish new webpages			Josh

EXHIBIT 6-10: TR 1A – MINNESOTA TRANSIT FUNDING PRIMER

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Minnesota Council on
Transportation Access

Minnesota Transit Funding Primer

Technical Report

Prepared for:
Minnesota Council on Transportation Access

January 2015

Prepared by:
Hubert H. Humphrey School of Public Affairs University of Minnesota

Introduction

In the state of Minnesota, state and federal funding for public transit systems is administered by a number of different agencies, with coordination efforts encouraged by the Minnesota Council on *Transportation Access (MCOTA). The Minnesota Legislature established MCOTA in 2010.* MCOTA was established in order to "study, evaluate, oversee, and make recommendations to improve the coordination, availability, accessibility, efficiency, cost-effectiveness, and safety of transportation services provided to transit public[1]". MCOTA is tasked with duties related to the following key areas: vehicle and client sharing, cost sharing and purchasing, communication and coordinated planning, reporting and evaluation, and research and demonstration[2].

This MCOTA Research Project is aimed at providing an inventory of the transportation funding programs available from the federal and state government in Minnesota, including funding levels and details about the administration of each program. The goal is to identify opportunities for coordination.

What is Human Services transportation (community-based transportation)?

Human Services transportation includes broad range of transportation services for transportation-disadvantaged population; primarily persons with disabilities, veterans, seniors, low-income individuals, and children. Since Human Service transportation is not centrally coordinated in Minnesota, the goal of this report is to more fully understand all sources that fund this service. As stated on MCOTA's website, "While there have been significant investments in transit at the federal, state, and local levels, serious gaps in service exist in many communities. Unfortunately, a multitude of funding programs and requirements across dozens of departments and agencies make transportation coordination and communication a daunting task."

What are the purposes of human Services transportation?

In order to support and increase transportation options for transportation-disadvantaged people, funding would be allocated to different organizations with various transportation purposes. Transportation-disadvantaged people have different needs and require a variety of transportation services with different trip purposes. Based on the survey results, most trip purposes would be as following:

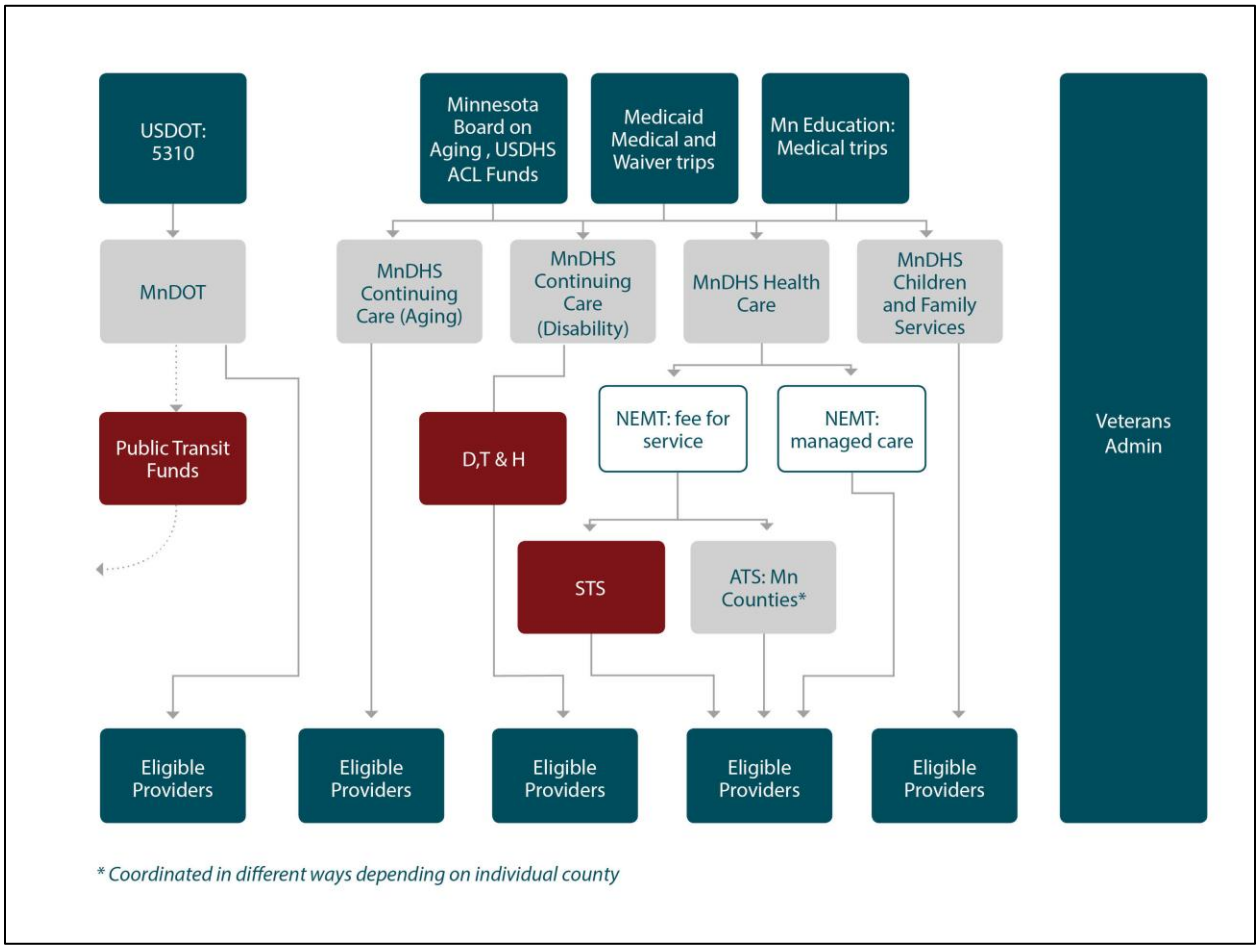
-Health/medical (e.g., single or periodic trips to doctor, clinic, drug store, treatment center)
- Health maintenance (e.g., dialysis or other recurring and frequent trips that require regular transport)
- Nutrition
- Income maintenance (e.g., trips to food stamp or social security office)
- Social trip (e.g visit to friends/relatives)
- Recreation (e.g., trip to cultural or athletic events)
- Education/ training
- Employment (e.g., trips to work, including job interviews. welfare-to-work trips)
- Social services (e.g., trips to meet with counselors, social workers, and other staff related to the receipt of social services)
- K-12 education (school children)

What types of organizations are eligible to receive funding for Human Services transportation?

Organization that might be eligible to receive funding for their transportation services to transportation-disadvantaged people could fall in different categories. Primarily there are public transportation operator, human services agencies, private for profit or private nonprofit organizations.

Who are the Federal and State Agencies funding Human Services transportation?

The following agencies are involved in funding transit in Minnesota.



United States Department of Transportation
The mission of the United States Department of Transportation is to "serve the United States by ensuring a fast, safe, efficient, accessible and convenient transportation system that meets our vital national interests and enhances the quality of life of the American people, today and into the future"[3].

MAP-21

Section 5310 formula grants for the enhanced mobility of elderly individuals and individuals with disabilities. MAP-21 consolidated the Section 5317 New Freedom program (a formula-based federally-funded program established under SAFETEA-LU. The goal of the New Freedom grant program is to provide additional tools to overcome existing barriers facing Americans with disabilities seeking integration into the workforce and full participation in society) into the Section 5310 program.

Section 5310 Elderly Individuals and Individuals with Disabilities Program (a capital program as a part of the amended Federal Transit Act of 1991, that provides grant funds for the purchase of accessible vehicles and related support equipment for private non-profit organization to serve elderly and/or disabled people, public bodies that coordinate services for elderly and disabled, or any public body that certifies to the state that non-profits in the area are not readily available to carry out the services) provides capital and operating assistance grants for organizations that serve elderly and/or persons with disabilities. Section 5310 funding is approximately $2,483,572.

Section 5310 pays for vehicles and other capital equipment for elderly individuals and individuals with disabilities. After the consolidation of Section 5317 New Freedom program, Section 5310 allows for additional funds used to provide transportation for low-income individuals.

Minnesota Department of Transportation
The mission of the Minnesota Department of Transportation is to "plan, build, operate and maintain a safe, accessible, efficient and reliable multimodal transportation system that connects people to destinations and markets throughout the state, regionally and around the world"[4]. "In creating the Department of Transportation in 1976, the Legislature determined that the Minnesota Department of Transportation would be the principal agency to develop, implement, administer, consolidate and coordinate state transportation policies, plans and programs"[5].

The Minnesota Department of Transportation allocates funding to both public transit and to eligible providers that provide services to individuals covered under the United States Department of Transportation 5310 funding programs.

State funding for public transit is appropriated from the general fund and from a percentage of motor vehicle sales tax revenue. For Greater Minnesota Transit, the public transit assistance

general fund is $16,451,000 in 2014. The Twin Cities Metro Area Transit public transit assistance general fund was $107,889,000 in 2014.

The Minnesota Department of Transportation "disburses funds for Greater Minnesota transit through the Public Transit Participation Program[6]" . State law requires local participation in funding public transit services in Greater Minnesota. A statutory fixed share funding formula sets a local share of operating costs by system classification as follows: elderly and disabled 15%, rural 15%, small urban 20%, and urbanized 20%[7].

United States Department of Health and Human Services
The United States Department of Health and Human Services is the government's "principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves"[8]. The United States Department of Health and Human Services is responsible for approximately 25 percent of all federal outlays and administers the largest amount of grant money in comparison to all other federal agencies[9].

Administration for Community Living
The United States Department of Health and Human Services' Administration for Community Living. The mission of the Administration for Community Living is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers.

The Administration for Community Living "brings together the efforts and achievements of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the Health and Human Services Office on Disability to serve as the Federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan"[10].

Minnesota Board on Aging
The Minnesota Board on Aging is the "gateway to services for Minnesota seniors and their families"[11]. The Minnesota Board on Aging allocates funding that is established by the Older Americans Act. The Older Americans Act authorizes "grants to states for community planning, services, research, and demonstration and training projects in the field of aging". The Older Americans Act also provides grants for local needs identification, planning and funding of services[12].

The Minnesota Board on Aging distributes money to the 7 Minnesota Area Agencies on Aging that award the money to partners at the local level.

Minnesota Department of Human Services
The Minnesota Department of Human Services "helps people meet their basic needs so that they can live in dignity and achieve their highest potential"[13]. The Minnesota Department of Human Services oversees Continuing Care for both aging and disability. The Minnesota Department of Human Services also oversees heath care and children and family services.

Continuing Care

The Continuing Care Administration of the Minnesota Department of Human Services' goals are to: "support and enhance the quality of life for older people and people with disabilities, manage an equitable and sustainable long-term care system that maximizes value, continuously improve how we administer services, promote professional excellence and engagement in their work"[14].

For the aging and the disabled, Continuing Care distributes its funds directly to eligible providers.

Medicaid Medical Trips

Medicaid Waiver Trips
Medicaid waivers are "vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid[15]".

The Disability Services division oversees four Medicaid disability waivers. Medicaid disability waivers include: BI Waiver-Brain Injury Waiver for people with a brain injury who would otherwise need neuro-behavioral hospital care or a specialized nursing facility care, CAC Waiver- Community Alternative Care for medically fragile people who otherwise would need hospital care, CADI Waiver- Community Alternatives for Disabled Individuals Waiver for people with a disability that would need nursing facility care, DD Waiver- Developmental Disability Waiver for people with a developmental disability for people who would otherwise need an intermediate care facility level of care.

The Aging and Adult Services Division oversees elderly waiver (a Medicaid waiver) which extends transportation for fee-for-service expenditures. The Aging and Adult Services also oversees alternative care which extends transportation for fee-for-services expenditures.

Section 1115 Research and Demonstration Projects waivers are waivers that Minnesota can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid. Section 1915(b) Managed Care Waivers are waivers that Minnesota can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers. Section 1915(c) Home and Community-Based Services Waivers are waivers that Minnesota can apply for waivers to provide long-term care services in home and community settings rather than institutional settings. Concurrent Section 1915(b) and 1915(c) Waivers are waivers that Minnesota can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met[16].

Medicaid Waiver trips allocate funding to both the Continuing Care for those with disabilities and to Health Care.

Health Care
Minnesota Department of Human Services' Health Care programs include medical assistance, MinnesotaCare, Minnesota Family Planning Program, Home and community-based waiver programs, and Medicare Savings programs. These programs may help pay for all of part of health care costs for those who do not have insurance, cannot get affordable health insurance

through a job, have a disability or chronic condition and need assistance paying for care and services to stay in one's home, need help paying for care in a nursing home, hospital or other medical facility, have other insurance or Medicare but need help paying the premiums, deductibles and copays or need services not covered [17]. Minnesota Health Care allocates funding to both NEMT fee for service and managed care.

NEMT

Non-Emergency Medical Transportation refers to non-emergency transportation services provided to Medicaid recipients so they can obtain covered medical services from health care providers outside their home. The type of Non-Emergency Medical Transportation assistance generally covers the cost of transportation and other costs associated with travelling to health service providers, such as meals and overnight accommodations.

In Minnesota, Non-Emergency Medical Transportation services are provided through the state's MA program. About two-thirds of MA recipients in Minnesota are enrolled in managed healthcare plans (Managed MA) and generally receive NEMT through these plans. The balance of recipients are covered by a fee-for service system operated by the Department of Human Services.

Non-Emergency Medical Transportation fee-for service allocates funding through Minnesota Counties, which then provide funding to eligible providers.

Non-Emergency Medical Transportation managed care allocates funding directly to eligible providers.

Counties

Counties report their social services expenditures to Minnesota Department of Human Services through the quarterly Social Services Expenditure and Grant Reconciliation Report.

Minnesota Education

School districts in Minnesota receive general education basic revenue in which there is an amount earmarked for transportation. In addition, districts receive state funding for certain situations including special education transportation and homelessness.

The Minnesota Department of Human Services administers the claims that school districts make for reimbursement for transporting students to medical assistance programs.

Children and Family Services

The Minnesota Department of Human Services' Children and Family Services allocates funding directly to eligible providers.

Veterans Administration

The United States Department of Transportation awarded $1.19 million to Minnesota Department of Transportation under a Veterans Transportation and Community Living Initiative

discretionary grant in late 2011. Using these funds, Minnesota Department of Transportation, Minnesota Department of Veterans Affairs, Minnesota Board on Aging, and Minnesota Department of Human Services are partnering to enhance the existing MinnesotaHelp Network, a virtual call center and website that facilitates referrals among human service agencies using a common communications platform. This project will extend this technology to transportation providers and veterans' organizations that provide rides to veterans, enabling these partners to easily refer customers to other agencies in the network or to call center staff who can provide customers individual assistance.

Although the Minnesota Department of Veterans Affairs is collaborating with other agencies through MinnesotaHelp Network, the Minnesota Department of Veterans Affairs has generally separated its services to vulnerable adults from the services of other non-Veteran individuals. The existence of the Minnesota Department of Veterans Affairs separate statutory chapter and language regarding vulnerable adults supports the Minnesota Department of Veterans Affairs' commonly practiced risk averse policies and actions related to vulnerable adults in the transportation provided solely to vulnerable adults with Veteran status.

Federal Funding

5310 (elderly persons and person with disabilities) Statewide	$2,483,572
5316 (job access) Greater Minnesota	$ 751,000
5316 (job access) MET Council	$1,169,463
5317 (new freedom) Greater Minnesota	$ 552,000
5317 (new freedom) Met Council	$ 415,324
Veterans Transportation	$1,100,000
5311 (non-urbanized area grant) Greater Minnesota	$ 8.2 M
5311 (non-urbanized area grant) MET Council	$ 642,668
5307 (urbanized) Greater Minnesota	$ 3.5 Million
Older American Act Title III - Statewide	$1,000,000

State Funding

MVST	$ 225,127,379+ $24.6 m (OP)+$ 6.2m (CAP)
Public transit assistance	$ 152,255,021+ $14.2m (OP) + $ 800,000 (CAP)

Others

Medical Assistance	$6,300,000
Non-Emergency Medical Transportation	$24,000,000
Extended Transportation & Disability Waivers	$31,900,000

Funding Based on Recipients (Estimations based on Survey Responses)

Persons with disabilities	$40.7 M
Elderly	$18.2 M

[1] http://www.coordinatemntransit.org/MCOTA/
[2] http://www.coordinatemntransit.org/MCOTA/documents/MCOTA_Overview_Jun2011.pdf
[3] http://www.dot.gov/mission/about-us.
[4] http://www.dot.state.mn.us/vision/
[5] Minn. Stat. Ch. 174.
[6] 2013 MnDOT transit report.
[7] 2013 MnDOt transit report
[8] http://www.hhs.gov/about/
[9] http://www.hhs.gov/about/
[10] http://www.acl.gov/About_ACL/Index.aspx
[11] http://www.mnaging.net/en/About%20Us/WhoWeAre.aspx
[12] http://mn4a.org/policymakers/policies-that-matter/
[13] http://mn.gov/dhs/about-dhs/mission-and-values.jsp
[14] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166609
[15] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html
[16] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.
[17]http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_136855

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EXHIBIT 6-11: TR 3A – MNDOT ADA TRANSITION PLAN

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ADA Transition Plan

Minnesota Department of Transportation

www.mndot.gov/ada

We all have a stake in A to B

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Minnesota Department of Transportation
395 John Ireland Boulevard
Saint Paul, MN 55155

January 20, 2015

Dear Citizens of Minnesota,

I am pleased to share with you the revised ADA Transition Plan for the Minnesota Department of Transportation. This plan demonstrates MnDOT's ongoing commitment to providing accessibility and continued collaboration between MnDOT and citizens, stakeholders, and partners throughout Minnesota. In addition to establishing a baseline of the accessibility of the State's transportation system, the plan tracks MnDOT's progress to ensure that transportation is accessible to all users.

As Minnesota's transportation leader, Mn/DOT will uphold the vision and policies presented in this plan. The success of making our transportation system fully accessible depends on the coordinated efforts of all levels of government, the public, and the policies and strategies outlined in this plan. Mn/DOT will continue to look for opportunities to involve citizens, stakeholders and partners in the implementation of this plan, future updates to the plan, and in policy decisions affecting accessibility. Together, we can realize a shared vision of an accessible, safe, efficient, and sustainable transportation system.

Sincerely,

(Original signed)

Susan Mulvihill P.E.

Deputy Commissioner/Chief Engineer

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Mn/DOT
ADA Transition Plan

Minnesota Department of Transportation

1/20/2015

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Table of Contents

Introduction

MnDOT Vision

This document is intended to serve as a guide to further the vision, mission and core values for the Minnesota Department of Transportation (MnDOT) by outlining key actions for making the transportation system in Minnesota accessible. The Vision, Mission and Core Values for MnDOT are as follows:

Vision

Minnesota's multimodal transportation system maximizes the health of people, the environment and our economy.

Mission

Plan, build, operate and maintain a safe, accessible, efficient and reliable multimodal transportation system that connects people to destinations and markets throughout the state, regionally and around the world.

Core Values

- Safety
- Excellence
- Service
- Integrity
- Accountability
- Diversity and Inclusion

Transition Plan Need and Purpose

The Americans with Disabilities Act (ADA), enacted on July 26, 1990, is a civil rights law prohibiting discrimination against individuals on the basis of disability. The ADA consists of five titles outlining protections in the following areas:

- Employment
- State and local government services
- Public accommodations
- Telecommunications
- Miscellaneous Provisions

Title II of ADA pertains to the programs, activities and services public entities provide. As a provider of public transportation services and programs, MnDOT must comply with this section of the Act as it specifically applies to state public service agencies and state transportation agencies. Title II of ADA provides that, "…no qualified individual with a

disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." (42 USC. Sec. 12132; 28 CFR. Sec. 35.130)

As required by Title II of ADA, 28 CFR. Part 35 Sec. 35.105 and Sec. 35.150, MnDOT is conducting a self-evaluation of its facilities and developed this Transition Plan detailing how the organization will ensure that all of its facilities, services, programs and activities are accessible to all individuals.

Transition Plan Management

MnDOT's transition plan is a living document that will receive routine updates. Updates are scheduled to occur on a four year cycle. To streamline plan updates and keep the document current and relevant, appendices will be updated annually if new information is available and does not alter the intent of the transition plan. When an appendix update is found to alter the intent of MnDOT's Transition Plan the appendix and affected section(s) will be opened for public review and comment. The update schedule may be altered at the discretion of MnDOT based on changes in guidance from the United States Access Board, Federal policy, and MnDOT policy. MnDOT's Transition Plan is available for continual public inspection through MnDOT's website.

Relationship to Other MnDOT and State Plans

The transition plan does not function as an independent document and informs several planning documents owned by the Minnesota Department of Transportation, including but not limited to the our 50 year vision: Minnesota Go, our 20-year Statewide Multimodal Transportation Plan, and our 20 year investment plan MnSHIP. The development of the plans and their relationship to accessibility is an iterative process led by the goals of the transition plan. As MnDOT's long range plans have been developed they take into account the role of accessibility in meeting multimodal goals, creating livable communities, and identifying investment needs.

In addition to MnDOT's planning and investment documents the transition plan supports the outcomes of Minnesota's Olmsted Plan which focuses on ensuring that individuals with disabilities are living, learning, working, and enjoying life in the most integrated setting of their choice. The Olmstead Plan was published in 2013 and is part of a legal settlement with the state. As part of the eight agencies named to develop and implement the Olmsted Plan MnDOT is focused on how the needs of the Olmstead population affect the prioritization and delivery of our transportation system particularly in the area of Greater Minnesota transit.

Title II of ADA is companion legislation to two previous federal statutes and regulations: the Architectural Barriers Acts of 1968 and Section 504 of the Rehabilitation Act of 1973.

The Architectural Barriers Act of 1968 is a Federal law that requires facilities designed, built, altered or leased with Federal funds to be accessible. The Architectural Barriers Act marks one of the first efforts to ensure access to the built environment.

Section 504 of the Rehabilitation Act of 1973 is a Federal law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any Federal department or agency. Title II of ADA extended this coverage to all state and local government entities, regardless of whether they receive federal funding or not.

When addressing accessibility needs and requirements, it is important to note that ADA and Title II do not supersede or preempt state or local laws that may offer equivalent or greater protections, such as the Minnesota Human Rights Act.

Under Title II, MnDOT must meet these general requirements:

- Must operate their programs so that, when viewed in their entirety, the programs are accessible to and useable by individuals with disabilities (28 C.F.R. Sec. 35.150).
- May not refuse to allow a person with a disability to participate in a service, program or activity simply because the person has a disability (28 C.F.R. Sec. 35.130 (a).
- Must make reasonable modifications in policies, practices and procedures that deny equal access to individuals with disabilities unless a fundamental alteration in the program would result (28 C.F.R. Sec. 35.130(b) (7).
- May not provide services or benefits to individuals with disabilities through programs that are separate or different unless the separate or different measures are necessary to ensure that benefits and services are equally effective (28 C.F.R. Sec. 35.130(b)(iv) & (d).
- Must take appropriate steps to ensure that communications with applicants, participants and members of the public with disabilities are as effective as communications with others (29 C.F.R. Sec. 35.160(a).
- Must designate at least one responsible employee to coordinate ADA compliance [28 CFR § 35.107(a)]. This person is often referred to as the "ADA Coordinator."

The public entity must provide the ADA coordinator's name, office address, and telephone number to all interested individuals [28 CFR § 35.107(a)].

- Must provide notice of ADA requirements. All public entities, regardless of size, must provide information about the rights and protections of Title II to applicants, participants, beneficiaries, employees, and other interested persons [28 CFR § 35,106]. The notice must include the identification of the employee serving as the ADA coordinator and must provide this information on an ongoing basis [28 CFR § 104.8(a)].
- Must establish a grievance procedure. Public entities must adopt and publish grievance procedures providing for prompt and equitable resolution of complaints [28 CFR § 35.107(b)]. This requirement provides for a timely resolution of all problems or conflicts related to ADA compliance before they escalate to litigation and/or the federal complaint process.

MnDOT's Compliance History

Following the passage of ADA on July 6, 1990, MnDOT took initial steps to identify and address Title II requirements. In December of 1991 MnDOT received direction from the local Federal Highway Administration (FHWA) division to complete a curb ramp assessment and transition plan to comply with the new law. Based on direction from the FHWA and the requirements of the final rule passed on July 26, 1991 MnDOT developed the parameters to identify curb ramp needs and an investment plan which would be fully implemented by January 31, 1995. MnDOT records show that each district had completed a curb ramp inventory by December of 1992 and identified funding and a construction timetable that was to be completed by January 26, 1995.

During the same timeframe, the Minnesota Department of Administration conducted an assessment of all state owned and leased properties to identify barriers to be corrected by the individual agencies. According to available MnDOT records, all employee occupied buildings were retrofitted to meet the ADA requirements outlined in 1990 and all subsequent new construction has followed Minnesota Building Codes which meet or exceed ADA requirements. Construction plans and a timetable were developed in 1994 for barrier removal and accessibility improvement for all Class I and II rest areas with work to be completed at the end of 1995. MnDOT had begun barrier removal on rest areas when it was determined that funding administered by the Department of Administration could not be used on rest area improvements. A list of current barriers at MnDOT rest areas can be found in Appendix D.

From 1995 to 2001 MnDOT's ADA efforts were largely decentralized, focusing primarily on reasonable accommodation for employees and transit, with compliance and

oversight falling on individual offices and programs. In general, MnDOT had completed the retrofit requirements identified in ADA and was meeting compliance with new construction and reconstruction projects. During this time MnDOT did not maintain a centralized transition plan.

In 2001 ADA became a point of focus with the Access Board's issuance of the draft rules for public rights of way and the expiration of the moratorium on detectable warning surfaces. MnDOT provided comment to the draft rules in October of 2001, but only became aware of the detectable warning requirement in July of 2002 through an FHWA memo. A revised standard plan with truncated domes was issued in 2003 and has been required in new construction, reconstruction and alterations since 2003. In 2005 the Access Board issued a revision of the draft rules, titled Public Rights of Way Accessibility Guidance (PROWAG), to be utilized as best practices. The lifting of the detectable warning surfaces moratorium and the publication of PROWAG was the first new guidance affecting public rights of way since the initial passage of ADA in 1990.

In September 2006, MnDOT's Affirmative Action Office was asked to assess agency Title II compliance and determine needs in this area. As a result of the assessment, MnDOT took the following actions:

- Designated an ADA Coordinator.
- Drafted a Notice of Non-Discrimination to provide information about the rights and protections of ADA to employees and applicants, as well as participants and users of MnDOT services, programs and activities.
- Established a grievance/complaint process to address or correct user concerns related to inaccessible pedestrian and transportation facilities under MnDOT's jurisdiction.

In 2007, an internal MnDOT ADA Advisory Council was formed. The primary function of this council was to assess and determine accessibility program needs and provide guidance to MnDOT administrators. The group includes key staff from Technical Support, Design, Investment Management (Planning), Construction, Traffic Operations, Maintenance Operations, Transit, Aeronautics and State Aid.

Also in 2007, MnDOT updated its policy and procedures to more effectively respond to requests for Accessible Pedestrian Signals (APS). The policy and procedures require the installation of APS at every signalized intersection and at every pedestrian crossing in new and reconstruction projects.

MnDOT launched its ADA web pages for public use in the spring of 2008. The pages include MnDOT's Non-discrimination Notice, links to accessibility guidance and

information and an online grievance process for users to voice their concerns regarding barriers preventing access to MnDOT facilities, programs and services.

In 2008 MnDOT formed a standing external stakeholder advisory group, made up of citizens with disabilities and advocates for key disability groups in Minnesota. This committee provides important feedback and invaluable real-life experience regarding how persons with disabilities use MnDOT's facilities, programs and services. They also serve as a voice for members of Minnesota's disability community.

Technical Memorandum 08-13-TM-05 Pedestrian (Curb) Ramp Guidelines was adopted and issued by the Deputy Commissioner in 2008 to clarify pedestrian curb ramp installation requirements to MnDOT staff and city and county engineers.

In 2008, MnDOT contracted with an independent consultant to conduct an objective evaluation of the organization's current policies, procedures and practices regarding ADA and Title II. The evaluation analyzed the impact of MnDOT policies, procedures and practices on accessibility within our state, and how accessibility impacted people with disabilities. The report identified policies, procedures and practices potentially did not comply with Title II requirements. Please see Appendix E for the list of policies, procedure and practices and the action taken to address each.

MnDOT's Office of Affirmative Action, Office of Technical Support and Office of Transit began conducting ADA Title II training in 2008. The training provides an introduction to ADA Title II requirements and is offered to local partners and MnDOT engineers/employees in maintenance, design, construction and planning.

In 2009, as a part of the development of MnDOT's Transition Plan, MnDOT Issued Technical Memorandum 10-02-TR-01 *Adoption of Public Rights of way Accessibility Guidance* to MnDOT staff, cities and counties. The memo makes Public Rights-of-Way Accessibility Guidelines (PROWAG) the primary guidance for accessible facility design on MnDOT projects. MnDOT is currently beginning the integration of PROWAG into the Road Design Manual and other technical guidance.

Since the adoption of the transition plan and PROWAG guidance MnDOT has conducted numerous trainings for MnDOT staff and its contractors to raise awareness and provide specific technical knowledge on providing accessibility in the public right of way. The primary training was conducted in 2011 and 2012 for MnDOT employees, cities, counties and consultants to provide an overview of the ADA, MnDOT's compliance direction and design training. Over 600 individuals participated in the training which has provided a more universal understating of ADA needs and Title II obligation. In subsequent years MnDOT has run classes for its construction inspectors

improve the quality of accessibility features which MnDOT routinely provides on all projects that meet or exceed that alterations threshold.

Program Location and Staffing

Managing and implementing the MnDOT ADA Transition Plan requires a multidisciplinary approach encompassing policy development, outreach, technical support and oversight. These responsibilities, required by 28 CFR 35.107, are be managed by two peer positions: the Title II Coordinator/ADA Implementation Coordinator, and ADA Design Engineer in MnDOT's Operations Division

The Title II Coordinator/ADA Implementation Coordinator is responsible for addressing complaints as they are received and tracking the overall progress of the implementation of the MnDOT Transition Plan. The Title II coordinator is also responsible for the investigation of all formal grievances made against MnDOT. To ensure the obligations of ADA and the Transition Plan are met the Coordinator develops policy and procedures to integrate Title II requirements into MnDOT practices The Implementation Coordinator also functions as chair of the Internal ADA committee, the co-chair of ADA Stakeholders group, and the agency lead for implementing Minnesota's Olmstead Plan.

The ADA Design Engineer works with the ADA Implementation Coordinator to develop policy and provide technical support for design and construction at a project level. The position also oversees three full time staff that provides support and direction for project scoping and development, design, and construction oversight when necessary. Specifically, the unit works with districts to scope their projects for accessibility and conducts design review prior to final signature. In addition to providing support for projects, this position will also be available to assist districts in implementing design options that address accessibility complaints.

Please refer to Appendix B for contact information.

Committee Structure

Overview

Due to the far reaching and ongoing implications of the ADA, collaboration is an important tool for MnDOT to identify issues and solutions that reflects the needs of the agency and users. To ensure that stakeholders are represented MnDOT has established three committees, one external and two internal, to assist and advise on ADA policy development. The committees function independent of each other to, but their input is coordinated by ADA Implementation Coordinator who a co-chair on all of

the committees. Detail on the roles and membership of the individual committees follows.

MnDOT's ADA Accessibility Advisory Committee

The MnDOT ADA Accessibility Advisory Committee (MAAAC) was created in 2008 to begin a constructive dialogue on accessibility issues and advise MnDOT on compliance with Title II of the ADA. Since MAAAC's inception, the advisory role has expanded from a focus on achieving Title II compliance to providing input on prioritizing funds for ADA projects, design feedback and communication tools. The committee's current representation was identified and established by the Title II Coordinator. MAAAC's membership is composed of individuals with differing disabilities, MnDOT representatives from the Bicycle and Pedestrian section, the Commissioner's Office, and the Office of Policy, Analysis, Research and Innovation, and representatives from the Minnesota State Council on Disability and the Metropolitan Council Transportation Advisory Committee.

The MAAAC meets monthly in working session type meetings to provide feedback on policy development, including the Transition Plan, and learn about MnDOT operations and advise on accessibility issues. Meetings are co-chaired by the ADA Implementation Coordinator a member elected from the external representation. MnDOT is not a voting member of the committee. MAAAC is currently re-evaluating its structure to identify and recruit a broader cross-section to represent more types of disabilities and provide geographic balance. Expected outcomes of the re-evaluation include an application process for membership and an annual work plan.

Americans with Disabilities Act Advisory Committee (ADAAC) -Disbanded

In 2007 MnDOT convened an internal advisory committee with representation from a cross section of functional areas to assist in the development of policy and practice to integrate ADA into MnDOT project delivery and operations. ADAAC met on a bi-monthly basis, with additional meetings called as needed. The committee focused on issues with programmatic impact and identifies key resources for resolution. The ADA Implementation Coordinator was the ADAAC chair. Committee membership included the following offices and sections:

- Affirmative Action
- Aeronautics
- Maintenance
- Transit
- Traffic, Safety and Technology
- State Aid

- Information Resource Management
- Bridge
- Bicycle and Pedestrian Section
- Construction
- Pre-Construction
- Maintenance
- Technical Support

In 2010 it was determined that ADA integration was largely under way and that representation of the above groups would be met through other standing committees and ADAAC was no longer needed

ADA Implementation Committee – Disbanded

The ADA Implementation Committee was identified as a need during the development of the transition plan as an interim approach to develop and expand the agency's knowledge base and information sharing for ADA design and policy. The committee comprised of one design or traffic engineer from each MnDOT district and staff from the Office of Traffic Safety and Technology, Geometrics, Program Delivery and the Bicycle and Pedestrian Section and was co-chaired by The ADA Implementation Coordinator and the ADA Design Engineer. The members functioned as points of contact and were responsible for tracking ADA requests in their district, providing technical support for projects and providing feedback to ADA policy and practice. The committee met from in January 2010 until January 2011.

Grievance Procedure

Under the Americans with Disabilities Act users of MnDOT facilities and services have the right to file a grievance if they believe MnDOT has not provided reasonable accommodation.

The Grievance Procedure required by 28 CFR 35.107 can be found in Appendix A of this report or on MnDOT accessibility website provides details on how to file a complaint. Under the Grievance Procedure, a formal complaint must be filed within 180 calendar days of the alleged occurrence. MnDOT will act or respond only to complaints made through the grievance process identified in Appendix A.

Communications

Under Section 35.160(a) of ADA, "…A public entity shall take appropriate steps to ensure that communications with applicants, participants, and members of the public with disabilities are as effective as communications with others." This means that

MnDOT is required to provide equally effective communication to individuals with disabilities. Equally effective communication can be provided by offering alternative formats, auxiliary aid(s) and/or services upon request. For example, interpreters are hired as requested for the hearing impaired and text materials that are accessible by screen readers are made available to users.

Website Communications

Background

State Law requires that all of the State of Minnesota's information systems comply with the 2009 MN Law to incorporate Section 508 of the Rehabilitation Act and the Web Content Accessibility Guidelines 3.0.

Minnesota IT (MnIT) is responsible for the development and dissemination of standard state processes, tools, and guidelines in place. This will enhance end user accessibility to state information systems, and make sure that all Minnesota citizens have access to the information they need.

MnDOT will fully comply with or exceed the standards set by MnIT regarding compliance with this law. MnDOT is participating in a committee to set the state standard, and will participate in future committees advising on needs for training and oversight. We anticipate that MnIT will set the standard at WCAG 3.0, compliance level AA.

Current compliance actions

Several years ago MnDOT redesigned its internal and external Web templates to improve their overall accessibility. For example, templates are now controlled by style sheets and styles are set for headers and subhead navigation items. All Web editors are required to use these templates for new and revised pages.

Our Rules for the Web include several items relating to accessibility. For example, all images much include "alt tags" and blinking or scrolling script is not allowed. All Web editors are required to follow these rules; however, we know that some older pages are not in compliance.

We also have an internal Web site that includes additional resources for Web writers and developers, including links to the WCAG 3.0 standards and our Rules for the Web.

Communications is developing training for word processing and other staff about preparing accessible Word and PDF documents. We are also working with contractors to ensure that documents prepared as part of a contract with MnDOT are compliant.

We have developed an external page www.dot.state.mn.us/ada that includes a variety of information about MnDOT and the ADA. This includes our transition plan, a way to file complaints with MnDOT, links to other transportation-related resources and tips about how to use our pages. A link to this page is included in the footer of every MnDOT Web page.

2014-2018 Goals

- Develop contract language and training for our consultant contracts to ensure that accessible documents are a required part of the deliverables.

- Review the Rules for the Web and the templates for compliance with WCAG 3.0 and make revisions as necessary. This step includes educating Web writers and developers about changes to the current standards.

- Develop and implement a plan for spot checking and ensuring compliance with WCAG for all new or redeveloped pages.

- Continue to work provide training for those who develop content that is posted on the web, with the highest priority being given to those who develop content that is seeking comment form the public.

Public Involvement

MnDOT recognizes that broad public participation is essential to the development of Minnesota's transportation system. As required by the ADA and MnDOT's public participation guidance Hear Every Voice, any public meeting, hearing, or comment period held by MnDOT is accessible. MnDOT provides qualified interpreters upon request and will provide documents in an accessible electronic format or other alternative formats, such as large print or Braille. All public notices shall contain contact information for accommodation requests.

Public meetings, trainings, programs and other events must be in an accessible location and indicated on the meeting notice. Project managers and other MnDOT staff are directed to use the Department of Justice Guide to Conducting Accessible Meetings to assist in planning public meetings.

Self-Evaluation

MnDOT, as required by Title II of ADA, must conduct a self-evaluation of physical assets and current policies and practices. MnDOT has identified seven areas that will need to have and maintain inventories. As inventories are updated, they will be the transition plan will be updated accordingly.

Fixed Work Sites

MnDOT owns and leases numerous buildings throughout the state. MnDOT has identified 46 buildings that are routinely accessed by the public. The 46 buildings were re-evaluated in 2013 for potential accessibility improvements. The buildings have been divided into two categories; Priority One and Priority Two. Priority One buildings are those buildings that have employee use and a high potential for public use. Priority Two buildings are those buildings that employees use and have moderate potential for public use. The evaluation of the worksites found that there are no major barriers to public access however there are numerous recommendations for minor accessibility improvements as ongoing maintenance work and renovations are conducted.

The status of the individual worksites can be found in the district breakdowns in Appendix C

Rest Areas

All rest areas and their associated elements are required to adhere to the 2010 ADA Standards. Minnesota State Building Code, Chapter 1341 also includes specific requirements related to accessibility. Some State accessibility requirements in Chapter 1341 are more restrictive than the 2010 ADA Standards.

In addition to the 2010 ADA Standards, the Code of Federal Regulations (CFR) includes regulations related to accessibility that apply to Interstate rest areas and historic rest areas and waysides:

- Interstate Rest Areas: 49 CFR 27.75 requires States to make Interstate rest area facilities accessible whenever the State uses federal financial assistance to improve the rest area or whenever the State uses federal financial assistance to construct, reconstruct or otherwise alter the roadway adjacent to or in the near vicinity of the rest area.
- Historic Rest Areas & Waysides: Several State rest areas and waysides are historic properties listed in or eligible for listing in the National Register of Historic Places or are designated as historic under an appropriate State or local law. 28 CFR 35.151(d) requires alterations comply, to the maximum extent feasible, with Section 4.1.7 of ADAAG.

In 1990, the Minnesota Department of Administration (DOA) contracted with architectural consultants to survey all buildings and facilities owned and managed by the State. The survey included MnDOT rest areas and waysides. Unfortunately, DOA completed the survey before the Federal government finalized ADAAG in 1991. MnDOT staff resurveyed all Class I rest areas by 1994 using ADAAG and recorded actual conditions and identified corrective measures required to comply. (See Appendix D)

In March 1994, the DOA approved a priority listing of MnDOT facilities. Additionally, during FY 1993-04 the DOA distributed $1,700,000 in State funds to MnDOT for ADA improvements to buildings and facilities. Since Travel Information Centers, Class I and II rest areas in the southern portion of the state receive the highest public use, MnDOT considers these facilities the highest priority for rest area accessibility improvements. MnDOT took action to correct then-current deficiencies at the highest priority facilities, except those actions deemed technically infeasible or where MnDOT had identified and scheduled the facility for comprehensive replacement in the near future.

Since 1991, MnDOT has designed and built all new rest area facilities, including buildings, site features and parking areas in compliance with then current ADAAG and Minnesota State Building Codes. Also, since that time, MnDOT has completed rest area rehabilitation and reinvestment projects that included corrective action to bring facilities into compliance with ADAAG and Minnesota State Building Code requirements. MnDOT has not corrected deficiencies at all lower priority facilities.

In 2007, MnDOT retained a consultant to conduct a comprehensive assessment of the physical condition of (49) Class I rest areas. The consultant found accessibility deficiencies at (46) of the rest areas evaluated. MnDOT estimates it would cost $1.9M-2.5M to correct the accessibility deficiencies found at the 46 Class I rest areas.

Accessible Pedestrian Signals (APS)

In 2008, MnDOT completed a statewide inventory of all 1,171 signalized intersections with push buttons that are owned and operated by MnDOT. As part of the inventory each intersection received a rating to determine the priority for conversion to an APS signal. The ranking of the intersections was done utilizing the methodology laid out in the National Cooperative Highway Research Project 3-62 *APS Prioritization Tool.* In general the signalized intersections with higher scores are the ones with the greatest need for conversion to APS, but the rankings are always considered within context so that the greatest needs are served first. Factors outside the ranking that affect an intersection's priority for APS include the number of pedestrians at the intersection, the presence of nursing homes, hospitals, transit, and other public services, and requests for APS. Each district traffic engineer will be responsible for determining which

intersections are priorities in their district, taking the intersection score and other factors into consideration.

MnDOT's policy is to install APS at any eligible intersection where an existing traffic signal has aged to the point of needing replacement. APS is also required for all new signals installed at eligible locations. Based on normal replacement intervals for aging signals, MnDOT expects to achieve 100 percent statewide APS compliance by the year 2030. Since the 2009 publication of the transition plan MnDOT has increased the total number of intersections with APS installations from 120 to 330 or 28 percent of the total system.

Curb ramps and sidewalks

At the time of the 2010 transition plan MnDOT had not completed the self-evaluation for sidewalks and curb ramp. Over the course of three summers each MnDOT district has located and cataloged all sidewalks and curb ramps on MnDOT right of way. The inventory includes both an accounting of the facilities and their condition. The system at the time of this writing consists of 617 miles of sidewalk and 19,324 curb ramps. An analysis of the each system and their condition follows.

Curb Ramps

In determining the compliancy of curb ramps MnDOT inventoried the locations and five accessibility elements for each curb ramp:

- Presence of a landing
- Landing slope – no more than 2% in any direction
- Ramp running slope – 5% - 8%
- Cross slope – no more than 2%
- Presence of detectable warnings

To be compliant under PROWAG a curb must meet all five requirements so even if one element is non-compliant the ramp technically does not meet accessibility requirements even though it may be usable. In reporting on MnDOT's compliance level we include all ramps that meet all five requirements and those that meet all requirements with the exception of having truncated domes. The reason for including both types of ramps is that truncated domes were not introduced as a requirement until 2001 and they are not a retrofit requirement meaning that a compliant ramp built prior to the requirement is still compliant until the alterations threshold is met. Of the 19,324 curb ramps on MNDOT's right of way of those 3543 or 18% are compliant.

Sidewalks

During the summer of 2013 districts completed an inventory of their sidewalks. The total system consists of over 600 miles of sidewalk on MnDOT right of way. The inventory includes an assessment of width, cross slope, barriers, and general condition. The most common deficiency in our network is the violation of cross slope at driveway. The total number of miles of sidewalk in MnDOT's system that is fully compliant is 263.5 miles.

Pedestrian Bridge Inventory

MnDOT owns 170 pedestrian bridges and underpasses throughout the state. Any pedestrian bridge or underpass crossing an interstate or state highway is the responsibility of MnDOT, unless an agreement has been made with a local government agency. The location and condition of all pedestrian bridges within MnDOT's right of way can be found in the district inventory in Appendix C. To be accessible, pedestrian bridges and underpasses must have a ramp leading up to the overpass, the ramp must meet the PROWAG standards for ramps, railings must meet the requirements found in the MnDOT Bikeway Facility Design Manual, the bridges must have a cross slope of no more than 2 % and a running slope of no more than 5%. Those that do not meet accessibility requirements according to PROWAG will be replaced as necessary. Bridges and underpasses that are compliant with the standards in place when they were built will require further discussion to determine the feasibility of compliance with PROWAG and the future of the structure in general.

Greater Minnesota Transit

As the administrating agency for Federal Transit Administration grant programs, MnDOT is required to ensure that grant recipients comply with the Americans with Disabilities Act. Specific transit-related aspects of ADA fall into two distinct categories: (1) ensuring that transit services and facilities are designed to allow access by individuals with disabilities and (2) ensuring that transit vehicles purchased with federal funds meet the accessibility standards of ADA.

With respect to the first function, the Office of Transit has developed tools for MnDOT staff to use to monitor ADA compliance as part of grant oversight. This includes checking that the telephone reservation system is accessible to all; schedulers capture necessary passenger information to ensure that the person's trip needs can be fully accommodated; ADA trip requests in Duluth, East Grand Forks, La Crescent, Mankato, Moorhead, Rochester and St. Cloud are not denied at a higher rate than other trip requests; system advertising and information is produced in a variety of formats; transit facilities are laid out with appropriate clearances and accessibility; etc.

Some older bus garages and administrative facilities are not fully ADA accessible, but the noncompliant elements do not provide a barrier to the services provided to the general public. As facilities are replaced or receive major remodeling they will be required to be constructed to current ADA and Minnesota Building code standards. Reasonable accommodations will be provided at all locations as needs are identified.

With respect to vehicle purchases, the Office of Transit maintains a full array of vehicle specifications – all of which meet the accessibility standards of ADA. All transit vehicles acquired with grants through MnDOT are fully ADA-compliant. Because this policy has been in place for many years, the current fleet acquired through MnDOT is ADA-accessible.

MnDOT's inventory of right of way features will include an assessment of the accessibility of transit stops on MnDOT right of way that have received funding from MnDOT. To be accessible, bus stop boarding and alighting areas must provide a clear length of 8 feet minimum, measured perpendicular to the curb or street or highway edge, and a clear width of 5 feet minimum, measured parallel to the street or highway. Bus stop boarding and alighting areas must connect to streets, sidewalks, or pedestrian paths by a pedestrian access route. The grade of the bus stop boarding and alighting area must be the same as the street or highway, to the maximum extent practicable, and the cross slope of the bus stop boarding and alighting area must not be greater than 2 percent.

In addition to meeting the operations obligations of ADA MnDOT is reaching out to communities in the development of local service plans to ensure that as service is developed and expanded the needs of the Olmstead population are included.

Policies

In 2009, MnDOT contracted with an outside consultant to conduct an audit of its policies and procedures in order to identify areas where modifications may be needed to ensure full compliance with ADA Title II and Section 504. The study involved a review of over 200 policies and procedures that MnDOT uses to provide facilities, services, and programs to the public. Forty-one policies, primarily focused on project development and design, were identified as potentially needing improvement to integrate accessibility more consistently into MNDOT projects and operations. No policies were identified as a barrier to providing accessibility. MnDOT will be developing a systematic approach to ensure long-term compliance with ADA Title II and Section 504 for all policies and procedures. A listing of policies and procedures that MnDOT reviewed and their status can be found in Appendix E.

Maintenance

MnDOT is responsible for the seasonal and structural maintenance of its facilities. As part of the policy review identified in the Transition Plan, MnDOT is examining its current policies and procedures to improve maintenance for pedestrian facilities. MnDOT's Maintenance Office will be leading the policy development and is scheduled to have a policy identified by summer of 2011.

The policy will identify operation guidance for maintaining sidewalks. Guiding the discussion is Federal Code 23 U.S.C. § 116 which obligates a State DOT to maintain projects constructed with Federal-aid funding or enter into a maintenance agreement with the appropriate local official where such projects are located. The discussion will also address snow removal and ice treatment on sidewalks in accordance with 28 CFR § 35.133, which requires public agencies to maintain walkways in an accessible condition for all pedestrians, including persons with disabilities, with only isolated or temporary interruptions in accessibility. Part of this maintenance obligation includes reasonable snow removal efforts.

Correction Program

The Minnesota Department of Transportation is committed to addressing the barriers identified in the self-evaluation. Curb ramp improvements are required on all projects that meet the alteration thresholds. Facilities that are accessible, but do not meet PROWAG standards will continue to be improved through MnDOT's routine construction program. Facilities that are inaccessible and will not be improved in the course of a typical roadway project will be prioritized by districts as part of a separate barrier removal program. The funding and schedule of accessibility improvements that are being made as part MnDOT's routine construction program are determined through MnDOT's Statewide Transportation Improvement Plan (STIP).

Since 2010 MnDOT has improved numerous facilities around the state with a particular emphasis on curb ramps and during the last three construction seasons MnDOT has found that rote application of ADA policy and design does not immediately ensure accessible facilities. Emerging issues in our correction program include the role of right of way in alterations thresholds, the appropriate expansion of scope to ensure the right fix for achieving accessibility, and the quality of construction.

Much of MnDOT's construction program is focused on preserving our existing system and the project that we do typically have a very limited scope focused on working on pavement and working within our existing right of way. Often the improvement of accessible features requires that MnDOT obtain right of way or a temporary easement to construct the facility. Under Minnesota statues the process to obtain right of way

averages around eighteen months often longer than the project development time for the a pavement project. The ADA unit has been working with the districts at a project level to make certain that they are scoping projects with the entirety of ADA needs including right of way so that the proper facility can be built. Ensuring quality construction of accessible facilities is also an area of improvement for MnDOT. Under ADA the specifications provided for a facility do not include construction tolerances so it is important that facilities are built to design and are inspected to ensure that they meet our design requirements. MnDOT has developed contractor requirements and trains inspectors to address this issue, but we are still not at the performance level we desire.

Training

Part of MnDOT's adoption and implementation of Public Rights of Way Accessibility Guidelines and the Transition Plan, included agency-wide training on both design and policy. MnDOT has trained over 600 individuals which included MnDOT staff, cities and counties, and external partners on ADA and Title II in 2012 and 2013. MnDOT is looking at revising and resuming in 2015.

The training is based on policy, mobility needs and design. Modules identified for development and deployment in 2010 include:

- ADA and Title II overview and requirements
- Policy & Procedure
    - Public Involvement
    - Complaint Procedures
- Technical Training
    - PROWAG (Public Right OF Way Accessibility Guidelines)
    - Curb Ramps
    - APS (Accessible Pedestrian Signals)
    - Intersection Geometrics
    - Pedestrian Design & Planning
    - Maintenance, e.g., Inventory, Snow & Ice, Faulting, Maintenance Agreements
    - Bicycle & Pedestrian Planning

In addition to the ADA Overview training MnDOT's ADA Unit provides annual training to inspectors and presents at MnDOT's Signal Certification classes.

Appendix A

How to file a Grievance

The procedure to file a grievance is as follows:

1. A formal written grievance should be filed on ADA Grievance Form. An oral grievance can be filed by contacting ADA Title II Coordinator. The oral grievance will be reduced to writing by ADA Coordinator utilizing ADA Grievance Form. Additionally, individuals filing a grievance are not required to file a grievance with MnDOT, but may instead exercise their right to file a grievance with the Department of Justice.

    - The name, address, and telephone number of the person filing the grievance.
    - The name, address, and telephone number of the person alleging ADA violation, if other than the person filing the grievance.
    - A description and location of the alleged violation and the remedy sought.
    - Information regarding whether a complaint has been filed with the Department of Justice or other federal or state civil rights agency or court.
    - If a complaint has been filed, the name of the agency or court where the complaint was filed, and the date the complaint was filed.

2. The grievance will be either responded to or acknowledged within 10 working days of receipt. If the grievance filed does not concern a MnDOT facility, it will be forwarded to the appropriate agency and the grievant will be notified.

3. Within 60 calendar days of receipt, the ADA Title II Coordinator will conduct the investigation necessary to determine the validity of the alleged violation. If appropriate, ADA Title II Coordinator will arrange to meet with the grievant to discuss the matter and attempt to reach a resolution of the grievance. Any resolution of the grievance will be documented in MnDOT's ADA Grievance File.

4. If a resolution of the grievance is not reached, a written determination as to the validity of the complaint and description of the resolution, if appropriate, shall be issued by ADA Title II Coordinator and a copy forwarded to the grievant no later than 90 days from the date of MnDOT's receipt of the grievance.

5. The grievant may appeal the written determination. The request for reconsideration shall be in writing and filed with the Minnesota Department of Transportation Ombudsman within 30 days after the ADA Title II Coordinator's determination has been mailed to the grievant. MnDOT's Ombudsman shall

review the request for reconsideration and make a final determination within 90 days from the filing of the request for reconsideration.

6. If the grievant is dissatisfied with MnDOT's handling of the grievance at any stage of the process or does not wish to file a grievance through the MnDOT's ADA Grievance Procedure, the grievant may file a complaint directly with the United States Department of Justice or other appropriate state or federal agency.

   The resolution of any specific grievance will require consideration of varying circumstances, such as the specific nature of the disability; the nature of the access to services, programs, or facilities at issue and the essential eligibility requirements for participation; the health and safety of others; and the degree to which an accommodation would constitute a fundamental alteration to the program, service, or facility, or cause an undue hardship to MnDOT. Accordingly, the resolution by MnDOT of any one grievance does not constitute a precedent upon which MnDOT is bound or upon which other complaining parties may rely.

File Maintenance

MnDOT's ADA Coordinator shall maintain ADA grievance files for a period of three years.

Appendix B

ADA Program Contacts

Title II Coordinator

Lynnette M. Geschwind
395 John Ireland Blvd.
MS 200
St. Paul, MN 55155

Ph: 651-366-4717
Fax: 651-366-4155
E-mail: lynnette.geschwind@state.mn.us

ADA Implementation Coordinator

Kristie M. Billiar
395 John Ireland Blvd.
MS 670
St. Paul, MN 55155

Ph: 651-366-3174
Fax: 651-366-4155
E-mail: kristie.billiar@state.mn.us

ADA Design Engineer

Todd Grugel
395 John Ireland Blvd.
MS 670
St. Paul, MN 55155

Ph: 651-366-3531
Fax: 651-366-4155
E-mail: todd.grugel@state.mn.us

Appendix C

Inventory by MnDOT District

District 1 Asset Inventory

Buildings

T7910090221 - Duluth District Headquarters
T7915090143 - Grand Rapids Truck Station
T7915090123 - Virginia Maintenance Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	1755
Number of Non-Compliant Ramps	1445
Number of Compliant Ramps	310
Number of Compliant Ramps without Detectable Warnings	420
Number of Ramps with Compliant Slope and Cross Slope	892
Number of Ramps with Compliant Slope	1329

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
16006	PED-BIKE	TH 61	2009	Compliant
38014	SOIL	PED	2004	Compliant
5953	MN 23	PEDESTRIAN	1941	Excessive Running Grade on Bridge Deck

69122	MILLER CREEK	US 53	2003	Excessive Cross Slope on Bridge Deck and Approach Ramp
Asset Number	**Featured Intersected**	**Facility Carried by Structure**	**Year Built**	**Compliant Issues**
69804	EXCURSION TRACKS	PEDESTRIAN	1989	Excessive Running Grade on Bridge Deck
69805	EXCURSION TRACKS	PEDESTRIAN	1989	Excessive Running Grade on Bridge Deck and Approach Ramp
69811	PED WALK WAY	PEDESTRIAN	1967	Excessive Running Grade on Bridge Deck
69838	I 35	PEDESTRIAN AT 17TH AVE E	1988	Excessive Running Grade and Cross Slope on Bridge Deck
69843	I 35	PEDESTRIAN AT 25TH AVE	1990	Excessive Running Grade on Bridge Deck
69853	KEENE CREEK	PEDESTRIAN	1973	Excessive Running Grade on Bridge Deck and Excessive Cross Slope on Approach Ramp
69855	DITCH	PEDESTRIAN	1973	Excessive Running Grade on Bridge Deck and Approach Ramp
69858	EB I35 RAMP & MICH RAMP	PEDESTRIAN	1989	Excessive Running Grade on Bridge Deck and Approach Ramp
69885	I 35 & TWO RAMPS	PEDESTRIAN AT MESABA	1968	Stairs
69885A	FILL	BIKEWAY AT MESABA	1987	Compliant

Sidewalks

Total Miles of Sidewalks	55.27
Sidewalks < 48" (Miles)	0.38
Cross Slopes > 2% (Miles)	21.96
Condition 1 Sidewalks (Miles) (Best Rating)	0.32
Condition 2 Sidewalks (Miles)	37.77
Condition 3 Sidewalks (Miles)	14.76
Condition 4 Sidewalks (Miles) (Worst Rating)	2.44

Driveways > 2% (Number)	926

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	29
Driveway	0
Hand Hold	1
Hydrant	0
Light Post	29
Mailbox	0
Manhole	1
Minor Gap	2
Narrows to less than 48"	8
Other	5
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	0
Signs	0
Slope Issues	0
Stairs	0
Street Furniture	0
Traffic Poles	2
Trees	6
Utility Cabinet	0
Vegetation	36

Accessible Pedestrian Signals

APS Push Buttons	103
Non-Compliant APS Push Buttons	22
APS Complaint Push Buttons	81
Number of APS Intersections	15
Total Number of Signalized Intersections	83

District 2 Asset Inventory

Buildings

T7920090330 - Bemidji District Headquarters
T7925090530 - Crookston Maintenance Headquarters
T7925090533 - Thief River Falls Truck Station

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	1291
Number of Non-Compliant Ramps	1129
Number of Compliant Ramps	162
Number of Compliant Ramps without Truncated Domes	296
Number of Ramps with Compliant Slope and Cross Slope	776
Number of Ramps with Compliant Slope	949

Pedestrian Bridges

There are no MnDOT owned pedestrian bridges in District 2.

Sidewalks

Total Miles of Sidewalks	58.42
Sidewalks < 48" (Miles)	0.49
Cross Slopes > 2% (Miles)	28.77
Condition 1 Sidewalks (Miles)	17.29
Condition 2 Sidewalks (Miles)	35.87
Condition 3 Sidewalks (Miles)	7.06
Condition 4 Sidewalks (Miles)	2.61
Driveways > 2% (Number)	1009

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	54
Driveway	0
Hand Hold	0
Hydrant	2
Light Post	43
Mailbox	1
Manhole	1
Minor Gap	17
Narrows to less than 48"	4
Other	4
Power Poles	0
Railroad Crossing	3
Sand, Gravel Mud	0
Signs	4
Slope Issues	1
Stairs	1
Street Furniture	0
Traffic Poles	5
Trees	3
Utility Cabinet	2
Vegetation	5

Accessible Pedestrian Signals

APS Push Buttons	34
Non-Compliant APS Push Buttons	20
APS Complaint Push Buttons	14
Number of APS Intersections	26
Total Number of Signalized Intersections	61

District 3 Asset Inventory

Buildings

T7930090443 - Baxter District Headquarters
MnROAD (Monticello)
T7935090735 - St. Cloud Maintenance Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2249
Number of Non-Compliant Ramps	1748
Number of Compliant Ramps	501
Number of Compliant Ramps without Truncated Domes	582
Number of Ramps with Compliant Slope and Cross Slope	1053
Number of Ramps with Compliant Slope	1576

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
6847	MN 23	PEDESTRIAN	1958	Stairs
73029	MN 15	PEDESTRIAN	1987	Compliant
73871	I 94	PEDESTRIAN	1977	Compliant

Sidewalks

Total Miles of Sidewalks	67.71
Sidewalks < 48" (Miles)	1.21
Cross Slopes > 2% (Miles)	24.48
Condition 1 Sidewalks (Miles)	14.48
Condition 2 Sidewalks (Miles)	38.75
Condition 3 Sidewalks (Miles)	12.74
Condition 4 Sidewalks (Miles)	1.34
Driveways > 2% (Number)	937

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	52
Driveway	0
Hand Hold	0
Hydrant	2
Light Post	55
Mailbox	6
Manhole	0
Minor Gap	10
Narrows to less than 48"	11
Other	3
Power Poles	8
Railroad Crossing	1
Sand, Gravel Mud	0
Signs	9
Slope Issues	0
Stairs	4
Street Furniture	6
Traffic Poles	7
Trees	10
Utility Cabinet	1
Vegetation	4

Accessible Pedestrian Signals

APS Push Buttons	318
Non-Compliant APS Push Buttons	136
APS Complaint Push Buttons	182
Number of APS Intersections	67
Total Number of Signalized Intersections	174

District 4 Asset Inventory

Buildings

T7940090616 - Detroit Lakes District Headquarters
T7940090615 - Fergus Falls Truck Station
T7940090658 - Moorhead Truck Station
T7945090820 - Morris Maintenance Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	1381
Number of Non-Compliant Ramps	1151
Number of Compliant Ramps	230
Number of Compliant Ramps without Truncated Domes	324
Number of Ramps with Compliant Slope and Cross Slope	676
Number of Ramps with Compliant Slope	899

Pedestrian Bridges

There are no MnDOT owned pedestrian bridges in District 4.

Sidewalks

Total Miles of Sidewalks	45.71
Sidewalks < 48" (Miles)	0.1
Cross Slopes > 2% (Miles)	26.59
Condition 1 Sidewalks (Miles)	24.42
Condition 2 Sidewalks (Miles)	16.4
Condition 3 Sidewalks (Miles)	3.56
Condition 4 Sidewalks (Miles)	4.68
Driveways > 2% (Number)	861

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	129
Driveway	41
Hand Hold	0
Hydrant	5
Light Post	53
Mailbox	9
Manhole	3
Minor Gap	7
Narrows to less than 48"	22
Other	6
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	0
Signs	11
Slope Issues	0
Stairs	3
Street Furniture	3
Traffic Poles	9
Trees	4
Utility Cabinet	0
Vegetation	0

Accessible Pedestrian Signals

APS Push Buttons	7
Non-Compliant APS Push Buttons	4
APS Complaint Push Buttons	4
Number of APS Intersections	18
Total Number of Signalized Intersections	64

District 6 Asset Inventory

Buildings

Albert Lea Truck Station
T7965091327 - Owatonna Maintenance Headquarters
Wilson Truck Station (Winona)

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2122
Number of Non-Compliant Ramps	1584
Number of Compliant Ramps	539
Number of Compliant Ramps without Truncated Domes	882
Number of Ramps with Compliant Slope and Cross Slope	1404
Number of Ramps with Compliant Slope	1551

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
50802	I 90	PEDESTRIAN	1997	Compliant
55019	US 63	PEDESTRIAN	1963	Stairs
55044	TH 52, FRONT RD	PEDESTRIAN AT 16th ST NW	2004	Compliant
85003	US 14	PEDESTRIAN (ST MARYS)	1963	Stairs
9218	CEDAR RIVER	PEDESTRIAN	1958	Compliant

Sidewalks

Total Miles of Sidewalks	66.54
Sidewalks < 48" (Miles)	0.58
Cross Slopes > 2% (Miles)	24.02
Condition 1 Sidewalks (Miles)	5
Condition 2 Sidewalks (Miles)	32.88
Condition 3 Sidewalks (Miles)	21.2
Condition 4 Sidewalks (Miles)	6.8
Driveways > 2% (Number)	1010

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	30
Driveway	0
Hand Hold	0
Hydrant	0
Light Post	5
Mailbox	0
Manhole	0
Minor Gap	4
Narrows to less than 48"	4
Other	2
Power Poles	0
Railroad Crossing	7
Sand, Gravel Mud	0
Signs	0
Slope Issues	0
Stairs	2
Street Furniture	0
Traffic Poles	1
Trees	9
Utility Cabinet	0
Vegetation	0

Accessible Pedestrian Signals

APS Push Buttons	63
Non-Compliant APS Push Buttons	19
APS Complaint Push Buttons	44
Number of APS Intersections	31
Total Number of Signalized Intersections	102

District 7 Asset Inventory

Buildings

Mankato District Headquarters
T7980091523 - Marshall District Headquarters
T7975091614 - Windom Maintenance Headquarters
T7975032119 - Worthington Scale

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2568
Number of Non-Compliant Ramps	2160
Number of Compliant Ramps	408
Number of Compliant Ramps without Truncated Domes	541
Number of Ramps with Compliant Slope and Cross Slope	1167
Number of Ramps with Compliant Slope	1628

Pedestrian Bridges

There are no MnDOT owned pedestrian bridges in District 7.

Sidewalks

Total Miles of Sidewalks	76.49
Sidewalks < 48" (Miles)	4.76
Cross Slopes > 2% (Miles)	29.84
Condition 1 Sidewalks (Miles)	17.45
Condition 2 Sidewalks (Miles)	45.61
Condition 3 Sidewalks (Miles)	9.63
Condition 4 Sidewalks (Miles)	3.8
Driveways > 2% (Number)	1045

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	33
Driveway	0
Hand Hold	0
Hydrant	1
Light Post	6
Mailbox	0
Manhole	3
Minor Gap	17
Narrows to less than 48"	1
Other	7
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	4
Signs	1
Slope Issues	0
Stairs	0
Street Furniture	1
Traffic Poles	3
Trees	2
Utility Cabinet	2
Vegetation	1

Accessible Pedestrian Signals

APS Push Buttons	105
Non-Compliant APS Push Buttons	20
APS Complaint Push Buttons	85
Number of APS Intersections	18
Total Number of Signalized Intersections	59

District 8 Asset Inventory

Buildings

T7980091030 - Hutchinson Truck Station
T7980091036 - Litchfield Truck Station
T7980091023 - Willmar District Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2019
Number of Non-Compliant Ramps	1801
Number of Compliant Ramps	218
Number of Compliant Ramps without Truncated Domes	390
Number of Ramps with Compliant Slope and Cross Slope	926
Number of Ramps with Compliant Slope	1328

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
43006	US 212	PEDESTRIAN	1971	Stairs

Sidewalks

Total Miles of Sidewalks	58.67
Sidewalks < 48" (Miles)	0.38
Cross Slopes > 2% (Miles)	24.74
Condition 1 Sidewalks (Miles)	34.05
Condition 2 Sidewalks (Miles)	18.17
Condition 3 Sidewalks (Miles)	5.09
Condition 4 Sidewalks (Miles)	1.11
Driveways > 2% (Number)	970

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	10
Driveway	0
Hand Hold	0
Hydrant	4
Light Post	20
Mailbox	0
Manhole	1
Minor Gap	0
Narrows to less than 48"	3
Other	1
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	1
Signs	6
Slope Issues	0
Stairs	4
Street Furniture	0
Traffic Poles	3
Trees	5
Utility Cabinet	0
Vegetation	2

Accessible Pedestrian Signals

APS Push Buttons	23
Non-Compliant APS Push Buttons	0
APS Complaint Push Buttons	23
Number of APS Intersections	12
Total Number of Signalized Intersections	52

Metro District Asset Inventory

Buildings

T7906092055 - Aeronautics
T7902092039 - Arden Hills Training Center
T7990092139 - Daytonport Scale
T7990090931 - Golden Valley District Headquarters
T7990091138 - Oakdale District Headquarters
Office of Materials and Road Research
T7900092043 - Plymouth Driver's License
T7990091194 - Waters Edge

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	7800
Number of Non-Compliant Ramps	6040
Number of Compliant Ramps	1832
Number of Compliant Ramps without Truncated Domes	2439
Number of Ramps with Compliant Slope and Cross Slope	4596
Number of Ramps with Compliant Slope	6223

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
02017	MN 47	PED @ 49th Ave	1967	Stairs
02021	MN 65	PEDESTRIAN	1970	Compliant
02022	MN 65 & Frontage Rd	PED @ 80th Ave NE	1973	Stairs
02044	US 10	Pedestrian	1997	Compliant
10048	US 212	PED/BIKE	2007	Compliant
10531	TH 5	PED	1995	Compliant
19025	US 52	PED @ Lewis St	1973	Excessive Running Grade on Bridge Deck and Approach Ramp

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
27003	I 94, Lyndale & Henn Av	PED at Whitney	1988	Excessive Running Grade on Approach Ramp
27004	Mississippi River	Ped at St Anthony	1883	Compliant
27012	TH 100	Ped at 26th St	1978	Excessive Running Grade on Approach Ramp
27028	TH 77	PED AT 88TH ST	1978	Compliant
27038A	TH 100	Ped Brooklyn Blvd	1976	Compliant
27038B	TH 100	Ped Brooklyn Blvd	1976	Compliant
27061	TH 121	PED at 61st St	1962	Stairs
27105	TH 100 & Vernon Ave	PED at 41st St	1968	Stairs
27135	US 12 & Ridgeview Dr	PED at Ridgeview	1970	Stairs
27202	TH 55 & NB off ramp	PEDESTRIAN	1998	Compliant
27220	TH 610	Pedestrian	1998	Excessive Running Grade on Approach Ramps
27272	TH 12 & BNSF RR	Luce Line Trail	2003	Compliant
27278	TH 12 & BNSF RR	Trail A	2005	Compliant
27284	TH 100	PED at 39th Ave	2000	Excessive Running Grade on Approach Ramp
27407	LEGION LAKE	TRAIL	2008	Compliant
27520	TH 62 & W 64th St	PEDESTRAIN	1963	Stairs
27530	TH 62	PED at 40th Ave S	1966	Stairs
27535	TH 62	PED at 14th Ave	1967	Stairs
27615	TH 100 & SB off ramp	Ped at 59th Ave N	1980	Compliant
27649	TH 100	Pedestrian Bridge	1983	Compliant
27685	TH 252	PED AT 85th AVE	2003	Complaint
27710	I 394	PED @ Pennsylvania	1989	Excessive Running Grade on Approach Ramp
27711	I 394	PED @ Florida Ave	1989	Excessive Running Grade on Approach Ramp
27755	I 394 & 394R Frontage Rd	PEDESTRIAN	1989	Compliant

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
27757	I 394, I394R & Frontage	PED @ Cedar Lake Rd	1988	Excessive Running Grade on Approach Ramp
27864	I 94 & I 694	PED @ Shingle Creek	1980	Compliant
27866	UP RAIL	PED Linden Avenue	1972	Compliant
27868	I 35W NB, TH 65 & STS	PED @ 24th St E	1971	Excessive Running Grade on Bridge Deck and Approach Ramp and Stairs
27908	ELM CREEK	PEDESTRIAN	1973	Compliant
27955	I 94 On/Off Ramps-Huron	PEDESTRIAN	1965	Stairs
27958	I 94	PED @ Seymour	1967	Compliant
27985	I 35W & NB off ramp	PED @ Summer St	1973	Excessive Running Grade on Approach Ramp
27987	I 35W & off-on ramps	PED @ 5th St SE	1971	Excessive Running Grade on Approach Ramps
27B42	US 169	PED-BIKE	2008	Compliant
27R15	MN 610/CSAH 81 railroad	Pedestrian bridge	2005	Compliant
27R17	Wet Lands	Pedestrian TH 610	2005	Compliant
27R30	US 212	PED/BIKE	2006	Compliant
27V57	I 494	PED AT MAYWOOD LN	2005	Compliant
4175	County 101 Minnesota R	Pedestrian	1927	Compliant
5114	TH 7	Recreation Trail	1934	Compliant
62023	Lafayette Rd (US 52)	PED at Winifred St	1969	Excessive Running Grade on Bridge Deck and Approach Ramp
62096	MN 36	PEDESTRIAN	2007	Compliant
62804	I 35E & Thompson St	Ped at Walnut St	1987	Excessive Running Grade on Approach Ramp
62809	I 94 & RAMP 16A	GRIGGS ST PED	2009	Compliant
62822	I 694	RECREATION TRAIL	1966	Compliant
62849	I 94	PED at ALDINE	1966	Excessive Running Grade on Bridge Deck and Approach Ramps

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
62868	I 94, Hudson & Pacific	PED at Maple	1973	Excessive Running Grade and Cross Slope on Approach Ramp
62869	I 94 EB on ramp	PED at Hazelwood	1974	Stairs
62872	I 35E	PED at Bayard Ave	1984	Excessive Running Grade on Approach Ramps
62X02	Ped Trail	TH 35E	2001	Compliant
6402	TH 36	BN Regional Trail	1954	Compliant
6512	I 35E	GATEWAY TRAIL	1960	Compliant
70536	US 169	PED E OF CSAH 17	2002	Compliant
70539	US 169	PED W OF CR 79	2002	Compliant
82012	GORGE	PED	1968	Compliant
82028	US 61, Hasting Ave, 7th	PED	2003	Compliant
82032	US 61 7th Ave BN &CP RR	PED	2003	Compliant
9078	I 494 & N & S Front Rds	PED at 2nd Ave S	1960	Stairs
9600F	Minnesota River	Ped Trail	1980	Compliant
9618	I 35W	PED at 40th St	1965	Compliant
9714	US 10	Pedestrian	1963	Compliant
9736	I 94	PED at Chatsworth	1964	Compliant
9737	I 94	PED at Mackubin St	1963	Compliant
9773	I 94	PED at Grotto	1963	Compliant
9888	I 35W	PED at 73rd Ave	1960	Stairs
9892	I 94	PED at 22nd Ave	1962	Excessive Running Grade on Approach Ramp
9895	TH 100, Frontage Roads	PED at S View Lane	1971	Excessive Running Grade on Bridge Deck
9896	TH 100, Frontage Roads	PED at Windsor Ave	1971	Excessive Running Grade on Bridge Deck and Approach Ramp

Sidewalks

Total Miles of Sidewalks	188.24
Sidewalks < 48" (Miles)	3.79
Cross Slopes > 2% (Miles)	64.61
Condition 1 Sidewalks (Miles)	42.07
Condition 2 Sidewalks (Miles)	115.37
Condition 3 Sidewalks (Miles)	25.96
Condition 4 Sidewalks (Miles)	4.84
Driveways > 2% (Number)	1143

Sidewalk Barriers

Bridge Joint	551
Damaged Panel	3289
Driveway	12
Hand Hold	24
Hydrant	8
Light Post	93
Mailbox	1
Manhole	36
Minor Gap	22
Narrows to less than 48"	40
Other	48
Power Poles	19
Railroad Crossing	13
Sand, Gravel Mud	39
Signs	20
Slope Issues	22
Stairs	13
Street Furniture	17
Traffic Poles	5
Trees	31
Utility Cabinet	5
Vegetation	319

Accessible Pedestrian Signals

APS Push Buttons	1238
Non-Compliant APS Push Buttons	719
APS Complaint Push Buttons	519
Number of APS Intersections	227
Total Number of Signalized Intersections	675

Appendix D

Rest Area Facility Condition Assessment

Facility Location	Cost	System	Correction	Distress	Qty	Unit
Adrian EB						
Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
East Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$4,199	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Damaged	2	Ea
\Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Damaged	1	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$1,017	Fittings	Install grab bars in accessible stall.	Missing	6	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Inadequate	2	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$824	Plumbing Fixtures	Provide protective insulation for exposed piping.	Missing	6	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Adrian EB Total	$64,673					
Adrian WB						
Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$4,057	Slab on Grade	Remove and replace concrete sidewalk, 4" wide	Damaged	100	L.F.
Main Building	$4,199	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Damaged	1	Ea
Main Building	$749	Fittings	Install mirror at accessible height	Inadequate	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage	Inadequate	4	Ea
Main Building	$1,017	Fittings	Install grab bars in accessible stall	Missing	6	L.F.
Main Building	$824	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	6	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea

Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Adrian WB Total	$65,379					

Anchor Lake

Site Features	$5,721	Site Development	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$749	Fittings	Install mirror at accessible height	Missing	2	Ea
Main Building	$2,280	Fittings	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$4,270	Fittings	Provide accessible service counter	Inadequate	14	L.F.
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$6,779	Communications & Security	Replace fire alarm control panel	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Anchor Lake Total	$75,341					

Baptism River

Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$2,880	Fittings	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$6,779	Communications & Security	Replace fire alarm control panel	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Baptism River Total	$63,572					

Beaver Creek

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
East Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Picnic Shelter East	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Picnic Shelter West	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Beyond Useful Life	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Main Building	$1,623	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	40	L.F.
Main Building	$24,345	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	600	L.F.
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Beaver Creek Total	$80,641					

Big Spunk

Site Features	$3,136	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	2	Ea
Site Features	$31,527	Pedestrian Paving	Construct & provide ADA conc. ramp and steps	Missing	40	L.F.
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
Main Building	$1,425	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Auto Parking	$607	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Inadequate	100	L.F.
Big Spunk Total	$93,944					

Blue Earth EB

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
East Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Blue Earth EB Total	$11,561					
Blue Earth WB						
North Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
South Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$1,171	Communications & Security	Replace public telephone	Inadequate	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Blue Earth WB Total	$8,087					

Burgen Lake

East Picnic Shelter	$1,623	Slab on Grade	Remove and replace concrete sidewalk 4' wide	Damaged	40	L.F.
West Picnic Shelter	$1,623	Slab on Grade	Remove and replace concrete sidewalk 4' wide	Damaged	40	L.F.
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Beyond Useful Life	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea

Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Burgen Lake Total	$47,302					

Cass Lake

Site Features	$3,136	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	2	Ea
Main Building	$1,190	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Cass Lake Total	$4,326					

Central Minnesota TIC

Site Features	$1,623	Slab on Grade	Remove and replace concrete sidewalk 4' wide	Damaged	40	L.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$1,566	Fittings	Replace directional signage	Inadequate	25	Ea
Main Building	$2,880	Fittings	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$4,270	Fixed Furnishings	Provide accessible service counter	Inadequate	14	L.F.
Central Minnesota TIC Total	$14,432					

Clear Lake

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$886	Plumbing Fixtures	Provide protective insulation for exposed piping	Inadequate	8	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Clear Lake Total	$68,935					

Dayton Port

Main Building Lobby	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building Men's Room	$8,497	Toilet Partitions	Replace toilet partitions	Damaged	3	Ea
Main Building Women's Room	$16,994	Toilet Partitions	Replace toilet partitions	Damaged	6	Ea

Dayton Port Total	$27,293					

Des Moines River

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
North Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
NW Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
South Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$4,199	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Beyond Useful Life	2	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$2,880	Plumbing Fixtures	Provide protective insulation for exposed piping	Inadequate	8	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Des Moines River Total	$56,306					

Dresbach TIC

Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Main Building	$1,624	Fittings	Toilet partitions laminate clad-overhead braced	Inadequate	1	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$13,004	Plumbing Fixtures	Replace drinking fountain	Inadequate	5	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$641	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	3	Ea
Auto Parking	$3,655	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Inadequate	910	L.F.
Dresbach TIC Total	$56,366					

Elm Creek

Site Features	$10,486	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	5	Ea
Patio Terrace	$6,524	Brick and Tile Plazas	Remove and replace asphalt sidewalk, 4' wide	Damaged	10	L.F.
Patio Terrace	$2,724	Brick and Tile Plazas	Replace expansion joints in concrete pavement	Damaged	50	L.F.
Main Building	$34,880	Slab on Grade	Mud jack floor slab.	Failing	500	S.F.
Main Building	$2,673	Exterior Doors	Repair aluminum frame and door	Inadequate	2	Ea
Elm Creek Total	$57,287					

Enfield

Site Features	$12,584	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	6	Ea
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
Main Building	$15,279	Exterior Doors	Automatic door opener on existing door	Missing	2	Ea
Main Building	$1,498	Fittings	Install mirror at accessible height.	Inadequate	4	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Enfield Total	$31,301					

Enterprise

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Enterprise Total	$36,038					

Fishers Landing

Site Features	$1,568	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	1	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,186	Fittings	Install grab bars in accessible stall.	Missing	7	L.F.
Main Building	$406	Fittings	Replace accessible restroom signage.	Inadequate	2	Ea
Main Building	$24,395	Floor Finishes	Replace quarry tile floor	Damaged	800	S.F.
Main Building	$720	Plumbing Fixtures	Provide protective insulation for exposed piping	Inadequate	2	Ea
Main Building	$4,270	Fixed Furnishings	Provide accessible service counter	Inadequate	14	L.F.
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Fishers Landing Total	$92,638					

Forest Lake

Site Features	$5,704	Site Development	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Main Building	$15,379	Exterior Doors	Automatic door opener on existing door	Missing	2	Ea
Main Building	$3,105	Identifying/ Visual Aid Specialties	Renew System	Beyond Useful Life	1	Ea
Main Building Lobby	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Forest Lake Total	$25,890					

Frazee

Main Building	$1,650	Exterior Doors	Repair aluminum storefront door	Damaged	3	Ea
Frazee Total	$1,650					

Fuller Lake

Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$15,709	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Beyond Useful Life	2	Ea
Main Building	$899	Fittings	Install mirror at accessible height	Missing	2	Ea
Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$2,439	Floor Finishes	Replace quarry tile floor	Damaged	80	S.F.
Main Building	$720	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Fuller Lake Total	$58,778					

General Andrews

Site Features	$6,292	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$275	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	2	Ea
Auto Parking	$2,413	Parking Lots	Re-Align & Re-stripe Parking Space for ADA Access	Inadequate	800	L.F.
Auto Parking	$2,204	Parking Lots	Replace Metal Reserved Parking Sign and Post	Missing	3	Ea
General Andrews Total	$11,184					

Goose Creek

Site Features	$4,704	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$6,086	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Inadequate	150	L.F.
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Inadequate	1	Ea
Main Building	$2,155	Identifying/ Visual Aid Specialties	Renew System	Beyond Useful Life	1	Ea
Main Building Lobby	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Auto Parking	$1,060	Parking Lots	Realign & Re-stripe Parking Space for ADA Access	Inadequate	264	L.F.
Goose Creek Total	$23,660					

Gooseberry Falls

Site Features	$3,217	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$730	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Damaged	12	L.F.
Auto Parking	$3,956	Parking Lots	Re-Align & Re-stripe Parking Space for ADA Access	Inadequate	1120	L.F.
Gooseberry Falls Total	$7,906					

Hansel Lake

Site Features	$2,164	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Inadequate	200	S.F.
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building.	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Hansel Lake Total	$55,892					

Hayward

Site Features	$413	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	3	Ea
East Picnic Shelter	$507	Site Earthwork	Remove & Replace Concrete Sidewalk, 4' wide	Damaged	10	L.F.
West Picnic Shelter	$507	Site Earthwork	Remove & Replace Concrete Sidewalk, 4' wide	Damaged	10	L.F.
Main Building	$5,665	Fittings	Replace toilet partitions	Inadequate	2	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Hayward Total	$59,011					

Heath Creek

North Picnic Shelter	$10,052	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	15	C.S.F.
Main Building	$609	Fittings	Replace accessible restroom signage.	Inadequate	3	Ea
Heath Creek Total	$10,661					

High Forest

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
High Forest Total	$38,114					

Kettle River

Site Features	$8,389	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	4	Ea
Auto Parking	$2,204	Parking Lots	Replace Metal Reserved Parking Sign and Post	Missing	3	Ea
Auto Parking	$2,413	Parking Lots	Realign & Re-stripe Parking Space for ADA Access	Missing	800	L.F.
Kettle River Total	$13,006					

Lake Iverson

Site Features	$6,872	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	3	Ea
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$25,492	Fittings	Replace toilet partitions	Damaged	9	Ea
Main Building	$812	Fittings	Replace accessible restroom signage	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Lake Iverson Total	$84,059					

Lake Latoka

Picnic Shelter East	$2,029	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	50	L.F.
Picnic Shelter West	$2,029	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	50	L.F.
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Lake Latoka Total	$5,860					

Lake Pepin

Site Features	$6,086	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Inadequate	150	L.F.
North Picnic Shelter	$1,420	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Inadequate	35	L.F.
South Picnic Shelter	$923	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Inadequate	35	L.F.
Auto Parking	$1,060	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Missing	264	L.F.
Lake Pepin Total	$9,489					

Middle Spunk

Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea

Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$4,704	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$2,434	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Inadequate	60	L.F.
Auto Parking	$607	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Inadequate	100	L.F.
Middle Spunk Total	$66,281					

MN Valley

Main Building	$15,279	Interior Doors	Automatic door opener on existing door	Inadequate	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$1,017	Fittings	Install grab bars in accessible stall.	Missing	6	L.F
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$2,880	Plumbing Fixtures	Provide protective insulation for exposed piping.	Missing	8	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
MN Valley Total	$58,162					

Moorhead

Site Features	$1,845	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	1	Ea
Moorhead Total	$1,845					

New Market

Main Building	$609	Fittings	Replace accessible restroom signage.	Inadequate	3	Ea
Site Features	$3,275	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
West Picnic Shelter	$10,052	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	15	C.S.F.
New Market Total	$14,074					

Oak Lake

Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,186	Fittings	Install grab bars in accessible stall.	Missing	7	L.F
Main Building	$2,439	Floor Finishes	Replace quarry tile floor	Damaged	80	S.F.
Main Building	$720	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea

Site Features	$3,136	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	2	Ea
East Picnic Shelter	$811	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Damaged	10	L.F.
Oak Lake Total	$47,914					

Oakland Woods

Main Building	$863	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$4,367	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	4	Ea
Oakland Woods Total	$58,737					

Rum River

Main Building	$2,339	Identifying/ Visual Aid Specialties	Renew System	Beyond Useful Life	1	Ea
Main Building	$1,042	Cabinets & Counters	Renew System	Beyond Useful Life	1	Ea
Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Inadequate	1	Ea
Main Building Men's Room	$5,665	Toilet Partitions	Replace toilet partitions	Damaged	2	Ea
Main Building Women's Room	$11,330	Toilet Partitions	Replace toilet partitions	Damaged	4	Ea
Main Building Women's Room	$6,479	Plumbing Fixtures	Replace lavatory vitreous china	Inadequate	8	Ea
Site Features	$6,292	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$4,057	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Missing	100	L.F.
Rum River Total	$46,278					

St. Croix TIC

Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Site Features	$10,486	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
St. Croix TIC Total	$11,921					

Straight River NB

Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$6,779	Communications & Security	Replace fire alarm control panel	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Main Building	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea

East Picnic Shelter	$6,006	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	10	C.S.F
West Picnic Shelter	$8,828	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	10	C.S.F
West Picnic Shelter	$3,483	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Damaged	10	L.F
Straight River NB Total	$60,911					

Straight River SB

Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
East Picnic Shelter	$3,003	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$6,006	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	10	C.S.F
Straight River SB Total	$12,154					

Thompson Hill

Main Building	$13,556	Fittings	Install grab bars in accessible stall	Missing	80	L.F.
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Site Features	$2,097	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Missing	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Thompson Hill Total	$51,098					

Watonwan

Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$1,092	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Missing	1	Ea
Site Features	$3,289	Water Supply	Install Domestic Water Faucet Piping and Drain	Missing	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Watonwan Total	$57,861					

Worthington TIC

Main Building	$431	Exterior Doors	Repair aluminum door	Damaged	1	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$3,660	Fittings	Provide accessible service counter	Inadequate	12	L.F.

Main Building	$812	Fittings	Replace accessible restroom signage	Inadequate	4	Ea
Main Building	$25,492	Fittings	Replace toilet partitions	Damaged	9	Ea
Main Building	$1,073	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$3,604	Communications & Security	Replace public telephone	Inadequate	2	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Worthington TIC Total	$94,354					

Grand Total	**$1,942,175**

Note: The following Rest Areas have no ADA Deficiencies: Brainerd Lakes Welcome Center, Albert Lea TIC, and Marion Rest Area

Appendix E

Policies and Procedures under Review by MnDOT

2008 Signal & Lighting Certification Manual	Revised 2010
60% REVIEW CHECKLISTS	N/A
95% REVIEW CHECKLISTS	N/A
Accessibility Grievance Procedure	Revised
ADA Checklist	Revised
ADA IMPLEMENTATION PLAN FOR METRO DESIGN	Revised
D-7 PRESERVATION PROJECT GUIDELINES	N/A
Design Layout Checklist	N/A
GDSU Process of Layout Review	N/A
Guidebook for Minnesota Public Transit Providers	Retired
Guideline for the Application of Tubular Markers and Weighted Channelizers	No impact to accessibility
Guidelines for Changeable Message Sign (CMS) Use	No impact to accessibility
Hear Every Voice (HEV): MnDOT Public and Stakeholder Participation Guidance	Compliant
Hear Every Voice II: Public Involvement Guidance 2008	Compliant
HPDP Accessibility Requirements	Revision in 2015
HPDP Geometric Layouts	N/A
Layout Approval Process	Not found
Maintenance Manual	Revision pending
Minnesota Manual on Uniform Traffic Control Devices (Mn MUTCD) CH 4E	Revised
MnDOT Road Design Manual (RDM)	Chapter 11-3 Revised 2010
MnDOT Traffic Signal Timing and Coordination Manual	
No Passing Zone Workbook	No impact to accessibility
Off-site accessibility checklist	Not found
OLM's Right of Way Manual section 5-491.810	N/A
Scoping and Cost Estimating	Compliant
Scoping Worksheets	Compliant
Standard Plan - Acceleration and Deceleration Lane (Urban) Rigid Design (5-297.210)	No impact to accessibility
Standard Plate 7105C	No impact to accessibility
Standard Plate 7107H	No impact to accessibility
Standard Plate 7108F	No impact to

	accessibility
Standard Plate 7109C	No impact to accessibility
Standard Plate 7113A	No impact to accessibility
Standard Plate 8400E Pipe Railing	Needs revision
Standard Plate 8401 At grade pipe railing	Needs revision
Standard Plate Pedestrian installation	Not Found
Standard Sign Summary	Compliant
Standard Signs Manual	Compliant
Tech. Memo. Minnesota Work Zone Safety and Mobility Policy	Revised 2010
Tech. Memo. Pedestrian Countdown Signals (PCSs) Usage.	No impact to accessibility
TRAFFIC ENGINEERING MANUAL	Revised
Work Zone Field Handbook	Revised

Appendix F

Inventory Attributes for Sidewalks, APS Signals, and Curb Ramps

Below is listing of the data that was collected for determining the accessibility of sidewalks, signals, and curb ramps in MnDOT's right of way.

Sidewalk Attributes

Pedestrian Activity

Sidewalk Width

Sidewalk Material

Boulevard Width

Boulevard Material

Cross Slope

Condition Rating

Signal Attributes

Intersection ID

APS Present

Walk Signal Present

Countdown Present

Pedestrian Phase Activation

Push Button Location

Push Button on correct side

Push Button Landing Area

Push Button Landing Slope

Push Button Landing Location

Push Button Height

Push Buttons 10' Apart

Photo

Curb Ramp Attributes

Intersection ID

Pedestrian Activity

Ramp Type

Location

Truncated Domes

Pedestrian Landing Area

Pedestrian Landing Slope

Ramp Width

Running Slope

Cross Slope

Condition Rating

Gutter In Slope

Gutter Flow Slope

Photo

Appendix G

Glossary of Terms

ABA: See Architectural Barriers Act.

ADA: See Americans with Disabilities Act.

ADA Transition Plan: MnDOT's transportation system plan that identifies accessibility needs, the process to fully integrate accessibility improvements into the Statewide Transportation Improvement Program (STIP), and ensures all transportation facilities, services, programs, and activities are accessible to all individuals.

ADAAG: See Americans with Disabilities Act Accessibility Guidelines.

Accessible: A facility that provides access to people with disabilities using the design requirements of the ADA.
Accessible Pedestrian Signal: A device that communicates information about the WALK phase in audible and vibrotactile formats. Also known as APS.

Alteration: A change to a facility in the public right-of-way that affects or could affect access, circulation, or use. An alteration must not decrease or have the effect of decreasing the accessibility of a facility or an accessible connection to an adjacent building or site.

Americans with Disabilities Act: The Americans with Disabilities Act; Civil rights legislation passed in 1990 and effective July 1992. The ADA sets design guidelines for accessibility to public facilities, including sidewalks and trails, by individuals with disabilities. Also known as ADA.

Americans with Disabilities Act Accessibility Guidelines: ADAAG contains scoping and technical requirements for accessibility to buildings and public facilities by individuals with disabilities under the Americans with Disabilities Act (ADA) of 1990.

APS: See Accessible Pedestrian Signal.

Architectural Barriers Act: Also known as ABA.

Class I Rest Areas: Rest area buildings are open 24 hours per day and offer modern facilities, drinking fountains, display case maps, travel displays, vending machines and public phones. They feature picnic facilities; lighted walkways; and lighted car, recreational vehicle and commercial truck parking lots.

Class II Rest Area: Class II rest areas feature vault toilet facilities with separate facilities for men and women, a water well, picnic facilities, paved parking lots and other site amenities. They are seasonally operated.
Detectable Warning: A surface feature of truncated domes, built in or applied to the walking surface to indicate an upcoming change from pedestrian to vehicular way.

DOJ: See United States Department of Justice
Federal Highway Administration (FHWA): A branch of the US Department of Transportation that administers the federal-aid Highway Program, providing financial assistance to states to construct and improve highways, urban and rural roads, and bridges.

FHWA: See Federal Highway Administration

PROWAG: An acronym for the *Guidelines for Accessible Public Rights-of-Way* issued in 2005 by the U. S. Access Board. This guidance addresses roadway design practices, slope, and terrain related to pedestrian access to walkways and streets, including crosswalks, curb ramps, street furnishings, pedestrian signals, parking, and other components of public rights-of-way.

Right of Way: A general term denoting land, property, or interest therein, usually in a strip, acquired for or devoted to transportation purposes. “Right of way” also may mean the privilege of the immediate use of the highway. (MN 169.01 Subd. 45)

Section 504: The section of the Rehabilitation Act that prohibits discrimination by any program or activity conducted by the federal government.

Travel Information Centers: Travel Information Centers (TICs) and Regional Welcome Centers are Class I rest areas that offer expanded customer services and feature a staffed travel information counter. The TICs offer a broad range of statewide travel information while the Welcome Centers provide more regional travel information.

Statewide Transportation Improvement Program: The Statewide Transportation Improvement Program (STIP) is Minnesota’s four year transportation improvement program. The STIP identifies the schedule and funding of transportation projects by state fiscal year (July 1 through June 30). It includes all state and local transportation projects with federal highway and/or federal transit funding along with 100% state funded transportation projects. Rail, port, and aeronautic projects are included for information purposes. The STIP is developed/updated on an annual basis.

STIP: See Statewide Transportation Improvement Program

Uniform Accessibility Standards (UFAS): Accessibility standards that all federal agencies are required to meet; includes scoping and technical specifications.

United States Access Board: An independent federal agency that develops and maintains design criteria for buildings and other improvements, transit vehicles, telecommunications equipment, and electronic and information technology. It also enforces accessibility standards that cover federally funded facilities.

United States Department of Justice: The United States Department of Justice (often referred to as the Justice Department or DOJ), is the United States federal executive department responsible for the enforcement of the law and administration of justice.

EXHIBIT 6-12: TR 4B: MCOTA'S ALIGNMENT WITH OLMSTEAD PLAN

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REPORT TO THE OLMSTEAD SUBCABINET

REPORT TO SUBCABINET ON

MCOTA'S WORKPLAN ALIGNMENT WITH MINNESOTA'S OLMSTEAD PLAN

ACTION ITEM 4B

AUTHORS:
MINNESOTA DEPARTMENT OF TRANSPORTATION

SUBMISSION DATE:
JANUARY 20, 2015

ACCEPTANCE DATE:
ADOPTION DATE
SUBMISSION TO COURT DATE:

Table of Contents

EXECUTIVE SUMMARY

The following is a report to the sub-cabinet on MCOTA's alignment with the Minnesota Olmstead Plan

PURPOSE

This report lays out the recommendation that MCOTA no longer be an action item in Minnesota's Olmstead Plan

BACKGROUND

The Minnesota Council on Transportation Access (MCOTA) was established by the Minnesota Legislature in 2010 (Minn. Statute 2010 174.285) to "study, evaluate, oversee, and make recommendations to improve the coordination, availability, accessibility, efficiency, cost-effectiveness, and safety of transportation services provided to the transit public." The Council succeeds the Interagency Committee on Transit Coordination (ICTC), which was established in 2005 by Minnesota Governor Tim Pawlenty.

Due to the cross agency nature of providing transportation for the Olmstead population MnDOT looked to MCOTA as potential venue to begin the cross agency conversation that will be needed to identify needs and expand overall awareness of Olmstead obligations.

APPROACH

Since June of 2013 MnDOT's agency lead has been providing updates to MCOTA's members on the progress on Minnesota's Olmstead Plan. The relationship has proved to be useful for primarily exchanging information, and the strategic actions focused on gathering baseline information have benefited from already planned MCOTA research.

LIMITATIONS

The primary limitation of this action item is that is process focused and the connection to a more concrete strategic direction to directly contribute to Olmstead's population based outcomes does not exist.

The MCOTA strategic directions inform and influence the member State agencies, which in turn attempt to influence and inform the local transportation agencies and organizations. The decisions as to the delivery of transportation service are the responsibility of the local transportation agencies and organizations. The Olmstead measurable outcomes are directly tied to the service delivery decisions at the local level.

COMMUNITY INVOLVEMENT

MCOTA follows Minnesota's open meeting law.

EFFECTS ON INDIVIDUALS' LIVES

MCOTA provides a process and support function for agencies and has not identified a measurable outcome for individuals' lives

RECOMMENDATIONS

While, many strides have been made in creating greater awareness on Olmstead needs among a broader group of transportation stakeholders MnDOT, in conjunction with the MCOTA membership, has determined that inclusion of MCOTA in the Olmstead Plan will be discontinued. The primary reason is that MCOTA's charge is advisory and the Olmstead Plan is seeking direct measurable impact to furthering Minnesota's Olmstead Plan which MCOTA is outside of MCOTA's purview. MnDOT does see value in the maintaining a connection and MnDOT's Olmstead agency lead will continue to provide updates on Olmstead progress to MCOTA and recommend Olmstead based research for consideration in MCOTA's work plan. A copy of MCOTA's current work plan is provided for reference.

NEXT STEPS

MnDOT is in the process of developing local level alternatives to replace MCOTA in the transportation section of Minnesota's Olmstead Plan. Three recommendations of potential replacements are below.

INCLUSIVE TRANSIT PLANNING

MnDOT in partnership with DHS will identify and provide technical assistance to transit systems on best models for increasing the participation of people with disabilities in the design and implementation of responsive, coordinated transportation systems.

ENHANCING COMMUNICATIONS

MNDOT will provide technical assistance on improving persons with disabilities access to transit through improved communication techniques. These techniques may include: travel training, driver sensitivity training and improved signage.

DEVELOPMENT OF PERFORMANCE MEASURES

MnDOT in partnership with DHS will identify key measures for determining increased access by persons with disabilities. These measures may include: overall disabled ridership, customer satisfaction responses, and level of investment.

EXHIBIT 6-13: SS 2G/SS 2G.1 – REPORT ON OTHER SEGREGATED SETTINGS

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Minnesota Olmstead Plan: Demographic Analysis, Segregated Settings Counts, Targets and Timelines

Continuing Care Administration

Children and Family Services Administration

September 30, 2014

For more information contact:

Minnesota Department of Human Services
Disability Services Division
St. Paul, MN 55101
651-431-4262

This information is available in accessible formats to individuals with disabilities by calling 651-431-4262,
Or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

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Olmstead Plan Language

Housing section

Action One: Identify people with disabilities who desire to move to more integrated housing, the barriers involved, and the resources needed to increase the use of effective best practices

- *By September 30, 2014 data gathering and detailed analysis of the demographic data on people with disabilities who use public funding will be completed.*

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 50.

Supports and Services section

Action Two: Support people in moving from institutions to community living, in the most integrated setting

For individuals in other[1] segregated settings:

- *By September 30, 2014 DHS will identify a list of other segregated settings, how many people are served in those settings, and how many people can be supported in more integrated settings.*
- *By September 30, 2014 DHS will review this data and other states[2] plans for developing most integrated settings for where people work and live. Based on this review DHS will establish measurable goals related to demonstrating benefits to the individuals intended to be served and timelines for moving those individuals to the most integrated settings.*

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 64.

Introduction

Minnesota's Olmstead Plan goal is to ensure that Minnesota is a place where people with disabilities live, learn, work and enjoy life in the most integrated setting. Services and supports that enable people to exercise their right of self-determination, to live in the most-integrated settings and to be able to freely participate in their communities will be appropriate to their needs and of their choosing.

To achieve this, the Olmstead Plan sets goals and identifies strategic actions in the following areas: employment, housing, transportation, supports and services, lifelong learning and education, healthcare and health living, and community engagement.

[1] In the Olmstead Plan, immediately preceding this quoted section, is a list of actions and measures related to certain segregated settings: Intermediate Care Facilities for Persons with Developmental Disabilities, nursing facilities (specifically for people under 65 who are there more than 90 days), Anoka Metro Regional Treatment Center, Minnesota Security Hospital and Minnesota Specialty Health System-Cambridge. The term used here, "other segregated settings", refers to places other than these previously listed five settings.

[2] "In particular, DHS will review plans from Massachusetts, Oregon, and Rhode Island."

This report focuses on moving people on increasing the number of people living in the most integrated settings and decreasing the number of people living unnecessarily in segregated settings.

The State must better align the design and provision of supports and services with these outcomes. The culture surrounding the delivery of supports and services will be based on a holistic approach to supporting people. Many factors influencing quality of life will have to come together, such as expectations and aspirations, skills developed over a lifetime, personal supports, location of one's home and transportation options.

Increasing flexibility and options in all of these areas will require collaboration among divisions within state agencies, across state agencies, with providers, businesses, community organizations and, of course, people with disabilities and their families.

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

- Increase in the number of people living in most integrated settings
- Decrease in people living unnecessarily in segregated settings
- Increase in the quality of life as reported by people with disabilities, using indicators described in the Quality Assurance section of the plan
- People will have timely transitions back to their community from hospital care or short-term institutional care

Background Information

People with disabilities in Minnesota receive long-term supports and services either in what we consider an institutional setting or through home and community based services. Home and community based services include home care and personal care assistant services covered through the Medicaid state plan, the Alternative Care program, the Elderly Waiver and the disability waivers.

In state fiscal year 2013, 93 percent of people with disabilities and 68 percent of older adults received their long-term supports and services through home and community based services (83 percent across both populations combined). Of those, 73 percent of people with disabilities and 76 percent of older adults received those services in their own homes.

Related Olmstead actions

This report was produced in conjunction with the Olmstead Plan actions cited on page one. There are several other closely related Olmstead Plan actions. This report includes demographic and baseline data about people receiving services in potentially segregated settings and lays out targets and timelines for moving people to more integrated settings. The related actions are what the state is planning to do, or currently implementing, to achieve those goals.

The plan lays out several actions to promote person-centered practices which identify people who would like to move to a more integrated setting, and those who would not be opposed to such a move. The plan includes actions to support people in more integrated settings and improve the quality of life of people with disabilities.

The plan includes developing and implementing transition protocols to support successful transitions. There are specific, measurable targets for transitioning individuals from Intermediate Care Facilities for

Developmental Disabilities (ICF-DDs), nursing facilities, the Minnesota Specialty Health System facility in Cambridge, the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital.

There are several actions in the plan that will identify people with disabilities who are exiting state correctional facilities, including youth who are leaving juvenile facilities, and connect them with appropriate services and supports upon release.

There are several actions in the plan related to increasing the use of positive practices. The plan also includes actions to increase planning in order to reduce crises and to respond quickly and effectively when crises do occur.

The plan directs the state to change the way prioritization for accessing limited services (waiver wait list) so that those who want to move to a more integrated setting will be able to access the necessary home and community-based supports in a reasonable amount of time.

The plan includes actions to increase flexibility of and access to certain services and supports.

The state has developed plans to provide training and technical assistance to services providers who have business models structured around segregated and non-competitive employment to transition their service delivery model to integrated, competitive employment models.

There are several Olmstead Plan actions related to housing that will facilitate meeting the state's targets and timelines for transitioning people from segregated to more integrated settings. One strategic action is to increase housing options that promote choice and access to integrated settings by reforming the Group Residential Housing (GRH) and Minnesota Supplemental Aid (MSA) Housing Assistance programs. The goal of the reform is to allow income supplement programs that typically pay for room and board in congregate settings to be more easily used in non-congregate settings. It is expected that this change would result in more people with disabilities transitioning from the potentially segregated settings identified in this report to more independent housing.

The plan also calls for increasing the availability of affordable housing. Another is to increase access to information about housing options. And, the plan includes actions to promote counties, tribes and other providers to use best-practices and person-centered strategies related to housing.

HCBS Settings Rule

Simultaneous to Minnesota's Olmstead Plan implementation, the Centers for Medicare and Medicaid Services (CMS) published a rule, effective March 17, 2014, outlining new requirements for states' Medicaid home and community-based services.

The intent of the rule is to ensure that individuals receiving long-term services and supports through home and community-based services programs have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate to meet the needs of the individual. The rule is designed to enhance the quality of home and community-based services and provide protections for people who use those services. The rule defines, describes and aligns requirements across the home and community-based services programs. It defines person-centered planning requirements for persons in home and community-based settings.

States have until March 17, 2019, to bring existing programs into compliance with the rule and must submit a plan to transition their existing home and community-based services waiver programs services

by that date. In Minnesota, this impacts the Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Individuals with Disabilities (CADI), Developmental Disabilities (DD), and Elderly Waiver (EW) programs. New programs under 1915(i), 1915(k) and any new 1915(c) will be required to be in full compliance from the date of implementation. In Minnesota, the new Community First Services and Supports (CFSS) program must meet this requirement.

The new federal HCBS rules require that individuals be afforded a real choice between settings in which they receive services. Minnesota's implementation of these rules will further the state's progress in implementing its Olmstead goals.

Process

Internal work groups

Two groups were convened to work on this project, one to develop the data set for measuring people in potentially segregated settings and another to analyze the data from a policy perspective and set the targets and timelines. The groups included data and policy experts from the Minnesota Department of Human Services Adult Mental Health, Children's Mental Health, Economic Assistance and Employment Support, Disability Services Division, Compliance Monitoring, and Chemical Health Divisions. The Department of Health and the Department of Employment and Economic Development also participated. This work has a direct link to the Olmstead Plan action to develop additional affordable housing and, therefore, included participation by the Minnesota Housing Finance Agency.

How people with disabilities were/will be involved in planning for community integration

Individuals can have significant impact on realizing their personal goals when their preferences as well as their needs are incorporated into assessment and service planning . Minnesota is currently rolling out MnCHOICES, which continues and enhances Minnesota's person-centered approach tailoring services to individual's strengths, preferences and needs. This major reform has been underway for several years and is now in the final stages of its staged roll-out.

People with disabilities also have the opportunity to participate as advocates and planning partners in shaping the future of Minnesota's HCBS system. A series of meetings and input sessions around the state were held as part of the preliminary planning for the HCBS settings rule implementation. Meetings specifically targeted for self-advocates were held to seek input in addition to other forums.

DHS also engaged stakeholders in providing input to the GRH/MSA reform efforts. This effort focused on receiving feedback regarding current housing options and barriers and comments on proposed future directions for this program. For this effort, six listening sessions were held throughout the state with over 450 participants, including people with disabilities and their families.

The Minnesota Department of Human Services conducts a biennial process to gather information about the current capacity and gaps in services and housing needs to support people with long-term care needs in Minnesota. The gaps analysis was originally focused on the needs of older persons but in 2011 the needs of children and adults with disabilities and/or mental illness were added to the study. As part of this process, people with disabilities, people with mental illness, older people and their families participated in focus groups to provide insights about long-term services and supports, based upon their personal experience. For the 2012/2013 study, focus groups were held in 16 communities across the state, with 260 individuals taking part. There were 110 people who participated by completing a short

on-line survey. Twenty-three percent of survey respondents identified as having a disability and 23 percent as parents and caregivers.

As part of the six-year Pathways to Employment initiative, the Department of Human Services, in conjunction with other state agencies, engaged people with disabilities and other stakeholders in a public process to identify what it will take to increase the employment of people with disabilities in Minnesota. Pathways supported three summits which brought together people with disabilities and other stakeholders with one focus—how to make employment the first and preferred choice of youth and adults with disabilities. Pathways also supported a series of events around the state, conversations with various disabilities sub-populations, that yielded nine policy briefs in the following areas: brain injury, mental health, Deaf-blindness, Deaf and hard of hearing, blindness, Autism Spectrum Disorder, intellectual/developmental disabilities, and physical disabilities.

Review of other state's plans (Olmstead Plan item SS 2G.2)

The policy work group that developed targets and timelines reviewed initiatives to reform state employment and day support services in Massachusetts, Oregon and Rhode Island. A chart showing their analysis of those plans is included in Appendix A.

The strategies that are being used by other states informed the development of Minnesota's implementation plans for increasing competitive employment and those plans informed the process for setting targets for competitive employment. The effort to support people to be competitively employed intersects with the targets to support people receiving day services in more integrated settings.

The strategies that Minnesota are pursuing include:

- Adopting an Employment First Policy
- Training and technical assistance to support day service providers to convert their service models from congregate and segregated, "sheltered workshop" day services to more individualized, person-centered approaches of community supports and competitive employment services
- Interagency collaboration to promote promising practices and coordinate services for transition-age youth
- Increasing expectations and work experiences
- Improved data system for tracking employment outcomes for students and adults with disabilities
- Documenting informed choice to enable tracking individuals' decisions and potential barriers to employment
- Service enhancements for people who are seeking competitive employment at minimum wages or higher
- Expanding self-advocacy and peer networks

Minnesota is using earned monthly income ≥$600/month as an indicator of competitive employment.

Our data base contains information about individuals' income, including what is earned income and what is the amount and type of unearned income. We recognize that many people have earned income, but would not necessarily be employed in what we consider "competitive employment"—that is, employment that is part of the regular workforce, not in a segregated setting, and which is compensated at a market rate. Minnesota is setting a relatively high threshold of monthly earned income to separate

those who have jobs that pay sub-minimum wages (more likely to be in segregated settings) from those who have jobs that pay at least a minimum wage.

This is an important distinction to keep in mind, particularly when comparing Minnesota to other states which may be using another benchmark, such as having *any* earned income as an indicator of employment. To illustrate this point, in 2013, 15.8 percent of people on a disability waiver have earned income over $250/month. (This is not the exact same population as used for the rest of our measures, but a number we've been tracking since 2007, and used here just for illustrative purposes).

Methodology

Available data sources

That data that is available comes from existing data systems that were designed for specific purposes. Therefore, there are many shortcomings with the data we have to inform and track our Olmstead implementation.

- Some data can only partially get at some questions
- Some data available for some of the people in the system but not for everyone
- Data fields that could be used, but which aren't reliably used or updated by the people who populate the data base.
- No data available to address some questions or track certain outcomes

MAXIS
MAXIS is a computer system used by state and county workers to determine eligibility for public assistance and health care. For cash assistance and food support programs, MAXIS also determines the appropriate benefit level and issues benefits.

For the purposes of this report, data from MAXIS were used to identify people with disabilities who receive benefits through the Group Residential Housing (GRH) program. This program pays for room and board costs related to living in a licensed or registered setting, as well as services for some people. GRH recipients were included in this report if they reside in one of the following settings: adult foster care, boarding care, board and lodge, board and lodge with special services, homeless shelter, housing with services establishment, or supervised living facility. For settings other than adult foster care, the individual had to be on the program for at least 90 days to be counted. This control sorted out people who are more likely to be living in a segregated setting, rather than passing through one on a temporary basis.

MMIS
Health care providers throughout the state – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in a Minnesota Health Care Program. These programs provide health care services to low-income families and children, low-income elderly people and individuals who have physical and/or developmental disabilities, mental illness or who are chronically ill.

For the purposes of this report, data from MMIS were used to identify people with disabilities who received long-term supports and services typically provided in licensed, and potentially segregated, settings.

Data limitations specific to this project

1. Olmstead Plan does not have measureable definitions or criteria to identify segregated settings
2. Current data bases have limited information regarding the type of settings in which people receive services
3. Current databases do not identify people who want to move to a more integrated setting
4. Current databases lack information required to indicate the type of setting in which the individual is being served (e.g., day/employment services settings). Therefore, it is also difficult, if not impossible, to track movement between settings with current databases.
5. Setting types, as recorded in DHS data systems, represent a wide variety of actual places where people live, and do not necessarily indicate how "integrated" a person in any particular setting is. For example, a person may receive customized living services in an assisted living residence which is comprised entirely of older adults, being in this residence may give the individual more access to community life than the person may have had in their own home.
6. Providers have up to 12 months through MMIS to submit a claim so the claims data for fiscal year 2014 is subject to change through June 30, 2015
7. There is different data kept for people depending on the program they use. For example, people who apply for a Developmental Disabilities waiver will have extensive assessment information in their records. People who are in a nursing facility also have assessment data, but from a different assessment tool with different data points. People who are in the Group Residential Housing program may not have any assessment data.

Data development plan

Because of the data which is currently available does not fully answer questions that could guide us in the process of assisting people move to the most integrate setting, we need to develop additional ways to get information. MMIS and MAXIS are large data bases that are central to the state's operations in administering public programs. The demands upon them are great and changes are not easily made. It is not practical to build additional statewide data systems so we need to work with our existing systems. MnCHOICES is a new assessment system, currently being rolled out, which will provide much more person-centered data in the future.

We are taking short-term and long-term approaches to improving our data. The HCBS segregated settings transition plan will provide the basis for most of the short-term improvements.

1. Develop criteria for measuring a setting's degree of segregation/integration.
2. HCBS waiver providers in potentially segregated settings will complete a self-assessment.
3. Develop a method for rating site-specific "integration-based" criteria using data from provider assessments.
4. Create short-term system for tracking numbers of people who make a move to more integrated setting.
5. Build long-term systems solution for identifying, verifying, collecting and sharing information about degree of integration/segregation.
6. Create long-term system for tracking numbers of people who move from to or from less integrated settings.

Data pull

The baseline and demographic data were compiled using the following process.

1. Data used came from fiscal year 2014 (July 1, 2013 – June 30, 2014).
2. Data included all people, irrespective of age.
3. MMIS data was queried using claim codes of services that are delivered in a potentially segregated setting. Individuals were included in the counts if there was at least one claim meeting criteria within fiscal year 2014. This list included specific waiver services and services commonly accessed by people with serious mental illness or serious and persistent mental illness.
4. Data from MMIS does not include data about Group Residential Housing (GRH). GRH recipients must meet disability criteria to qualify for this program. Therefore, data was pulled from MAXIS to capture people receiving GRH.
5. Some people are only on GRH for a short stay in a temporary setting and therefore would not be considered someone living in a segregated setting. To control for that, we narrowed the MAXIS group, for every setting except adult foster care, to only include people who were in the setting for at least 90 days.
6. We combined the MAXIS group and the MMIS group to arrive at the people that we consider to have been in potentially segregated settings in fiscal year 2014.

List of potentially segregated settings (requires further analysis)

Criteria

There is nothing in current state statute, policy or rule that defines what constitutes a segregated setting in Minnesota. The Olmstead Plan provides the following definition of 'segregated setting', taken from the *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.*[3]

> **Segregated settings:** Segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.

This definition needs to be broken down into measurable criteria, e.g., what constitutes "lack of privacy or autonomy."

The state will develop ways to measure these qualities. In the meantime, we identified settings that are *potentially segregating.* It is important to note that, in addition to developing measurable criteria, data, over and above that currently available to the State, will required in order to identify segregated settings. Additionally, our current data systems do not necessarily identify the setting in which a person receives a service.

In light of these limitations, this is where we are starting the task of identifying people in segregated settings, recognizing that this work will need further analysis, including possibly looking at other settings that weren't included in this first analysis.

[3] www.ada.gov/olmstead/q&a_olmstead.htm

The group divided settings into residential settings and day/employment services settings. The logic is that strategies for transitioning people to more integrated settings will be similar within those categories and different outside those categories. In other words, a strategy to help people change residence will likely be useful across residential settings but not necessarily in helping people change their day/employment services settings. Likewise, strategies to make day service settings more integrated will likely work across day/employment services but not necessarily with transition out of residential settings.

We included people who are homeless in the count of people living in segregated settings for two reasons. First, according to the U.S. Department of Housing and Urban Development, over 40 percent of America's homeless population is people with disabilities[4]. Second, we consider our goal to be not only decreasing the number of people living unnecessarily in segregated settings but also increasing the number of people living in the most integrated settings. From a quality of life perspective, the people who are homeless have fewer opportunities to participate in community life. Therefore, we chose to look for indicators of homelessness and include people who are likely to be homeless in the counts of being in potentially segregated settings.

The group then developed criteria to use to identify if settings and services in each group will be considered potentially segregated.

Residential – potentially segregated/not integrated criteria

- The setting is controlled by the service provider
    - The exception to this criterion is private family settings (i.e., family foster care)
- There are no limits to length of stay
- A person who is likely to be homeless is considered not well-integrated in their community

Day/employment services settings – potentially segregated criteria

- Services which are often delivered in a provider-controlled setting
- Services which are often delivered in settings with a predominance of other people with disabilities

List of potentially segregated settings

Figure 1: List of potentially segregated settings and services (See Appendix B for definitions)

Residential settings/services delivered in potentially segregated settings	Day/employment services delivered in potentially segregated settings
Adult foster care	Adult day services
Assisted living residence (customized living service)	Day training and habilitation center
Board and lodge (includes homeless shelters)	Family adult day services
Board and lodge with special services	Pre-vocational service
Boarding care	Structured day program
Child foster care	Supported employment services
Children's residential care (children's residential facilities- Rule 5)	
Crisis respite (foster care)	

[4] U.S. Department of Housing and Urban Development, 2013 Continuum of Care Homeless Populations and Subpopulations Report (See www.hudexchange.info/reports/CoC_PopSub_NatlTerrDC_2013.pdf).

Residential settings/services delivered in potentially segregated settings	Day/employment services delivered in potentially segregated settings
Housing with services establishment	
Supervised living facilities	
Supported living services	

Data analysis

Residential services/settings

Figure 2: Residential settings by age and gender, fiscal year 2014

	Setting	Recipient	Age Group 0-13	Age Group 14-18	Age Group 19-26	Age Group 27-35	Age Group 36-64	Age Group 65+	Gender Female	Gender Male
MAXIS	Adult Foster Care	873	-	30	198	161	444	40	413	460
	Boarding Care	521	-	4	63	67	368	19	231	290
	Board and Lodge	3,070	-	36	616	758	1,627	33	765	2,305
	Board and Lodge w/ Special Serv	5,003	-	76	817	1,021	3,017	72	1,207	3,796
	Homeless Shelter	4,715	-	79	890	1,034	2,683	29	1,308	3,407
	Housing w/ Services Establ	2,690	-	21	340	401	1,832	96	920	1,770
	Supervised Living Facility	1,046	-	17	257	257	508	7	371	675
	Unduplicated	**10,562**	**-**	**152**	**1,804**	**2,079**	**6,281**	**246**	**3,132**	**7,430**
Claims	Adult Foster Care	5,318	-	97	910	813	2,821	677	2,255	3,063
	Assisted Living	2,610	-	-	38	62	945	1,565	1,685	925
	Assisted Living w/ 24 Hr Care	8,282	-	-	43	98	1,264	6,877	6,017	2,265
	Child Foster Care	187	55	124	8	-	-	-	62	125
	Crisis Respite	188	34	30	64	25	33	2	56	132
	Children's Residential Care	462	221	241	-	-	-	-	174	288
	Supported Living Services	10,470	45	225	1,510	2,079	5,657	954	4,468	6,002
	Unduplicated	**27,517**	**355**	**717**	**2,573**	**3,077**	**10,720**	**10,075**	**14,717**	**12,800**
Total Unduplicated		**38,079**	**355**	**869**	**4,377**	**5,156**	**17,001**	**10,321**	**17,849**	**20,230**

- A total of 38,079 individuals resided in other potentially segregated setting at some point during fiscal year 2014.
    - Of the GRH-only recipients, the largest group (47 percent) was in Board and Lodge with Special Services facilities. Of those with MA claims, the largest group (30 percent) was in Assisted Living with 24 hour care.
- Of the total, 72 percent were over the age of 35.
- Of the total number in all settings combined, nearly 47 percent were female; however, among the GRH-only recipients 70 percent were male.

Figure 3: Residential settings by race/ethnicity, fiscal year 2014

	Setting	Recipient	Race White	Race Black	Race Am Indian	Race Asian	Race Pac Island	Race Hispanic	Race 2+	Race Unknown
MAXIS	Adult Foster Care	873	697	89	29	25	2	15	6	10
	Boarding Care	521	391	82	12	11	1	14	4	6
	Board and Lodge	3,070	1,858	805	153	45	4	84	50	71
	Board and Lodge w/ Special Serv	5,003	3,048	1,256	324	60	2	133	77	103
	Homeless Shelter	4,715	2,375	1,653	322	51	4	129	90	91
	Housing w/ Services Establ	2,690	1,196	1,207	147	18	1	66	27	28
	Supervised Living Facility	1,046	666	228	59	15	4	27	22	25
	Unduplicated	**10,562**	**6,300**	**2,895**	**599**	**141**	**11**	**271**	**147**	**198**
Claims	Adult Foster Care	5,318	4,533	344	137	91	6	91	38	78
	Assisted Living	2,610	2,263	173	38	59	-	26	6	45
	Assisted Living w/ 24 Hr Care	8,282	7,458	308	69	91	2	54	13	287
	Child Foster Care	187	116	24	13	1	-	14	12	7
	Crisis Respite	188	126	32	5	9	-	7	4	5
	Children's Residential Care	462	278	54	53	2	-	29	31	15
	Supported Living Services	10,470	9,528	424	181	123	1	109	26	78
	Unduplicated	**27,517**	**24,302**	**1,359**	**496**	**376**	**9**	**330**	**130**	**515**
Total Unduplicated		**38,079**	**30,602**	**4,254**	**1,095**	**517**	**20**	**601**	**277**	**713**

- Of individuals residing in other potentially segregated setting, blacks were overrepresented (11 percent versus 6 percent of Minnesota's entire population). This disparity increased in the GRH-only group, where 27 percent were black.
- American Indians were overrepresented among those residing in Children's Residential Care and Board and Lodge with Special Services (11 percent and 6 percent, respectively, versus 1 percent of Minnesota's entire population).

Figure 4: Residential settings by diagnosis, fiscal year 2014

	Setting	Recipient	Acquired Cognitive Disability	Austism Spectrum Disorder	Blind	IDD	Deaf	Hard of Hearing	Mental Illness	SMI	SPMI	Substance Abuse
MAXIS	Adult Foster Care	873	611	111	11	365	5	243	808	245	204	469
	Boarding Care	521	387	14	1	77	1	127	517	190	142	449
	Board and Lodge	3,070	2,017	64	3	157	3	544	2,695	633	447	2,736
	Board and Lodge w/ Special Serv	5,003	3,500	95	11	265	-	979	4,563	944	660	4,540
	Homeless Shelter	4,715	3,286	79	8	191	-	916	4,238	778	493	4,260
	Housing w/ Services Establ	2,690	1,928	41	6	147	-	596	2,432	260	158	2,310
	Supervised Living Facility	1,046	845	52	2	86	-	260	1,037	575	490	967
	Unduplicated	**10,562**	**7,304**	**298**	**28**	**914**	**9**	**2,177**	**9,534**	**1,958**	**1,418**	**9,053**
Claims	Adult Foster Care	5,318	4,675	918	124	2,814	25	2,163	5,180	1,538	1,148	3,164
	Assisted Living	2,610	2,203	77	57	518	13	1,006	2,112	282	193	1,026
	Assisted Living w/ 24 Hr Care	8,282	7,280	119	179	966	17	2,665	6,511	408	277	2,100
	Child Foster Care	187	146	85	6	109	-	79	187	116	93	29
	Crisis Respite	188	134	125	1	186	2	85	181	30	6	24
	Children's Residential Care	462	309	119	1	78	-	165	459	424	414	155
	Supported Living Services	10,470	8,049	3,452	311	10,417	123	5,899	9,762	604	45	1,417
	Unduplicated	**27,517**	**22,796**	**4,895**	**679**	**15,088**	**180**	**12,062**	**24,392**	**3,402**	**2,176**	**7,915**
Total Unduplicated		**38,079**	**30,100**	**5,193**	**707**	**16,002**	**189**	**14,239**	**33,926**	**5,360**	**3,594**	**16,968**

- Individuals with an Intellectual/Developmental Disability were more likely to have an MA claim than were GRH-only recipients (55 percent versus 9 percent).
- Individuals with substance abuse issues were more likely to be GRH-only recipients (86 percent versus 28 percent of those with MA claims).
- Nearly all of the GRH-only recipients living in a Boarding Care facility had some history of mental illness, and 21 percent had a serious mental illness.

Figure 5: Residential settings by mobility, fiscal year 2014

	Setting	Recipient	No Impairment	Walks Aided (i.e. walker)	Uses Wheelchair	Not Mobile	Unknown
MAXIS	Adult Foster Care	873	369	81	30	13	380
	Boarding Care	521	291	15	2	-	213
	Board and Lodge	3,070	362	59	28	7	2,614
	Board and Lodge w/ Special Serv	5,003	655	117	23	5	4,203
	Homeless Shelter	4,715	433	98	20	6	4,158
	Housing w/ Services Establ	2,690	307	117	17	7	2,242
	Supervised Living Facility	1,046	285	30	6	1	724
	Unduplicated	**10,562**	**1,791**	**353**	**88**	**26**	**8,304**
Claims	Adult Foster Care	5,318	3,520	723	576	498	1
	Assisted Living	2,610	833	1,286	327	164	-
	Assisted Living w/ 24 Hr Care	8,282	1,849	3,500	2,137	796	-
	Child Foster Care	187	170	1	15	1	-
	Crisis Respite	188	113	70	4	-	1
	Children's Residential Care	462	81	1	1	-	379
	Supported Living Services	10,470	5,868	3,861	624	110	7
	Unduplicated	**27,517**	**12,434**	**9,442**	**3,684**	**1,569**	**388**
Total Unduplicated		**38,079**	**14,225**	**9,795**	**3,772**	**1,595**	**8,692**

- 40 percent of individuals residing in other potentially segregated setting were assessed to have some sort of mobility impairment (15,162 individuals), indicating a *potential* need for a physically accessible unit.
- Nearly half of the individuals receiving assisted living services were assessed to need assistance with walking.

Figure 6: Residential settings by income source, fiscal year 2014

	Setting	Recipient	Earned Income	Unearned Income	Earned or Unearned Income	Income Unknown	Unearned Subgroup: RSDI	Unearned Subgroup: SSI	Unearned Subgroup: RSDI or SSI	Unearned Subgroup: Other
MAXIS	Adult Foster Care	873	384	614	728	145	421	284	601	50
	Boarding Care	521	87	369	421	100	269	157	366	19
	Board and Lodge	3,070	842	733	1,495	1,575	407	380	656	200
	Board and Lodge w/ Special Serv	5,003	1,075	1,368	2,378	2,625	797	726	1,278	299
	Homeless Shelter	4,715	1,046	995	2,045	2,670	469	600	900	286
	Housing w/ Services Establ	2,690	345	784	1,095	1,595	380	481	700	135
	Supervised Living Facility	1,046	262	479	681	365	272	289	462	65
	Unduplicated	**10,562**	**2,426**	**3,524**	**5,491**	**5,071**	**2,082**	**1,867**	**3,297**	**607**
Claims	Adult Foster Care	5,318	2,197	4,966	5,238	80	3,707	2,049	4,959	229
	Assisted Living	2,610	209	2,503	2,598	12	2,214	598	2,501	93
	Assisted Living w/ 24 Hr Care	8,282	317	7,917	8,256	26	7,478	1,125	7,915	333
	Child Foster Care	187	16	86	119	68	23	73	86	28
	Crisis Respite	188	64	156	170	18	64	117	156	14
	Children's Residential Care	462	12	184	280	182	84	124	184	92
	Supported Living Services	10,470	7,626	10,043	10,430	40	8,025	3,834	10,030	342
	Unduplicated	**27,517**	**10,441**	**25,855**	**27,091**	**426**	**21,595**	**7,920**	**25,831**	**1,131**
Total Unduplicated		**38,079**	**12,867**	**29,379**	**32,582**	**5,497**	**23,677**	**9,787**	**29,128**	**1,738**

- Around one-third of individuals residing in other potentially segregated setting reported some amount of earned income.
- 26 percent (9,787 individuals) reported only receiving income from SSI. The maximum monthly benefit for SSI is $721; hence, people who receive SSI are likely to have limited ability to afford housing in the community.
- An additional 20 percent (10,968 individuals) were General Assistance recipients. This group has even less income. The General Assistance benefit for individuals living in the community is $203 per month.

Figure 7: Residence by region, fiscal year 2014

	Setting	Recipient	1 North West	2 Head-waters	3 Arrow-head	4 West Central	5 North Central	6 South West Central	7 East Central	8 South West	9 South Central	10 South East	11 Twin Cities	Unkn	Frontier
MAXIS	Adult Foster Care	873	2	14	56	18	15	10	241	8	45	133	318	13	4
	Boarding Care	521	3	1	9	4	5	4	70	1	1	25	396	2	3
	Board and Lodge	3,070	4	7	142	65	90	46	159	39	75	336	2,076	31	7
	Board and Lodge w/ Special Serv	5,003	20	19	615	111	129	51	278	54	108	246	3,338	34	29
	Homeless Shelter	4,715	8	18	326	76	44	28	166	13	39	229	3,707	61	9
	Housing w/ Services Establ	2,690	3	9	111	14	39	4	37	1	58	41	2,363	10	1
	Supervised Living Facility	1,046	11	14	68	19	7	29	67	30	32	35	722	12	9
	Unduplicated	**10,562**	**37**	**54**	**833**	**191**	**204**	**100**	**676**	**87**	**258**	**669**	**7,361**	**92**	**44**
Claims	Adult Foster Care	5,318	107	134	470	469	199	231	637	135	261	505	2,166	4	56
	Assisted Living	2,610	105	64	268	230	146	142	170	49	151	234	1,046	5	37
	Assisted Living w/ 24 Hr Care	8,282	134	141	1,162	404	317	235	829	148	489	920	3,499	4	71
	Child Foster Care	187	6	1	26	14	8	8	27	9	14	11	62	1	6
	Crisis Respite	188	1	1	6	8	2	3	18	-	-	7	142	-	-
	Children's Residential Care	462	9	26	103	27	13	24	59	11	41	28	120	1	4
	Supported Living Services	10,470	286	163	920	520	338	505	856	396	587	1,253	4,643	3	174
	Unduplicated	**27,517**	**648**	**530**	**2,955**	**1,672**	**1,023**	**1,148**	**2,596**	**748**	**1,543**	**2,958**	**11,678**	**18**	**348**
Total Unduplicated		**38,079**	**685**	**584**	**3,788**	**1,863**	**1,227**	**1,248**	**3,272**	**835**	**1,801**	**3,627**	**19,039**	**110**	**392**

- Half (50 percent) of individuals residing in other potentially segregated setting were in the Twin Cities Metro Area.
- Of GRH-only recipients, however, nearly three-quarters (70 percent) were in the Twin Cities Metro Area.

Figure 8: Unduplicated provider count by setting/service type (residential), fiscal year 2014

Residential setting/service	Unduplicated provider count
Adult Foster Care (MMIS)	1,074
Adult Foster Care (MAXIS)	491
Assisted living Residence (customized living service)	664
Assisted living Residence (24-hour customized living service)	1,047
Board and Lodge	173
Board and Lodge w/ Special Services	167
Boarding Care	18
Child Foster Care	91
Children's Residential Care (Children's Residential Facilities-Rule 5)	69
Crisis Respite (Foster Care)	18
Housing w/ Services Establishment	992
Supervised Living Facility (SLF)	31
Supported Living Services	708

Day/employment services

Figure 9: Service utilization by age, fiscal year 2014

	Setting	Recipient	Age Group 0-13	Age Group 14-18	Age Group 19-26	Age Group 27-35	Age Group 36-64	Age Group 65+
Day	Adult Day Center	5,782	0	6	119	140	1271	4246
	Day Training & Habilitation	10,135	0	34	1940	2383	5134	644
	Family Adult Day Servcies	46	0	0	2	0	6	38
	Prevocational Services	2,556	0	23	539	461	1464	69
	Structured Day Program	182	0	0	13	39	123	7
	Supported Employment Services	2,827	0	15	719	721	1324	48
	Unduplicated	20,055	0	70	3033	3411	8557	4984

- The data pull included people of all ages and therefore included older Minnesotans using long-term supports and services whose need for those services may have resulted from conditions acquired as they aged and/or conditions that were disabling, independent of their aging.

Figure 10: Service utilization by diagnosis, fiscal year 2014

	Setting	Recipient	Acquired Cognitive Disability	Austism Spectrum Disorder	Blind	IDD	Deaf	Hard of Hearing	Mental Illness	SMI	SPMI	Substance Abuse
Day	Adult Day Center	5,782	4,780	232	129	1,338	32	2,724	5,043	261	160	1,230
	Day Training & Habilitation	10,135	7,302	3,363	287	10,135	124	5,352	9,095	394	13	963
	Family Adult Day Servcies	46	39	-	-	6	-	18	44	3	2	10
	Prevocational Services	2,556	2,175	557	66	1,733	34	1,104	2,449	596	400	1,261
	Structured Day Program	182	181	28	1	121	1	65	177	13	6	100
	Supported Employment Services	2,827	2,195	826	39	2,242	12	1,182	2,645	455	284	1,115
	Unduplicated	20,055	15,461	4,634	497	14,467	194	9,788	18,066	1,466	698	4,084

- Individuals may have more than one diagnosis so these are not unduplicated counts. The service called day training and habilitation is only covered under the Developmental Disabilities waiver, so everyone receiving that service had that diagnosis. Individuals may have had additional diagnoses, as well.

Figure 11: Service utilization by source of income, fiscal year 2014

	Setting	Recipient	Earned Income	Unearned Income	Earned or Unearned Income	Income Unknown	Unearned Subgroup: RSDI	Unearned Subgroup: SSI	Unearned Subgroup: RSDI or SSI	Unearned Subgroup: Other
Day	Adult Day Center	5,782	427	4944	5663	119	2036	3371	4933	717
	Day Training & Habilitation	10,135	8079	9794	10127	8	7395	4165	9785	300
	Family Adult Day Servcies	46	6	42	44	2	19	26	42	2
	Prevocational Services	2,556	2229	2445	2550	6	1839	956	2443	80
	Structured Day Program	182	121	175	182	0	139	65	175	7
	Supported Employment Services	2,827	2483	2669	2824	3	2122	925	2665	94
	Unduplicated	20,055	12008	18666	19919	136	12437	9022	18641	1156

- The chart shows only the source of income, not the amount of income. The 'earned income' category does not distinguish between competitive employment and earnings at sub-minimum wages.
- Individuals could have multiple sources of income so counts are not unduplicated, unless specified.

Figure 12: Service utilization by living arrangement, fiscal year 2014

	Setting	Recipient	Home	Family Foster Care	Corp Foster Care	ICF-DD	NF	Board and Lodge	Housing with Services	Corr Facility	Hospital	Unknown
Day	Adult Day Center	5,782	4,656	119	597	3	80	116	185	-	9	17
	Day Training & Habilitation	10,135	2,879	582	6,549	29	32	2	-	-	-	62
	Family Adult Day Servcies	46	36	-	5	-	1	4	-	-	-	-
	Prevocational Services	2,556	1,022	153	1,147	1	29	92	80	1	10	21
	Structured Day Program	182	36	4	118	-	3	12	9	-	-	-
	Supported Employment Services	2,827	1,423	155	1,090	1	23	53	43	-	6	33
	Unduplicated	20,055	9,427	937	8,814	34	158	248	291	1	25	120

Figure 13: Unduplicated provider count by service type (day/employment), fiscal year 2014

Day/employment services	Unduplicated provider count
Adult day services center (EW) & Adult Day Care	229
Family adult day services setting	14
Structured Day Program	57
Day Training and Habilitation center	246
Pre-Vocational Service	177
Supported Employment Services (SES)	187

Targets and timelines

There are initiatives across the state agencies to support people moving to more integrated settings. While some are smaller in scale and targeted, others are larger and geared to systems-level changes. The systems changes take longer to implement and longer to see results, and will ultimately have a larger impact. The smaller projects will impact the lives of individuals quickly.

The targets given here set a base, but do not limit the number of people that can move. As strategies outlined in the Olmstead Plan, and reforms by DHS are implemented, such as those to promote community living and employment options, shift provider business models, peer mentoring to share their stories of moving to homes of their own or working, manage waiver resources differently, and support experiential learning of options to inform choice, momentum will build, needed community capacity and infrastructure will expand, and increasingly more people every year will seek and obtain community living and employment options.

The ability to transition people to more integrated settings will be affected by the availability of resources to support this work. The DHS will assess progress annually and will adjust targets as necessary to incent movement to the most integrated community living and employment.

These are targets for the settings identified in this report, and do not reflect targets that have been set elsewhere for Anoka Metro Regional Treatment Center, the Minnesota Security Hospital in St. Peter, Intermediate Care Facilities for Developmental Disabilities and nursing facilities.

These are some of the strategies the state is pursuing to reduce the number of people in segregated settings.

Residential interventions

- Continuing moratoriums on development of new ICF-DDs and corporate adult foster care beds
- Reforms to the Group Residential Housing (GRH) and Minnesota Supplemental Assistance (MSA) programs
- Expansion of Housing Access Services
- Technology grants to assist people in developing ways to use technology to support them in the homes and to otherwise meet their needs and goals
- Local planning grants to counties to develop alternatives to corporate foster care
- Providing technical assistance to service providers
- Quality improvement processes
- Transition protocols
- New and modified services
- Changes in payment for services
- HCBS transition plan

Day services interventions

- Working with school districts (Minnesota Department of Education to lead effort)
- Continue to develop and promote the use of Disability Benefits 101 (DB101), a benefits and work planning tool
- Provide technical assistance to providers
- Family outreach

- Develop opportunities for youth work experiences
- New and modified services
- Changes in payment for services
- HCBS transition plan
- Developing standards and managing capacity for day services

Figure 14: Targets and timelines for "other segregated settings"

RESIDENTIAL SETTINGS TARGETS	DAY SETTINGS TARGETS
In SFY 2015 Without additional resources: 50	In SFY 2015 Without additional resources: 50
In SFY 2016 Without additional resources: 125	In SFY 2016 Without additional resources: 150
In SFY 2017 Without additional resources: 300	In SFY 2017 Without additional resources: 200
In SFY 2018 Without additional resources: 350	In SFY 2018 Without additional resources: 500
In SFY 2019 Without additional resources: 400	In SFY 2019 Without additional resources: 500

Appendix A: Analysis of State Plans from Massachusetts, Oregon and Rhode Island

KEY ELEMENTS LEADING TO COMPETITIVE, COMMUNITY SUPPORTED EMPLOYMENT and COMMUNITY-BASED DAY SUPPORT SERVICES:

A Summary of Rhode Island, Oregon and Massachusetts State Reform Initiatives

KEY ELEMENTS LEADING TO COMPETITIVE, COMMUNITY SUPPORTED EMPLOYMENT and DAY SUPPORT SERVICES REFORM	RI Settlement Agreement	OR Governors Executive Order *(Lawsuit Pending)*	MASS Blue Print For Success
Response to U.S.D.O.J. litigation of Title II-ADA, Olmstead.	Y (reactive)	Y (preemptive)	Y (proactive)
Response to CMS' HCBS Final Rule Regulation and Requirements.	Y (reactive)	N	Y (proactive)
Parties Involved in the Plan.	Human Services, VR & Education	ODHS-ODDS, ODE & ODVR	MADDS, MASS ARC MA Provider Org.
Develop and conduct a comprehensive, statewide educational outreach campaign directed at state and local government agencies, providers, schools, people with disabilities and their families.	Y	Y	Y
Close new referrals to congregate, segregated sheltered workshops and facility-based day service programs providers.	Y	Y	Y
Discontinue the purchase of congregate, segregated sheltered workshop services and facility-based day services.	Y	N	Y (within 5 years)
Require providers to convert from congregate, segregated sheltered workshop programs and facility-based day service providers to community-based, competitive employment service providers and day support service providers.	Y	N	Y
Provide comprehensive training, business consultation, strategic planning and technical assistance support to providers on redesigning services and restructuring organizations to convert from congregate, segregated sheltered workshop programs and facility-based day service providers into individualized, community-integrated employment service providers and individualized, community-integrated day support service providers.	Y	Y	Y
Adopt Employment First Policy, and align all provider service and support practices with Employment First Policy.	Y	Y	Y
Create a financial system or service rate structure that incentivizes integrated, community-based, competitive employment services, supports and outcomes.	Y	Y	Y
Develop transition or action plans for people to move from congregate, segregated sheltered workshops and facility-based day service programs to individualized, community-based, competitive employment services and supports or individualized, community-based day services and supports.	Y	Y	Y
Design and implement a community-based, competitive employment services and support plan that gradually phases out special/subminimum wage work and increases minimum wage or higher jobs for people.	Y (Variances are allowable)	N	Y
Construct a comprehensive, compendium of community-based services and supports that produce an individualized employment plan for assessing, exploring, acquiring and maintaining community-based, competitive employment.	Y	Y	Y
Construct a set of community-based services and supports that assist people in other supportive activities such as transportation training, learning independent living skills, teaching personally-effective social skills, recreation and leisure assistance.	Y	N	Y
Identify and implement services and supports for transition age school students and young adults that produce individualized employment plans for assessing, exploring, acquiring and maintaining community-based, competitive employment as well as other supportive activities that assist with life skills instruction.	Y	Y	N
Build a comprehensive employment database system to track community-based, competitive employment and progress on system reforms.	Y	Y	Y

Establish and finance oversight positions that monitor outcomes and quality.	Y	Y	Y
Fund system transformation by converting existing funding, which supports congregate, segregated sheltered workshops programs and facility-based day service, to support individualized, community-based employment service and individualized, community-integrated day support services.	Y	Y	Y
Fund system reform and transformation initiatives with increased state dollars to possibly receive matched by federal financial participation money.	Y	N	Y

RHODE ISLAND

RHODE ISLAND SETTLEMENT

(Rhode Island Consent Decree)

BACKGROUND

On January 14, 2013, the United States Department of Justice initiated an investigation into whether the State has violated Title II of the Americans with Disabilities Act and Olmstead v. L.C. through its administration and operation of its day activity services system, including employment, vocational, and sheltered workshop day services for individuals with intellectual and developmental disabilities.

FINDINGS

1.) Approximately 80 percent of the people with I/DD (about 2,700 individuals)receiving state services are placed in segregated, sheltered workshops or congregate, facility-based, day service programs.
2.) Only about 12 percent (approximately 385 people) participate in individualized, community-integrated employment.
3.) Only about five percent of students with disabilities transitioned into jobs in community-integrated settings.
4.) Placement in segregated settings is frequently permanent:

A.) nearly half (46.2 percent) of the individuals in sheltered workshops have been in that setting for ten years or more, and
B.) over one-third (34.2 percent) have been there for fifteen years or more.

5.) Individuals with I/DD in sheltered workshops reportedly earn an average of about $2.21 per hour.

AGREEMENTS and ACTIONS

1.) Permanently stop placements and funding into sheltered workshops and facility-based, day service programs.
2.) On a scheduled basis, conduct supported employment placements of about 2,000 individuals between January 2015 and January 2024, including:

A.) at least 700 people currently in sheltered workshops;
B.) at least 950 people currently in facility-based non-work programs; and
C.) approximately 300-350 students leaving high school.

3.) Adults transitioning to supported employment services (SES) will receive:

A.) Person-centered career planning process that includes asset-based vocational assessments such as discovery, situational assessments and time-limited, trial work exploration experiences;
B.) Supports Intensity Scale ("SIS") assessment;
C.) Benefits analysis and planning;
D.) Medicaid Buy-In program information and counseling; and an
E.) array of other vocational services and supports to ensure that they have meaningful opportunities to live and work in the community (***Appendix # 1, item # 1***).

4.) School youth in transition (ages 14 – 21 years old), approximately 1,250 students, will receive:

A.) Person-centered, individual learning plans;
B.) Person-centered, school-to-work transition career plans;
C.) Integrated vocational and situational assessments including discovery, vocational assessment, situational assessment and time-limited trial work exploration experiences; and an
D.) array of other transitional services and supports to ensure that they have meaningful opportunities to live and work in the community after they exit school (***Appendix # 1, item # 2***).

5.) SES placement in community integrated employment settings must:

A.) pay at least minimum wage;
B.) allow the person to work the maximum number of hours consistent with their abilities and preferences;

C.) allow the person interact with peers without disabilities to the fullest extent possible;
D.) average 20 hours of work per week in integrated employment settings;
E.) allow access to community-integrated work and non-work day services and supports for a total of 40 hours per week; and
F.) receive transportation and other direct (face-to-face) and indirect (not-face-to-face) employment services and supports.

6.) Supported employment placements cannot be in group job enclaves, mobile work crews and time-limited work experiences.
7.) No vocational or situational assessments shall be conducted in segregated, sheltered workshops and congregate day service program settings.
8.) Employer-sponsored training or provider-subsidized trial work exploration experiences can only occur for 4 – 8 weeks prior to job placement.
9.) Work compensated by any other entity than the employer of record will not qualify as a job placement.
10.) Community-integrated, (non-work) day services and supports shall not be services provided as part of a sheltered workshop, day services facility, group home, or residential program service provider.
11.) Develop an informational outreach campaign for schools and the general public that educates about the benefits of supported employment, and addresses families' concerns about supported employment.
12.) Create an employment first advocacy task force of local stakeholders, advocacy organizations, business networks, individuals with I/DD and family representatives for oversight and monitoring.
13.) Develop Interagency MOU Collaboration Agreements among human services, VR and education.
14.) Adopt an Employment First Policies and presumptions that all people with disabilities can competitively work at jobs in the community given proper services and support.
15.) Variances to SES placements can occur if the eligible person:

A.) makes a voluntary, informed choice for placement in a group work arrangement (e.g., enclaves, crews, etc.), segregated sheltered workshop facility, congregate day services program;
B.) receives one vocational or situational assessment;
C.) receives one trial work exploration experience, except when a documented medical condition poses an immediate and serious threat to their health or safety, or the health or safety of others;
D.) receives outreach educational information and counseling about SES;
E.) receives benefits planning;
F.) annual re-assessment for SES; and
G.) elects an integrated day supports-only placement in lieu of a SES placement.

<u>FUNDING and FINANCING PROJECT INITIATIVES</u>

1.) Establish a Sheltered Workshop Conversion Institute and Trust Fund ($800,000) to assist providers of sheltered workshop services to convert to SES.
2.) Pursue and fund a contract for training and technical assistance vendors to provide leadership, competency and value based training and TA to state staff, employment, sheltered workshop and day service providers.
3.) Reallocate financial resources now spent on segregated sheltered workshop and congregate day service programs to instead fund SE and/or community-integrated day services. Allow funding to follow the person without an increase in cost (maintaining budget neutrality).
4.) Develop and implement performance-based contracts for SES providers to meet goals and objectives.
5.) Provide ongoing funding sources to sufficiently support a competent and qualified system of providers with the capacity to deliver effective SES and Integrated Day Services.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

1.) Identify information and data elements to measure and collect for the U.S. DOJ and the court monitor:

A.) number of individuals in segregated sheltered workshop programs, congregate day services facilities, group job enclaves, mobile work crews and time-limited trial work exploration experiences

B.) number of completed career development plans

C.) number of individuals referred to and receiving SES

D.) number of transition youth exiting or graduating from school with career planning goals, and where they are transitioning to following their graduation or exit from school

E.) number and client capacity of supported employment providers

F.) number of qualified and trained SES professionals

G.) number of qualified and trained vocational counselors and assessment professionals

H.) number of hours worked per week, hourly wages paid, and job tenure in a community integrated employment setting

I.) number and reason(s) for lost jobs and/or terminations from employment along with plans for re-employment

J.) number and client capacity, hours per week, and tenure within community integrated day services providers, including the number of individuals participating in Integrated Day-Only Services

K.) number of variances granted

L.) number of outreach educational information campaign efforts performed

2.) Public reports to the U.S. DOJ and the selected court monitor on identified information and data elements also include:

A.) findings and results of regularly conducted on-site reviews of converting sheltered workshops and day service programs;

B.) identified program service provider deficiencies and required corrective action plans;

C.) employment service and support outcomes and recommendations; and

D.) compliance with the consent decree

Appendix # 1: Services and Supports

1. Vocational services and supports

job discovery and development, job-finding, job carving, job coaching, job training, job shadowing, co-worker and peer supports, reemployment supports, benefits planning and counseling, transportation services, environmental modifications and accessibility adaptations, behavioral supports, personal care services, case management services, assistive technology, social skills training, self-exploration, career exploration, career planning and management, job customization, time management training, self-employment opportunities and supports, adaptive behavior and daily living skills training.

2. Transitional services and supports

career instruction, employment preparation training, school-based preparatory job experiences, integrated work-based learning experiences, business site visits, job shadowing, work skill development, internships, part-time employment, summer employment, youth leadership, self-advocacy, peer and adult mentoring, living skills training, teaching community services, post-secondary school educational opportunities, transportation instruction, benefits planning, and assistive technology.

Appendix # 2: Supported Employment and Integrated Day Services Placements Schedule

Rhode Island Sheltered Workshop and Rhode Island Youth Exit Target Populations

a. By January 1, 2015, the State will provide Supported Employment Placements to at least 50 individuals in the Rhode Island Youth Exit Target Population who left during the 2013-2014 school year.
b. By July 1, 2015, the State will provide Supported Employment Placements to all remaining individuals in the Rhode Island Youth Exit Target Population who left, or will leave, school during the 2013-2014 and 2014-2015.
c. By January 1, 2016, the State will provide Supported Employment Placements to at least 50 individuals in the Rhode Island Sheltered Workshop Target Population.
d. By July 1, 2016, the State will provide Supported Employment Placements to all individuals in the Rhode Island Youth Exit Target Population who left school during the 2015-2016 school year.
e. By January 1, 2017, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.
f. By January 1, 2018, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.
g. By January 1, 2019, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.
h. By January 1, 2020, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.
i. By January 1, 2021, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.
j. By January 1, 2022, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.
k. By January 1, 2023, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.
l. By January 1, 2024, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

Rhode Island Day Target Population

a. By January 1, 2016, the State will provide Supported Employment Placements to at least 25 individuals in the Rhode Island Day Target Population.
b. By January 1, 2017, the State will provide Supported Employment Placements to at least an additional 25 individuals in the Rhode Island Day Target Population.
c. By January 1, 2018, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Day Target Population.
d. By January 1, 2019, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Day Target Population.
e. By January 1, 2020, the State will provide Supported Employment Placements to at least an additional 75 individuals in the Rhode Island Day Target Population.
f. By January 1, 2021, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Day Target Population.
g. By January 1, 2022, the State will provide Supported Employment Placements to at least an additional 200 individuals in the Rhode Island Day Target Population.
h. By January 1, 2023, the State will provide Supported Employment Placements to at least an additional 200 individuals in the Rhode Island Day Target Population.
i. By January 1, 2024, the State will provide Supported Employment Placements to at least an additional 225 individuals in the Rhode Island Day Target Population.

OREGON

OREGON EXECUTIVE ORDER

(Oregon Executive Order)

BACKGROUND

On January 25, 2012, the first class action lawsuit case in the nation that challenges sheltered workshops as a violation of the integration mandates in Title II of the Americans with Disabilities Act and Olmstead v. L.C was filed. The case, ***Lane v. Kitzhaber***, was filed on behalf of eight named plaintiffs who are:

1.) stuck in sheltered workshops;
2.) spending years, and often decades in these congregate, segregated settings;
3.) qualified and prefer to work at real jobs in the community; and
4.) often paid less than a $1.00/hour for their labor in the workshops.

The class action lawsuit case is brought on behalf of thousands of similarly situated and qualified persons with disabilities placed in Oregon's sheltered workshop system. The class action lawsuit case seeks an injunction to require the State of Oregon, and its' Department of Human Services, to end the segregation of persons with intellectual and development disabilities, and to assist them in obtaining integrated employment opportunities with supported employment services. The case is pending and proceeding to court, unless a settlement can be reached.

FINDINGS

1.) In October 2011, the United States Department of Justice concluded via a lengthy investigation that the State of Oregon has violated Title II of the Americans with Disabilities Act and Olmstead v. L.C. by funding, structuring, and administering its disability employment services system in a manner that segregates persons with intellectual and developmental disabilities in sheltered workshops.

2.) The U.S. DOJ determined that segregated workshops constitute an ADA violation and a Rehabilitation Act violation, and that the state's employment service system must be reformed in order to expand integrated employment opportunities.

3.) The DOJ claims that Oregon's disability employment service system perpetuates segregation of individuals with disabilities by unduly relying upon sheltered workshops rather than providing employment services in integrated settings, thus causing the unnecessary segregation of individuals who are capable of, and not opposed to, working at jobs in the community.

4.) 2,691 persons receive employment and vocational services. 1,642 – 61% – received at least some of those services in sheltered workshops. By contrast, only 422, or less than 16%, of these persons received services at any time in individual supported employment settings.

5.) The average hourly wage for sheltered workshop participants is currently $3.72. Over 52% of participants earn less than $3.00 per hour. By contrast, the overwhelming majority of persons with disabilities in individual supported employment earn Oregon's minimum wage of $8.80 or above.

6.) The DOJ recommended that Oregon implement certain remedial measures, including the development of sufficient supported employment services to enable those individuals who are unnecessarily segregated, or at risk of unnecessary segregation, in sheltered workshops to receive services in individualized, integrated employment settings in the community.

7.) The DOJ determined that voluntary compliance was not possible after months of negotiations to reach a settlement and avoid litigation.

OREGON GOVERNOR'S EXECUTIVE ORDER (July 1,2013) – AN UNSUCCESSFUL REMEDY

1.) The Oregon Department of Human Services (ODHS) and the Oregon Department of Education (ODE) shall work together to further improve Oregon's systems of designing and delivering employment services to those with intellectual and developmental disabilities.

2.) Oregon will make significant reductions in state support for sheltered work over time.
3.) Oregon will make increased investments in employment services and supports for people with disabilities.
4.) Employment services will be provided immediately to working age people with I/DD who receive sheltered workshop services. Employment services shall be individualized and evidence-based or recognized as effective practices.
5.) Employment services will be provided immediately to transition age young adults (@ 16 – 23). Employment services shall be individualized and evidence-based or recognized as effective practices.
6.) Individualized employment Services shall be based on an individual's capabilities, choices, and strengths.
7.) ODDS and OVRS will provide Employment Services to at least 2000 individuals in the ODDS/OVRS Target Population, in accordance with a schedule (please refer to Appendix 1).
8.) ODDS shall adopt and implement policies and procedures for developing individualized career development plans. The policies will include a presumption that all individuals in the ODDS/OVRS are capable of working in an integrated employment setting. The primary purpose of all vocational assessments shall be to determine an individual's interests, strengths, and abilities, in order to identify a suitable match between the person and an integrated employment setting.
9.) By January 1, 2014, ODDS and OVRS will establish competencies for the provision of Employment Services, and will adopt and implement competency-based training standards for career development plans, job creation, job development, job coaching, and coordination of those services.
10.) By July 1,2016, ODDS and OVRS will purchase Employment Services for people with I/DD only from agencies or individual providers that are licensed, certified, credentialed or otherwise qualified as required by Oregon Administrative Rule. Such requirements for the provision of Employment Services will be competency-based and may include national credentialing programs as the APSE Certified Employment Support Professional exam or a substantial equivalent.
11.) By January 1, 2014, ODDS and OVRS will develop an outreach informational education campaign for all people receiving services from ODDS/OVRS that explains the benefits of employment, addresses family and perceived obstacle concerns to participating in employment services.
12.) Through a developed MOU agreement, ODE will partner with OVRS and ODDS to establish and implement a Statewide Transition Technical Assistance Network to assist high schools in providing Transition Services.

FUNDING and FINANCING PROJECT INITIATIVES

1.) By July 1, 2014, Oregon will no longer purchase or fund vocational assessments for individuals with I/DD that occur in sheltered workshop settings.
2.) By July 1, 2015, Oregon will no longer purchase or fund ***NEW*** sheltered workshop placements.
3.) State agencies will make good faith efforts, within available budgetary resources, to ensure that there are a sufficient number of qualified employment providers to deliver the services and supports necessary for individuals in the ODDS/OVRS system to receive competent employment services.
4.) By January 1, 2014, DHS will financially support new or existing technical assistance provider(s) or use other available training resources to provide leadership, training and technical assistance to counties, employment service providers, support service providers, and vocational rehabilitation staff.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

1.) By July 1, 2014, DHS will develop and implement a quality improvement initiative that is designed to promote Employment Services and to evaluate the quality of Employment Services provided to persons with I/DD.
2.) Starting January 1, 2014, an appointed State Employment Coordinator (as of 10/2013) and a newly formed Policy Review Committee (as of 07/2013) will monitor progress semi-annually through data

collection, data analysis, quality improvement activities and make annual recommendations to the Governor and legislature for performance improvements.
3.) Starting January 1, 2014, and semi-annually thereafter, ODDS and OVRS shall collect data and report to the Employment Coordinator and the Policy Review Committee data for working age individuals that will include:

- **a.** The number of individuals receiving Employment Services;
- **b.** The number of persons working in the following settings: individual integrated employment, self-employment, sheltered employment, and group;
- **c.** The number of individuals working in an integrated employment setting;
- **d.** The number of hours worked per week and hourly wages paid to those persons;
- **e.** The choices made by individuals between integrated work, sheltered work, and not working;
- **f.** Problems or barriers to placement and retaining employment in community-integrated settings;
- **g.** Service gaps;
- **f.** Complaints and grievances.

Appendix # 1: Services and Supports

a. By July 1, 2014, ODDS and/or OVRS will provide Employment Services to at least 50 individuals.

b. By July 1, 2015, ODDS and/or OVRS will provide Employment Services to at least an additional 100 individuals.

c. By July 1, 2016, ODDS and/or OVRS will provide Employment Services to at least an additional 200 individuals.

d. By July 1, 2017, ODDS and/or OVRS will provide Employment Services to at least an additional 275 individuals.

e. By July 1, 2018, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

f. By July 1, 2019, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

g. By July 1, 2020, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

h. By July 1, 2021, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

i. By July 1, 2022, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

Massachusetts

MASS. - Blueprint for Success: Employing Individuals with Intellectual Disabilities in Massachusetts

BACKGROUND

In response to recent United States Department of Justice (DOJ) litigation regarding Title II of the Americans with Disabilities Act and Olmstead v. L.C. , and CMS' "HCBS Final Rule" requirements regulating size and settings of non-residential service settings; a group of Massachusetts (MA) disability service providers, advocates, and the Department of Developmental Services (DDS) examined day and employment support service programs for adults with intellectual disabilities (ID). As a result of their analysis, the Massachusetts Association of Developmental Disabilities (ADDP), the Arc of Massachusetts, and the Massachusetts Department of Developmental Services (DDS) entered into a proactive plan to increase community-integrated competitive employment opportunities for people with intellectual disabilities (ID). The plan emphasizes the importance and benefits of having a job and contributing to community businesses through work.

ACTION STEPS

1.) Inform providers that purchasing sheltered workshop services will discontinue within five years.
2.) Require providers to submit business plans on how they are going to increase community-integrated, competitive employment and phase out sheltered workshop services.
3.) Require providers to make concerted efforts to assist people to enter into community-based, supported employment (individual or group), and re-structure their programs into employment services.
4.) Define and align all provider service practices with Employment First Policy.
5.) Develop, establish and implement a new standardized services rate structure that incentivizes integrated, community-based, supported employment (individual or group) services and outcomes (please refer to Appendix 2).
6.) Close new referrals to sheltered workshop programs as of January 1, 2014 as a first step to phase out by June 30, 2015.
7.) During fiscal year 2015, individuals currently in sheltered workshop programs will gradually transition into individual supported employment, group supported employment, and/or community-based day services (CBDS) programs (please refer to Appendix 1). Facility-based, day training and habilitation will only be a service option when it has been determined the most appropriate service option for the person.
8.) Increase the number of people who participate in community integrated individual and group supported employment that pays minimum wage or higher in fiscal years 2016, 2017 and 2018. Gradually phase out group employment settings that pay less than minimum wage.
9.) Expand the scope of CBDS programs to include service options with a career exploration/planning component to serve as a pathway to employment through use of a variety of different volunteer, internships (e.g., Project Search), situational assessments/discovery opportunities, skills training or other community-based experiences. Continue to transition individuals from CBDS into community-integrated work opportunities that pay minimum wage or higher. The CBDS model will also be used to provide complementary supports for individuals who work part-time and need and want to be engaged in structured, program services for the remainder of the work week.
10.) Develop and implement a common framework for a planning and assessment process that allows informed choice as an integral part of the development of a person-centered career plan.
11.) Recruit and fund state advocacy organizations to develop and conduct a comprehensive, statewide educational outreach campaign directed at people with disabilities and their families that includes informational resources, regional forums, family-to-family connection groups and peer support groups.
12.) Create via appointment an Employment First review council to facilitate implementation and monitor ongoing progress of the transition plan.

TRAINING AND SYSTEM DEVELOPMENT

1.) Engage in business consultation, strategic planning and technical assistance to providers on redesigning services and restructuring organizations to convert from congregate and segregated, sheltered workshops into individualized, community-integrated employment services and support provider, including Community-Based Day Services (CBDS).

2.) Develop comprehensive training for employment specialists/job developers with curriculum and field work experiences that are aligned with credentialing //certification entities for employment specialist professionals.

3.) Design educational material and resources for benefits analysis, planning and work incentives.

4.) Produce training on (a) career exploration and discovery approaches; (b) customized job development; (c) systematic instruction techniques, (d) working with specific populations; (e) technology on the job, and (f) other relevant topic areas to be identified.

5.) Create communities of practice that provide in-service learning courses.

6.) Conduct Peer-to-Peer learning sessions for providers to work together on common issues.

7.) Build and fund a coalition of regional employment collaboratives across the state to maximize resources, share best practices, share lessons learned, conduct macro-level job development and provide opportunities for partnership among state agencies, employment service provider organizations and employers. Central Massachusetts Employment Collaborative uncovered over 248 employment opportunities and 136 individuals with disabilities were hired at minimum wage or higher by businesses in the community.

8.) Draft a comprehensive MOU agreement that cooperatively collaborates and coordinates inter-agency responsibilities, resources, services and funding to achieve a unified effort toward getting youth and adults competitively employed in the community.

9.) UMass-Boston ICI will establish a consultant pool consisting of individuals and/or qualified organizations as subject matter experts and technical advisors.

FUNDING and FISCAL STRATEGY (please refer to Appendix #2)

1.)* A total investment of $26.7 million over four fiscal years, from 2015 through 2018 is projected.

2.) Cost analyses are based on the number of people who are receiving facility-based, sheltered workshop services on a full-time basis or part-time basis as of July 1, 2013. The total number of individuals participating in sheltered workshop services is 2,608: 1,251 attend sheltered workshops full-time (typically 30 hours/week) and 1,357 attend part-time (52%).

3.) An investment of new funding is needed to provide resources and opportunities for people to move from sheltered workshop services (rate = $8.42/hour) to individual (rate = $47.96/hour) or group (rate = $13.80/hour) supported employment, and/or CBDS programs (rate = average $12.92/hour). These services have higher rates due to service design and staffing ratio requirements. The incremental infusion of new funding provides a “bridge” to new service options for individuals currently receiving sheltered workshop services.

Important Note: The net cost to the state would only be approximately $13 million dollars due to Medicaid HCBS waiver reimbursement via federal financial participation at almost 50%. for these services.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

With UMass – Boston ICI, continue to develop and implement an employment outcome data collection system that:

1.) effectively records and reports relevant information and data on new job placements and movement within the service system in order to track and document progress; and

2.) informs the planning processes and transformation initiatives.

Appendix # 1: Services Descriptions

Center-Based Work Services (activity code 3169)

Center-based work services ("sheltered workshops") are essentially work preparatory services that are delivered in segregated settings and that provide supports leading to the acquisition, improvement, and retention of skills and abilities that prepare an individual for work and community participation. Services are not predominantly job-task oriented, but are intended to address underlying generalized habilitative goals, such as increasing a participants attention span and completing assigned tasks, goals that are associated with the successful performance of compensated work. It is intended that the service should be time-limited to assist individuals to move into supported employment options. This service must be provided in compliance with Department of Labor (DOL) requirements for compensation.

Individual Supported Employment (activity code 3168)

An individual receives assistance from a provider to obtain a job based on identified needs and interests. Individuals may receive supports at a job in the community or in a self-employed business. Regular or periodic assistance, training and support are provided for the purpose of developing, maintaining and/or improving job skills, and fostering career advancement opportunities. Natural supports are developed by the provider to help increase inclusion and independence of the individual within the community setting. Employees should have regular contact with co-workers, customers, supervisors and individuals without disabilities and have the same opportunities as their non-disabled co-workers. Individuals are generally paid by the employer, but in some circumstances may be paid by the provider agency.

Group Supported Employment (activity code 3181)

A small group of individuals, (typically 2 to 8), working in the community under the supervision of a provider agency. Emphasis is on work in an integrated environment, with the opportunity for individuals to have contact with co-workers, customers, supervisors, and others without disabilities. Group Supported Employment may include small groups in industry (enclave); provider businesses/small business model; mobile work crews which allow for integration, and temporary services which may assist in securing an individual position within a business. Most often, the individuals are considered employees of the provider agency and are paid and receive benefits from that agency.

Community-Based Day Supports (activity code 3163)

This program of supports is designed to enable an individual to enrich his or her life and enjoy a full range of community activities by providing opportunities for developing, enhancing, and maintaining competency in personal, social and community activities. Services include, but are not limited to, the following service options: career exploration, including assessing interests through volunteer experiences or situational assessments; community integration experiences to support fuller participation in community life; skill development and training; development of activities of daily living and independent living skills; socialization experiences and support to enhance interpersonal skills; and pursuit of personal interests and hobbies. This service is intended for individuals of working-age who may be on a "pathway" to employment; as a supplemental service for individuals who are employed part-time and need a structured and supervised program of services during the day when they are not working, which may include opportunities for socialization and peer support; and individuals who are of retirement-age and who need and want to participate in a structured and supervised program of services in a group setting.

Appendix # 2: Funding and Fiscal Strategy

FY 2014: This is an important planning year to conduct assessments and develop plans with individuals in sheltered workshop programs to determine which alternative service option(s) will best meet their needs.

FY 2015: The largest investment is needed this year to facilitate transition to individual or group supported employment, and/or to CBDS programs for **all** participants in center-based/sheltered workshops. It is expected a majority of individuals will initially move to CBDS programs, which will provide opportunities to explore work-related possibilities. This will enable DDS to reach the goal of phasing out sheltered workshop services and removing the concern of sub-minimum wage payments related to sheltered work programs by June 30, 2015. (Proposed investment: $11.1 million; Net state cost: 5.55 million).

FY 2016: It is expected that a larger number of individuals will move to individual or group supported employment options this year from CBDS programs. In addition, funding will provide participation in CBDS for individuals who work part-time. (Proposed investment: $6.3 million; Net state cost: $3.15 million).

FY 2017: There will be continued movement of individuals from CBDS programs to individual and/or group supported employment services to provide integrated employment opportunities for all individuals who had previously been participating in sheltered workshop programs. (Proposed investment: $8.3 million; Net state cost: $4.15 million).

FY 2018: The final year of investment is used to solidify gains made in integrated employment services for individuals in CBDS and also facilitate movement of individuals to group supported employment earning above minimum wage. (Proposed investment: $1 million; Net state cost: $500,000).

Results

- Ends the purchasing of sheltered workshop services and successfully transition individuals into other employment or service options by the end of fiscal year 2015.
- Eliminates sub-minimum wage payments used by sheltered workshops.
- This funding investment would support individuals to:
    (a) obtain community-integrated, competitive jobs through individualized supported employment services, and
    (b) facilitate movement of individuals in group supported employment to earning minimum wages or higher.
- Develops an employment services provider network and system of supports that are more responsive in meeting the needs of people with ID.
- Establishes a system of inclusive employment and day service options that support people with disabilities in competitive, community employment and life pursuits.

Appendix B: Service and settings definitions

Residential Setting/Service	Description
Adult foster care	Licensed, living arrangement that provides food, lodging, supervision, and household services. They may also provide personal care and medication assistance. Adult foster care providers may be licensed to serve up to four adults or five adults if all foster care residents are age 55 or older, have no serious or persistent mental illness, nor any developmental disability. There are two types of adult foster care: Family Adult Foster Care is an adult foster care home licensed by the Minnesota Department of Human Services. It is the home of the license holder and the license holder is the primary caregiver. Non-Family Adult Foster Care (Corporate Adult Foster Care) is an adult foster care home licensed by the Minnesota Department of Human Services that does not meet the definition of Family Adult Foster Care because the license holder does not live in the home and is not the primary caregiver. Instead, trained and hired staff generally provide services. The same foster care license requirements apply to both family and non-family homes. BI, CAC and CADI waiver recipients may use waiver services of adult foster care when the scope of services assessed and identified in the service plan exceeds the scope of services provided through the foster care payment rate paid from the person's assessed resources and the Group Residential Housing rate.
Assisted living residence	Assisted Living residences generally combine housing, support services, and some kind of health care. Individuals who choose assisted living can customize the services they receive to meet their individual needs. To be considered an assisted living residence, the facility must provide or make available, at a minimum, specified health-related and supportive services. Examples include: assistance with self-administration of medication or administration of medication, supervised by a registered nurse; two meals daily; daily check system; weekly housekeeping and laundry services; assistance with three or more activities of daily living (dressing, grooming, bathing, eating, transferring, continence care, and toileting); and assistance in arranging transportation and accessing community and social resources. Every assisted living facility must have a license from the Minnesota Department of Health in order to operate
Board and lodge	Board and Lodge vary greatly in size, some resemble small homes and others are more like apartment buildings. They are licensed by the Minnesota Department of Health (or local health department). Board and lodges provide sleeping accommodations and meals to five or more adults for a period of one week or more. They offer private or shared rooms with a private or attached bathroom. Substance abuse - Board and Lodge can provide housing for up to six months for clients who need stable supportive housing, and strives to provide its residents with additional support services, including Peer Support Services, yet many of these additional services are not currently reimbursable. Often, the client will reside in a "Sober House" while at the same time receive outpatient services from another provider. Homeless shelters are a subset of board and lodge facilities.
Board and lodge with special services	Many Board and Lodge facilities offer a variety of supportive services (housekeeping or laundry) or home care services (assistance with bathing or medication administration) to residents
Boarding care	Boarding Care homes are licensed by the Minnesota Department of Health and are homes for persons needing minimal nursing care. They provide personal or custodial care and related services for five or more older adults or people with disabilities. They have private or shared rooms with a private or attached bathroom. There are common areas for dining and for other activities.
Child foster care	Children under the age of 18 - BI, CAC and CADI waiver recipients may use the waiver service of child foster care when the scope of services assessed and identified in the service plan exceeds both the scope of services provided in the Out of Home Placement Plan and the payment rate that the lead agency is required to cover.
Children's residential care (Children's residential facilities – Rule 5)	Children's residential facilities standards (Minnesota Rules, Chapter 2960) govern the licensing of providers of residential care and treatment or detention or foster care services for children in out-of-home placement. These standards contain the licensing requirements for residential facilities and foster care and program certification requirements for program services offered in the licensed facilities. Statutory language defines "certification" as meaning the commissioner's written authorization for a license holder licensed by the Commissioner of Human Services or the Commissioner of Corrections to serve children in a residential program and provide specialized services based on certification standards in Minnesota Rules. The term "certification" and its

	derivatives have the same meaning and may be substituted for the term "licensure" and its derivatives.
Crisis respite (foster care)	Short-term care and intervention strategies to an individual for both medical and behavioral needs that support the caregiver and/or protect the person or others living with that person. Crisis respite services may be provided: • In-home or • Out-of-home in a specialized licensed foster care facility developed for the
Housing with services establishment	Generally apartment building settings with individual units. Family adult day services must meet standards in Minn. Stat. §245A.143 or Minn. R. 9555, parts 5105 to 6265. If you hold a license as an adult foster care provider and meet the family adult day services standards, DHS does not require you to obtain a separate family adult day services license.
Supervised living facilities	Group home setting serving five or more people with disabilities. SLF provides supervision, lodging, meals, counseling, developmental habilitation or rehabilitation services under a Minnesota Department of Health license to five or more adults who have a developmental disability, chemical dependency, mental illness, or a physical disability.
Supported living services	Developmental disability waiver services provided in a foster care setting are called Supported Living Services (SLS) under Residential Habilitation. Residential Habilitation: Services provided to a person who cannot live in his or her home without such services or who need outside support to remain in his or her home. Habilitation services are provided in the person's residence and in the community, and should be directed toward increasing and maintaining the person's physical, intellectual, emotional and social functioning.
Employment/Day Service/Setting	
Adult day services/Adult day care	Adult day services /Adult day care: Services provided to persons who are 18 years of age or older that are designed to meet the health and social needs of the person. The plan identifies the needs of the person and is directed toward the achievement of specific outcomes.
Family adult day services	A family adult day service program is a program that operates fewer than 24 hours per day and provides functionally impaired adults, none of which is under age 55, have serious or persistent mental illness or people with developmental disabilities or a related condition, with an individualized and coordinated set of services including health services, social services and nutritional services that are directed at maintaining or improving the participants' capabilities for self-care. A family adult day services license is only issued when the services are provided in the license holder's primary residence, and the license holder is the primary provider of care. The license holder may not serve more than eight adults at one time, including residents, if any, served under an adult foster care license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.
Structured day program	Service designed for persons who may benefit from continued rehabilitation and community integration directed at the development and maintenance of community living skills. (Only available through the Brain Injury waiver.)
Day training & habilitation	Licensed supports to provide persons with help to develop and maintain life skills, participate in community life and engage in proactive and satisfying activities of their own choosing.
Pre-vocational service	Services designed to prepare persons for paid or unpaid employment, as reflected in the plan of care.
Supported employment services	Services for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, needs intensive ongoing support to perform in a work setting. The person receiving services must be in a paid employment situation.

EXHIBIT 6-14: SS 3C, 3D, 3E – STATEWIDE PLAN FOR POSITIVE PRACTICES AND SUPPORTS

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Minnesota Departments of Human Services and Education

Minnesota's State-wide Plan

Building Effective Systems for Implementing Positive Practices and Supports

Department of Human Services
10/22/14

Publication Date: 2014

Primary Contributors

State of Minnesota

Rick Amado	Positive Supports & Person-centered Practices Consultant, Disability Services Division
Carol Anthony	Lead State-wide Team Contact & Program Coordinator, Community Supports & Consumer Safeguards, Disability Services Division
Faye Bernstein	Mental Health Program Consultant, Adult Mental Health
Stacy Danov	Clinical Coordinator, Community Supports & Consumer Safeguards Unit, Disability Services Division
Jason Flint	Supervisor, Community Supports & Consumer Safeguards, Disability Services Division
Tom Jensen	Project Manager to Olmstead Implementation Office, Direct Care Treatment
Jelaine Johnson	Mental Health Program Consultant, Children's Mental Health Division
Eric Kloos	Supervisor, Research, Practice and Implementation Unit, Special Education Division, Minnesota Department of Education
Dan Newman	Operations Manager, Disability Services Division
Robyn Widley	Supervisor, Interagency Partnerships Unit, Special Education Division, Minnesota Department of Education
Charles Young	Positive Supports Lead, Community Supports & Consumer Safeguards Unit, Disability Services Division
Brian Zirbes	Planner Principal State, Alcohol and Drug Abuse Division

University of Minnesota

Rachel Freeman	Research and Training Center for Community Living (RTCCL), Institute for Community Integration (ICI)
Amy Hewitt	ICI, RTCCL Director
Barb Kleist	ICI, RTCCL
Susan O'Nell	ICI, RTCCL

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Table of Contents

Executive Summary

This report was completed by state leaders from the Minnesota Departments of Human Services and Education (e.g. DHS and MDE respectively) in collaboration with the Institute on Community Integration at the University of Minnesota. The purpose of this report is to summarize progress made on assigned objectives that are associated with Minnesota's Olmstead Plan. All of the efforts reflected in this report are driven by a vision to improve the lives of all people living in Minnesota. This report provides a framework for organizing policies, technical assistance, and resources to ensure people receiving services, are treated with respect, and receive the support they need to live independent, self-determined and meaningful lives in their home communities. Real change occurs when one's vision for a better life is not merely a set of words that are referred to in written form. *When a vision that is articulated by a group of people is made a part of everyday actions taken within an organization, county, region, and state-wide, significant and meaningful work can be achieved* (Fullan, 2005).

The state plan described in this report will be successful by a) designing and implementing a technical assistance plan that involves teaching organizations to embed the values and vision outlined in the Minnesota Olmstead plan into the everyday actions taken by individuals providing services, and b) working collaboratively to implement the plan with stakeholders who represent people receiving services across the lifespan, family members, caregivers, advocates, practitioners and community members. For this reason, the report represents a first step in the state-wide planning process. Four major activities that are being used to make the vision outlined in the Olmstead Plan a reality are included in this report. These activities are described in this summary and with a locator table (see Table 1) to align the work being completed with the objectives listed in Action 3 of the Olmstead Plan.

Inventory of Minnesota Policies and Best Practices. DHS and MDE initiated a system for the inventory and analysis of both restrictive procedures and positive practices currently used across agencies. The results from the first dissemination of an online survey is available in Appendix A. Responses from the survey and earlier work from various team members was used to gather the initial identification of policies and practices from 25 different statutory citations. Once inventory data for DHS and MDE are finalized, the inventory review process will be expanded to other agencies. A subset of staff members from a state-wide planning team are continuing to meet regularly to complete the DHS and MDE inventory by January, 2015.

Unified Cross-agency Definition of Key Terms. The first step in aligning definitions across agencies is to evaluate the extent to which these terms currently vary starting with DHS and MDE. Key terms were identified for common reporting purposes. The inventory survey included questions used to gather more information about terms used within each agency. A grid compiling the definitions for any terms that were submitted as part of the survey is being compiled but has not yet been finalized due to the need for further information (see Appendix B). The same workgroup assigned to finalizing the inventory will continue working on the definitions first identified in this activity.

Best Practice in Positive Supports. The state recommends that teams use a collaborative data-based decision making framework to support people and adopts the

broader term *positive supports* to reflect practices that are person-centered, encourage self-determined behavior, build on social and emotional skills, and take a person's physical, social, and mental health into consideration. Positive behavior support provides a larger framework for implementing systems change. This implementation framework will be used to guide technical assistance efforts with the assumption that technical assistance efforts reflected in this state-wide plan will include a number of positive practices for preventing problem behavior. However, person-centered planning and positive behavior support are recommended whenever a person would clearly benefit from these practices and/or when other positive supports have not been effective.

Minnesota's State-wide Plan for Implementing Positive Supports. The state-wide team recommends using research findings summarized by Fixsen and his colleagues (2005) to create a state-wide communication and technical assistance framework for coordinating efforts to decrease the use of restrictive procedures and increase implementation of positive supports across agencies. This infrastructure will be used to ensure the following six implementation goals are implemented: 1) establishing a technical assistance infrastructure across agencies, 2) designing and implementing strategies for data-based decision making and evaluation, 3) creating a marketing plan for increasing awareness of positive supports across the state, 4) expanding preservice and aligning inservice training systems state-wide, 5) developing and maintaining an inventory of policies related to restrictive practices and positive supports, and 6) expanding interagency crisis prevention planning. A logic model was developed by the team to summarize the expected outcomes related to positive support implementation (see Figure 3 and the Appendix D for more details). The first steps taken by the state-wide team is to recruit workgroup chairs and initial team members for each of six major implementation tasks. Initial meetings (one or more) within each workgroup will occur on or before January, 15, 2015. Quarterly state-wide team meetings will be scheduled for November, 2014 January, 2015 April, 2015, and July, 2015.

Table 1. Locator Table with Page Numbers Related to Action 3 of the Olmstead Plan.

Activities (Pages 65-67)	*** Olmstead Activities from Action 3**	**Timeline**	**Page Numbers**
Action 1 [SS 3A]	The state will implement the new Minnesota Statute §245D standards.	1-1-14	
Action 2 [SS 3B]	A Rule with operational details that replaces Minnesota Rules, parts 9525.2700 to 9525.2810 (also known as Rule 40) will be promulgated. [SS 3B]	7-1-15	
Action 3 [SS 3C]	The state will create an inventory and analysis of policies and best practices across state agencies related to positive practices and use of restraint, seclusion or other practices which may cause physical, emotional, or psychological pain or distress.	7-1-14	5-6 10-12 26, 27 Appendix A
Action 4 [SS 3D]	A report outlining recommendations for a state-wide plan to increase positive practices and eliminate use of restraint or seclusion will be delivered to the Olmstead Subcabinet or their designee by an assigned team of representatives from Olmstead Subcabinet agencies.	7-1-14	5-6 15-30 Appendix D
Activity 5 [SS 3E]	The state will develop, across state agencies, a common definition of incidents, including emergency use of manual restraint, that are to be reported, and create common data collection and incident reporting processes.	8-1-14	5-6 12-13 22-24 Appendix B
Action 6 [SS 3F]	State-wide implementation of common incident reporting will begin.	7-1-15	22-23 26-27 Appendix D
Action 7 [SS3G.1-3G.4]	Quarterly summaries of incidents of emergency use of manual restraint or other types of restraint, seclusion or other practices that may cause physical, emotional, or psychological pain or distress will be reported to an assigned team of representatives from each state agency for review and to inform recommendations to reduce the incidents.	10-1-15	15-24 25 Appendix D
Action 8 [SS H.1, 3H.2]	Annually thereafter, the team will provide recommendations to the Olmstead Subcabinet to reduce emergency use of restraints, or other practices that may cause physical, emotional, or psychological pain or distress, and to increase positive practices.	7-1-15	26 Appendix D
Action 10	A coordinated triage and “hand-off” process for crisis	8-1-14	26-27

[SS 3I]	intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation. Report will be delivered to the Olmstead Subcabinet.		Appendix D
Action 11 [SS 3J]	An assigned team of representatives from state agencies, community organizations, community corrections and people with disabilities who have used the crisis system will: identify best practices, including use of technology; set service standards; and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions (e.g. person-centered planning, positive practices, available resources). Progress toward goal will be reported to the Olmstead Subcabinet or their designee.	12-1-14	26-27 Appendix D
Action 12 [SS 3J.1]	DHS will have completed the necessary analysis and planning to expand crisis services, diversion, and early intervention services to persons at risk of experiencing a crisis situation. The expansion plan will include projected start dates for implementation of the services.	1-15-15	22-23 25,27 Appendix D
Action 13 [SS 3J.1]	Crisis services, including diversion and early intervention services, will be made available to any person in need of these supports and at risk of experiencing a crisis situation. The purposes of this intervention include stabilizing the person's situation or avoiding the use of civil commitment.	7-1-15	26-27 Appendix D
Action 14 [SS 3K]	Develop measurements to better understand and track crisis episodes across service systems; create a data collection plan and mechanisms; establish baseline data and set targets (e.g., number of crisis calls made, reason for the call, response given, follow-up information.) Baseline data and targets will be delivered to the Olmstead Subcabinet or their designee.	7-1-15	26, 27 Appendix D

** While not the Direct Focus of the Report, the Actions Indicated in Light Grey are Addressed as Part of State-wide Planning and Future Targeted Timelines*

Minnesota's State-wide Plan: Building Effective Systems for Implementing Positive Practices and Supports

Purpose and Introduction

This report was completed by state leaders from the Minnesota Departments of Human Services and Education (e.g. DHS and MDE respectively) in collaboration with the Institute on Community Integration at the University of Minnesota. The purpose of this report is to summarize progress made on objectives that are associated with Minnesota's Olmstead Plan including the actions related to an inventory of policies, creating common definitions for reporting purposes, best practice technical assistance in the implementation of positive supports, and state-wide planning. All of the efforts reflected in this report are driven by the vision that seeks to improve the lives of all people living in Minnesota as outlined in the Olmstead Plan report (pages ten and eleven). The actions taken by the state-wide team will help to articulate how services will be delivered in a manner that will ensure all people are treated with respect and receive the support they need to live independent, self-determined and meaningful lives in their home communities.

Research in systems change indicates that it is not sufficient to create a vision and mission statement that is referenced in written reports or placed on posters that are hung on the wall. Significant and meaningful change occurs when one's vision for a better life is not merely a set of words that are referred to in a passive manner; a vision and mission must be made a part of the actions taken within an organization and that drive decisions on an every day basis (Fullan, 2005). The goal of implementing positive and proactive interventions and decreasing the use of restrictive procedures across the state of Minnesota will become a reality when the vision that has been articulated in the Olmstead Plan has been embedded within the state system and within organizations providing services across the state. To make this vision a reality, it is important to align and improve policies at state and organizational levels, disseminate ongoing and coordinated training and technical assistance, and recognize, reward, and empower leaders who demonstrate to others how people across the lifespan can be empowered and supported using person-centered services and supports.

Furthermore, the state planning described in this report will only be successful if all of the stakeholders across the state of Minnesota are actively involved in making decisions and guiding all implementation efforts. Team-based collaboration is necessary to achieve these changes with participants representing people receiving services across the lifespan, family members, caregivers, advocates, practitioners, and community members. For this reason, the state-wide plan described in this report is considered a first draft that will be expanded and modified based on feedback from stakeholders who are assisting the state in these systems change efforts. This planning process presumes that the changes that are implemented will occur across and within state systems including Direct Care and Treatment and services provided under Disability Services Division (DSD) as well other divisions (mental health, aging education, etc.).

The report will describe four major activities that will assist the state in making the vision outlined in the Olmstead Plan a reality. These tasks include:

- Creating an inventory of policies that refer to limiting the use of restraint,

seclusion or other practices and establishing best practices across state agencies related to positive support practices;
- Developing a common definition of incidents that will lead to (including emergency use of manual restraint), common data collection and incident reporting processes;
- Identifying best practices, setting service standards, and developing and delivering training and technical assistance in order to respond to a request for assistance with least intrusive service/actions; and
- Outlining recommendations for a state-wide plan to increase positive practices and eliminate use of restraint or seclusion.

The locator table (see Table 1) provides information regarding how the report addresses objectives listed in Action 3 of the Olmstead Plan. Timelines for actions in the report are aligned with the objectives listed on pages 65-67 of the Olmstead Plan report. Each section of this report describes important elements related to the four objectives including: a) the process used to establish an inventory of policies related to restrictive practices and positive strategies for increasing person-centered prevention-based interventions, b) steps taken to define key terms associated with incidents of problem behavior and positive strategies for supporting people, c) best practices in positive behavior support for large-scale technical assistance, d) a first draft of a state-wide plan to decrease the use of restrictive practices and increase person-centered prevention-based supports, e) an evaluation plan for measuring the impact of the state's implementation efforts, and f) next steps for moving forward.

Inventory of Policies and Practices

The Minnesota Department of Human Services initiated a process for creating an inventory and analysis of both restrictive procedures and positive practices across state agencies. To accomplish this task, a plan was developed to complete the inventory and analysis with input from state leads. The Minnesota Department of Human Services (DHS) (including Disability Services Division, Adult Mental Health, Aging, Alcohol and Drug Abuse Division, Children's Mental Health etc.), and the Department of Education (MDE) were identified as the first two state agencies to complete the inventory survey. The following state agencies are identified for next phase of inventory include the Department of Health (MDH), Department of Employment and Economic Development (DEED), Department of Corrections, Department of Human Rights and other state agencies identified during the inventory process. Key deliverables of the plan included:

- Identifying inventory categories,
- Creating an online inventory survey using a format accessible to state agency staff,
- Recruiting key staff to complete inventory survey,
- Launching the online survey,
- Reviewing and analyzing inventory results, and
- Identifying next steps for finalizing what will become an annual inventory assessment process.

An online inventory survey was created by the University of Minnesota ICI using Qualtrics Survey platform to collect information about current policies and practices across state agencies. Key DHS and MDE staff with policy-related expertise were recruited to assist in designing the cross-agency inventory. Staff members from DHS representing Disability Services Division, Adult Mental Health, Alcohol and Drug Abuse Division, Children's Mental Health were then recruited to participate in completing the initial survey inventory. Lead staff members from MDE were also sent a request to complete the inventory. MDE representation included key staff from Compliance and Assistance Division.

A draft of a survey that would be used to gather information for the inventory was reviewed on Oct. 3, 2014 and revisions were made to this survey on Oct 8, 2014. The inventory survey was activated on Oct. 10, 2014 and sent to identified staff who were asked to complete the survey on or before October 15, 2014. The online survey, available in Appendix A of this report, asked respondents to identify: a) policies and practices that restrict, limit, define the use of non-positive supports including approaches that are prohibited; and /or b) best practices/promising practices that support prevention of problem behavior through positive, self-directed support to people at risk. Survey details to be completed by respondents included:

- State agency and division,
- Identification of policies related to restrictive practices and promote positive, proactive strategies for preventing problem behavior,
- Identification of best practices/evidence-based practices used to address restrictive/restricted or prohibited practice and promote positive, proactive strategies for preventing problem behavior,
- Source of document including hyperlink, when applicable;
- Publication date of document and whether it's in process of being revised or updated including status;
- Identification of type of document (policy, procedure, statute/law, rule/regulation, practices manual etc.);
- Citation of state or federal regulation, statute, rule or policy, if applicable;
- Names of related documents and numbers, where applicable;
- Application of policy or practice for personnel requirements related to practices or programs;
- Definition of incidents requiring reporting and documentation;
- Information about data collection systems (how information is recorded and summarized);
- Identification of who is intended audience for policy or practice; and
- Contact information for the staff completing the inventory survey.

The result of the first dissemination of the survey is available in the Appendix A Responses from the survey and earlier work from various team members produced the initial identification of policies and practices from 25 different statutory citations; 13 rule citations; five (5) trainings and six (6) policy and practice citations. Those policies and practices identified through the inventory survey include five (5) responses identifying the policy as best practice/evidence based practice for positive supports, ten (10)

responses identifying that the policy restricts, limits, defines the use of non-positive supports such as restrictive procedures, seclusion, restraint, prohibited procedures etc. Additionally, eight (8) of the survey responses indicated that the policy or practice contained a definition of incidents that must be reported. The next step in gathering inventory information will be to reach out to state staff who can provide information about the areas of the inventory that are not completed. After the complete inventory process is finalized across DHS and MDE, the process will be expanded to other agencies.

A subset of staff members from the state-wide planning team are continuing to meet regularly to complete the inventory of DHS and MDE policies and to analyze the final results. The inventory of policies for DHS and MDE will be completed by January, 2015 and timelines for expanding the inventory to other agencies will also be reported at that time. The subset of staff working on this task will be reaching out to stakeholders to share the inventory results and the finalized inventory of policies will available online for public use. The inventory survey included questions about the definitions that are used by DHS and MDE to record significant problem behaviors. Of particular interest is how incident reports and office discipline-related terms are used to document problem behavior occurring in educational contexts, and within residential and community settings.

Unified Cross-agency Definition of Key Terms

The state team identified a list of common terms that are used across DHS and MDE in common reporting systems while the inventory survey was being completed. Clear and consistent definitions are important for establishing the data collection systems that will be used by the state but are also essential for creating a common language of prevention across the state. The following were identified by the team as examples of terms that need to be formally defined:

- reportable incidents,
- restrictive procedures/restricted procedures,
- crisis,
- emergency,
- positive supports,
- positive behavior support,
- person-centered planning,
- evidence-base practices, and
- best practices.

The first step in aligning definitions across agencies is to evaluate the extent to which these terms currently vary across DHS and MDE contexts. A grid outlining the definitions of key terms that were submitted as part of the online survey cannot be summarized until the inventory of policies are completed. However, Appendix B provides the initial organizational structure that will be used to complete this task. The same workgroup assigned to complete the inventory will continue working on the definitions in collaboration with state information technology (IT) staff and state personnel involved in incident report data collection systems. Lead staff across each

agency and representatives of stakeholder groups will be asked to provide feedback and gain consensus on the definitions as a part of a consensus-building process. Since the definitions in question will be used for evaluation and data-based decision making at the local, regional, agency-wide, and state-wide levels, the state is proceeding systematically to ensure the data collected will align with technical assistance efforts. Part of the technical assistance efforts that are implemented related to positive supports will include teaching organization-wide teams to use data to implement interventions, engage in progress monitoring, and to report decreases in incidents, crises, use of restraints and other responses associated with problem behavior. A number of important terms that will help make the vision and mission of the Olmstead plan a reality are addressed in the next section of this report including: evidence-based practices, positive behavior support, and positive support strategies, a broader term that describes a broader array of value and prevention-based practices.

Evidence-based Practices

The term, evidence-based practice, is now widely used at the federal and state levels and across many fields of study. Most of these definitions share similar features across different fields (for example, please see Table 2 and http://nrepp.samhsa.gov/AboutNREPP.aspx).

Table 2. Definitions of Evidence-based Practice Across Different Fields.

American Psychological Society	"Evidence-based practice in positive behavior support is defined as the integration of rigorous science-based knowledge with applied expertise driven by stakeholder preferences, values, and goals within natural communities of support."
Institute for Medicine	"...the integration of best research evidence with clinical expertise and patient values".
Association for Positive Behavior Support	"Evidence-based practice in positive behavior support is defined as the integration of rigorous science-based knowledge with applied expertise driven by stakeholder preferences, values, and goals within natural communities of support."

Not all current practices have fully completed the rigorous large-scale research studies necessary to be considered an evidence-based practice. Practices that are evidence-based must establish the efficacy of the approach and its applicability across the diversity of today's settings, people, and contexts. Many practices across different fields of study are still in the process of acquiring this evidence and are not yet recognized as a formally approved evidence-based practice. For this reason, the need for individual data-based decision making is essential for people and their teams to ensure that each person's services are evaluated closely.

Positive Supports as a Broader State Term for Prevention

During early discussions with state team members and other stakeholders, the importance of honoring all positive prevention-based practices used across agencies was described as an essential consideration. Person-centered planning, dialectical behavior therapy, cognitive behavior therapy, positive behavior support, trauma informed therapy, and many other practices were identified as strategies for preventing problem behavior. This conversation led to the identification of a broader term, *positive supports*. *The state-wide team recommends the use of positive supports as a more inclusive term referring to all practices that include the following characteristics: 1) person-centered interventions, 2) prevention of problem behavior, 3) skill-building, independence, and self-determination, and 4) interventions that focus on changing the social, emotional, and physical environment around a person (sensitivity training for staff members, increasing predictability, stability, etc.).*

Team-based action planning requires interagency teams to work together to empower an individual and his/her family in identifying the practices that will help the person achieve self-determination, independence and a high quality of life. Interventions and practices are selected to fit the unique skills, communication preferences, mental health status, and physiological and health needs of each person receiving support. The state recommends that teams evaluate practices and use data-based decision making to improve outcomes for people receiving services. One approach that naturally encourages interagency collaboration within a team-based data-based decision-making framework is positive behavior support.

National experts define positive behavior support as a set of tools and strategies incorporating: 1) valued outcomes (plans must improve the quality of a person's life and fit cultural views, skills, and resources of people implementing the plan), 2) research based on the principals of behavior, mental health and biomedical sciences, 3) validated procedures that are proven to be effective, and 4) systems change strategies to ensure supports are both effective and sustainable over time. Positive behavior support includes an assessment process that is used to identify the reason, or function, maintaining problem behavior. Once the function of the problem behavior is identified, interventions for teaching new social, emotional, and communication skills are used to prevent problem behavior. Changes in the social and physical environment are made, mental health and wellness strategies implemented, and biomedical and physiologically-base interventions are put in place to improve quality of life and decrease problem behavior.

Positive behavior support is an approach that places great importance on interagency collaboration as an essential feature necessary for effective planning and supports. Each positive behavior support plan is based on a trans-disciplinary team including the people receiving services, family members and caregivers, community representation, and professionals representing key areas of expertise who provide services across wide variety and type of services including but not limited to disabilities, mental health, education, juvenile justice, foster care and family preservation, and aging. Each professional involved in assisting a person in need of support brings a wealth of knowledge about important prevention-based practices that are complementary in nature with positive behavior support. The goal is to empower the individual and his/her family in identifying the unique supports and services needed to improve quality of life, ensure self-determination, and assist people in living meaningful lives in their own communities.

However, positive behavior support is not always necessary in all situations and settings. For instance, person-centered planning can result in significant decreases in problem behavior making a positive behavior support plan unnecessary. A person and his/her team will select the practices that are the best fit while providing evaluation data showing evidence that these practices are successful. For this reason, the state recommends that person-centered planning be implemented prior to positive behavior support. Furthermore, both person-centered planning and positive behavior support are recommended in situations where people who engage in problem behavior would benefit from applied behavior analysis, physiological and biomedical interventions, data-based evaluation, and evidence of improved quality of life outcomes. If other positive support strategies that have been implemented do not prove to be successful as a stand-alone intervention, positive behavior support should be added to a person's planning process.

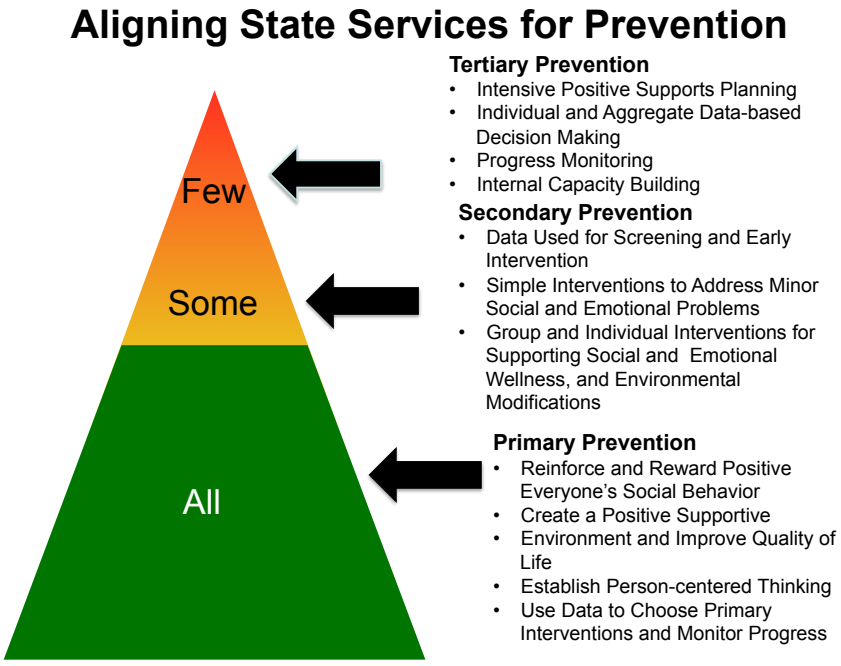
Creating a Framework for Large-scale Implementation

A unique feature of positive behavior support is its emphasis on systems change and strategies for larger scaling up implementation efforts. An interagency synthesis of research on systems change conducted by Dean Fixsen and his colleagues 2005) provides a framework for implementing large-scale technical assistance and training. Positive behavior support efforts are underway across the nation and in a growing number of countries using the information outlined by Fixsen and his colleagues. Large-scale, state-wide implementation of positive behavior support using a three-tiered prevention model is now implemented in the disability field, juvenile justice, early childhood, education, and mental health. A growing number of states are working on strategies for improving interagency communication at the state-wide level as different agencies move forward implementing technical assistance in positive behavior support.

Three-tiered Prevention of Problem Behavior. Key elements of these systems-change efforts include establishing a framework or infrastructure that will assist state teams in training, supporting, and monitoring schools and organizations involved in the implementation of three different levels of systems change (See Figure 1). The three tiered model described in this section was adopted by the World Health Organization (2004) and adapted to address the prevention of problem behavior (Gordon, 1983). The three prevention levels are described as universal or *primary prevention interventions* including practices for promoting person-centered environments and encouraging positive social communication among staff members and people receiving services. At the primary prevention level, teams use data to guide decision making and monitor progress. S*econdary prevention strategies* involve the use of data for early identification and intervention to support people who are at risk for engaging in more serious problem behavior. *Tertiary prevention systems* provide intensive and individualized person-centered planning, positive behavior support, and other practices that will assist people who do not respond to primary and secondary interventions. An important element of positive behavior support at each prevention level is the use of data for decision making. Trainers using a three-tiered model for preventing problem behavior teach organization-wide teams to use data on a regular basis to change inservice and preservice training, improve management, increase or modify supervision, and tailor services and supports for people receiving services. *The state-wide team recommends the use of the implementation framework used to implement positive behavior support but will broaden*

the goals of this infrastructure by using it as a vehicle for implementing the broader array of positive support practices that are identified within state-wide planning processes.

Figure 1. Aligning State Services with a Three-tiered Prevention Model.



Organization-wide Team-based Planning. The goal of positive behavior support at an organizational level is to teach people receiving services, staff members, administrators, and family and community members to work together to solve problems (for example, how do we improve staff training, increase positive reinforcement, become more sensitive to past trauma, accommodate mental health issues, etc.). Consensus building and buy-in increases when all individuals within a setting contribute to important decisions that are made. This empowering message combined with data for progress monitoring, commitment to continuous improvement, troubleshooting, and celebration of success provides a powerful model for building community. Organization-wide teams choose to participate in positive behavior support knowing it requires a long-term commitment. Administrator leadership and direct participation is essential to the change process. Buy–in and consensus-building processes using a team approach and all individuals (people receiving services, staff, management, family members, etc.) within a particular setting increases the likelihood of effective implementation. Regular team meeting processes employ the use of data to drive action planning over time. Positive reinforcement systems are used to acknowledge and recognize staff members' efforts in improving a person's quality of life, encouraging independence, and facilitating meaningful friendships with others. In some organizations, people receiving services actively reinforce staff members they observe engaging in positive person-centered actions.

Agency-wide Coordination. Figure 2 shows how state-wide agency teams are organized to produce large-scale coordination of positive behavior support. The purpose of the agency-wide team is to provide oversight and coordination of technical assistance to organizations learning to make fact-based, data-based decisions for improving outcomes for the people they serve. The data collected by these organizations are summarized at the agency-wide team with an emphasis on using these data in a manner that is dedicated to the ethical principles associated with continuous services and personal improvement. State-wide leadership teams coordinating the implementation of positive behavior support within one service area (e.g. education, mental health, etc.) ensure open communication and transparent processes are established by recruiting people who represent important stakeholders. Examples of stakeholders include people receiving services, family members, administrators, managers, professionals, community members, higher education, and anyone else who represents an important stakeholder associated with services within a particular agency context. Figure 2 describes the important roles of the leadership team. Teams meet on a regular basis to ensure funding is available for technical assistance efforts, there is visibility and awareness of the positive behavior support efforts taking place (website, newsletters, board presentations, community outreach), technical assistance content is in place, and policies are aligned with best practices. Interagency systems are established to improve coordination of services and communication.

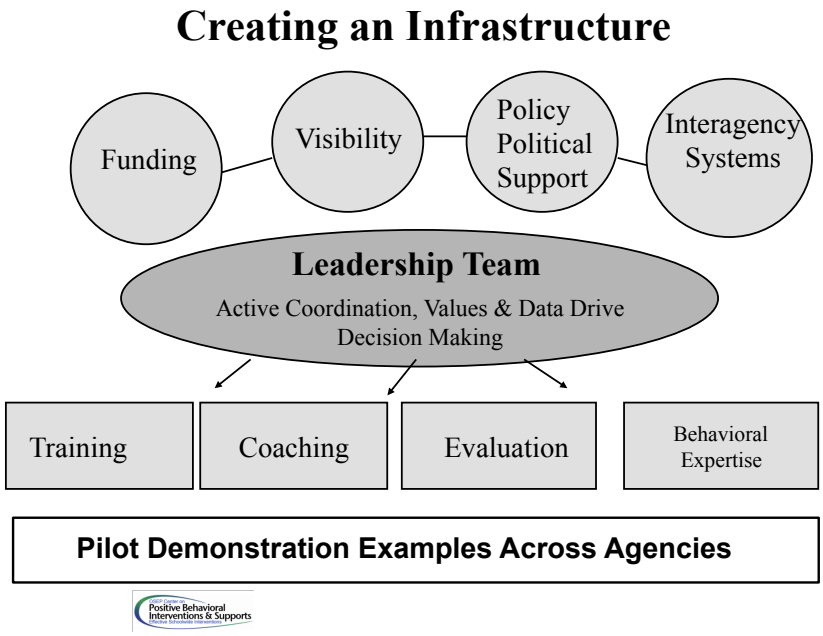
The leadership team establishes the curriculum needed for technical assistance with an agency-wide coordinator taking on the role of ensuring training events are organized, handling logistics related to state-wide meetings, and prompting organizations to collect and submit data for reporting purposes. The coordinator supports and monitors coaches who work within each organization to ensure that organization-wide teams are meeting, action plans are moving forward, and data are being collected and submitted. The evaluation process is monitored through the agency-wide team with the coordinator working with coaches to collect data regularly and to assist in problem solving when issues arise.

An immediate consideration for most organizations is the need to train professionals who will facilitate positive behavior support plans as well as other positive support strategies and who will, over time, take on the role of inservice and preservice preparation within the organization. It takes time for people to become confident facilitating positive behavior support. For this reason, organizations are encouraged to start training professionals to facilitate positive behavior support immediately, plan for unexpected staff attrition, and provide staff incentives for participating in intensive positive behavior support facilitator training.

Internal Organizational Capacity for Positive Support. The state team recommends that an investment of intensive positive support facilitator training should occur with evaluation methods put in place and monitored over time to provide evidence that outcomes are improving for people receiving services. The team is now discussing intensive training needs for a number of positive supports and identifying the types of instruction that will be needed to build capacity across the state. Positive behavior support and person-centered planning facilitator training will be selected as practices that will be used to pilot the first implementation efforts. Evidence provided by person-centered positive behavior support facilitators include: direct observation data collected

across baseline, intervention, and follow-up phases for problem behavior as well as for social behavior intended to help an individual achieve a self-determined lifestyle, evidence of improved quality of life, and survey data that show that the plan meets the needs of family members, caregivers, and other people who implement the positive behavior support plan.

Figure 2. Establishing Technical Assistance Systems to Ensure Effective Sustainable Implementation.



Adapted From: Sugai, G., Horner, R., Sailor, W., Dunlap, G., Eber, L., Lewis, T., Kincaid, D., Scott, T., Barrett, S., Algozzine, B., Putnam, B., Massanari, C., & Nelson, M. (2005). *School-wide positive behavior support: Implementers' blueprint and self-assessment.* T echnical Assistance Center on P ositive Beha v-ioral Interventions and Supports.

Reinforcement and Recognition. An important role of the agency-wide team is to consider strategies for reinforcing organization-wide efforts that are successful implementing positive behavior support and can show evidence that incident reports and the use of restrictive procedures are decreasing while positive support strategies are increasing over time. Currently, many individuals associate sharing of data with punishment. This can occur when systems focus more on remediation rather than on encouraging the use of positive supports by the organization. Teaching organizations to use data to monitor and celebrate progress can increase the perceived value of data. Nationally, agency-wide teams have established benchmarks for organizations to reach by providing data summaries with incentives tied to key accomplishments. In some states, organizations receiving these "bronze, silver, and gold" awards create friendly competition with other organizations and are a cause for celebration. Creating opportunities for organizations to meet annually to report successes, celebrate progress, problem solve together, and share resources provides another type of reinforcement that can bolster implementation efforts. Annual conferences or meetings that allow organization-wide teams, coaches, and mentors to come together in this manner is an

important way in which to establish a positive culture of innovation and changes the way in which people perceive the use of data. Sending champions, mentors, and coaches to annual positive support-related conferences for ongoing learning is yet another example of how some states have considered reinforcement systems at a state-wide level. While punishment for organizational misbehavior is necessary at times, the use of reinforcement and recognition for positive implementation efforts can increase motivation and morale.

State-wide Coordination. States with more than one agency implementing scaling up methods for positive behavior support often form an overall state-wide interagency team including coordinators representing state agencies that are implementing positive behavior support, state leaders, professionals representing major prevention efforts (e.g. positive supports), people receiving services, family members, higher education professionals, state policy professionals, non-profit community leaders, and any other representation that will further the team's action planning efforts. The goal of the interagency team is to establish a common language for prevention efforts, leverage limited state resources, align state-wide technical assistance, and summarize evaluation data for policy, funding, and state reporting issues. A number of states currently maintain interagency state-wide teams. However, since state systems are unique, these teams vary in vision, mission, and overall action planning efforts.

Minnesota's State-wide Implementation Plan

The best practice information described in this report was used to establish a state-wide action plan for implementing positive supports. *This report will refer to positive behavior support when discussing the infrastructure for establishing technical assistance systems and data collection processes but will consider the broader term positive supports when discussing all content and practices that will be disseminated via the technical assistance efforts that take place.* The information in this report sets the stage for future legislative requests that will drive technical assistance efforts. The state will re-allocate existing funds working smarter not harder to implement the action plan. The information in this report will be used to guide implementation efforts and to move forward using funds that are available. The scale, progress, timeline, and impact of these efforts across the state will determined by the ability of the state-wide team to acquire the funds necessary for moving forward.

An initial interagency team was formed to begin state-wide planning with the understanding that more individuals representing different stakeholder groups will be recruited once the October 22, 2014 report is complete. The team that met to create the initial state-wide report included state personnel at the Department of Human Services' Disability Services Division, the Adult Mental Health Division, the Alcohol and Drug Abuse Division and the Division of Direct Care and Treatment at the Department of Human Services as well as Positive Behavior Support professionals from the Minnesota Department of Education. The goal of this team was to report on the actions already taken by the state across the four main tasks outlined in the introduction (inventory, definitions, best practice, and state-wide report) and to design a communication infrastructure and implementation plan that would allow for systematic growth of positive supports across agencies in Minnesota.

Figure 2 shows a second part of the overall infrastructure. Regional, agency-wide, county-wide, and the interagency state-wide teams will use the leadership model

described in Figure 2 as a way to guide implementation efforts. At the bottom of Figure 2, pilot demonstration exemplars are considered a helpful feature for launching positive behavior support. The state's efforts to implement positive supports will be more successful when there are organization-wide teams sharing success stories and providing examples of exemplary implementation using data to evaluate progress. Agencies involved in the first implementation efforts, aging, disabilities, mental health, and education will begin action planning at county-wide and region-wide levels. Each agency will have a unique plan with targeted positive supports that will be implemented. The agency-wide teams will establish exemplary organization-wide demonstrations and create a plan for taking these efforts to scale across the state.

Development of Roles and Responsibilities. The state is already implementing technical assistance across a number of positive support practices. These technical assistance efforts use terms to describe the implementation process with clear roles and responsibilities and terms used for types of trainers. The term "coach" and "mentor," for instance, are used within the training person-centered planning. The state-wide team will work with already existing implementation efforts like person-centered planning to establish the overall technical assistance infrastructure and to define key terms within the overall infrastructure including:

- Organization-wide, county-wide, region-wide, and state-wide teams,
- Coordinators who guide meetings, provide oversight at regional, agency-wide, and state levels, and assist in gathering and summarizing data,
- Coaches who assist individuals within their organizations to implement positive supports, and
- Mentors who provide training to individuals within organizations.

Consistent use of terms such as coaches, mentors, etc. will improve consistency of communication across state training efforts and streamline communication at organization-wide, county-wide, region-wide, and state-wide levels.

Regional Teams and Facilitation. Regional teams are recommended as an addition to the Minnesota technical assistance system. This regional team model will encourage interagency collaboration and improve communication across agencies. The regional teams will include broader goals for improving service coordination and communication. Regional Coordinators will be added to the Minnesota state-wide infrastructure with the role of facilitating regional action plans, assisting in oversight of training systems, and gathering data for regional decision making. The number and types of organizations in each region will vary depending on the number and type of organizations that choose to participate each year.

Since Minnesota school-wide PBS is already in progress, implementation efforts in education will be tailored to meet the unique needs of each region. In some regions, exemplary school coaches and teams will be able to assist in regional training and supports. For example, in some states, new coaches from outside agencies will visit with school coaches spending time observing how similar tools and procedures are used in education. This helps coaches from the different agency learn more about the universal elements of the training and contributes to cross-agency awareness. Coaches then return to their own trainer/mentors and learn how to use similar types of tools in mental health

settings, nursing homes, residential settings or employment contexts. Taking advantage of the strengths of the current positive behavior support implementation in education is an opportunity unique to Minnesota's state-wide planning efforts. This strength-based approach to organization-wide training will help model the importance as it is applied to each field.

Establishing Communities of Practice. The state-wide team will use communities of practice across many levels of the infrastructure for Minnesota's technical assistance efforts. The goal of the large-scale technical assistance efforts will be to ensure that organization-wide teams can identify the unique needs within local and regional contexts. This information is used to initiate, organize and facilitate local communities of practice events. Examples of community of practice events include self-advocate led learning opportunities, meetings for families interested in learning more about positive supports, or interagency meetings held to share information about positive support resources available within the community. Each coaching level within the Minnesota technical assistance efforts (state agency coordinators, regional coaches, organization-wide coaches) will form a community of practice with events scheduled to encourage ongoing learning, troubleshoot together, and share ideas about implementation efforts. Individuals who learn to facilitate specific positive support strategies will form another type of community of practice. Individuals who participate in facilitator-level communities of practice continue learning about the new research strategies, systems change approaches, and other information that can be used to continuously improve services for people across the state.

Gradual Expansion of Agency-wide Coaching. State coordinators who will oversee implementation in mental health, DSD, and aging will be recruited as a first step in building an infrastructure for positive behavior support implementation. Training and supports will be provided to new state coordinators as initial implementation steps are taken within their agency. State-wide coordinators will learn to communicate regularly with regional coaches, facilitate agency-wide action planning to gradually expand the number of organizations participating, and assist in summarizing data for state-wide action planning purposes. Early training steps will include inviting the current state-wide school-wide positive behavior support coordinator to present to new agency coordinators. Training systems will be created in each agency starting positive support implementation. Each agency will have the opportunity to ensure that the tools and larger positive supports curriculum needed are organized for implementation. By August, 2015, action plans for implementation will be established for aging, mental health, and DSD and a tailored expansion plan will be in place for education as it continues its implementation efforts. Each organization recruited will be asked to prepare for training by identifying a coach, establishing a team, and completing a readiness assessment that includes clear administrator buy in and support for implementation of positive behavior support. Prior to August, 2015, the agency coordinators will work with the interagency state-wide team to recruit organizations within five regional teams as a first step in the implementation process.

Mentors and Local Champions. Mentors are also considered an important element within the Minnesota State-wide plan. Although similar, coaches and mentors have different roles within the implementation process. Coaches prompt organization-wide teams to schedule and record meetings, work with the team to collect and submit

data, and communicate with agency-wide team coordinators. Mentors provide training to coaches and organization-wide teams with guidance provided on an ongoing basis throughout the implementation process. Mentors will be identified and recruited over time through a variety of methods to ensure that ongoing technical assistance and training will continue in a sustainable manner at the local level. For instance, professionals who complete intensive positive behavior support facilitator training, coaches who show extraordinary skills supporting people who are learning new skills, regional professionals who might take on an autonomous role in facilitating regional team meetings are all examples of future mentors within the overall state-wide plan. The role of the state-wide team is to actively seek out and enroll individuals to champion state-wide efforts and to monitor the growing number of professionals who are assisting in overall state-wide efforts. *As mentioned earlier, the terms used to refer to individuals who provide training and mentoring in different contexts will be aligned with current terms that are used in technical assistance efforts.*

Data-based Decision Making. Data will be collected at the organizational level using the state's incident reporting system as a key mechanism for gathering and sharing data. Incident report data will include information about the events occurring including average incidents per day per month, types of problem behavior, time of problem behavior, the person for whom the incident was written, other people involved in incidents, and location of problem behavior. Other data will be included such as restraints used, police or legal contacts, and contextually relevant terms such as in and out of school suspension, acute care short-term stays, or emergency room visits. Organization-wide teams will also learn to collect other types of data to guide decision making including staff attrition, and climate surveys for staff members and people receiving services. A statistical measure that will assist the state in making comparisons will be identified. For instance, office referral data are often organized using "incident reports by 100 students". This allows for comparisons to be made across larger and smaller organizations across the state. The state-wide interagency team will work with IT staff to establish summaries of incident report data for teams at the organization-wide, regional, agency-wide, and state-wide levels. Table 3 describes the types of data that will be used by different teams for decision-making purposes. The next section of this report describes how the state-wide plan will be organized and evaluated using a logic model to describe the details related to implementation efforts.

Aligning State Services to a Three-tiered Prevention Model. In addition to establishing a system for implementing technical assistance in positive supports across agencies, the state-wide team will assess how funds, services, training and technical assistance, and other resources are used to address primary, secondary, and tertiary prevention systems. The team will complete the prevention triangle for each agency with assistance from representative stakeholders, identify gaps in the types of prevention-based services that exist, and closing them by changing policy.

Table 3. Types of Data Used by Teams for Decision Making.

Teams Implementing Action Plans	Types of Data Summarized
Organization-wide Teams (Examples Include Schools, Districts, Residential Support, Supported Employment, Mental Health Centers)	• Action Planning Evaluation (What the Organization Achieved) • Incident Reports • Restraints and Crisis Events • Injuries, Emergency Room Visits • Acute Care/ Restrictive Settings • Climate Data Related to People Receiving Services and Staff • Fidelity of Implementation • Individual Support Plans Evaluated and Aggregated Attrition, Workers Compensation
County Teams	• Action Planning Evaluation (What the County Teams Achieved) • Number and Type of Organizations within County • Growth Patterns for Organizations by County • Summary of Implementation Outcomes and Fidelity of Implementation *Across County Agencies* • Individual Support Plans Evaluated and Aggregated
Regional Teams (Interagency Regional Teams)	• Action Planning Evaluation (What the Regional Teams Achieved) • Number and Type of Organizations per Region • Growth Patterns for Organizations by Agency • Summary of Implementation Outcomes and Fidelity of Implementation *Across Agencies* • Individual Support Plans Evaluated and Aggregated
Agency-wide Teams (Mental Health, Aging, DSD, Education)	• Action Plan Evaluation (What the Agency Teams Achieved) • Number of Organizations implementing Within Each Agency • Growth Patterns for Organizations *by Region* • Summary of Implementation Outcomes and Fidelity of Implementation *Across Organizations and Regions* • Individual Support Plans Evaluated and Aggregated *by Organization and Region*
State-wide Interagency Team (Responsible for Oversight of Entire System)	• Action Plan Evaluation (What the State-wide Team Achieved) • Growth Patterns for Organizations *Across Agencies and Regions* • Summary of Implementation Outcomes and Fidelity of Implementation *Across Agencies* • State-wide Summary of Implementation Outcomes and Fidelity of Implementation • Individual Support Plans Evaluated and Aggregated *by Organization, Region, State*

The goal will be to assess whether additional waiver services, training systems, data collection and progress monitoring systems, or other resources are needed to ensure that each agency provides services addressing primary, secondary, and tertiary prevention. Actions will be taken to ensure that each agency has outlined a three-tiered prevention model with positive support practices addressing each prevention level.

The meetings that takes place to gather this information will provide state personnel with an opportunity to gather information from key stakeholders about: the overall state-wide plan, progress made on developing an inventory of policies, thoughts related to building common definitions for key terms, as well as the types of positive support practices that are unique to each particular agency. Strategies for continuing to disseminate information across each agency will be discussed as well. The information that is gathered will be brought back to the state-wide team and a plan for continuing to reach out via various marketing and awareness strategies will be established. In the next section of this report, the way in which the state-wide team will implement the overall state-wide planning goals and objectives are described.

Logic Model and Outcome Measures

The state-wide team met during the month of October, 2014 to outline the draft of a state-wide plan. Special attention was given to how this state-wide plan would be organized and linked to the infrastructure for technical assistance and to the alignment of services across a three-tiered prevention model. The first step taken was to create a logic model to summarize the major elements associated with implementation and evaluation of the state-wide plan.

Description of Logic Model. A logic model provides a helpful framework for implementing positive supports (see Figure 3). This particular logic model in Figure 3 summarizes the major details while Appendix D contains a more detailed description of state-wide planning. The word "Context" is written in a vertical band on the left hand side of this visual. Due to page/figure size constraints, details related to important contextual elements of Minnesota's state-wide planning are summarized in this report. In program development and evaluation terms, "Context" refers to the political, fiscal, social, and organizational settings and situations that, collectively, constitute the broader cultural environments ("Contexts") in which programs operate (i.e., the historical, contemporary and future influences that are expected to support or hinder the anticipated inputs, implementation, reach, and/or outcomes for Minnesota's state-wide plan). The first main column of the logic model starting on the far left hand side of Figure 3 describes how and to what extent a state-wide team uses and/or allocates its resources, described as "Inputs" in the first main column. The goals that will be put into place are listed in the second column called "Implementation". The third column describes the people the state-wide plan intends to impact, referred to as "Reach". The "immediate", "intermediate", and "longer-term" outcomes are then listed as they relate to the implementation goals listed in column two.

"Impacts," refer to the broader changes that occur due to implementation of a project. Contextual features can influence these potentially larger-scale "Impacts" of a program in ways which can affect larger-scale quality well beyond that of program participants. In order to draw meaningful conclusions or make judgments about the efficiency, fidelity of implementation, and/or effectiveness of Minnesota's state-wide

planning efforts, it is first necessary to understand the contextual features that have influenced its conception, development, implementation, and outcomes. The next section of the report provides a summary of each of the elements of the logic model starting with context.

Context. The Olmstead plan and efforts to decrease the use of restrictive procedures is an important contextual feature influencing the state-wide plan for implementing positive supports. The pressure to implement key action-planning goals by specific timelines already guide the state's efforts to decrease restrictive practices and increase proactive and prevention-based efforts. The emphasis on the development interagency and common policy and procedures is an important contextual feature to state-wide planning and works well with what is known about improving outcomes for people in need of positive supports. Focusing on interagency systems and a common language for prevention can be seen as a contextual strength for implementation. Currently, there are not enough professionals who have experience facilitating positive supports such as person-centered planning, trauma informed thinking, positive behavior support, and other important practices. This contextual feature must be considered within the planning process. The other issue discussed by some state-wide team members was that it would be important to ensure that within agency contextual issues would be addressed to ensure that communication and collaboration would occur *within* agencies as well as *across* the different state agencies.

Inputs. The Minnesota state-wide team benefits from a number of resources that can be used within the action planning process. There are a number of stakeholders who can participate in and contribute to the planning process. These stakeholders represent people across the lifespan who receive one or more services from the state. Family and community members, state professionals across agencies, university and college professionals, practitioners and providers, and individuals with a background in positive supports. A variety of funds can be leveraged or added to state-wide planning efforts. For instance, the State-wide School-wide Positive Behavior Support team has funding for current implementation efforts and provides a helpful model for other agencies moving forward. State-wide FTE dedicated to issues related to behavioral support can be helpful when thinking how to "work smarter, not harder" with existing funds. There are also state-wide and national resources that can be used to assist in the implementation of positive supports. Several universities are moving forward with training and technical assistance related to positive supports and online resources are available to providers across the state. The International Association for Positive Behavior Support encourages members to share ideas, tools, and resources with individual networks often collaborating in different ways on state-wide planning related tasks.

Implementation. Six implementation goals were identified and outlined in Figure 3. These goals include:

1) Establishing Technical Assistance Infrastructure Across Agencies,
2) Designing and Implementing Strategies for Data-based Decision Making and Evaluation,
3) Creating a Marketing Plan for Increasing Awareness of Positive Supports Across the State,

4) Expanding Preservice and Align Inservice Training Systems State-wide,
5) Developing and Maintaining an Inventory of Policies Related to Restrictive Practices and Positive Supports, and
6) Expanding Interagency Crisis Prevention Planning.

Each implementation goal is broken down into further objectives with strands of immediate, intermediate, and long-term goals documented to show how the timeline and impact of action planning over a five year period of time. Appendix D provides more detailed information about outcomes that are targeted for implementation based on funding allocated for these tasks.

Reach. The individuals and organizations that the state-wide team will reach out to are listed in the third column of Figure 3. A number of agencies will start the implementation and planning process first. These agencies include: aging, education, disabilities, and mental health. Once the framework for implementing positive supports technical assistance is established and large-scale implementation is initiated, additional agencies will be added to the technical assistance efforts. The agencies that will follow the "First Step" agencies as part of the "Expansion of Reach" includes: Department of Corrections, DEED, Department of Health, Human Rights, the Courts, and ombudsman. The variety of stakeholders that will be involved in the planning process includes people receiving services across the lifespan, family and members, practitioners across services, legal professionals (judges, police, attorneys, etc.), and higher education.

Immediate Intermediate, and Long-term Outcomes. Figure 3 is also organized so that the immediate, intermediate, and long-term outcomes are considered across pathways associated with the main implementation goals. For instance, the technical assistance planning occurring with the first step agencies (aging, disabilities, education, and mental health) is in place within the first six months. By the first few years, pilot demonstrations that provide evidence of the effectiveness of the state's efforts are provided at the organizational level and with individual positive behavior support plans within those organizations. This means that the people receiving services (living, working, and learning) within those settings are reporting that they are happier, that they have more opportunities for making choices, engaging in self-determined actions that are meaningful to them, and that their quality of life has been impacted due to the implementation efforts taking place. Individual PBS plan summaries would provide evidence that restrictive procedures are decreasing and that the lives of people who have experienced challenges within their settings are improving over time.

The state-wide team will form workgroups to ensure that the implementation details outlining immediate, intermediate, and long-term goals and objectives (see the Appendix D for more information) for all six of the main implementation efforts are achieved. Workgroups will be assigned a state staff person to take on the role of Chairperson although Co-chairs also may represent other stakeholder groups. Teams will include representation across diverse stakeholder groups and anyone who learns about the planning process and is interested in joining a workgroup will be encouraged to contact the state-wide team coordinator. The coordinator will make sure that each workgroup has an adequate number of team members.

Figure 3. Minnesota's State-wide Planning Logic Model.

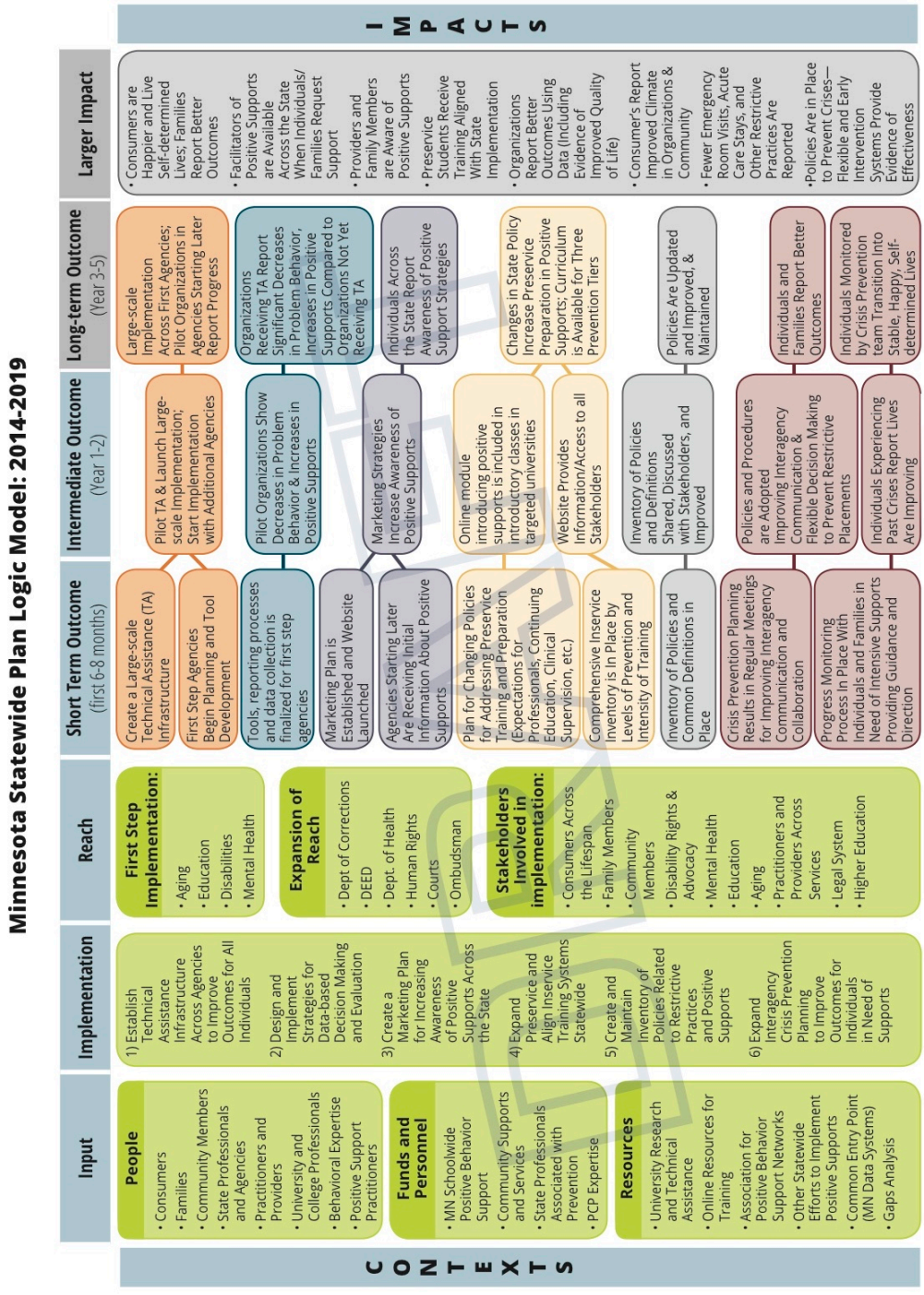
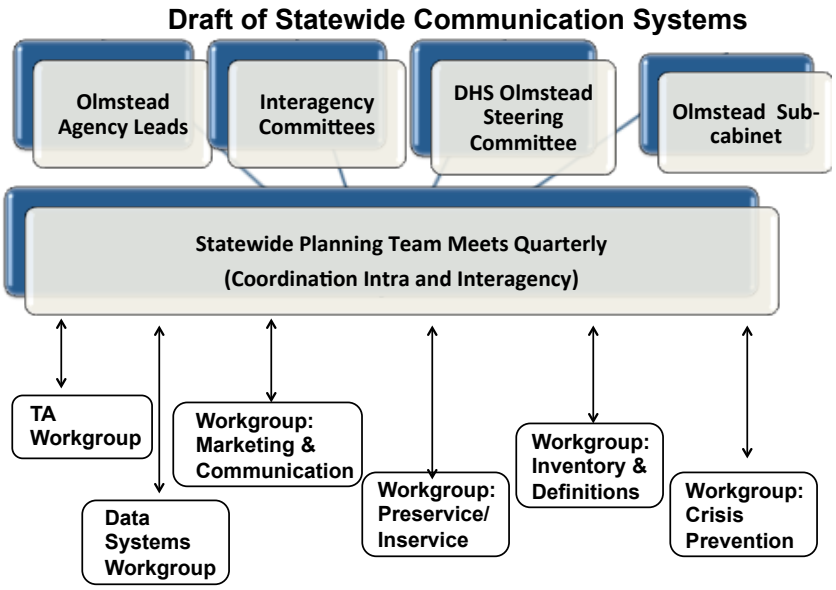


Figure 4 describes the communication infrastructure that will be used to monitor the state-wide plan and to ensure data are used for decision making. There are a four groups meeting at the state level related to implementing the Olmstead plan: DHS Olmstead Steering Committee, Olmstead Agency Leads, Interagency Committees (addressing topics including, for example, the Employment Interagency Leadership Panel), and Olmstead Sub-cabinet. Figure 3 demonstrates how the Interagency State-wide Team will form a hub of communication with information coming from each of the six workgroups and from the Minnesota Olmstead Planning teams. The state-wide team will meet quarterly with workgroups meeting schedules meeting more frequently in order to report progress on the action plan outlined in the Appendix D at the quarterly state-wide meetings. The coordinator of the state-wide meeting will share information with the three Olmstead committees and will ensure that information is shared with the state-wide team and each of the workgroups.

Figure 4. Communication and Feedback Systems for Interagency State-wide Positive Supports Planning



The workgroup associated with data collection systems will work closely with the technical assistance workgroup to ensure that the data entered into the state monitoring system can be summarized and shared at the organizational, regional, agency, and state-wide levels. In addition to quantitative data gathered using the state's data collection systems, qualitative information will gathered to ensure that people receiving services and their families or caregivers will be able to communicate their perspectives on an ongoing basis. The state has a number of surveys and quality of life measures that are already in the planning stage. The workgoup responsible for data collection will gather information about the various activities already planned and ensure that all elements of

the state-wide planning process will include opportunities to gather information from people receiving services and other stakeholders. This information will be used to ensure that the state-wide planning, technical assistance and training, marketing and communication, preservice training, crisis management systems will be guided by people receiving services across the state of Minnesota.

Impacts. This essential element of the logic model is referred to as "Impacts" and is visible in Figure 3 as a vertical band on the right hand side of the logic model. Impacts are the results of a project that goes well beyond long-term outcomes and reflect the larger shifts that may occur as a result of the implementation efforts. The impacts of programs can be positive, whether planned or unplanned, or impacts can be well intended, but ultimately counter- productive ("iatrogenic") in nature. The challenge of the state-wide team is to ensure that all elements of the implementation efforts described here encourage people to participate in the implementation of positive supports and seek strategies to decrease restrictive practices. As Fullan (1993) stated most eloquently, "You can't mandate what matters... the more complex a change effort is, the less likely you can force individuals to become involved in the process" (p. 21). For this reason, the state will work diligently to establish positive and proactive strategies for encouraging participation, collaboration, and consensus-building strategies throughout all elements of the implementation process. Systems change research highlights the need to establish champions at all levels within systems. This means that everyone is important and plays an essential role in systems change. The state will seek out champions of positive supports across the state of Minnesota and encourage these individuals to become leaders within their region of the state. Strategies for rewarding organizations and individuals who champion the positive supports efforts will be considered as an essential part of the state-wide planning process. Individuals who are recruited to participate in intensive person-centered planning or positive support training will be recognized and rewarded for participating in these certification processes and the state-wide team will seek out ways to ensure these trainings are considered essential requirements for organizations. In summary, the goal will be to model the behaviors that are expected by the same practices recommended in positive prevention-focused efforts with the people we expect to change their behaviors as part of the implementation process. Practitioners, administrators, and community members respond to the same respectful, positive and proactive approaches we demand are used with all people who receive services.

Next Steps

Many of the tasks reflected in this state-wide plan are already being implemented by professionals representing state, university, and other stakeholders. The goal of this state-wide plan is to create a communication infrastructure to ensure that information is shared systematically and action-planning efforts are streamlined. The first steps taken by the state-wide team is to recruit workgroup chairs and initial team members for each of the six major implementation tasks. Some of these workgroups are already operational even though a full workgroup with stakeholder representation has not yet been achieved. For instance, the group involved in policy inventory and definition of common terms have completed the initial assessment and are conducting further work to establish a system for refining and maintaining the inventory of polices. While some workgroups are already moving forward, the goal is to launch all workgroups and achieve one or more

meetings within each workgroup before January, 15, 2015. Quarterly state-wide team meetings will be scheduled for November, 2014 January, 2015 April, 2015, and July, 2015. The first full meeting with a more representative stakeholder group will occur by January, 2015. A plan for sharing information about this state-wide plan, the work mentioned earlier related to establishing common terms, and details about the policy inventory will also be in place by January, 2015

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World Health Organization (2004). *Prevention of mental disorders: Effective interventions and policy options*. Gevena: WHO

Appendix A

Progress Defining Common Terms

The following statutes, rules, policy and practices was identified by DHS staff to be included in inventory survey.

Identified For Inventory

Statutes:

Minnesota Statute 245D Home and Community Based Services Standards
- Protection Standards 245D.06
- Emergency Use of Manual Restraint 245D.061
- Service Planning and Delivery; Intensive Supports 245D.071

Minnesota Statute 245.8261 Restrictive Procedures Planning and Reporting (Mental health services for children)
Minnesota Statute 125A.094 Standards for Restrictive Procedures (Schools)
Minnesota Statute 125A.0941 Standards for Restrictive Procedures (Definitions)
Minnesota Statute 125A.0942 Standards for Restrictive Procedures (Standards)
Minnesota Statute 121A Students Rights, Responsibilities and Behavior
- Exclusion and expulsion of pupils with a disability 121A.43
- Corporal Punishment - Banned 121A.58
- Student Discipline; Reasonable Force 121.582
- Discipline and Removal of Students from Class 121A.61
- Removal by Peace Officer – Specifically for Students with IEP's 121A.67

Minnesota Statute 245.461 Minnesota Comprehensive Adult Mental Health Act; Policy and Citation
Minnesota Statute 245.487 Minnesota Comprehensive Children's Mental Health Act Citation; Declaration of Policy; Mission
Minnesota Statute 245A.66 Requirements; maltreatment of minors
Minnesota Statute 252A.111 Powers and Duties of Public Guardian or Conservator
Minnesota Statute 253B Civil Commitment
Minnesota Statute 256B Medical Assistance for Needy Persons
Minnesota Statute 524.5-101 to 524.5-502 Uniform Guardianship and Protective Proceedings Act
Minnesota Statute 6090.255 False Imprisonment
Minnesota Statute 626.566 Reporting of Maltreatment of Minors
Minnesota Statute 626.557 Reporting of Maltreatment of Vulnerable Adults
- Definitions 626.5572

Rules:

Minn. R. 9525.2700 to 9525.2810 (formerly known as Rule 40)
Proposed Minn. R. 9544.000-9544.0160 (Positive Supports)
Minn. R. 3525.0850 (State Policy to encourage use of positive approaches in schools)
Minn. R. 3525.2810 (Behavioral Interventions and Supports in schools)
Minn. R. 9555 Social Services for Adults
Minn. R. 9502 Licensing of Day Care Facilities
Minn. R. 9520 Mental Health Services

Minn. R. 9503 Child Care Center Licensing
Minn. R. 2960 Licensure and Certification of Programs for Children

Policy & Practice:
Behavior Intervention Reporting Form – Form 5148
Positive Support Transition Plan – Form 6810
Positive Support Transition Plan Review – Form 6810A
Instructions for Completing Positive Support Transition Plan – Form 6810B
Sample Policies and Forms for Basic Supports and Services
Sample Policies and Forms for Intensive Supports and Services

Incidents
Emergency Use of Manual Restraint Policy
Behavior Intervention Reporting Form – Form 5148
Positive Support Transition Plan – Form 6810
Positive Support Transition Plan Review – Form 6810A
Instructions for Completing Positive Support Transition Plan – Form 6810B

Initial Report of Survey Results

Initial Report 10.19

Last Modified: 10/19/2014

1. Is this a policy or a practice? Check all that apply

#	Answer		Response	%
1	Policy		11	50%
2	Practice		0	0%
3	Other, please specify		11	50%

Other, please specify
State Statute
Statute
Statute
Rule and Variance
case law
Training
Training
Training
Training
Training
Training

Statistic	Value
Min Value	1
Max Value	3
Total Responses	22

2. Which best describes this policy or practice? Check all that apply

#	Answer		Response	%
1	A. This policy or practice is best practice/evidence based practice for positive supports		5	36%
2	B. This policy or practice restricts, limits, defines the use of non-positive supports such as restrictive procedures, seclusion, restraint, prohibited procedures etc.		10	71%
3	C This policy or practice is a prohibited practice		2	14%
4	Other, please specify		0	0%

Other, please specify Statistic	Value
Min Value	1
Max Value	3
Total Responses	14

3. Which of the following does this policy or practice that restricts, limits and or defines the use of non-positive supports influence or guide? Check all that apply

#	Answer		Response	%
1	Personnel requirements such as licensure, certification or professional development		9	75%
2	Practice		12	100%
3	Programs		12	100%

Statistic	Value
Min Value	1
Max Value	3
Total Responses	12

4. Does this policy or practice contain a definition of incidents that must be reported?

#	Answer		Response	%
1	Yes		8	67%
2	No		4	33%
	Total		12	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.33
Variance	0.24
Standard Deviation	0.49
Total Responses	12

5. If you responded yes to question above, what data must be collected for reportable incidents?

Text Response
Annual report stating number and types of restrictive procedures performed.
each use of protective procedure is documented in the client record;
use of restraint and seclusion
"Subdivision 1.Incident response and reporting. (a) The license holder must respond to incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person... h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b) within 24 hours of the occurrence. The license holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061."
Subd. 5.Reporting emergency use of manual restraint incident. (a) Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the designated coordinator the following information about the emergency use:

Statistic	Value
Total Responses	5

6. What happens to incident report data once collected?
Text Response
This has been an unfunded mandate that the department does not collect.
there is a quarterly administrative review required by the rule
administrative review

Statistic	Value
Total Responses	3

7. State Agency Select one				
#	Answer		Response	%
1	Department of Human Services (DHS)		16	89%
2	Depart of Education (MDE)		2	11%
3	Department of Health (MDH)		0	0%
4	Department of Employment & Economic Development (DEED)		0	0%
5	Department of Corrections (DOC)		0	0%
6	Department of Human Rights		0	0%
7	Other, please specify		0	0%
	Total		18	100%

Other, please specify Statistic	Value
Min Value	1
Max Value	2
Mean	1.11
Variance	0.10
Standard Deviation	0.32
Total Responses	18

8. Division
Text Response
Children's Mental Health
Alcohol and drug abuse
Alcohol and Drug Abuse Division
Alcohol and Drug Abuse Division
Adult Mental Health
Disability Services
DSD
Compliance and Assistance
DSD
Compliance and Assistance
DSD

Statistic	Value
Total Responses	11

9. Document Name and Number, where applicable
Text Response
RESTRICTIVE PROCEDURES PLANNING AND REPORTING
Chemical Dependency Licensed Treatment Facilities (Rule 31): Behavioral Emergency Procedures
Detoxification Programs: Protective Procedures
Integrated Dual Diagnosis Treatment: Policies, Procedures, and protocols
Civil Commitment; temporary confinement; emergency admission; authority to detain and transport a missing patient
Chapter 2960 Licensure and certificatio of programs for children
Vulnerable Adult Act and Maltreatment of Minors Act
Civil Commitment Act
Rule 36 and the IRTS Variance to Rule 36
the Jarvis decision and the Price Sheppard decision
Home & Community Based Standards-Protection Standards
Emergency Use of Manual Restraint
Standards for Restrictive Procedures
Positive Behavior Support – SOS0000830
Intro-Positive Behavior Supports in Mental Health – SOS0001397
MN Positive Behavior Support Initiative – SOS0001488
Positive Behavior Supports on the Job – SOS0001558
CDS: PBS – Understanding Positive Approaches – SOS0001734
Intro to Function Based Positive Behavior Supports – SOS0001770
Service Planning and Delivery; Intensive Supports
Standards for Restrictive Procedures
Administrative Rule-Formerly known as Rule 40

Statistic	Value
Total Responses	22

10. Citation of State or Federal Regulation, Statute, Rule or Policy, if applicable
Text Response
Minnesota Statutes 245.8261.
Rule 9530.6475
Rule 9530.6535
9530.0050 Subp. 3 Behavioral emergency procedures
Chapter 253B; 253B.045; 253B.05; 253B.141
2960.0710
Minnesota Statutes 626.557 and 626.5572, 626.556
253b
Caselaw
Minn. Stat. 245D.06
Minn. Stat. 245D.061
Minn. Stat. 125A.094
Minn. Stat. 245D.071
Minn. Stat. 125A.0941
Minn. R. 9525.2700 to 9525.2810

Statistic	Value
Total Responses	15

11. Document SourceInclude hyperlink to on-line location when applicable
Text Response
https://www.revisor.mn.gov/statutes/?id=245.8261
https://www.revisor.leg.state.mn.us/rules/?id=9530.6475
https://www.revisor.leg.state.mn.us/rules/?id=9530.6535
https://www.revisor.leg.state.mn.us/rules/?id=9533.0050
https://www.revisor.leg.state.mn.us/statutes/?id=253B
https://www.revisor.leg.state.mn.us/rules/?id=2960.0710
https://www.revisor.leg.state.mn.us/statutes/?id=245D.06
https://www.revisor.leg.state.mn.us/statutes/?id=245D.061
https://www.revisor.leg.state.mn.us/statutes/?id=125A.094
https://www.revisor.leg.state.mn.us/statutes/?id=245D.071
https://www.revisor.leg.state.mn.us/statutes/?id=125A.0941
https://www.revisor.leg.state.mn.us/rules/?id=9525.2700

Statistic	Value
Total Responses	12

12. Publication Date of Document
Text Response
2011
10/15/2013
10/15/2013
11/12/2013
08/05/2008
Ongoing
Ongoing
Ongoing
Ongoing
2013- Amended in 2014
2013
2013
2013
October 16, 2013

Statistic	Value
Total Responses	14

13. Type of Document/Publication.Check all that apply.				
#	Answer		Response	%
1	Policy		0	0%
2	Procedure		0	0%
3	Practices Manual		0	0%
4	Statute/Law		9	41%
5	Rule/Regulation		6	27%
6	Interpretative Guideline		0	0%
7	Bulletin		0	0%
8	Form		0	0%
9	Case Law		1	5%
10	Training (State funded)		6	27%
11	Technical Assistance Guide/Manual		0	0%
12	Other, please specify		1	5%

Other, please specify
Variance

Statistic	Value
Min Value	4
Max Value	12
Total Responses	22

14. Who is the intended audience for this policy or practice? Check all that apply

#	Answer	Response	%
1	Policymakers	13	81%
2	Organization Leaders	12	75%
3	Regulators/Licensors	12	75%
4	Lead agencies, counties, tribes	13	81%
5	Service Providers-Management	14	88%
6	Service Providers-Supervisory	12	75%
7	Service Providers-Direct Support Professionals	12	75%
8	Educators - K-12	3	19%
9	Educator - Post Secondary	1	6%
10	Clinicians	9	56%
11	Family members	6	38%
12	Self-advocates	5	31%
13	People being supported with services	10	63%
14	Guardians	6	38%
15	Other, please specify	0	0%

Other, please specify

Statistic	Value
Min Value	1
Max Value	14
Total Responses	16

15. Is this policy or practice currently being revised or updated?

#	Answer	Response	%
1	Yes	2	18%
2	No	9	82%
	Total	11	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.82
Variance	0.16
Standard Deviation	0.40
Total Responses	11

16. If responded yes, what is status of the revision or update?	
Text Response	
draft proposals are being vetted with stakeholders; DHS commissioner working on a plan to include detoxifcation services as a medical assistance benefit	
Statistic	Value
Total Responses	1

17. Name	
Text Response	
Jill Johnson	
Brian Zirbes	
Brian Zirbes	
Brian Zirbes	
Brian Zirbes	
Brian Zirbes	
Faye Bernstein	
Faye Bernstein	
faye bernstein	
faye bernstein	
ICI Staff	
ICI Staff	
Robyn Widley by ICI Staff	
Stacy Danov	
Stacy Danov	
Stacy Danov	
Stacy Danov	
Stacy Danov	
Stacy Danov	
ICI Staff Entry	
Robyn Widley	
ICI Staff for Charles Young	
Statistic	Value
Total Responses	22

18. Title
Text Response
Children's Mental Health Consultant
Planner Principal State
Planner Principal State
Planner Pricipal State
Planner Principal State
Planner Principal State
Mental Health Program Consultat
Program Consultant
mental health program consultant
mental health program consultant
ICI Staff
ICI Staff
Community Capacity Building Clinical Coordinator

Statistic	Value
Total Responses	13

19. Email
Text Response
jelaine.johnson@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
ICI Staff
ICI Staff
Stacy.e.danov@state.mn.us

Statistic	Value
Total Responses	13

Appendix B

Sample Crosswalk for Definition of Incident across state agencies:

State Agency	DHS	MDE	MDH	DOC	DEED
Definition					
Reporting Requirements					

Inventory Survey Results for Policies and Practices that include a definition of incidents that must be reported.

Incidents

Last Modified: 10/19/2014

Filter By: Report Subgroup

1. Is this a policy or a practice? Check all that apply

#	Answer		Response	%
1	Policy		5	63%
2	Practice		0	0%
3	Other, please specify		3	38%

Other, please specify
State Statute
statute
Rule and Variance

Statistic	Value
Min Value	1
Max Value	3
Total Responses	8

2. Which best describes this policy or practice? Check all that apply

#	Answer		Response	%
1	A. This policy or practice is best practice/evidence based practice for positive supports		1	14%
2	B. This policy or practice restricts, limits, defines the use of non-positive supports such as restrictive procedures, seclusion, restraint, prohibited procedures etc.		7	100%
3	C This policy or practice is a prohibited practice		1	14%
4	Other, please specify		0	0%

Other, please specify Statistic	Value
Min Value	1
Max Value	3
Total Responses	7

3. Which of the following does this policy or practice that restricts, limits and or defines the use of non-positive supports influence or guide? Check all that apply

#	Answer		Response	%
1	Personnel requirements such as licensure, certification or professional development		6	86%
2	Practice		7	100%
3	Programs		7	100%

Statistic	Value
Min Value	1
Max Value	3
Total Responses	7

4. Does this policy or practice contain a definition of incidents that must be reported?

#	Answer		Response	%
1	Yes		8	100%
2	No		0	0%
	Total		8	100%

Statistic	Value
Min Value	1
Max Value	1
Mean	1.00
Variance	0.00
Standard Deviation	0.00
Total Responses	8

5. If you responded yes to question above, what data must be collected for reportable incidents?

Text Response
Annual report stating number and types of restrictive procedures performed.
each use of protective procedure is documented in the client record;
use of restraint and seclusion
"Subdivision 1.Incident response and reporting. (a) The license holder must respond to incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person... h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b) within 24 hours of the occurrence. The license holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061."
Subd. 5.Reporting emergency use of manual restraint incident. (a) Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the designated coordinator the following information about the emergency use:

Statistic	Value
Total Responses	5

6. What happens to incident report data once collected?
Text Response
This has been an unfunded mandate that the department does not collect.
there is a quarterly administrative review required by the rule
administrative review

Statistic	Value
Total Responses	3

7. State Agency Select one				
#	Answer		Response	%
1	Department of Human Services (DHS)		7	100%
2	Depart of Education (MDE)		0	0%
3	Department of Health (MDH)		0	0%
4	Department of Employment & Economic Development (DEED)		0	0%
5	Department of Corrections (DOC)		0	0%
6	Department of Human Rights		0	0%
7	Other, please specify		0	0%
	Total		7	100%

Other, please specify Statistic	Value
Min Value	1
Max Value	1
Mean	1.00
Variance	0.00
Standard Deviation	0.00
Total Responses	7

8. Division
Text Response
Children's Mental Health
Alcohol and Drug Abuse Division
Adult Mental Health
Disability Services
DSD
DSD

Statistic	Value
Total Responses	6

9. Document Name and Number, where applicable
Text Response
RESTRICTIVE PROCEDURES PLANNING AND REPORTING
Detoxification Programs: Protective Procedures
Chapter 2960 Licensure and certificatio of programs for children
Vulnerable Adult Act and Maltreatment of Minors Act
Rule 36 and the IRTS Variance to Rule 36
Home & Community Based Standards-Protection Standards
Emergency Use of Manual Restraint
Administrative Rule-Formerly known as Rule 40

Statistic	Value
Total Responses	8

10. Citation of State or Federal Regulation, Statute, Rule or Policy, if applicable
Text Response
Minnesota Statutes 245.8261.
Rule 9530.6535
2960.0710
Minnesota Statutes 626.557 and 626.5572, 626.556
Minn. Stat. 245D.06
Minn. Stat. 245D.061
Minn. R. 9525.2700 to 9525.2810

Statistic	Value
Total Responses	7

11. Document SourceInclude hyperlink to on-line location when applicable
Text Response
https://www.revisor.mn.gov/statutes/?id=245.8261
https://www.revisor.leg.state.mn.us/rules/?id=9530.6535
https://www.revisor.leg.state.mn.us/rules/?id=2960.0710
https://www.revisor.leg.state.mn.us/statutes/?id=245D.06
https://www.revisor.leg.state.mn.us/statutes/?id=245D.061
https://www.revisor.leg.state.mn.us/rules/?id=9525.2700

Statistic	Value
Total Responses	6

12. Publication Date of Document
Text Response
2011
10/15/2013
08/05/2008
Ongoing
Ongoing
2013- Amended in 2014
2013
October 16, 2013

Statistic	Value
Total Responses	8

13. Type of Document/Publication.Check all that apply.

#	Answer		Response	%
1	Policy		0	0%
2	Procedure		0	0%
3	Practices Manual		0	0%
4	Statute/Law		4	50%
5	Rule/Regulation		4	50%
6	Interpretative Guideline		0	0%
7	Bulletin		0	0%
8	Form		0	0%
9	Case Law		0	0%
10	Training (State funded)		0	0%
11	Technical Assistance Guide/Manual		0	0%
12	Other, please specify		1	13%

Other, please specify
Variance

Statistic	Value
Min Value	4
Max Value	12
Total Responses	8

14. Who is the intended audience for this policy or practice? Check all that apply

#	Answer	Response	%
1	Policymakers	7	88%
2	Organization Leaders	7	88%
3	Regulators/Licensors	8	100%
4	Lead agencies, counties, tribes	8	100%
5	Service Providers-Management	8	100%
6	Service Providers-Supervisory	7	88%
7	Service Providers-Direct Support Professionals	7	88%
8	Educators - K-12	1	13%
9	Educator - Post Secondary	1	13%
10	Clinicians	4	50%
11	Family members	3	38%
12	Self-advocates	2	25%
13	People being supported with services	5	63%
14	Guardians	3	38%
15	Other, please specify	0	0%

Other, please specify

Statistic	Value
Min Value	1
Max Value	14
Total Responses	8

15. Is this policy or practice currently being revised or updated?

#	Answer	Response	%
1	Yes	2	33%
2	No	4	67%
	Total	6	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.67
Variance	0.27
Standard Deviation	0.52
Total Responses	6

16. If responded yes, what is status of the revision or update?	
Text Response	
draft proposals are being vetted with stakeholders; DHS commissioner working on a plan to include detoxification services as a medical assistance benefit	
Statistic	Value
Total Responses	1

17. Name	
Text Response	
Jill Johnson	
Brian Zirbes	
Brian Zirbes	
Faye Bernstein	
faye Bernstein	
ICI Staff	
ICI Staff	
ICI Staff for Charles Young	
Statistic	Value
Total Responses	8

18. Title	
Text Response	
Children's Mental Health Consultant	
Planner Principal State	
Planner Principal State	
Mental Health Program Consultat	
mental health program consultant	
ICI Staff	
ICI Staff	
Statistic	Value
Total Responses	7

19. Email	
Text Response	
jelaine.johnson@state.mn.us	
brian.zirbes@state.mn.us	
brian.zirbes@state.mn.us	
faye.bernstein@state.mn.us	
faye.bernstein@state.mn.us	
ICI Staff	
ICI Staff	
Statistic	Value
Total Responses	7

APPENDIX C

Vision and Goals of the Minnesota Olmstead Plan (Pages 10-11)

The Olmstead Subcabinet adopted a vision statement at one of its first meetings:

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

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

Olmstead Plan Goals

To move the state forward, towards greater integration and inclusion for people with disabilities, the state has set an overall goal. If Minnesota's Olmstead Plan is successful, Minnesota will be a place where:

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

To achieve this overall goal, Minnesota's Olmstead Plan addresses goals related to broad topic areas:

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

Housing: People with disabilities will choose where they live, with whom, and in what type of housing.

Transportation: People with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections.

Supports and Services: People with disabilities of all ages will experience meaningful, inclusive, and integrated lives in their communities, supported by an array of services and supports appropriate to their needs and that they choose.

Lifelong Learning and Education: People with disabilities will experience an inclusive education system at all levels and lifelong learning opportunities that enable the full development of individual talents, interests, creativity, and mental and physical abilities.

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

Community Engagement: People with disabilities will have the opportunity to fully engage in their community and connect with others in ways that are meaningful and aligned with their personal choices and desires.

Action Three: ***Build effective systems for use of positive practices, early intervention, crisis reduction and return to stability after a crisis*** **(pages 65-67)**

An essential component of quality of life is being treated with dignity and respect. Minnesota is committed to supporting people through the use of positive practices, and prohibitions on use of aversive and restrictive procedures. There is no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques. There is strong evidence that positive approaches and planning that builds on the strengths and interests of the person are effective. Implementation of this vision will require a culture change throughout the service system, reinforcing positive skills and practices and replacing practices which may cause physical, emotional, or psychological pain or distress. This new culture and standards to evaluate it will include:

- Person-centered planning that includes a balance of what is important *for* the person with what is important *to* the person;
- Individual plans for services that reflect principles of the most integrated setting, consistent with Minnesota's Olmstead Plan;
- Types and use of positive and social behavioral supports;
- Prohibitions on use of restraints and seclusion; and,
- Requirement that care is appropriately informed by a recognition and understanding of past trauma experienced by an individual. People will be able to move to and remain in integrated settings when plans and supports are in place to avoid crises and timely and appropriate crisis intervention is available. The term 'crisis' covers a range of situations, such as behaviors that present potential harm, the loss of a caregiver, or a significant change in a medical or health condition that compromises the ability of a person to manage their symptoms.

Timeline:

- By January 1, 2014 the state will implement the new Minnesota Statute §245D standards,[SS 3A], and by July 1, 2015 a Rule with operational details that replaces Minnesota Rules, parts 9525.2700 to 9525.2810 (also known as Rule 40) will be promulgated. [SS 3B]

Responsibility: The Commissioner of the Department of Human Services (DHS) will designate a responsible person.

- By July 1, 2014 the state will create an inventory and analysis of policies and best practices across state agencies related to positive practices and use of restraint, seclusion or other practices which may cause physical, emotional, or psychological pain or distress. [SS 3C]
- By July 1, 2014 a report outlining recommendations for a state-wide plan to increase positive practices and eliminate use of restraint or seclusion will be delivered to the Olmstead Subcabinet or their designee by an assigned team of representatives from Olmstead Subcabinet agencies. [SS 3D]
  Responsibility: The Olmstead Subcabinet will designate a responsible person.
- By August 1, 2014 the state will develop, across state agencies, a common definition of incidents, including emergency use of manual restraint, that are to be reported, and create common data collection and incident reporting processes. [SS 3E] By July 1, 2015, state-wide implementation of common incident reporting will begin. [SS 3F] Beginning October 1, 2015, quarterly summaries of incidents of emergency use of manual restraint or other types of restraint, seclusion or other practices that may cause physical, emotional, or psychological pain or distress will be reported to an assigned team of representatives from each state agency for review and to inform recommendations to reduce the incidents. [SS 3G.1 – 3G.4] By July 1, 2015 and annually thereafter, the team will provide recommendations to the Olmstead Subcabinet to reduce emergency use of restraints, or other practices that may cause physical, emotional, or psychological pain or distress, and to increase positive practices. [SS 3H.1, 3H.2] **Responsibility:** The Olmstead Subcabinet will designate a responsible person.
- By August 1, 2014 a coordinated triage and "hand-off" process for crisis intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation. Report will be delivered to the Olmstead Subcabinet. [SS 3I] **Responsibility:** The Commissioner of DHS will designate a responsible person.
- By December 1, 2014 an assigned team of representatives from state agencies, community organizations, community corrections and people with disabilities who have used the crisis system will: identify best practices, including use of technology; set service standards; and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions (e.g. person-centered planning, positive practices, available resources). Progress toward goal will be reported to the Olmstead Subcabinet or their designee. [SS 3J] **Responsibility:** The Olmstead Subcabinet will designate a responsible person.
- By January 15, 2015 DHS will have completed the necessary analysis and planning to expand crisis services, diversion, and early intervention services to persons at risk of experiencing a crisis situation. The expansion plan will include projected start dates for implementation of the services. **Responsibility:** The Commissioner of DHS will designate a responsible person.
- By July 1, 2015 crisis services, including diversion and early intervention

services, will be made available to any person in need of these supports and at risk of experiencing a crisis situation. The purposes of this intervention include stabilizing the person's situation or avoiding the use of civil commitment. [SS 3K] **Responsibility:** The Commissioner of DHS will designate a responsible person.

- By July 1, 2015 develop measurements to better understand and track crisis episodes across service systems; create a data collection plan and mechanisms; establish baseline data and set targets (e.g., number of crisis calls made, reason for the call, response given, follow-up information.) Baseline data and targets will be delivered to the Olmstead Subcabinet or their designee. [SS 3L] **Responsibility:** The Commissioner of DHS will designate a responsible person.

APPENDIX D

Minnesota's State-wide Plan

Work Group Name: Establishing Infrastructure for Technical Assistance and Data Systems

Date: _____ Committee/Work Group Members:_____

Implementation Goal #1: Establishing Infrastructure for Technical Assistance and Data Systems

Immediate Term Objectives *(To Be Achieved Within Next 6-8 Months)*

What Actions Are Needed to Meet This Goal?	How will the success of the immediate-term objective be evaluated?	What are steps to achieve the immediate-term objective?	How is this immediate-term objective relevant to the long-term objective?	What is the time frame for achieving the immediate-term objective?
Establish Interagency State-wide Organizational Chart to Show Communication System	Organizational Chart	• Establish Workgroup • Draft of Organizational Chart • Gather Feedback From All Relevant Stakeholders	Creates the Communication and Feedback Systems Necessary for Achieving Goal	To Be Finalized in First Six Months (April, 2015)
Identify Facilitator of the Interagency State-wide Team	FTE Assigned to Facilitator Meeting Minutes	• Recruit Individual • Provide Mentoring to New Coordinator	Assigns a Person Who Will Schedule Meetings, Reserve Rooms, Send Communication, Address Logistics, etc.	To Be Finalized in First Six Months (April 2015)
Workgroup creates plan to address training for each of the agencies in first step implementation with timeline for steps involved	A document showing the timeline for implementation of technical assistance with be established and progress will be documented within the state's annual interagency evaluation report	• Timeline for Implementation Established: Aging Disabilities Mental Heal *Education Ombudsman • Timeline for Agencies Implementing Later: DEED Dept. of Corrections Dept. of Health Human Rights Courts	A System for Implementing positive supports is necessary to ensure organizations receive effective technical assistance (TA)	Timeline for Implementation Available With First Six Months (April 2015)

What Actions Are Needed to Meet This Goal?	How will the success of the immediate-term objective be evaluated?	What are steps to achieve the immediate-term objective?	How is this immediate-term objective relevant to the long-term objective?	What is the time frame for achieving the immediate-term objective?
Curriculum is developed for each agency	Curriculum and TA Systems Described as Training Manual Online at Designated Time for Each Agency Implementing	Each Agency That Begins Implementation Will 1. Form an Agency Oversight Team 2. The Team Will Assign an Agency-wide Coordinator 3. Team will meet regularly to establish training and data collection systems 4. Agency will report to Interagency state-wide team quarterly and provide annual summary of progress	Agency representation must be involved in the creation of the content to establish buy in, ensure content meets the need of the agency, and that professionals will be prepared to participate in training when it is implemented	Timeline will be dictated by when agencies start implementing
State and regional coaching systems will be established for the TA system	State-wide Team will document assessment and action plan for using state FTE to organize efforts – annual report will document decisions made State Coordinators, Regional Coaches, and Organization-wide (local) coaches roster will be available Meetings scheduled regularly for training and to monitor implementation	State Coordinators will be recruited based on timelines for agencies to start process State coordinators recruited for agencies starting as part of the legislative ask proposal Regional Coordinators recruited as part of the legislative ask proposal Organization-wide coaches will be recruited from organizations participating in	Coordinators and coaches are "positive nags" who ensure dates for meetings are set, agendas are ready, meeting minutes are sent, and data are being completed at local, regional, and state-wide levels These individuals communicate via the interagency state-wide communication system when problems are encountered or	Identification of State-wide Coordinators starting the TA: (April 2015) Regional Coaches: prior to legislative ask implementation (August, 2015) Coaches will be identified once implementation is organized (September,-October, 2015)

		legislative ask proposal Curriculum and training for coordinators and coaches will be prepared prior to the legislative ask implementation timeline	assistance is needed	
Workgroup meets with IT to ensure training is set up for local and regional decision making and that data are available for decision making	Meeting minutes indicating IT and workgroup are meeting Curriculum for all providers describing new incident reporting system	Webinars, website information, and local awareness presentations give to providers. Documentation of organizations who have received training within each agency area shows expansion of training across the state State requires all providers to complete simple online training explaining how to complete incident report and IT are available to support and answer questions	The accuracy of data collection is important to ensure information is accurate Organizations receiving additional TA in positive supports will learn how to collect additional data for decision making The goal is to show that TA is an effective way in which to decrease problem behavior, crises, etc.	

* School-wide PBS is already being implemented; SWPBS goals address expansion plan

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Agencies participating in TA process later are involved in curriculum and tool development DEED Dept. of Corrections Dept. of Health Human Rights Courts	Meeting minutes from state-wide and agency wide teams Agency workgroups formed to work on tasks Tools and curriculum available	As per plan described in immediate steps, agencies targeted to move forward will: • Establish an agency coordinator • Develop curriculum and training system • Work with regional coaches to recruit organizations to participate in TA	Training systems for moving forward systematically with agencies will ensure organizations receive what they need to be successful	October, 2015-October 2016
Infrastructure for interagency state will move from initial implementation to full implementation of TA systems	Org chart will be finalized Annual report will describe changes made to improve feedback and communication systems, data collection, etc.	State-wide team will meet with regional coaches, local coaches, and other stakeholders to share how systems can be improved Team will review surveys of satisfaction from participants in TA for organizations and Cohort training	The implementation process requires modifications and improvements to ensure effectiveness and sustainability	August, 2015-October, 2016 Annual Reports for each year
Curriculum for agencies starting the process will move from initial implementation to full operation	Meeting minutes from agency-wide team Curriculum Annual report will describe changes made	Agency-wide teams will meet regularly to discuss what worked well, what needs to be modified Team will review surveys of satisfaction from	The implementation process requires modifications and improvements to ensure effectiveness and sustainability	August, 2015-October, 2016 Annual Reports for each year

		participants		
Annual report and quarterly report systems will be move from initial formats to a more formalized system	State-wide team's meeting minutes Annual reports at different levels will be simple but include key updates • Agency-wide summary • State-wide summary • Regional summary • Organization-wide summary	State-wide team will meet with key participants to review the initial reporting system and make improvements based on feedback	Data summaries at different levels of the system are important for communication systems	Annual Reports for each year
Champions will be identified across the state from coach roles, cohort training, leadership, people receiving services, etc. These individuals will be recruited to assist in state-wide efforts	Number of stakeholders participating in state-wide planning processes Diversity of stakeholders participating in process Annual report will document progress in this area	Encourage individuals to assist in state-wide planning efforts Identify and recruit individuals during trainings, awareness presentations, webinars, local events, etc. Create incentives for champions to ensure there are positive outcomes associated with participation	Buy in and consensus will increase when individuals from different stakeholder groups are advocating, teaching, and sharing successes	October 16 should show significant listing of "champions" participating in state-wide planning in different ways (providing awareness trainings, attending meetings, testimonials and quotes, case studies, etc.)

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Agencies show that organizations receiving TA have higher levels of positive support implementation, lower problem behaviors, and fewer restrictive interventions	**Outcome data that include:** Organization-wide Data • Fidelity of implementation • Incident reports • Restrictive interventions • Emergency room visits • Acute care events • Staff attrition, injury • Workers comp **Individual Plan Data** • Fidelity of Implementation • Baseline intervention data showing decreases in problem behavior, increases in positive social behavior • Quality of life data • Goodness of fit (how plan fits family, caregivers) **Qualitative Data** • Focus Groups • Interviews • Surveys **Pre-post Conceptual Knowledge** • Staff in organizations participate in survey before and after TA is	• Implementation of training for TA in positive supports, • Training for all providers in collecting effective incident report form data • IT systems are in place to gather and report data at local, regional, agency, and state-wide levels	This long-term objective will show that the state's efforts to provide training and support has been effective	Annual report of progress August 15, 2015 (first organizations participating in TA) August 15, 2016 (evaluation data for organizations in first training efforts) August 15, 2017 (evaluation data for first organizations and organizations starting in next implementation year)

	provided • Regional teams ask all organizations in catchment area to complete survey (organizations not yet participating) with incentive			
State-wide infrastructure moves from full operation to innovation with examples of improvements and changes made based on mature implementation efforts	Qualitative review of meeting minutes, focus group and interviews with key participants, Review Annual report -- describe changes made to improve feedback and communication systems, data collection, etc.	Data workgroup summarizes results of qualitative efforts to evaluate effectiveness of infrastructure Data workgroup presents information via the interagency state-wide team for discussion Quantitative and qualitative data are used to create new and innovative changes to systems	Moving to innovation stages of implementation requires data-based decision making	Annually 2016, 2017, 2018
Expansion of leaders and champions in the system lead to larger impact level changes across the state	Qualitative and Quantitative data will show that the numbers of people receiving support is growing faster compared to previous years as measured by • Aggregate data on individual plans • Organizations reporting data • Champions available to assist the state • State-wide incident report and data overall	State-wide interagency team uses workgroups to • Evaluate progress over time • Create incentives for people interested in becoming champions • Establish a tracking system to monitor evidence of expansion	State will reach a "critical mass" when there the number of people who implement positive supports will market the implementation efforts beyond the state-wide team's efforts	Evidence is available within the 2018-2019 annual report

Work Group Name: __Design Qualitative and Quantitative Systems for State-wide Data-based Decision Making

Date: _____ Committee/Work Group Members_____

Implementation Goal #2: Design Qualitative and Quantitative Systems for State-wide Data-based Decision Making

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Incident report system collect key data used for local, regional, agency, and state decision making—List of key data included in recording will be clearly outlined	New system is beta tested with participants indicating successful data collection via simple survey and report	Create templates for incident report forms and plan for beta test implemented Feedback from beta test used for last edits Plans to analyze local, regional, and state-wide data are in draft including how regional and local coaches will access the data regularly	Data will be a key outcome for state-wide planning	
Data workgroup will work with the infrastructure workgroup to ensure that training systems are in place for providers who will use the incident reporting system	Meeting minutes Documented plan for training Curriculum	Infrastructure and data workgroups will meet to outline training curriculum and system	Accurate data collection will be essential for state-wide planning	
Tools for fidelity of implementation at the organization-wide and individual level are in draft for first participating agencies	Fidelity documents are available for first participating organizations	Representatives from first participating organizations learn how MN SW data are collected at state-wide meeting	It is important to show that positive supports are actually being implemented	June, 2015

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Workgroup will provide a list of data that will be collected via local, regional, agency, and state-wide levels for first step agencies	Document listing all data not included in incident report that will be part of the decision making process – this will be completed in collaboration with the infrastructure workgroup	Infrastructure and data workgroups will meet to outline the key data collection procedures	An important key to success will be the training systems for providers to ensure accurate data	
Plan for qualitative data collection is in place	Documented plan is available describing how data will be gathered, analyzed, and used	Workgroup identifies key professionals who will gather data State team identifies all qualitative data already being collected Plan is written describing how different sources of qualitative information will be used	Qualitative data will provide rich information about how the state-wide planning is impacting the lives of people receiving services and providers	August 2015

* School-wide PBS is already being implemented; SWPBS goals address expansion plan

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Tools for fidelity of implementation at the organization-wide and individual level are in draft for agencies expanding later in the timeline	Fidelity documents are available for participating organizations expanding later in timeline	Representatives from participating organizations learn how MN SWPBS data are collected at state-wide meeting Agency team meets regularly to establish data that will be used to evaluate organizational and individual planning progress Tool will be created in draft form and circulated to gather feedback	It is important to show that positive supports are actually being implemented	August, 2016
Summaries of incident report data are available for annual report purposes a the local, regional, agency, and state levels	Annual report will include data at each level	Infrastructure workgroup and data workgroup will ensure data are gathered and reported for report	Content and IT professionals are needed to create the most effective summaries of data	August 2016
Qualitative workgroup team analyzes first year of data and provides a summary for the annual report	Qualitative transcripts analyzed, themes established, and summary of results are included in annual report	From August 2015-April, 15, 2015 data collection occurs, transcribing completed, and themes identified April, 2015-August, 2016 Written summary organized and presented to state-wide team for report	Quotes and stories that can be used for marketing, awareness, etc will come from this type of evaluation Information about changes in quality of life for people receiving services and providers will be available in descriptive form	September, 2016

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Pre-post conceptual knowledge about positive supports will be conducted prior to organizations participating in TA and a plan for systematically surveying organizations not yet started will be in place	Survey data gathered August-September, 2015 and again during August-September, 2016 will be available for review	Workgroup will work with infrastructure workgroup to establish survey draft Survey will be shared with key content professionals across the state and nationally A system for gathering data from participating organizations and nonparticipating organizations will be approved by the state-wide team Data will be gathered and analyzed for annual report	Pre post data provides some evidence that the TA process is contributing to increased awareness and knowledge of key positive support terms	August-September, 2015 August-September, 2016 Annual Report for 2016-2017
State-wide team provides evidence that efforts to implement TA after first year of implementation outlining in detail successful pilot/exemplary implementation sites	Case studies of pilot/exemplary case examples of implementation based on TA support for marketing purposes	Data workgroup and marketing workgroup will use the case studies gathered for awareness trainings, newsletters, website, etc.	The goal is to show how data can be used to celebrate and reinforce people; Marketing by stakeholders to stakeholders is more effective than by state or university professionals alone	

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
State-wide team provides evidence that efforts to implement TA on a wide-scale basis is effective in decreasing problem behavior, incident reports, emergency room visits, acute care stays, restrictive procedures, etc.	Interagency Annual report data Interagency Annual Report for 2017-2018 Interagency Annual Report for 2018-2019	Data are gathered from infrastructure system at the local level; Regional coordinators summarize data and share with agency teams; Agency teams share progress across regions with state-wide team State-wide team will review the MN SWPBS annual report and discuss as a first step discussion for agency-level reporting Responsibility for gathering and summarizing data occurs at each level of the system: • Local Coach • Regional Coordinator • Agency Coordinator • State-wide Coordinator State-wide coordinator works with interagency team to design and finalize interagency report format	Creating a system for summarizing data allows for a distribution of work related to preparing the final report	First Draft of an Interagency Report occurs September, 2016 September 2017 September, 2018

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Qualitative evaluation data show that people receiving services, family members, and provider lives are improving over time	Annual report – section dedicated to qualitative analysis	Qualitative team provides summary of progress each year; Changes in themes are captured as implementation occurs over time across regions Team reports if any changes are occurring in organizations that have implemented positive supports over 2-3 years	Perspectives of stakeholders are an important consideration in state-wide evaluation	August 2017 Annual Report August 2018 Annual Report August 2019 Annual Report
Pre-post conceptual knowledge about positive supports will show that organizations not yet participating in intensive training is showing increases in key terms via simple awareness and marketing (comparison with outcomes from prior years with nonparticipating organizations---but also showing slightly lower scores compared to organizations participating in intensive training)	Survey data gathered August-September, 2017 and again during August-September, 2018 will be available for review for organizations in later expansion Survey data will continue to be gathered for agencies expanding number of organizations participating August-September, 2017 and again during August-September, 2018	Workgroup will work with infrastructure workgroup to establish survey draft for agencies in later expansion Survey will be shared with key content professionals across the state and nationally A system for gathering data from participating organizations and nonparticipating organizations will be approved by the state-wide team Data will be gathered and analyzed for annual report	Pre post data provides some evidence that the TA process is contributing to increased awareness and knowledge of key positive support terms	August-September, 2017 August-September, 2018 August – September, 2019 Annual Report for 2017-2018 Annual Report for 2018-2019

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Cost Benefit Analysis Evaluation is conducted to evaluate: Costs of TA, costs related to crises (state costs) Decreases in Costs related to Problem behavior at the organizational level (workers comp, staff attrition	Annual report for 201- 1019	Recruit professional who can consult with state on cost effectiveness/cost benefit related issues Create a plan to evaluate costs involved in training and gather data related to costs incurred by state and by organizations related to problem behavior	It is important to evaluate the costs involved in large-scale implementation efforts and to establish sustainable and affordable strategies while maintaining prevention-focused state-wide planning	August, 2018

Work Group Name: __Establishing a Marketing Plan to Increase Awareness of Positive Supports_____

Date: _____ Committee/Work Group Members: _____

Implementation Goal #3: Establish a Marketing Plan to Increase Awareness of Positive Supports

Immediate Term Objectives *(To Be Achieved Within Next 6-8 Months)*

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Create a plan for marketing positive supports strategies across the state	Document summarized for annual report documenting plan for expanding awareness	Create a list of stakeholders that will be targeted for marketing purposes Establish timeline for posting website; Identify a team representing the TA efforts, cohort training, IT, etc.	It is important to make sure people know how to access information and join training and TA efforts	May, 2015

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Share state-wide plan with representative stakeholders across the state via onsite meetings and webinars; use feedback to modify and improve plan for final formalized document	Feedback documentation; evidence of modifications made to plan	Meet with interagency team to present recommendations from the workgroup that includes: • Number of webinars • Placement of state-wide plan on public website for access • Number of presentations • Locations of onsite presentations	It is important to increase awareness of the state-wide plan, and to build buy in and consensus by the direct involvement of stakeholders; this process may help to identify possible champions and participants	To Be Finalized in First Six Months (April, 2015)
Create a website that will be used as an entry point for awareness, a place to learn more about data collection, and the site of all training materials including: • Awareness • Skill building materials • Cohort training in PBS, PC thinking/PCP, Trauma informed thinking/Therapy, positive psychology, etc.) • Trainer/Champion Level (How to become a trainer in positive supports)	Website Pages Launched Website Stats	Create a first draft of the website Identify an easy to remember URL Find a website stats program to monitor visitors, unique visitors, downloads, etc. Create a password system to allow for champion/leader communication systems Pilot website and gather feedback via online survey Launch fully functional website in time for TA from legislative		May, 2015

		ask		
What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Monitor Website Statistics, Awareness trainings, cohort trainings, etc. and provide annual summaries of progress	Quarterly and Annual Website Data Reports	Work with Data team to set up website statistics and set up quarterly access to data Review data in workgroup meetings and at interagency state-wide meeting once a year	Website statistics are used to increase awareness and usage over time	August 15, 2015-August 15, 2016 August 2016-August, 2017 August 2018-August 2019
Market awareness materials to agencies involved in later expansion	Presentation materials and dates of events Documentation of awareness materials	Establish plan and timeline Recruit individuals to participate in tool development with infrastructure and data workgroups	It is important to prepare stakeholders and increase awareness--- this helps with later recruitment and increases buy in	August, 2016
Create newsletters, brochures, and other materials for expanding awareness; Use case studies, quotes, and other information from TA efforts and qualitative evaluation	Presentation materials and dates of events Documentation of awareness materials	Establish actions dedicated to expanding awareness of positive supports to DEED Dept. of Corrections Dept. of Health Human Rights Courts	Increase awareness of positive supports and how to participate in training opportunities	First plan by April, 2015 Annually each year
The workgroup will use state-wide plan to submit petition to the Association for PBS to become a network; Five APBS members are needed in this first petition	Petition documentation Email confirmation from APBS	Obtain petition documentation Finalize state-wide planning document (logic model, annual report document, action plan tool example) Identify lead network person and submit petition	Becoming an APBS network provides the state with access to other state networks interested in sharing resources	January, 2015

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Create main sections of website to meet the needs of state-wide planning including: • Entry to training materials (Organization-wide positive supports, person-centered thinking, person-centered planning, trauma informed care, etc.) • Resources for stakeholder groups • Awareneness materials • Information about state-wide planning • Communication site for implementers • Place for Champions to access information • Reinforcement for • Evaluation data summaries	Online surveys evaluating site, feedback from agency-wide teams, feedback from professionals participating in training events, website statistics	Agency-wide planning teams work with the marketing workgroup to place content related to positive practices and to ensure pages address context	Information for marketing, easy to located training materials, and communication are key contributions of the website	**August 15, 2015**
Ensure events are scheduled that allow individuals to share implementation success and for the state to recognize exemplary practice (award ceremonies, certificates of completed trainings, etc.)	Conference evaluation surveys, number of individuals in attendance	Assess the events already scheduled that could be reorganized to address reinforcement, sharing of positive supports, etc.	Stakeholders will be more likely to implement new practices when their colleagues are recommending it; Buy in increases when leadership occurs from implementation levels	Annually starting in 2016 (Date to be identified in a manner that meets the needs of interagency stakeholders)

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Materials developed for marketing purposes become a part of every presentation, webinar, training, and event (e.g. postcards, business cards, newsletters, case study stories, etc.)	Materials available in marketing portfolio both in hard copy and online	Workgroup uses marketing plan to create timeline for creating materials for distribution and infrastructure workgroup assists by distributing within training and TA Evaluation of marketing materials occurs annually to ensure all agencies are represented starting with first step agencies Workgroup places all marketing materials in a portfolio that can be used by all state professionals Agency-wide teams review portfolio and makes recommendations to improve representation of all stakeholders	Representation of case studies and information must reach all stakeholders using context, language, and stories that fit unique people served	Portfolio created by April, 2016 Evaluation of portfolio annually starting in 2016

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Qualitative and Quantitative Data indicate that stakeholders know what positive supports are and how to receive assistances	Evidence: pre post conceptual knowledge, qualitative evaluation, number of people impacted via presentation, google search shows MN-PBS website in first 10 links, website stats show visitors from MN increase every year, etc.	Collaborates with state-wide team to make sure that evidence evaluating marketing plan is in place	The first step in systems change is awareness of a new practice	August, 2017 Annual Report August 2018 Annual Report
Awareness presentations are given across the state by MN Champions (individuals trained and recruited to assist in implementation)	Number of presentations, types of trainings, or other interactions with stakeholders implemented by individuals who are not part of initial training and TA	Work with state-wide team to ensure that a plan for tracking volunteer behavior is in place Incentive system is established to encourage individuals across the state to assist in marketing, presentations, and training Infrastructure workgroup trains champions to complete task they volunteer to complete	The implementation of positive supports will occur when stakeholders are advocating for its use	August, 2017 Annual Report August 2018 Annual Report
Website stats show that the state's website is known both within the state and nationally as an important interagency resource	Evidence of prominence includes visitors, unique visitors, downloads, visits from the state,	Promote website in all trainings and presentations (in and out of state)	It is important to create a site that is easy to find when people need assistance, that	August, 2017 Annual Report August 2018 Annual Report

	visits from other states/countries (indirect evidence of strong content), types of google search strings used, MN website shows up using regular search engines like google in first 10 links offered	Create brochures, flyers, etc. Recognize exemplary implementers in case studies Work with IT to ensure website can be found on search engines	offers problem solving ideas, assists MN providers in reaching out to others, and creates a place where individuals know they can access best practice training materials	

Work Group Name: __Design Comprehensive Preservice and Inservice Training Systems for Three-tiered Positive Support

Date: _____ Committee/Work Group Members:_____

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Implementation Goal #4: Design Comprensive Preservice and Inservice Training Systems for Three-tiered Positive Support

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Evaluate the extent to which the state can influence policy and supervisory systems to encourage universities to include specific training resources for preservice purposes (legislative requirements for education, clinical supervision, continuing education, etc.	Annual report, 2016 and annually thereafter will include section that addresses the expansion of preservice training in positive supports	Make a list of the universities and colleges in MN already providing positive supports education at bachelors and masters level Prioritize types of departments that workgroup will start contacting Use list of state-level actions to begin communicating with universities and colleges in the prioritized list	Professionals need to be prepared to implement positive supports and need to be exposed to practicum and supervisory experiences that will prepare them for success	Initial discussion, assessment, and prioritization occurs by March, 2015 Annual report 2016 summarized first actions taken and evaluates effectiveness

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Workgroup assesses all training materials related to inservice training across agencies and creates a summary of content-plan for comprehensive cross-agency inservice training systems is established (e.g. SWPBS, trauma informed care, cognitive behavior therapy, person-centered planning, cohort PBS training, etc.)	Section of annual report includes details regarding training materials and systems related to positive supports and where this training can be accessed	State-wide team discusses how to move forward with assessment process (e.g. SWPBS team presents training and evaluation tools, mental health presents information on trauma informed care, etc.) Workgroup organizes inventory of training materials and provides a way that individuals can access these materials	It can be helpful for professionals involved in implementation to gain access to the training materials used by, for instance, SWPBS teams to make comparisons and learn more about systems used to monitor progress	August, 2015

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Changes in state expectations leads to examples of policies and supervisory systems that are adapted and evidence that universities and colleges have responded will be provided	Policy documentation Meeting minutes and documented conversations Number of universities impacted	Based on initial assessment, state professionals change policies related to preparing professionals in different service areas—starting with content related to prioritized departments Work with one or two universities to establish new clinical supervision systems Evaluate the effectiveness of these efforts	Preparing individuals to provide effective services is a proactive strategy for changing behavior	Annual report 2016
Create short online introduction to the state's implementation of positive supports that can be included in introductory classes	Online training documentation	Based on conversations with universities and colleges, create a simple online training that can be included as an activity in a class that introduces students to education, psychology, special education, etc.	Awareness of positive supports must start in different ways including with the university professional	Online module available by summer, 2017

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Map out curriculum needed for preservice and inservice related to positive supports across the three-tiered model with curriculum that addresses • Universal prevention (wellness, person-centered strategies, data based decision making) • Secondary prevention (group interventions for social skills, counseling, communication) • Tertiary prevention (individualized behavioral support, cognitive behavior therapy, etc.)	Annual report, 2016 includes an inventory of training systems and curriculum addressing three tiers and plans for adding curriculum that may not be available (for instance, secondary prevention group instruction in sexuality education, friendship building, etc.)	Work with agency leads to establish initial inventory of training systems and materials Present to state-wide team and discuss need for curriculum to be developed Create a plan for continuing to build on curriculum and to add into infrastructure training	The infrastructure workgroup needs assistance in developing resources that can be used by organizations implementing positive supports	Inventory included in Annual Report 2016
Map out curriculum need for preservice and inservice training related to levels of intensity needed in positive supports training including: Awareness Skill building in positive supports Facilitation of positive supports Trainer-level preparing facilitators	Annual report, 2016 includes an inventory of levels of training intensity in positive supports	Work with infrastructure and marketing workgroups and agency leads to establish initial inventory of training systems and materials Present to state-wide team and discuss need for curriculum to be developed Create a plan for continuing to build on curriculum and to add into infrastructure	Although awareness level training materials have been targeted within the marketing workgroup, a comprehensive assessment will be helpful outlining the types of training material by level of intensity across positive supports (for instance, trauma informed	Inventory included in Annual Report 2016

		training	therapy vs. trauma informed thinking)	

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
State positions include application and hiring procedures that require individuals to have experience in positive supports	Documentation of state application, hiring, and related documents	Agency-wide teams take the lead by creating policy and documentation indicating all state positions strongly prefer professionals who have received training in positive supports in preservice or inservice settings	State professionals who are already aware of positive supports are better able to support implementation	2017 Annual Report includes progress made in this area
Curriculum is in place across three prevention tiers and across levels of intensity for positive supports; website provides a way in which individuals can learn more about accessing these layers of curriculum	Annual report 2017 described final steps in initial curriculum development Website describes layers of curriculum to individuals interested; access to training materials is available via the website	State-wide team works through immediate and intermediate steps to finalize this goal Workgroups responsible continue to refine and innovate curriculum over time	Data are used to improve training systems each year and website provides transparent and easy access to training for systems change purposes	2018 Annual Report
Departments in prioritized list across universities are providing preservice training and working with state professionals to prepare individuals for implementing positive supports	Annual report 2018 provides list of accomplishments including universities and departments that responded to requests Policy describing changes in personnel preparation via bachelor's degree,	State-wide team works through immediate and intermediate steps to finalize this goal State finalized documentation necessary to support changes in policy	Policy level changes helps to ensure sustainable practice	2018 Annual Report 2019 Annual Report

	master's degree, continuing education, and clinical supervision and practicum experiences to align with need for training in positive supports			

Committee/Work Group Name: Create and Maintain an Inventory of Policies

Date: _____ Committee/Work Group Members:_____

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Implementation Goal #5: Create and Maintain an Inventory of Policies

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
An inventory of policies across agencies related to restrictive practices and positive supports is conducted	Documentation (inventory)	Create excel file Send out online survey to gather information	The state is reviewing consistency of policies across agencies to improve practices	October 22, 2014
Team analyzes inventory and identifies strengths and areas of need	Annual report 2014 including summary of strengths, needs, and actions taken	State-wide team members review inventory and creates a summary to be shared with state-wide team	The analysis assists the state in moving forward with consistency and best practice	October 22, 2014
Inventory is placed on Sharepoint internally within the state for initial sharing of information	Sharepoint contains information	DHS will take the lead in posting materials	Transparency and communication is important in the state-wide planning process	November, 2014
A list of common terms that will be evaluated to ensure information is consistent across agencies	Documentation for annual report, 2015	Team is listing common terms based on overall inventory	Communication and consistency is an important goal in state-wide planning	October, 22, 2014

What Actions Are Needed to Meet This Goal?	How will the success of the immediate-term objective be evaluated?	What are steps to achieve the immediate-term objective?	How is this immediate-term objective relevant to the long-term objective?	What is the time frame for achieving the immediate-term objective?
A grid with definitions occurring across agencies for the common terms will be established	For October 22, 2014 report	Terms are gathered across agencies along with the inventory of policies	First steps in establishing common definitions is to assess similarities	October, 22, 2014
Action plan for continuing to link definitions to incident reporting system for data-based decision making is in place	For October 22, 2014 report	Definitions to increase commonality across specific terms (e.g. restraint, crisis, etc.) will be presented across stakeholder groups, placed online for common via online survey, and modified based on definitions that fit across agencies	Communication and consistency is an important goal in state-wide planning	October, 22, 2014 through July, 2015 as incident report system is finalized

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Inventory of terms are placed on the MN PBS website for all stakeholders	Website Documentation	Work with marketing workgroup to establish website Place content in section that is easy to access Monitor access to inventory via downloads	Communication and consistency is an important goal in state-wide planning	August 2015

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Training materials and incident report form information is available on MN PBS website	Website Documentation	Work with marketing workgroup to establish website Place content in section that is easy to access Monitor access to inventory via downloads	Communication and consistency is an important goal in state-wide planning	August 2015
Once inventory is stable and definitions confirmed with stakeholders, the state-wide team will organize a webinar and invite APBS network members from other states to participate in discussion	Webinar materials for presentation	Establish lead presenter Set up logistics (date, platform for sharing materials, etc.) Invite individuals using the apbs.org members site to identify individuals who may be interested	Sharing information with others may provide new ideas and ways to proceed forward	October, 2015

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	How will the success of the long-term objective be evaluated?	What are steps to achieve the long-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Inventory is refined and maintained online over time reflecting evolution of MN Positive Supports	Meeting minutes Inventory documentation Annual reports	State-wide team adds inventory to agenda each year and reviews whether changes are necessary	State-wide planning will move from initial implementation to innovation over time	Updates to inventory reported in Annual Reports 2016-2019
Definitions are reviewed and modifications made to data systems	Meeting minutes Grid with definitions	State-wide team adds inventory to agenda each year and reviews whether changes are necessary	State-wide planning will move from initial implementation to innovation over time	Updates to inventory reported in Annual Reports 2016-2019

Committee/Work Group Name: __Establish an Interagency Crisis Management Team to Monitor and Support Individuals Needing Intensive Plans

Date: _____ Committee/Work Group Members:_____

Implementation Goal #6: Establish an Interagency Crisis Management Team to Monitor and Support People Needing Intensive Plans

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Form an interagency crisis prevention team	Meeting minutes List of participants for public meeting List of sub team members to monitor people regularly	State-wide team makes a list of crisis systems teams, and state professionals; Other related stakeholders are invited (people receiving services, advocates, etc.) Part of meeting is public (2x a year for larger discussions) State sub team members will identify specific people who engage in serious problem behavior and have experienced multiple "crises"	Crisis prevention is part of Tier 3 services provided by the state	November, 2014
Identify an initial small number of people to follow and monitor progress Establish whether individualized plans are in place to support individual	Meeting minutes	Use information about a small group of people needing more intensive supports to: • Streamline communication across agencies • Improve flexibility of services for people • Establish	Providing a way to monitor people with a history of experiencing crisis can provide important information that is used to improve services	November, 2014

		strategies for improving positive supports • Brainstorm ways to increase behavioral expertise and supports		
Explore national crisis models and identify ways to improve outcomes and increase behavioral expertise for crises	Presentations by invited professionals	Invite presenters representing major crisis management systems	Learning about best practice in crisis management systems provides new information as new systems are reported over time	January, 2015 through July, 2015

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Outline lessons learned by crisis prevention team and create a report that outlines policies and procedures to improve crisis prevention	Annual report includes section on crisis prevention planning	Use information gathered from public discussions and private progress monitoring to make recommendations Workgroup shares recommendations with state-wide team Policies and procedural suggestions are made formally to state system	The crisis workgroup will provide details necessary to consider innovative strategies for prevention	Annual report 2015

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Create a plan to provide incentives to exemplary organizations who choose to work with people who have a history of challenging behavior since these systems are better able to prevent challenging behavior	Annual report provides this information based on workgroup recommendations	Crisis workgroup continues gathering information from public group and progress monitoring Recommendations are proposed to the state-wide team Information is shared via a proposal for new policy and supports	Use growing evidence and data from implementation to show why policies are needed	Annual report 2015 Policy documents 2016

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	How will the success of the long-term objective be evaluated?	What are steps to achieve the long-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
New policies and procedures are approved and legislative support in place to improve crisis prevention system	Policies and procedures approved Evidence of legislative proposals	Workgroup completes immediate and intermediate actions to accomplish this task	New ideas driven by workgroup experience improves interagency communication and service provision	Annual report 2016 and 2017 describes progress made
Data from state-wide planning show that organizations receiving TA have lower numbers of crises over time compared with organizations that have not yet started implementing	Data from local, regional, agency-wide and state-wide reports	Work with state-wide team to monitor data related to crises, injury, emergency room visits, acute care stays, etc. via the crisis management workgroup	Using data for decision making should occur at all levels of state-wide planning	Annual reports 2017, 2018, 2019 highlights evidence regarding long term implementation of positive supports
Incentives are in place for exemplary organizations to manage more	Policy documents finalized and approved	Plan for sharing information via organizations participating in	Transition planning occurs for people who are not well	Annual reports 2017, 2018

challenging cases since these systems are better able to support people with challenging behavior		TA Place information on the website Workgroup identifies people who would excel in certain conditions and assists in transition planning	suited for current living situations Organizations serving individuals choose to participate in TA training in order to improve services for individual the group is monitoring	

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EXHIBIT 6-15: SS 4D – FACT TEAM MODEL

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Olmstead Plan: Additional Information Requested For Court Monitor

(January 27, 2015)

SS4D: DOC and DHS will analyze the need for a FACT and/or ACT team with high fidelity and a forensics component and establish measurable goals for actual services to benefit individuals. (pg. 68)

Lead Contact Person(s): Jolene Rebertus, DOC, (651)361-7286; Lynette Studer, DHS, (651)431-2247

Transition into the community from prison is difficult, much more so if the individual has a disability. Forensic Assertive Community Treatment (FACT) is an adaptation of the evidence-based model of Assertive Community Treatment. It is a program that provides treatment, rehabilitation, and support services to individuals who have schizophrenia, schizoaffective disorder, bipolar disorder and who have significant and persistent functional impairments (homelessness, repeated hospitalizations, unemployment) coupled with significant involvement in the corrections system. All of these components combined contribute to high corrections and community system use.

Following a needs analysis, data provided from the Minnesota Department of Corrections (DOC) identified 110 individuals released from Minnesota Correctional facilities in 2013 who met the diagnostic criteria to be eligible for FACT services. (The majority of these individuals, 62 of the 110, were released to counties within the metropolitan geographic region.) This statement of need is underreported as it does not include those individuals exiting county jail correctional facilities who could be eligible for these services as that data was not available for this needs analysis.
Treatment and rehabilitation services are delivered by a multi-disciplinary team and works by reducing symptoms, meeting basic needs, securing necessary benefits, increasing skills and functioning in areas such as employment, interpersonal skills, community navigation, and activities of daily living. Clinical and staffing characteristics of a Forensic Assertive Community Treatment follow standards of the ACT model by including psychiatry, nursing, addiction counseling, and vocational rehabilitation. The forensic element will be addressed by engaging professionals from the correctional and criminal justice communities.

A fully operating team adhering to evidence-based practice admits no more than five individuals a month with a full census of between 70-100 individuals total at any one time. Since this is considered a long-term program, consumer turnover is low and averages less than 5 individuals per year. Additionally, the ACT model holds a consumer/staff ratio that is to not exceed 10:1.
Assertive Community Treatment has over 30 years of research that supports outcomes such as a decrease in hospitalizations, better community integration, and improved housing situations for individuals with serious and persistent mental illness. Additional outcome measures for individuals served through FACT include a reduction in incarceration and jail stays.

A legislative proposal was submitted and is currently moving through the Governor's budget process. The proposal requested resources in order to fund a FACT pilot project within the metropolitan geographic region. A FACT pilot team would work collaboratively with DOC Behavioral Health Release Planners and assist with a seamless transition into the community.

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EXHIBIT 6-16: HC 2D –HEALTH MEASURES ANALYSIS PLAN

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Olmstead Plan Implementation – HC 2D Analysis Plan

Establish data collection systems to measure health outcomes for people with disabilities

The Court has directed the State to "increase the number of people with disabilities receiving services that best meet their individual needs in the most integrated setting possible." Over time, we need to track the impact of policy and program changes on health outcomes for people with disabilities. We must coordinate among agencies and integrate data sources in order to measure health outcomes for people with disabilities. This will promote transparency and full accountability in the analysis and reporting of data and will help to assure the data are used for program and policy change/improvement for additional programs and services offered by state agencies serving people with disabilities.

While the health measure may be "health outcomes," the Olmstead measure is more along the lines of community inclusion / integration and life satisfaction.

There are five Department of Health (MDH) population health measures (to date) that have been identified and selected to serve as a proxy to help understand and track Olmstead Plan Implementation. They include: (**1**) utilization of healthcare services by type of service provided, as gleaned from the All Payers' Claim Database; (**2**) number of adult Minnesotans with disabilities receiving needed and desired services (from the Behavioral Risk Factor Surveillance System); (**3**) number of children and youth through transition age receiving desired and appropriate services (from the Children with Special Health Needs database); (**4**) number of persons with a TBI receiving needed services (from the MDH TBI Follow-up Survey, attached); and (**5**) number of persons with a spinal cord injury (SCI) receiving needed services (from the MDH SCI Follow-up Survey, attached).

As the data are analyzed, the MDH and the cross-agency data analysis team will determine the degree to which these population health measures in fact do describe community integration or if additional population health measures are needed to accurately track and describe progress.

Timeline:

a) By September 30, 2014: describe data needed and identify data sources. Note: no data sharing agreements between state agencies, local agencies and service organizations, and the academic community are needed as of December 31, 2014.

b) By December 31, 2014: complete analysis plan.

c) During 2015: conduct the analyses in the analysis plan and report progress bi-monthly to the MDH Olmstead Implementation Office.

Data Sources:

- TBI and SCI data from the State Registry, MDH
- All Payer Claims Database (APCD), MDH Division of Health Policy
- Behavioral Risk Factor Surveillance System (BRFSS), MDH

- Children with Special Healthcare Needs, MDH Division of Community & Family Health
- Resource Facilitation follow-up data (in partnership with the Minnesota Brain Injury Alliance)
- MHA hospital discharge data (Minnesota Hospital Association)
- Medicare and Medicaid data (from Department of Human Services)
- MDH TBI Short Survey (life satisfaction and needs provision assessment)
- MDH SCI Short Survey (life satisfaction and needs provision assessment)
- Mental illness data from SAVE and NAMI
- Death data, MDH
- TBI Gaps Analysis, Department of Human Services

Questions and Measures:

a) How is access to health care (dentists, chiropractors, mental health counselors, physicians and other specialty providers) changing over time?

b) Are referrals being made, and being made in a timely manner?

c) Is insurance coverage – or lack thereof – an issue that needs to be addressed?

d) To what degree are we able to measure or assess whether services are being provided and needs met in the "most integrated setting" possible?

e) To what degree are we able to measure life satisfaction?

Analysis Plans:

a) By County (or region or degree of urbanicity)

b) By age group

c) By gender

d) By disability

e) By race and ethnicity

Resources necessary:

In order to answer the analysis questions, the work is being built into workplans of MDH staff members. Funding to accomplish the analysis is principally federal, with an allotment of state special funding when and where possible. The MDH is receptive to an influx or input of state funding in order to accomplish the analyses in a timely manner. The MDH is not in position to speak to how other agencies are addressing the workforce and funding issues.