UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

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

Plaintiffs,

v.

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

Defendants.

Civil No. 09-1775 (DWF/FLN)

Memorandum to the Court:
Docketing State's November 10, 2014 Revised *Olmstead Plan* and Related Documents

David Ferleger
Court Monitor
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December 8, 2014

Pending before the Court is the State of Minnesota's unfiled proposed third version of its *Olmstead* Plan. This memorandum is to docket that version, with its cover letter and accompanying exhibit, as well as an amendment to the exhibit.

On November 10, 2014, the State submitted its proposed revised *Olmstead* Plan as ordered by the Court on September 18, 2014 (Doc. 344), along with a cover letter which highlighted the measureable goals which had been added to the Plan pursuant to that order. The additions were in Exhibit 1 to the cover letter. The State did not docket the revised plan or its cover letter; they are attached to this submission as **Appendix 1** (Revised *Olmstead* Plan) and **Appendix 2** (Letter to Court Monitor, November 10, 2014, with Exhibit 1).

Subsequent to the State's filing, the Court Monitor requested the State to provide the agency-by-agency goal-by-goal worksheets for each action item with proposed measureable goals.[1] These worksheets explain the basis and rationale for the proposed measureable goals. The worksheets were not in the original Exhibit 1.

On December 1, 2014, the State submitted an "amended Exhibit 1" to the Court Monitor, dated November 10, 2014. That document is attached here as **Appendix 3** (State's Amended Exhibit 1).

One further comment is appropriate. Without explanation and without requesting leave to do so, the State in Amended Exhibit 1 *redacted* three sets of specific numbers of individuals who "will benefit from the action item" "[w]ith additional resources" for three items:[2]

- Increasing competitive employment for adults with disabilities (EM 1G.1 / 1G.2) (page 15)
- The number of people who move to the most integrated residential setting (SS 2G / 2G.1) (page 35)
- The number of people who spend their days in more integrated settings (SS 2G / 2G.1) (page 35).

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[1] Court Monitor, Request No. 2014-23 (November 24,2014).

[2] Under prior orders, the State is to provide the Court Monitor with all requested information and documents.

For these three items, the State provides numbers of individuals who can be served "without additional resources" but blacks out the numbers who can be served "with additional resources."

Respectfully submitted,

/s/David Ferleger

Court Monitor

December 8, 2014

Putting the Promise of *Olmstead* into Practice: Minnesota's 2013 Olmstead Plan

Plan date: November 1, 2013
Proposed plan modifications to Court Monitor: June 30, 2014
Proposed plan modifications to United States District Court: July 10, 2014
Modified plan approved by the Court: [date to be determined]

Proposed plan modifications to Court Monitor: November 6, 2014

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Note to readers: the Table of Contents has been updated. To make it easier to read the text and to find the information, changes are not displayed.

STATE OF MINNESOTA
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October 31, 2013

My Fellow Minnesotans,

On behalf of the Olmstead Subcabinet, I am pleased to present Minnesota's Olmstead Plan. The Subcabinet, and our entire administration, share a strong desire to affirmatively address issues facing individuals with disabilities. We are firmly committed to making Minnesota an inclusive, integrated state. There is much work to be done, but we are confident that, with shared vision and direction, we can make our desire a reality.

Minnesota's Olmstead Plan is the result of many months of effort by staff from multiple state agencies. The Olmstead Subcabinet, in cooperation with these agencies, will continue to oversee implementation of this plan. The Subcabinet will hold public meetings on a periodic basis to listen and respond to issues, concerns, and feedback. It is our commitment to make clear progress on the plan and to continue to refine and shape it with the guidance of people with disabilities.

On behalf of the Olmstead Subcabinet, I would like to extend a personal and public thank you to all of the individuals with disabilities, family members, professionals, providers, advocates, business leaders and others who have been involved in the development of the Olmstead Plan. I also appreciate the personal commitment of Subcabinet members and agency staff who collaborated to develop this plan.

Sincerely,

Yvonne Prettner Solon

Information about this document

An order dated January 22, 2014 from United States District Judge Donovan Frank[1] states the following: "The Court provisionally accepts and approves the Olmstead Plan, subject to the Court's review after the State of Minnesota revises the Olmstead Plan based upon the Report by the Court Monitor and after the Court has reviewed any submissions by Plaintiffs' Class Counsel and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities and the Ombudsman for Mental Health and Developmental Disabilities." The order further states: "The Court respectfully directs that the Subcabinet use all of its combined resources and talents to implement the Olmstead Plan." This document contains proposed modifications to Minnesota's 2013 Olmstead Plan. The effective date of the full plan is November 1, 2013, but the proposed modifications have not yet been approved by the Court.

To develop the 2013 Olmstead Plan, writing teams from Olmstead Subcabinet agencies developed specific actions and timelines related to topic areas such as employment, housing, and transportation. The teams used an iterative writing process, listening to input from individuals with disabilities, family members and guardians, advocacy organizations, service providers, and national experts as they revised the draft plan. To develop the proposed modifications in this document, teams conferred with stakeholders and agencies, considered comments from subcabinet listening sessions held across the state, and reviewed comments from the Court Monitor overseeing the *Jensen* settlement agreement.

Modifying the Olmstead Plan

Minnesota's Olmstead Plan will continue to be refined and updated over the coming years as the state implements the actions described in this plan, and as the subcabinet hears from stakeholders about what is working and what is not working. The subcabinet intends to review the need for modification of the plan every six months. Reasons for proposed modification of the plan include: changes that are needed to clarify measurable outcomes, changes that expand benefits to people or improve quality of life, and changes that are needed because the state learns that a different action will be necessary to accomplish the strategic goal.

The Plan and its modifications are subject to the approval of the Court in *Jensen et al. v. Minnesota Department of Human Services et al.* As such, and pursuant to the Court's August 28, 2013, Order, "[a]ny requests for . . . modification of the Plans' deadlines or other elements, shall be in writing, for good cause shown, and shall, in the first instance, be addressed and resolved by the Court Monitor, subject to review by the Court on written application by any party."

The Court Monitor has requested that the Minnesota Department of Education consider additional modifications to the section of the Olmstead Plan regarding prone restraint

[1] A copy of the order is available at http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_181843.pdf.

Feedback on the Olmstead Plan

The State of Minnesota welcomes feedback to refine and implement Minnesota's Olmstead Plan. To provide feedback, use the contact form on the Minnesota Olmstead Plan website (use an internet search on the phrase "Minnesota's Olmstead Plan" or use this shortened web address: http://bit.ly/14fcGSL) or send an email to opc.public@state.mn.us). Please keep in mind that we may not be able to respond to individual comments, but we will consider everyone's comments as we refine and implement the plan. For more information about how individuals will be involved in implementing and monitoring the Olmstead Plan, go to pages 35 and 36 of this document.

Executive Summary

Minnesota's 2013 Olmstead Plan is the result of many people working together, across and within state agencies. This executive summary provides an overview of the plan; more information is contained in the specific sections of this document.

Stakeholder input

To develop Minnesota's first Olmstead Plan, the state used an iterative approach, with stakeholder input and feedback at the core of the process.

The Olmstead Subcabinet and agency staff listened to feedback from stakeholders, particularly people with disabilities and their families. Some of the most important ideas included:

- People with disabilities should be leading; the government should be listening.
- People with disabilities know what they want and what will promote inclusion; current systems have to change.
- People with disabilities want control over their own lives; they don't want to wait for the system to decide what service they will receive.
- People with disabilities are individuals and want to be treated as such; there can't be a one-size-fits-all approach to government services.

Minnesota's Olmstead Plan incorporates these ideas. The plan also includes concrete commitments to listen to and engage people with disabilities in refining and implementing the plan. An additional element of Minnesota's Olmstead Plan is an annual assessment of Quality of Life for people receiving services. The purpose of the Quality of Life survey is to ensure the state is continually made aware of whether changes in the system actually improve people's quality of life.

Developing Minnesota's Olmstead Plan

Governor Mark Dayton established an Olmstead Subcabinet in January 2013; this group of state agencies is charged with developing and implementing Minnesota's Olmstead Plan.

An Olmstead Plan is a way for a government entity to document its plans to provide services to individuals with disabilities in the most integrated setting appropriate to the individual. In the landmark civil rights case, *Olmstead v. L. C.*, 527 U.S. 581 (1999), the United States 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. The Court and subsequent United States Department of Justice guidance encourages states to develop plans to increase integration.

Minnesota has made progress in increasing community-based supports and integrated options, but now is the time for Minnesota to develop a comprehensive Olmstead Plan to work towards full inclusion of people with disabilities. Importantly, Minnesota is also required to develop and implement an Olmstead Plan as part of a settlement agreement in a federal court case.

The Olmstead Subcabinet realizes that there are real opportunities for improvement in areas such as employment, transportation, housing, lifelong learning and education, health care and healthy living,

community engagement, and supports and services. These are the areas where Minnesota must make changes in order to achieve integration for people with disabilities.

Excerpt from Governor Mark Dayton's Executive Order 13-01

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the power invested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, the State of Minnesota is committed to ensuring that inclusive, community-based services are available to individuals with disabilities of all ages;

…

Whereas, barriers to affording opportunities within the most integrated setting to persons with disabilities still exist in Minnesota; and

Whereas, the State of Minnesota must continue to move more purposefully and swiftly to implement the standards set forth in the *Olmstead* decision and the mandates of Title II of the ADA through coordinated efforts of designated State agencies so as to help ensure that all Minnesotans 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.

Now, Therefore, I hereby order that:

1. A Sub-Cabinet, appointed by the Governor … shall develop and implement a comprehensive Minnesota Olmstead Plan…

Olmstead Subcabinet Vision Statement

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:[2]

- **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.

[2] The order of these goals is roughly based on the relative proportion of stakeholder comments.

Key Olmstead Plan actions

The plan's aspirational goals are connected to concrete actions. The chart below summarizes a number of detailed actions described in the plan.

Topic	Action	Responsible Agency(ies)
Overarching/Quality Assurance/Accountability	Begin with the individual in all phases of service (assessment, planning, service delivery, and evaluation)	Subcabinet
	Review all policies, procedures, laws, and funding through the perspective of the *Olmstead* decision; address barriers through administrative alignment and collaboration, legislative action, policy and rule changes, and funding changes and prioritization.	Subcabinet
	Design and implement opportunities for people with disabilities to be involved in leadership capacities in all government programs that affect them.	Subcabinet
	Identify quality of life outcome indicators; contract with an independent entity to conduct annual assessment	Subcabinet
	Establish an Olmstead dispute resolution process	Subcabinet
	Design an implementation and oversight structure, establish an Olmstead implementation office	Subcabinet
	Adopt an Olmstead Quality Improvement Plan	Subcabinet
Employment	Expand integrated employment for students and adults with disabilities	DEED, DHS, MDE
	Align policies and funding to increase integration and expand employment opportunities	DEED, DHS, MDE
	Provide training, technical assistance, public information and outreach	DEED, DHS, MDE, MDHR
Housing	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	DHS, DOC
	Increase the amount of affordable housing opportunities created	MHFA, DHS
	Increase housing options that promote choice and access to integrated settings	DHS
	Increase access to information about housing options	MHFA
	Actively promote and encourage providers to implement best-practices and person-centered strategies related to housing	DHS
Transportation	Establish a baseline of services and transit spending across public programs	DHS, MnDOT
	Engage community members to expand flexibility in transportation systems	DHS, MnDOT
	Integrate *Olmstead* principles into transportation plans	MnDOT
	Engage Minnesota Council on Transportation Access in Olmstead work	DHS, MnDOT

Topic	Action	Responsible Agency(ies)
Supports & Services	All individuals with disabilities will be offered supports and services in the most integrated settings	Subcabinet, DHS
	Support people in moving from institutions to community living, in the most integrated setting	DHS, DOC
	Build effective systems for use of positive practices, early intervention, crisis reduction and return to stability after a crisis	Subcabinet, DHS
	Provide access to the most integrated setting through the provision of supports and services	DHS, DOC
Lifelong Learning & Education	Work to reduce the use of restrictive procedures, develop recommendations to eliminate the use of prone restraints in schools	MDE, DHS
	Build staff capacity at the school level to effectively improve school-wide systems of positive behavior interventions and supports	MDE
	Students will have interagency supports and services to access integrated employment options before exiting high school	MDE, DHS, DEED
	Increase the number of students with disabilities enrolling into postsecondary education and training programs	MDE, DHS, DEED
	Ensure that students with disabilities who are placed out of state or in juvenile corrections can return to their resident district or most integrated setting	MDE, DOC
Healthcare & Healthy Living	Integrate primary care, behavioral health and long-term care/supports	MDH, DHS
	Reduce gaps in access and outcomes	MDH, DHS
Community Engagement	Support individuals with disabilities to engage in their community in ways that are meaningful to them	Subcabinet
	Provide access and opportunity for individuals with disabilities to be full community participants	Subcabinet

The colors for the topic areas used in the chart above are used in the specific sections of the plan.

Year One at a Glance: Changes that will make a difference in people's lives

Many of the actions described in this plan will take time and resources to implement, but there are important changes that will happen in the first year of this plan. These changes will make a real difference in the lives of individuals with disabilities:

- Concrete changes to reduce the number of people in segregated service settings:
    - New community based services for people with disabilities as an alternative to Minnesota Specialty Health System—Cambridge.
    - Movement to more integrated settings 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.
    - Reduction in discharge times for people in Anoka Metro Regional Treatment Center.
    - Transition supports for people discharged from Minnesota Security Hospital.
    - Identification of individuals in other integrated settings and establishment of targets and timelines for those individuals to access the most integrated settings.
- Expansion of effective transitions from high school to postsecondary education or training programs.
- Expansion of self-advocacy and peer support options.
- Increased individual control over housing.
- Increased individual control over support services, such as personal care assistance.
- Increased integrated employment opportunities.
- Movement towards positive practices and away from use of seclusion, restraints and other restrictive practices.
- New practices to improve health outcomes.

Background information: Minnesota's Olmstead Plan in context

State and federal law

The Minnesota Human Rights Act, the Americans with Disabilities Act (ADA), and other laws prohibit discrimination against people with disabilities. Additionally, under these laws, government entities are required to ensure that people with disabilities can access services and programs. This requirement means more than ensuring *physical* access for people with disabilities: to comply with these laws, government entities may also be required to change the way they provide services or modify how programs are administered so that individuals with disabilities can participate and benefit. Regulations developed under the ADA also specifically require that government entities provide services in the *most integrated* setting appropriate to the needs of qualified individuals with disabilities.[3] The United States Department of Justice (DOJ) explains that the *most integrated* setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible…"[4]

Olmstead v. L. C.

In 1999, the United States Supreme Court considered a case involving two women with disabilities who were confined in an institution, even after health professionals determined they were ready to move into a community-based program. In *Olmstead v. L. C.*, 527 U.S. 581 (1999), the Court held that unjustified segregation of people with disabilities violates the ADA. The decision means that states must offer services in the *most integrated setting*. In particular, the Court held that states are required to provide community-based treatment for people with disabilities when:

a) The state's treatment professionals determine that such placement is appropriate;
b) The affected individuals do not oppose community-based treatment; and
c) The community-based placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.[5]

In its opinion, the Court emphasized that it is important for governments to develop and implement a comprehensive, effectively working plan to increase integration.

From one perspective, the *Olmstead* decision is about how services are provided *by* the government *to* people with disabilities (that is, services must be provided in the most integrated setting). From another perspective, the *Olmstead* decision is a landmark civil rights case "heralded as the impetus to finally move individuals with disabilities out of the shadows, and to facilitate their full integration into the mainstream of American life."[6]

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[3] 28 C.F.R. § 35.130(d): http://www.ecfr.gov/cgi-bin/text-idx?SID=8e0a7c758dd371dfdf081d5c2f63a5a5&node=28:1.0.1.1.36&rgn=div5.

[4] 28 C.F.R. Pt. 35, App. A (2010): http://www.ecfr.gov/cgi-bin/text-idx?SID=3878071b2ac0b3880c5944edc741f1f3&node=28:1.0.1.1.36&rgn=div5#28:1.0.1.1.36.7.32.3.11. Also US DOJ, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L. C., Accessed August 30, 2013, http://www.ada.gov/olmstead/q&a_olmstead.pdf.

[5] A copy of the *Olmstead* decision is available at http://www.law.cornell.edu/supct/html/98-536.ZO.html.

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

Because this is a government planning document, much of the detailed content in Minnesota's Olmstead Plan is necessarily focused on the first perspective. The vision of the Olmstead Subcabinet and the goals contained in this plan are firmly grounded in the civil rights perspective.

Federal enforcement and guidance related to the *Olmstead* decision

Presidents Bill Clinton, George W. Bush, and Barack Obama acted to support the *Olmstead* decision through federal agency initiatives. In recent years, the DOJ has applied an expansive understanding of the *Olmstead* decision. As examples, the DOJ has taken action against government entities that had long waiting lists for community-based services, against programs that placed too much emphasis on segregated employment, and against governments that attempted to reduce funding for personal care services (which could force people into institutional settings).[7] The DOJ has also issued guidance for government entities to help them comply with the principles of the ADA and the *Olmstead* decision. Minnesota has consulted this guidance in developing its Olmstead Plan.[8]

Why does Minnesota have an Olmstead Plan?

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

There are three main reasons why Minnesota has developed an Olmstead Plan:

- Developing a comprehensive and effectively working plan to increase integration will ensure that the State of Minnesota is in compliance with the letter and spirit of the *Olmstead* decision and the ADA.
- As part of a settlement in a recent case (*Jensen et al v. Minnesota Department of Human Services, et al*), the State of Minnesota agreed to develop and implement an Olmstead Plan.[9] The subcabinet has consulted the settlement agreement and subsequent court orders during development of this plan, and will submit the plan to the federal court for review and approval.
- Governor Mark Dayton issued an executive order, forming an Olmstead Subcabinet and directing identified agencies to develop and implement an Olmstead Plan[10].

[7] For a list of recent DOJ enforcement actions, review US DOJ, "What's New." Accessed August 30, 2013, http://www.ada.gov/olmstead/olmstead_new.htm.

[8] In particular, drafting teams consulted Question and Answer #12, *What is an Olmstead Plan?* in "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C." Accessed August 30, 2013, http://www.ada.gov/olmstead/q&a_olmstead.pdf

[9] A copy of the settlement agreement can be found at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&noSaveAs=1&Rendition=Primary&allowInterrupt=1&dDocName=opc_jensenv_pdf

[10] A copy of Executive Order 13-01 can be found at http://mn.gov/governor/images/EO-13-01.pdf

People with disabilities in Minnesota: Demographics & implications

In developing Minnesota's Olmstead Plan, state agencies considered demographic realities and trends. Some relevant demographic information includes (Appendix A contains visuals of some of this data)[11]:

- In 2011, 10.1% of Minnesotans were people with disabilities; Minnesota ranks as the 4th lowest state in in the U.S. in terms of rate of disability.[12]
- 12% of all Minnesotans lived in poverty in 2011. By comparison, 22% of Minnesotans with disabilities lived in poverty in 2011.[13]
- The highest rates of disabilities among working-age Minnesotans are American Indians (20%) and U.S.-born African Americans (17%).[14]
- Working age Minnesotans experience different rates of disability—ambulatory (3.4%); cognitive (3.6%); hearing (2.0%); independent living (2.7%); self-care (1.4%); vision (1.0%) and one or more disabilities (8.1%).[15]
- Older Minnesotans (65 years +) experience different rates of disability—ambulatory (18.4%); cognitive (6.4%); hearing (15.0%); independent living (12.7%); self-care (6.8%); vision (4.9%) and one or more disabilities (32.0%). [16]
- There are regional differences in disability rates (which likely result from aging differences). The highest rates of disability are in the northern and western regions of the state (14%) and the lowest rate of disability is in the Twin Cities (8%).[17] Within the Twin Cities metropolitan area, parts of Ramsey County and Hennepin County have higher rates of disability.[18]
- Minnesota's population is aging. The current retirement-to-working age ratio is about 22%, but by 2040, the retirement-to-working age ratio is projected to be almost 40%. [19]
- Recent data shows that 80% of Minnesotans with no disabilities are working, compared to only 43% of Minnesotans with disabilities. Rates of employment differ among different types of disability.[20]
- According to a 2012 study on homelessness in Minnesota, 55% of adults experiencing homelessness reported a serious mental illness, 51% reported a chronic physical health

[11] Different data sources count people with disabilities differently—for example, poverty rate data does not include people living in institutions.
[12] Data from the American Community Survey and Decennial Census and Population Estimates, via Minnesota Compass, http://www.mncompass.org/demographics/.
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Data from the Minnesota State Demographic Center, using Public Use Microdata from the American Community Survey 2009-2011.Additional data is in Appendix A, chart 5b, chart 5c, and table 5d.
[19] Data from the American Community Survey and Decennial Census and Population Estimates, via Minnesota Compass, http://www.mncompass.org/demographics/.
[20] Data from the American Community Survey, via the Minnesota State Demographic Center.

condition, 31% reported evidence of a traumatic brain injury, and 22% reported a substance abuse disorder. 70% (3,719 adults) reported at least one of these conditions.[21]

- Recent media attention has focused on one disability that has increased dramatically. According to the Centers for Disease Control, autism has increased from a prevalence of 1 in 1000 in 1970, to 1 in 150 in 2000, to 1 in 88 in 2012.[22]

The implications of these trends for Minnesota's Olmstead Plan include:

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

Accomplishments and challenges in Minnesota

As part of developing the Olmstead Plan, Minnesota has taken stock of our accomplishments and challenges related to integration and inclusion of people with disabilities. In some areas, we know that we're making good progress, but we have opportunities for more positive changes. In other areas, we know that we have much work to do.

Accomplishments, strengths, advantages, and opportunities

- Minnesota has a long history of commitment to people with disabilities.
- Minnesota has invested in services to people with disabilities.
- Minnesota has moved people with disabilities out of large state operated facilities.
- Some people with disabilities live, learn, work and enjoy life in a wide variety of settings (though many other people with disabilities are awaiting these opportunities).
- There are good practices in place in areas like housing, employment, and education, but these practices need to be scaled up to reach all people with disabilities who would like to participate or benefit.
- Compared with other states, Minnesota typically ranks high in quality of life measures (though people with disabilities do not necessarily agree).

[21] Wilder Research, "2012 Minnesota Homeless Study Fact Sheet," 2012, 2–3. Accessed October 3, 2013, http://www.wilder.org/Wilder-Research/Publications/Studies/Homelessness%20in%20Minnesota%202012%20Study/Long-term%20Homelessness,%20Fact%20Sheet.pdf.

[22] CDC, "Autism Spectrum Disorders: Data & Statistics." Accessed August 30, 2013, http://www.cdc.gov/ncbddd/autism/data.html.

- Though Minnesota has a long history of cross-agency collaboration, this is the first time agencies have come together at both leadership and staff levels to find ways to increase integration and inclusion for people with disabilities.
- The Olmstead Subcabinet and Olmstead Plan process have given people the opportunity to work across agency lines in new ways; there is substantial momentum in the subcabinet agencies' work.
- The Olmstead Plan development process has given state agency leaders and staff the opportunity to hear from people with disabilities about what is important to them.
- There are real opportunities for improvement in employment, transportation, housing, lifelong learning and education, health care and healthy living, community engagement, and supports and services.

Challenges, weaknesses, and risks

- People with disabilities are not usually (or routinely) asked about their preferences of where to live, learn, work and enjoy life; or their preferences are ignored or not factored into the supports and services provided.
- Employment opportunities have been limited, especially during the economic downturn.
- On the whole, supports and services are not consumer driven.
- Service growth has been limited, but more so during the past economic downturn.
- Data systems do not track important indicators such as "most integrated setting."
- While Minnesota state agencies are often very good at measuring program performance (such as how many people received a certain benefit, or how quickly a license was issued), agencies are not uniformly measuring whether people's quality of life is improved *because of* a program.
- Cultural and geographic differences result in people with disabilities being unserved and underserved.
- People with disabilities in Minnesota experience significant health disparities compared to the general population because of a lack of integrated services.
- The Olmstead planning process has created strong interagency cooperation and an interest in reform, but that interest could wane. Strong leadership, and the willingness and authority to make decisions must be expanded and maintained.
- If Minnesota does not effectively implement the Olmstead Plan, individuals with disabilities may seek relief through the courts or administrative processes.
- Minnesota does not have complete control over necessary funding—Congressional actions or inactions could result in funding problems.
- There are risks associated with making many changes at the same time.
- Training and education will be necessary to overcome inertia and resistance to change. This training must include everyone—the general public; people with disabilities; employers; the state legislature; the executive branch; and state, county and tribal organizations, service providers/employees, and government staff.
- People with multiple complex needs who move (or may want to move) from segregated settings to most integrated settings cannot access necessary services.

Developing the Olmstead Plan

Minnesota began work to develop the Olmstead Plan in 2012. The plan development process has included state agency staff, with input from individuals with disabilities, their families, other stakeholders and advocates, and nationally regarded experts.

Minnesota's Olmstead Planning Committee formed in 2012. The committee included individuals with disabilities, family members, providers, advocates, and decision-makers from the Minnesota Department of Human Services (DHS). In fall 2012, the committee submitted recommendations to DHS.

In January 2013, Governor Mark Dayton issued an executive order establishing a subcabinet to develop and implement a comprehensive plan supporting freedom of choice and opportunity for people with disabilities. The Olmstead Plan Subcabinet, chaired by Lieutenant Governor Yvonne Prettner Solon, includes the commissioner or commissioner's designee from the following state agencies:

- 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

Representatives from the Office of the Ombudsman for Mental Health and Developmental Disabilities and the Governor's Council on Developmental Disabilities are *ex officio* members of the subcabinet.

In the months since the Executive Order, staff from subcabinet agencies worked within their organizations and across departments to develop Minnesota's Olmstead Plan. The subcabinet itself met at least monthly from January 2013 to November 2013 to discuss progress on planning efforts and to respond to drafts and information. Subcabinet agencies committed to a collaborative and iterative process in developing the plan—they incorporated initial feedback from other agencies and stakeholders as they prepared drafts, and they know that the plan must be regularly updated with ongoing input from Minnesotans.

After the 2013 Olmstead Plan was published, the Olmstead Implementation Office and subcabinet agencies reviewed feedback and identified areas of the plan that should be modified. The subcabinet intends to review the need for modifying the Olmstead Plan every six months (as described on page 7 of this document).

Minnesota's Olmstead Plan is not a replacement for the many existing state and federal plans produced by government agencies—the Olmstead Plan can help guide the implementation of other plans.

Olmstead Subcabinet Vision Statement

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.

External consultations

The Olmstead Subcabinet was assisted by a grant from the Substance Abuse & Mental Health Services Administration (SAMHSA) to obtain expert consultation on critical Olmstead Plan topics (education, family supports, housing, health care, employment, measurement, and self-determination) and on writing the Olmstead Plan itself. Agency drafting teams met with experts as they drafted parts of the plan, and national experts provided feedback on drafts. (Appendix B has a list of experts.)

Stakeholder feedback

Several hundred stakeholders have been involved throughout the drafting process, both formally and informally, in the following ways:

- Olmstead Planning Committee (March 2012 – October 2012), and written comments on the committee's recommendations (November 2012 – January 2013).
- Informal, agency-based stakeholder feedback and information gathering for the first draft plan (February 2013 – May 2013).
- Written comments on the first draft of the Olmstead Plan (June 2013 – August 2013). About 100 people and organizations provided written comments on the plan (a few organizations provided comments summarizing the feedback of many individuals).[23] Of all the written comments, almost 40% were family members or guardians of people with disabilities, over 20% were advocacy or other organizations, and over 20% were service providers. About 5% of comments came from people who self-identified as individuals with disabilities (additionally, many of the organizations that provided comments include people with disabilities as leaders or board

[23] For example, three different advocacy groups submitted comments representing the views of about 50 people with disabilities.

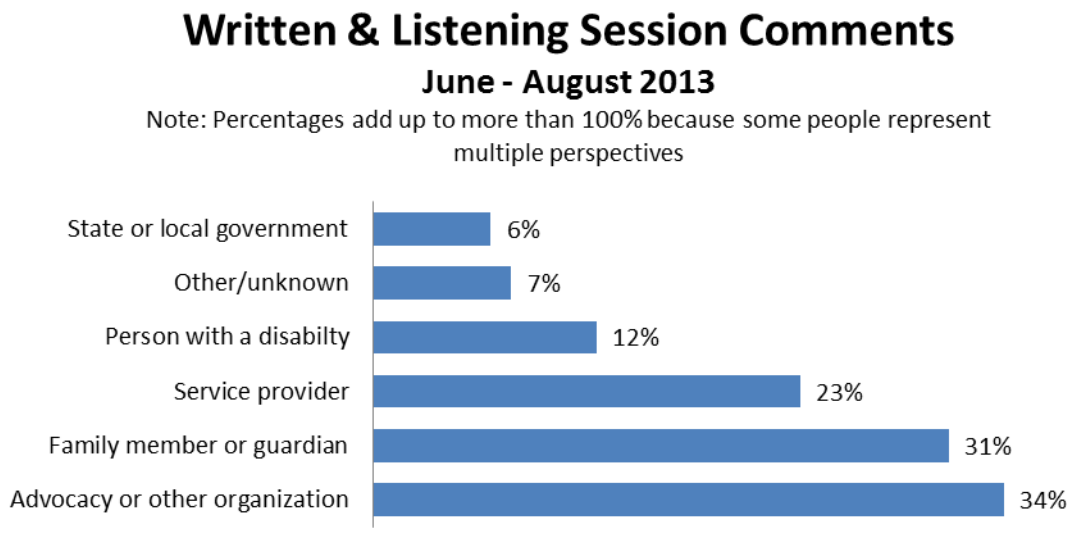
members). All of this feedback was reviewed, and the comments were summarized and categorized. (Figure 1, below, shows information about written and listening session comments; Figure 2, below, shows information about topics in written comments.) Note that individual comments may reflect more than one perspective.

- Olmstead Subcabinet listening sessions in St. Paul, Moorhead, Duluth, and Rochester (July 2013–August 2013). About 80 people provided input at listening sessions (some people spoke more than once, and some people read comments from others). Of these, almost half were representatives of advocacy or other organizations, about 25% were service providers, and over 20% were family members or guardians. About 20% of people who spoke at listening sessions were people who self-identified as individuals with disabilities. (Figure 1, below, shows information about written and listening session comments.) Note that individual comments may reflect more than one perspective.[24]
- Online and email comments about revised drafts of the plan (August 2013 – October 2013).
- Agency-based outreach to stakeholders about the draft plan (ongoing).
- Focus group results, survey research results, and other analyses (ongoing).

The subcabinet thanks every person for taking time to provide input and feedback during the drafting process. The input was heartfelt, respectful, represented broad viewpoints, provided insight and identified successes (not just problems).

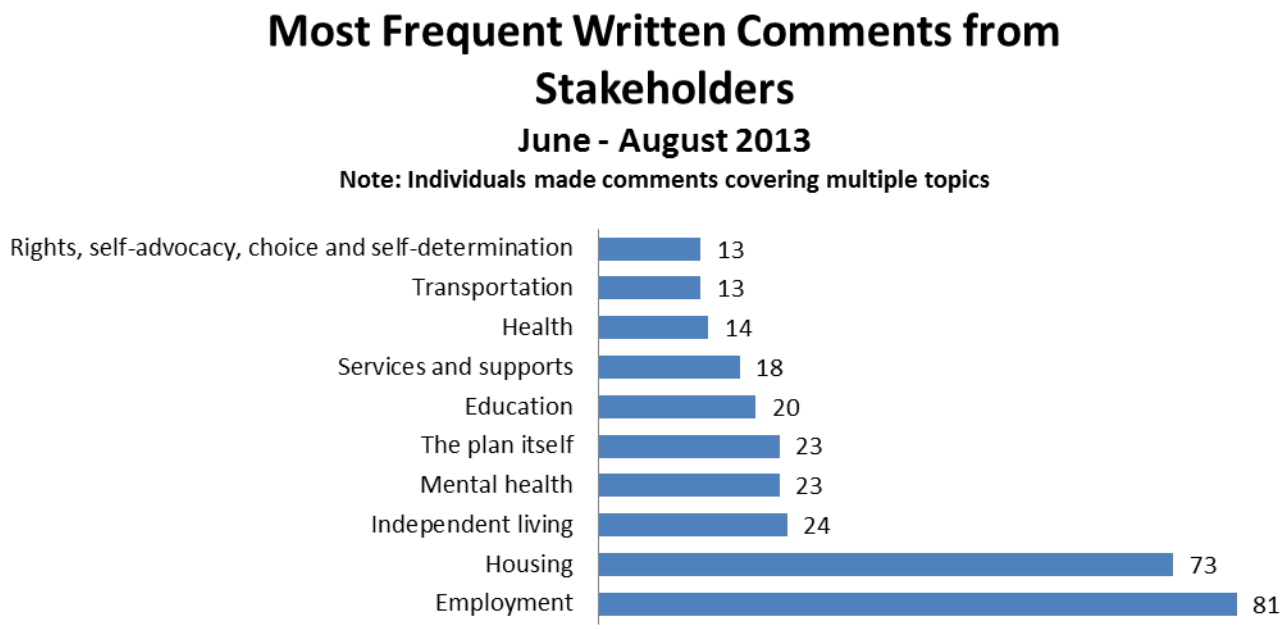
Plan drafting teams have considered all of the input from stakeholders in preparing this plan.

Figure 1: Online and Listening Session Commenters: June – August 2013.



[24] Copies of notes from the listening sessions are available at the Olmstead Plan website.

Figure 2: Most Frequent Written Comments from Stakeholders: June – August 2013.



Themes from stakeholders

Several themes emerged from team discussions about stakeholder comments:[25]

Important issues to be addressed in the Olmstead Plan

- People with disabilities said that they should be treated as individuals—their interest in making choices is the same as everyone's.
- Employment, housing, transportation, education, community engagement, and access to services (including technology) are important across the state. People requested expansion of programs and approaches that provide access to the most integrated setting.
- Perspectives differed inside and outside of the Twin Cities metropolitan area: inside the metro area, people talked about the need for enhancement of existing services; outside the metro area, people noted the need for additional resources for more basic services. In rural areas, people said they have no choices and no options.
- People with disabilities and their families want a range of options in housing, employment, and services—there have to be real choices. People said they don't want to have one decision affect all other possible decisions. People want flexibility in the whole system.
- Employment:
    - People with disabilities want real jobs with real wages.
    - Many family members and service providers are concerned about potential loss of supported employment options.

[25] These themes are based on the plan drafting teams' qualitative review of information from individuals who made comments online or at listening sessions from June 2013 – August 2013. We realize that these opinions may not reflect the opinions of all relevant stakeholders or of Minnesotans in general.

  - Disincentives to employment (like loss of needed benefits) should be removed.
  - Many participants recommend that the state use an Employment First approach.
  - People expressed concerns that the Olmstead Plan would use a one-size-fits-all approach to employment, and some noted that individuals choose not to work.
- Housing:
  - People are dissatisfied with caps and moratoriums regarding housing options.
  - Lack of affordable, accessible housing and homelessness are significant issues for people with disabilities.
  - People with disabilities said that their only choice is to live with roommates they don't know.
  - People said that their choices to leave home and to associate with friends and family are unnecessarily limited.
  - Some people with disabilities and service providers believe that housing with supports is the best option for many people (particularly people recovering from chemical dependency).
  - Concentration of group homes has triggered concerns from some neighbors.
  - People expressed concerns that the Olmstead Plan would use a one-size-fits-all approach to housing.
- Education:
  - People said inclusion and integration efforts must start early (well before the transition from youth to adult), and carry through to adulthood.
  - People said that even educational settings that may be classified as integrated may not be integrated in practice.
  - People expressed concerns about the use of prone restraints in schools.
- Supports and Services:
  - People think that the plan should enhance self-advocacy, self-determination, independent living, peer support services, and certified peer specialists.
  - People say that supports and services are needed before someone is in crisis so that people do not face hospitalization, jail, or homelessness.
  - People expressed concerns about reimbursement rates, budget problems, lack of waivers, and waiting lists.
  - People think that more attention should be given to developing and maintaining a quality direct service workforce—pay, benefits, and professional development are all important. People expressed concerns about shortages, turnover, and reliability of workers.

Expectations of the Olmstead Plan and implementation

- People with disabilities expect to be involved and provide leadership in developing and implementing Minnesota's Olmstead Plan.
- People want the Olmstead Plan to be more than a list of activities—it should include large strategic efforts, as well as goals, measurable results, and timelines.

- The Olmstead Plan should address all people with disabilities of all ages, and planners should realize that different individuals have different needs and preferences.
- People expect state agencies, counties, providers, and other organizations to work together to improve state services and systems.
- The Olmstead Plan must address the known problems from a Department of Justice and *Olmstead* perspective, such as waiting lists, segregated work settings, and people who are institutionalized unnecessarily.
- People know that additional funding will be needed to make significant changes, and people are concerned that there will be reduction in funding for some programs.
- People see the Olmstead Plan as an opportunity for positive changes in Minnesota, but some participants were concerned about possible unintended outcomes of changes.
- People are concerned that the plan won't be implemented or that nothing will change.

The goals, actions, and priorities outlined in this plan are responsive to the feedback we heard from stakeholders, and the State of Minnesota is committed to including stakeholders in further development and implementation of the plan. More information is in the Quality Assurance and Accountability section (beginning on page 33).

Selected stakeholder comments are incorporated in this draft to provide context in the sections of the plan. Appendix C contains more comments from listening sessions.

Stakeholder feedback: November 2013 – May 2014

After adopting the Olmstead Plan in November 2013, the subcabinet continued to solicit input online. The subcabinet also held public listening sessions across the state in Bemidji, Duluth, Mankato, and St. Paul. The Olmstead Implementation Office reviewed the information from all stakeholders and sent comments to state agencies and writing teams for review. All public comments are posted on the Olmstead Plan website. Some of the main themes from stakeholders from November to May include:

- The Olmstead Plan and implementation should focus more on the mental health system and mental illness.
- There should be more attention on the justice system and corrections.
- People have differing opinions about employment options. Some are very concerned about how changes will affect organizations, families, and individuals.
- There is not enough funding in the social service system; programs have been cut, and reimbursement is too low.
- The state should avoid a "one size fits all" approach—individuals and communities are different.
- Transportation is a significant issue—inside and outside the Twin Cities metropolitan area.
- People with disabilities should be more involved in policy development and service design—"nothing about us without us."
- People need more information about the Olmstead Plan and about the rights of individuals.
- Too many educational settings continue to be segregated; restriction and seclusion practices must be reduced.

- There must be accountability in the Olmstead Plan and in all state services—monitor progress on goals and quality.

The Olmstead Implementation Office and agency teams will continue to review and consider information provided by stakeholders with regard to implementation of the Olmstead Plan adopted by the Court as an enforceable order. Is the plan working? How is implementation succeeding or failing to achieve its measurable goals? Where are the gaps? In particular, stakeholder input will be reviewed as part of Overarching Strategic Action Two: Olmstead perspective.

Person-Centered Planning in Minnesota's Olmstead Plan[26]

Throughout Minnesota's Olmstead Plan there are references to the requirement of person-centered planning. This section of the document is meant to help clarify the importance of person-centered plans and how they are defined in the Minnesota Olmstead Plan.

Context of Person-Centered Planning

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

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

Terms like "person-centered planning" and "person-driven planning" are distinct, but they share the fundamental principle that government and service providers begin by listening to individuals about what is important to them in creating or maintaining a personally-valued, community life. Planning of supports and services are not driven or limited by professional opinion or available service options but focused on the person's preferences and whole life context. Effective support and services are identified to help people live, work, and participate in their preferred communities and on their own terms. Many state and federal policies now mandate person-centered delivery of long-term services and supports. In January 2014, the Centers for Medicare and Medicaid Services issued a rule that applies to all Home and Community Based Services; this rule provides a description of a person-centered service plan. The full rule, 42.C.F.R.Pt.430, 431 et al, is available at http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf (§441.725 contains the description of a person-centered service plan).

The Minnesota Olmstead Plan sees person-centered planning as foundational to overcoming system biases and supporting people's ability to engage fully in their communities. The following definition is meant to help providers, families, communities and individuals in understanding what qualifies as a

[26] The references to "person-driven" in the section titled "Context of Person Centered Planning" are not to be understood as limiting or altering the later sections on "definition" and the statement of "core values and principles of person-centered planning."

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

Definition of Person-Centered Planning

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

Statement of Core Values and Principles of Person-Centered Planning

Person-centered planning embraces the following values and principles:

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

- Plans include sufficient proactive support and organization to prevent unnecessary life disruption and/or loss especially during transition periods or crisis recovery.
- Community presence, participation, and connection are expected and supported through the use of natural relationships and community connections in all aspects of the plan to assist in ending isolation, disconnection and disenfranchisement of the individuals.
- The process is based on mutually respectful partnerships that empower the person who is the focus of the plan and are respectful of his/or her important relationships and goals.
- The context of a person's unique life circumstances including culture, ethnicity, language, religion, gender and sexual orientation and all aspects of the person's individuality are acknowledged when expressed and embraced and valued in the planning process.

Appendix D contains additional context and information related to person-centered planning from the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Minnesota's goals: Putting the promise of Olmstead into practice

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[27]:

- **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.

Minnesota's Olmstead goals are aspirational—Minnesota should be a place where people with disabilities are fully included in all aspects of community and civic life. In establishing this Olmstead Plan, Minnesota has identified actions that will help Minnesota meet these goals for all people with disabilities, while focusing on actions that will have the biggest impact on people with disabilities whose choices may be constrained by current systems. Minnesota's Olmstead Plan is just the start of a larger, ongoing conversation about how state government can facilitate real inclusion for all individuals with disabilities.

Minnesota's Olmstead Plan is not a plan to eliminate certain options or close certain facilities—it's a plan to increase integration options for individuals with disabilities, in line with the goals expressed above.

[27] The order of these goals is roughly based on the relative proportion of stakeholder comments.

Overarching strategic actions

Stakeholder Comments	
	If people have greatly limited life experiences, it's really not informed choice just to tell people what their options are. *Mary Kay Kennedy*
	Integration is not inclusion. Inclusion is about being welcomed and a sense of belonging into a community. *Jennifer Lewin*
	One of the primary challenges is ensuring that we are not creating one-size-fits-all solutions. People have a full spectrum of needs. We must have a full spectrum of solutions. *Sandra Gerdes*

Description and purpose of this section

To achieve the vision and goals of Minnesota's Olmstead Plan, and in response to stakeholder feedback regarding the first draft Olmstead Plan, the state has adopted the following overarching strategic actions. These actions are the foundation of the transformation that is needed to increase integration and inclusion of individuals with disabilities. The subcabinet as a whole is responsible for the following actions.

Strategic actions

Action One: *Begin with the individual*

Begin with the individual: listen to individuals to ascertain their preferences for services and their views about quality of life, ensure that their rights are recognized, and incorporate this perspective through all phases (assessment, planning, service delivery, and evaluation).

Timeline:

- By December 31, 2014: [OV 1A[28]]
  - 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.
  - Develop a plan to initiate this service in the first quarter of 2015. [OV 1B]
- Additional actions and timelines to support this overarching strategy are identified in the topic area sections of this document.

Action Two: *Olmstead perspective*

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.

[28] References to letters and numbers after descriptions of actions (such as [OV1A]) are included to help the Olmstead Implementation Office and the Olmstead Subcabinet monitor completion of these actions.

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).

Timeline:

- In other sections of this plan, the state has identified immediate actions that can be taken administratively in 2014; timelines are identified in the other sections of this plan.
- By February 25, 2014 prepare legislative proposals for the 2014 legislative session. [OV 2A]
- 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]
- By January 6, 2015 prepare proposals for legislative and fiscal changes for the 2015 legislative session. [OV 2C]

Action Three: People with disabilities as leaders

Design and implement opportunities for people with disabilities to be involved in leadership capacities in all government programs that affect them. These opportunities will include both paid and volunteer positions. Provide support, training, and technical assistance to people with disabilities to exercise leadership. This will lead to sustainability of the Olmstead Plan over time.

Timeline:

- In other sections of this plan, the state has identified immediate actions that can be taken administratively in 2014; timelines are identified in the other sections of this plan.
- By December 31, 2014 leadership opportunities will be identified and implemented. [OV 3A]

Action Four: *Quality of life outcomes*

Identify and implement mechanisms to better measure and track quality of life outcomes for people with disabilities and overall performance of the Olmstead Plan. These mechanisms will include consistent definitions across agencies. Greater detail about quality of life measurement is in the Quality Assurance and Accountability section beginning on page 33.

Timeline:

- Information is on page 33.

Responsibility: The Olmstead Subcabinet is responsible for these actions.

Quality Assurance and Accountability

Stakeholder Comments	
	One person's outcome is not going to be the same as another person's outcome, so you need to take time to really determine what [are] those outcomes that you're looking for, and they need to be based on that individual and their families and [their] value system. *Dan Zimmer*
	Please continue to listen to people who receive services. They know what they need. They know what works best for them. *Rick Hammergren*

Description and purpose of this section

In developing the plan, state agencies realized that there will be an ongoing need for collaboration on the Olmstead Plan—both in terms of effectively implementing the plan and making sure that the plan is working for individuals. Also, the *Jensen* settlement agreement and subsequent court orders make it clear that the state of Minnesota is expected to demonstrate that the plan is being monitored and is effectively implemented. The state is developing several new processes and structures to make sure this happens.

The purpose of the Quality Assurance and Accountability section of the Olmstead Plan is to establish a statewide quality structure that measures performance, provides transparency, and assures accountability. The state will utilize this structure to monitor performance and initiate necessary changes. The structure will provide people with disabilities, their families, and their advocates the necessary and sufficient information on outcomes to hold the state and other public entities accountable for implementation and—when necessary—recommend modification of the plan.

There are four main strategic actions to ensure quality and accountability:

1. Quality of life measurement
2. Dispute resolution process for individuals with disabilities
3. Oversight and monitoring implementation of the plan
4. Quality improvement

Strategic actions

Action One: *Quality of life measurement*

Minnesota will conduct annual surveys of people with disabilities to determine quality of life, including:

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

The selected survey instrument will be tested, reliable, validated, low cost, systematic, and repeatable, and it will apply to all people with disabilities.

Timeline:

- Quantitative quality of life measurement:
    - By March 31, 2014 the state will select a set of quality of life outcome indicators and contract with an independent entity to conduct annual assessment of the quality of life measures listed above. [QA 1A]
    - By July 1, 2014 identify the survey instrument that will establish a baseline and allow ongoing evaluation of quality of life outcome indicators. [QA 1B]
    - By December 31, 2014 conduct a pilot of the survey. [QA 1C]
    - By December 31, 2015 conduct the survey to establish a baseline, mechanisms will be designed and in operation. [QA 1D.1]
    - By December 31, 2016 and annually for two years thereafter, surveys will be conducted to determine whether the Olmstead Plan is improving people's lives. [QA 1D.2 – QA 1D.4]
- Qualitative quality of life measurement: To enhance quantitative quality of life data, the state will begin collecting individual stories (qualitative data) to inform public policy and change public perception:
    - By August 31, 2014 identify best practices in qualitative reviews, including validated methodologies for collecting individual stories; determine if other agencies are utilizing such qualitative measures and if those processes could be adopted or modified; begin including individual stories in the subcabinet's bimonthly report. [QA 1E]
    - By July 1, 2015 assess resources and identify actions necessary for continued collection, consideration, and publication of individual stories; set target dates for completion of identified actions. [QA 1F]

Responsibility: The Olmstead Subcabinet is responsible for these actions.

Action Two: *Dispute resolution process*

Individuals who believe that they have not received services or supports in accordance with the principles set forth in *Olmstead v. L.C.* will have a way to raise their concern and address the problem.

Timeline:

- By June 30, 2014 the state will establish a dispute resolution process that has the following components: [QA 2A]
    - The process will initially operate out of the Olmstead implementation office under the direction of the Olmstead Subcabinet.
    - The Olmstead Implementation Office will designate dispute resolution staff, with understanding of the ADA and the Minnesota Olmstead Plan, to receive complaints, discuss the issues with the individual and work informally with them to resolve the complaint. This staff will establish working relations with agencies for the purpose of finding resolutions to identified complaints.

- It is expected that the majority of complaints will be resolved through informal efforts.
- In the event the informal process is not successful, staff will assist the individual to connect with established grievance/dispute resolution processes available through agencies.
- In the event the individual is unable to resolve the issue using existing grievance/dispute resolution processes staff will assist the individual in accessing an informal hearing process.
- The Olmstead Implementation Office will track all complaints and outcomes/resolutions and provide a summary report to the subcabinet for the purpose of quality improvement.
- This process will not be the exclusive remedy available to the aggrieved individual.

Responsibility: The Olmstead Subcabinet is responsible for these actions.

Action Three: *Oversight and monitoring*

The state will design an implementation structure that extends the Olmstead Subcabinet and assigns responsibility to monitor progress, convene regular meetings to update people with disabilities and others on progress, issue annual reports, solicit comments and recommendations for any changes, and initiate necessary legislative initiatives in support of the plan.

Timeline:

- By November 15, 2013 the subcabinet will ensure that appropriate persons are assigned for all actions described in this plan that will occur in 2013. [QA 3A]
- By December 1, 2013 the Olmstead Subcabinet will adopt a structure for: [QA 3B]
  - The periodic system-wide monitoring of the implementation and status of the plan.
  - Ensuring interagency coordination.
  - Scheduling periodic public meetings to (a) hear from the public regarding implementation of the Olmstead Plan and (b) review with the public any proposed changes to plan goals or strategies.
  - Engaging people with disabilities, their families, advocates and others in monitoring implementation, raising concerns or problems, and recommending changes to the plan.
  - Developing an Olmstead Quality Improvement Plan.
  - Issuing an annual report on implementation and quality of life outcomes.
  - Initiating needed changes including proposing legislative action in support of changes in policy and funding.
  - Monitoring legislative proposals to provide analysis and input to Minnesota Management and Budget and the Governor's office about impact on the Minnesota Olmstead Plan.
  - Developing a financial strategy that includes increasing flexibility in funding, reprioritizing funding, and seeking additional funding as necessary to implement the plan.

- By December 1, 2013 the subcabinet will establish an Olmstead implementation office that will report to the Olmstead Subcabinet. The purpose of the office will be to: [QA 3C]
    - 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.
- By January 15, 2014 the subcabinet will ensure that appropriate persons are assigned for all actions described in this plan that will occur in 2014. [QA 3D]
- 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. [QA 3E]

Responsibility: The Olmstead Subcabinet is responsible for these actions.

Action Four: *Quality Improvement*

The subcabinet will adopt an Olmstead Quality Improvement plan, which will include the following components:

- Methods to engage the Governor's appointed disability councils and advisory committees (Appendix E) in monitoring Minnesota's Olmstead Plan.
- Policies and procedures that establish best practice in the prevention of abuse and/or neglect of persons with disabilities.
- Methods to conduct ongoing quality of life measurement, quality improvement structures, and needs assessment.
- Description of the availability of self-advocates, peer support specialists, or similar peer delivered services that promote self-determination and greater independence in life choices.
- Methods to monitor all legislative proposals that may impact the rights of persons with disabilities in accordance with the *Olmstead* decision and the ADA.
- A description of how people with disabilities and their families are involved in monitoring and reviewing the community services and supports, and how they serve in leadership roles in modifying the services and supports over time.

The Quality Improvement plan will be separate from the accountability components in the plan and will not negate other quality assurance efforts of the affected agencies.

The Quality Improvement plan will include a coordinated data system and an established process to measure and analyze existing data from abuse, neglect, exploitation, injuries, and deaths reporting

systems. Priority will be given to establishing uniform definitions, standards and protocols; assuring transparency to the consumer; tracking trends; identifying problem areas; and aiding in the development of interventions using state of the art technology.

Timeline:

- By September 30, 2014 the subcabinet will adopt an Olmstead Quality Improvement plan to be administered by the Olmstead implementation office. [QA 4A]
- By September 30, 2015 and annually thereafter, the subcabinet's designee will prepare a report on statewide levels and trends of abuse, neglect, exploitation, injuries, and deaths. The report will include analysis of trends in the amount of time to investigate allegations of abuse and neglect and quality of investigations (from complaint to disposition, recommendations, and follow-up). [QA 4B.1-QA 4B.3]

Responsibility: The Olmstead Subcabinet is responsible for this action.

Introduction to topic-specific plans

The next sections of the Olmstead Plan contain Minnesota's plans to meet our Olmstead goals—each section is based on a particular topic area, but there are many interrelationships among these topics.

Each topic area contains the following information:

- **Where we are:** A description of what the topic means and the current status of this issue in Minnesota.
- **What we want**: A restatement of the Olmstead Plan goal in the topic area. These goals are at the level of the whole population or community—results for all people with disabilities. We've also identified indicators to evaluate whether we're making progress towards meeting the population-level goal we've set. For some indicators, we already track data to measure our progress; for other indicators, we'll have to begin tracking data as part of our implementation of the plan. Beyond our regular program performance measures, indicators in the Olmstead Plan provide an additional level of accountability to show whether we are "turning the curve" in the right direction[29]. Specific numerical targets related to the Olmstead Plan are included in sections that describe strategic actions.
- **What we'll do:** Concrete, strategic actions the state will take to meet the goal. These actions range from things state agencies can do right away by working together, to things that will require significant administrative, legislative, or financial changes. Timelines are set for completion of every action.[30] If the subcabinet determines later that timelines cannot be met the subcabinet might need to seek modification of the plan. In some topic areas, agencies have determined that baseline information is necessary to determine what actions will work best—after the baselines have been established, the subcabinet will identify specific strategic actions, set timelines, and seek modification of the Olmstead Plan as needed. Similarly, in areas of the plan where it is necessary to adopt a policy or process before taking action, the subcabinet may need to seek modification of the plan with actions and timelines once the policy or process is adopted. Any modifications to the plan will be submitted to the Court Monitor for approval and subject to review by the Court. Refer to page 7 of this document for information on the modification process.

In this Olmstead Plan, the state is focusing on actions that will have the biggest impact on people with disabilities who experience barriers to integration and inclusion. All of these actions move the state towards the broad goals set in this plan.

[29] The subcabinet used Mark Friedman's (2005) Results Based Accountability framework as a guide in developing the Olmstead Plan. "Turning the curve" is a way of talking about and showing success—how we can do better than the pattern shown by current trends and baselines.

[30] To review timelines chronologically, go to Appendix G. Chronological timetable for implementation.

Employment

Stakeholder Comments	
	I want to see Mayo Clinic and Minnesota [have as] our goal, to be a trail-blazer and employ people with disabilities. *Hiyas Quelle*
	Employment is a critical gateway to the core goals of Olmstead and drives many individual choices associated with living and participating in the most integrated community setting. Without a competitive job, many of the goals of *Olmstead* are challenging, if not impossible to achieve. *Don Lavin*
	Provide education to employers about how to improve their human resources practices about the benefits of hiring a diverse and inclusive workforce. *Guy Finne*

Description: What this topic means

Employment is about:

- Ensuring that people with disabilities have choices for competitive, meaningful, and sustained employment in the most integrated setting.
- Changing the prevailing attitudes, expectations, and beliefs about the integration of persons with disabilities into the competitive workplace.
- Making broad-based and significant system changes to ensure that persons with disabilities will be equitably represented in the competitive labor pool.

Employment Statistics

According to the Cornell University Employment and Disability Institute's *Disability Status Report* (data for 2010, published in 2012):[31]

- The employment rate of working-age people (ages 21 to 64) with disabilities in Minnesota was 44.4%. For the general population it was 81.7%.
- The percentage of working-age people with disabilities who were unemployed and actively looking for work was 12.3%. For persons without a disability who were actively looking for work it was 33.5%.
- The percentage of working-age people with disabilities working full-time/full-year was 22.2% with average annual earnings of $36,300. For working-age people without disabilities, 58.3% were working full-time/full-year with average annual earnings of $45,300.

[31] Erickson, W., Lee, C., & von Schrader, S. *2010 Disability Status Report, Minnesota*, Ithaca, NY: Cornell University Employment and Disability Institute (EDI), 2012.

According to the Minnesota State Rehabilitation Council—General 2012 annual report:[32]

- In 2012, 81% of 2490 vocational rehabilitation placements in Minnesota were in competitive employment without supports, 18% were in competitive employment with supports, and 1% were in self-employment.
- In 2012, the average hourly wage for people placed in competitive employment positions without long term job supports was $11.13 per hour (the average wage for *all* job openings in Minnesota was $13.74 per hour.)

Olmstead Plan goal: What we want

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

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

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

Strategic actions: What we'll do

Action One: *Expand integrated employment*

Expanding integrated competitive[33] employment opportunities begins with the individual with a disability. As discussed in the Overarching Strategic Actions (page 31), the state will begin all individual planning by asking the person what they want. In the employment context, students with disabilities will have the supports to help them transition from school to work, and adults with disabilities who seek competitive employment will have support to access employment and to succeed. Minnesota has identified strategies that work to increase integrated employment, and will build on those strategies.

Expanding opportunities for students with disabilities

Timeline:

- By June 30, 2014 establish consistent baselines for measuring progress on increased employment of transition-age students; establish goals for annual progress. [EM 1A]
- For students with disabilities:
  The current baseline of students in competitive employment within one year of leaving secondary education is 263.

[32]Minnesota State Rehabilitation Council — General, "2012 Annual Report." Accessed October 17, 2013, http://www.positivelyminnesota.com/JobSeekers/People_with_Disabilities/PDFs/Annual_Report_2012.pdf.

[33] Competitive employment is full-time or part-time employment, with or without supports, in an integrated setting in the community that pays at least minimum wage, as defined by the Fair Labor Standards Act, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by workers without a disability.

- By September 30, 2015 the number of students in competitive employment within one year of leaving secondary education will increase by 25 individuals.
- By September 30, 2016 the number of students in competitive employment within one year of leaving secondary education will increase by 25 individuals.
- By September 30, 2017 the number of students in competitive employment within one year of leaving secondary education will increase by 25 individuals.
- By September 30, 2018 the number of students in competitive employment within one year of leaving secondary education will increase by 25 individuals.
- By September 30, 2019 the number of students in competitive employment within one year of leaving secondary education will increase by 25 individuals.

- By June 30, 2014 establish a baseline for measuring how many students with disabilities have at least one paid job before graduation; establish goals for annual progress. [EM 1B]
- For students with disabilities:

  The current baseline of students who have paid employment by the age of 18 is 1,412.
  - By December 31, 2016, the number of students who have paid employment by the age of 18 will increase by 23 individuals.
  - By December 31, 2017, the number of students who have paid employment by the age of 18 will increase by 45 individuals.
  - By December 31, 2018, the number of students who have paid employment by the age of 18 will increase by 45 individuals.
  - By December 31, 2019, the number of students who have paid employment by the age of 18 will increase by 45 individuals.
- By June 30, 2015 and each subsequent year, there will be a minimum of 20 additional schools per year adopting evidence-based practices that result in integrated competitive employment outcomes. [EM 1C.1, 1C.2]
- By June 30, 2015, 14-21 year old transition age students on Supplemental Security Income (SSI)/Social Security Disability Insurance (approx. 1000) will receive benefit summary and Disability 101 (DB101) estimator sessions to inform employment planning choices and understand how integrated competitive employment and benefits can work together. [EM 1D]
- Beginning July 1, 2015, expansion of benefit summary and DB101 estimator sessions will occur, to include 14-26 year olds (approximately 2,500) entering transition-age services in public schools, on Home and Community Based Service (HCBS) Disability Waivers, or on Medical Assistance for Employed Persons with Disabilities (MA-EPD). [EM 1E]
- By June 30, 2016 there will be an increase of five local education agencies adopting new and innovative practices to expand integrated competitive employment for transition age youth. [EM 1F.1]
- By June 30, 2017 there will be an increase of five local education agencies adopting new and innovative practices to expand integrated competitive employment for transition age youth. [EM 1F.2]

Expanding opportunities for adults with disabilities

Timeline:

- Establish concrete goals for increasing competitive employment:
  - By June 30, 2014 identify consistent baseline measures to assess progress on increased competitive employment of adults with disabilities (including but not limited to people with mental illness and intellectual/developmental disabilities). [EM 1G]
  - By September 30, 2014 establish a baseline for the measures and establish measurable goals to demonstrate progress in increasing competitive employment for adults with disabilities. [EM 1G.1]
  - By September 30, 2014 set annual deadlines beginning in 2015 to achieve goals for a defined significant portion of the population affected. The measureable goals will be related to demonstrating benefits to the individuals intended to be served. [EM 1G.2]
- For individuals receiving home and community-based long-term supports and services:
  The current baseline of working-age people with disabilities who are competitively employed is 4,069.
  - By June 30, 2015 the number of individuals who are competitively employed will increase by 380 individuals.
  - By June 30, 2016 the number of individuals who are competitively employed will increase by 553 individuals.
  - By June 30, 2017 the number of individuals who are competitively employed will increase by 638 individuals.
  - By June 30, 2018 the number of individuals who are competitively employed will increase by 801 individuals.
  - By June 30, 2019 the number of individuals who are competitively employed will increase by 1,006 individuals.
- For individuals receiving Workforce Development Unit services (State Services for the Blind):
  The current baseline of individuals who are competitively employed is 116.
  - By December 31, 2015 the number of individuals who are competitively employed will increase by 3 individuals.
  - By December 31, 2016 the number of individuals who are competitively employed will increase by 4 individuals.
  - By December 31, 2017 the number of individuals who are competitively employed will increase by 4 individuals.
  - By December 31, 2018 the number of individuals who are competitively employed will increase by 4 individuals.
  - By December 31, 2019 the number of individuals who are competitively employed will increase by 4 individuals.
- For individuals receiving Vocational Rehabilitation Services (VRS):
  The current baseline of individuals who are competitively employed is 2,738.
  - By December 31, 2015 the number of individuals who are competitively employed will increase by 112 individuals.

- By December 31, 2016 the number of individuals who are competitively employed will increase by 57 individuals.
- By December 31, 2017 the number of individuals who are competitively employed will increase by 58 individuals.
- By December 31, 2018 the number of individuals who are competitively employed will increase by 59 individuals.
- By December 31, 2019 the number of individuals who are competitively employed will increase by 31 individuals.

- By June 30, 2014 establish baseline plan (including identifying process for securing resources) for Extended Employment (EE) program rule change to cap enrollment in non-integrated and subminimum wage subprograms. [EM 1H]
- By September 30, 2014 fully implement local placement partnership model[34] for providing professional employment services to Minnesotans with significant disabilities in the metropolitan area. [EM 1I.1]
- By June 30, 2015 expand Individual Placement and Supports (IPS) employment for Minnesotans with serious mental illness in 17 additional counties, providing integrated employment for an additional 200 individuals. [EM 1J]
- By June 30, 2015 establish plan to expand Individual Placement and Supports (IPS) employment for Minnesotans with serious mental illness statewide. [EM 1K]
- For individuals receiving Individual Placement and Support Services (IPS): The current baseline of individuals who are competitively employed is 330.
- By July 1, 2015 promulgated changes to the state rule governing the Extended Employment (EE) program will be effective that cap non-integrated and subminimum wage subprograms and define procedures that shift funding to integrated competitive employment. [EM 1L]
- By September 30, 2015 fully implement local placement partnership model for providing professional employment services to Minnesotans with significant disabilities with one northern area team and one southern area team. [EM 1I.2]

Responsibility: The Commissioners of the Department of Employment and Economic Development (DEED), Department of Human Services (DHS), and Minnesota Department of Education (MDE) will designate responsible persons.

Action Two: *Align policies and funding*

To achieve the types of system changes needed to meet the state's Olmstead goal in employment, policies and funding (including but not limited to the state's own employment practices) will be aligned to increase integration and expand employment opportunities. Agencies will work together to coordinate systems and ensure consistency. Minnesota will adopt an Employment First policy and use these principles in service design and delivery.

[34] The local placement partnership model is used by DEED-Vocational Rehabilitation Services. It is a unique collaboration of state, private, and non-profit placement professionals that work together in an agreed-upon service or geographic area to connect the needs of employers and job seekers in a defined partnership. More information is in the Definitions section (page 90~~82~~).

Timeline:

- By March 31, 2014 an Employment Community of Practice[35] will be formed to identify promising and non-traditional practices and approaches and partnerships that lead to successful employment outcomes and to discuss strategies that adopt Employment First principles, informed choice and support of job seekers who choose to work. [EM 2A]
- By July 1, 2014 an Interagency Employment Panel[36] using Employment First principles to align policy and funding will be convened. [EM 2B]
- Beginning September 1, 2014, implementation plans will be developed to provide access to most integrated settings in our service, standards and funding priorities as identified in Interagency Employment Panel in order to increase integrated competitive employment outcomes. [EM 2C]
- By September 30, 2014 the state will adopt an Employment First policy. [EM 2D] **[Responsibility:** The subcabinet is responsible for this action.]
- Integrated Memorandum of Agreements (MOA/MOUs) across state agencies will be necessary to assure the implementation of Interagency Employment Panel recommendations and to ensure the implementation of policy and practices that support integrated competitive employment and Employment First Principles. By September 30, 2014, key agencies will be convened and will establish a process and timeline to develop MOA/MOUs. The objective is to have all necessary MOA/MOUs in place by July 1, 2015. [EM 2E.1, 2E.2]
- By October 1, 2014 Vocational Rehabilitation (VR) purchased services baseline will be established and policy will be developed to provide all VR purchased services in most integrated setting. [EM 2F.1]
- By January 1, 2015 clarify roles and responsibilities for cross-agency employment service planning and coordination that leverages DEED/VRS, DHS and MDE funding streams to expand competitive employment in the most integrated setting. [EM 2G]
- By July 1, 2015 the Interagency Employment Panel will develop a data sharing agreement between DEED/VRS, DHS and MDE. [EM 2H]
- By October 1, 2015 policy to provide all VR purchased services in the most integrated setting will be implemented. [EM 2F.2]
- By December 31, 2015 in collaboration with members of the Interagency Employment Panel, there will be an alignment of workforce development policies, funding and data systems across state agencies. [EM 2I]
- By December 31, 2015 common definitions for employment and employment-related services will be established to be used across the interagency service system. [EM 2J]

[35] Employment Community of Practice is an intentional but voluntary network of persons engaged in providing employment services and supports that come together to share information, knowledge and practices to advance the progress of individuals with significant disabilities in achieving their goals for employment in the most integrated setting. More information is in the Definitions section (page ~~82~~90).

[36] The Interagency Employment Panel is the principal interagency leadership group responsible for the alignment of interagency policies and funding needed to meet the state's Olmstead goal in employment. Representatives from DEED, DHS, and MDE would be appointed by the Commissioners of the respective Departments

- By December 31, 2015 specific strategies to utilize waiver funding to expand employment in the most integrated setting will be implemented. [EM 2K]

Responsibility: Except as noted, the Commissioners of DEED, DHS, and MDE will designate responsible persons for the above action.

Action Three: *Provide training, technical assistance, public information and outreach on employment in the most integrated setting*

Myths and misunderstandings about employing people with disabilities are significant barriers to expanded integrated employment. Minnesota will provide training, technical assistance, and outreach so that competitive employment in the most integrated setting is understood and expected to be the first and preferred option by and for persons with disabilities. Outreach and education efforts will include specific information to assist employers.

Training

Timeline:

- 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. [EM 3A]
- By September 30, 2014 Disability Employment Specialists will provide training to employment service providers on single point of contact framework, labor market trends, and localized approaches to demand-driven strategies. [EM 3B]
- 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.[37] [EM 3C]
- By September 30, 2014 establish plan to provide cross-agency training on motivational interviewing. [EM 3D]

Technical Assistance

Timeline:

- By June 1, 2014 establish an Employment Practice Review Panel[38] consisting of state and local agencies, providers and people with disabilities to discuss issues and successes at the individual level in order to identify policy and practice areas to promote or to change, and to facilitate immediate actions to increase individuals living and working in the most integrated settings. [EM 3E]

[37] US Department of Labor, Office of Federal Contract Compliance Programs (OFCCP) "Final Rule to Improve Job Opportunities for Individuals with Disabilities." Accessed October 17, 2013 http://www.dol.gov/ofccp/503Rule/ .

[38] The Employment Practice Review Panel is a strategically selected representative group from county/local social services agencies, employment programs and non-profit organizations that work with multi-system funding and policy issues on a daily basis in service delivery. More information is in the Definitions section (page 9082).

- By January 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. [EM 3F]
- By June 1, 2015 develop an improvement strategy on the state and local level for educators and families about the economic benefits of integrated competitive employment. [EM 3G]

Public Information

Timeline:

- By June 30, 2014 promote the business case for hiring people with disabilities; align supports and services with business needs so that businesses successfully hire and retain employees with disabilities. [EM 3H]
- By June 30, 2014 provide information about effective employment strategies, such as supported and customized employment that make competitive employment possible for individuals with complex and significant disabilities. [EM 3I]
- By December 31, 2014 publicize statistics, research results and personal stories illustrating the contributions of persons with disabilities in the workplace. [EM 3J]

Outreach

Timeline:

- By June 30, 2014 information on employment in the most integrated setting is available for individuals, families, schools, service providers and businesses. [EM 3K]
- Beginning January 1, 2015 and on yearly basis thereafter, distribute findings, policy interpretations and recommendations from Interagency Employment Panel to state and local agencies, providers and stakeholders to ensure policy and practice strategies align with Employment First principles and increase successful competitive employment outcomes [EM 3L.1, 3L.2]
- By July 1, 2014 establish an outreach plan for families illustrating the impact of integrated competitive employment on individual benefits through the use of DB101 and Work Incentives [EM 3M]

Responsibility: The Commissioners of DEED, DHS, and MDE will designate responsible persons, in consultation with the Minnesota Department of Human Rights (MDHR) as needed.

Housing

Stakeholder Comments	
Some of the folks I've been working with that are in nursing homes desperately want to return to the homes they've lived in most of their lives.	*Jan Peterson*
Do not restrict their choices in your effort to provide more independence for others.	*Nancy Cashman*
The Parkwood development where I live was home to seven foster care homes that have now increased to nine. This is a newer subdivision of Duluth which has been overrun by foster home operations.	*Sherri Fedora*
The cages are back but they're gilded now. Providers are investing [in] the lovely high-end homes so residents do have nice bedrooms, but they're spending way too much of their free time in their bedrooms and not in the communities.	*Lee Ann Erickson*
[Use measures like] I have my own lease; a roommate isn't forced on me; I can come and go as I please. That makes sense. That's real.	*Ethan Roberts*

Description: What this topic means

Housing *is about where people live—with their family, on their own, or with other people.*

- Housing Affordability
  - More than 600,000 households in Minnesota are housing cost-burdened, meaning they pay more than 30% of their income for their housing. This represents nearly 30% of all Minnesota households.[39]
  - The median monthly rent in Minnesota is $764, based on the most recent American Communities Survey data.[40]
  - The monthly maximum SSI benefit for an individual is $710;[41] 30% of this amount is $213.
  - As demonstrated in Chart 1 of Appendix A, persons with disabilities are nearly twice as likely to live in poverty as the population as a whole. Persons living in poverty who do not have housing assistance are usually housing cost burdened.
- Rental Assistance programs
  - Waiting lists for most public housing and for Section 8 vouchers are years long and are opened infrequently.
  - Twenty-one percent (21%) of the 30,000 Section 8 project-based assistance units in Minnesota are occupied by households with a member who is non-elderly and has a

[39] US Census Bureau. "American Community Survey 2012." http://www.census.gov/acs/www/data_documentation/data_main/.
[40] Ibid
[41] Social Security Administration. "SSI Federal Payment Amounts For 2013." http://www.ssa.gov/OACT/COLA/SSI.html.

disability; persons with disabilities are served in the Section 8 program at twice the rate as they appear in the general population overall (10.1%). In addition, 8% of the 21,000 housing tax credit units are occupied by persons with a mobility impairment.[42]

- Minnesota Housing Finance Agency (Minnesota Housing) assists between 70,000 and 73,000 low and moderate income households each year.[43]
- Minnesota Housing utilizes all available resources each year to provide affordable housing for low-and moderate-income Minnesotans and employs numerous strategies to make affordable housing available throughout the state including financing of permanent supportive housing (capital and operating subsidies), state funded rental assistance, participation in partnership with the Department of Human Services (DHS) in the Section 811 program and giving funding priority to housing that serves the lowest income households.

- Income supplements[44]
  - The primary ways that DHS funds housing for persons with disabilities are through two income supplement programs: Group Residential Housing (GRH), which pays for room and board in licensed and registered settings, and Minnesota Supplemental Aid (MSA) Housing Assistance, which provides an enhanced income supplement ($200 per month) for SSI recipients living in the community and paying 40% or more of income towards housing.
  - GRH is a 100% state-funded income supplement that pays for room and board for around 20,700 low-income elderly and adults with disabilities living in more than 5,700 licensed or registered settings. Nearly 70% of participants had been diagnosed with a serious mental health condition in the last three years.
  - About half of all GRH participants reside in Adult Corporate Foster Care, 17% of the participants reside in a Board and Lodge with Special Services, and 12% live in Housing with Services establishments.
  - In December 2012, 527 adults were receiving MSA Housing Assistance.

A note about measuring integration and choice in housing:

When it comes to integration and choice, housing for people with disabilities exists within a broad range of options, with more institutional-like settings on the one end and more community-based settings on the other, and many combinations in between. Where a particular individual lives depends on many factors. Some of these factors are specific to an individual, such as individual preference, level of need and individual resources (income and support). Other factors, such as the availability of affordable housing options and supports, are the result of systemic influences. The goal of this Olmstead Plan is to

[42] Data from Minnesota Housing's analysis of portfolio data.
[43] Minnesota Housing, "2012 Annual Report and Program Assessment." Accessed October 15, 2013, http://www.mnhousing.gov/wcs/Satellite?c=Page&cid=1358904866274&pagename=External%2FPage%2FEXTStandardLayout.
[44] Data in this section is from Department of Human Services databases.

reduce the barriers on both an individual and systemic level that prohibit a person from being able to live in the most integrated setting *of their choice*.

There are a number of characteristics that can be used to help gauge the level of integration and choice within a particular setting. These include:

- Person has a lease or own their own home
- Person has their own living, sleeping, bathing and eating areas
- Person has privacy in their living or sleeping area (no unwanted roommates)
- Unit has lockable access and egress
- Person can decorate and furnish unit to their choosing
- Person controls their own schedule and activities
- Person has access to their own food and kitchen
- Person can have visitors at any time
- Person is free to choose their service provider without being at risk of losing housing, and to choose not to receive services
- Unit is not in a building that also provides inpatient treatment, or is adjacent to or on the grounds of a building that does
- Person has opportunities to interact with non-disabled persons who are not paid staff (may be measured by percent of non-disabled persons living in building or area)

It is not necessary for every housing option to meet the above requirements at all times. These characteristics may not be appropriate for all persons in all settings. However, it is important that: 1) Each individual has the option to live in the most integrated setting of their choice; 2) Each housing option strive to attain the highest level of integration possible; and 3) As a state, we provide the broadest range of housing options, responding to each individual's preferences and needs.

Olmstead Plan goal: What we want

Housing: People with disabilities will choose where they live, with whom, and in what type of housing.

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

- **Primary indicators**:
    - Increase in percentage of persons on public funding who have a lease or own their own home. This indicator is a crucial measure of self-determination.[45]

[45] A lease agreement or purchase agreement is a reflection of the tenant's or purchaser's decisions regarding where to live and the circumstances under which they will live. A lease or purchase agreement is the common manner of securing housing in the community. The lease or purchase agreement sets out rights and responsibilities. Institutional settings, including homeless shelters, typically do not enter into lease agreements with the residents. An increase in the number of persons with disabilities who rely on public funding for health care, supportive, and or social services who have a lease or purchase agreement is an indication of an increase in the number of persons living in integrated settings and should directly correspond to a decrease in the number of persons living in institutional settings.

- Increase in individual choice and in the number of persons living in the most integrated settings appropriate to their needs.
- Increase in persons with disabilities living in affordable housing (defined as not cost-burdened, or paying 30% or less of their income towards housing costs).[46]

- **Secondary indicators**:
  - Increase in percent of housing options with high levels of community characteristics
  - Increase in percent of persons with disabilities moving to settings with a higher level of community characteristics.
  - Increase in persons who are not severely housing cost-burdened (paying 50% or less of their income towards housing costs).

Strategic actions: What we'll do

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.*

The state's goal is to provide real and meaningful choice for persons with disabilities. If the new housing opportunities created do not meet the needs of the population or the needed services are unavailable in the community, we will have failed to fulfill our vision. Detailed information about persons with disabilities who use public funding is needed to determine the quantity of new affordable housing opportunities needed, the appropriate affordability levels, the appropriate physical features, and the desired locations of the housing as well as the types and levels of services needed for a person with disabilities to successfully remain in the community.

Individual assessments of what is necessary to facilitate movement from a restrictive setting to a more integrated setting will provide key information to refine the housing actions.

People with disabilities who are leaving state correctional facilities face particular challenges. Minnesota has determinate sentencing which mandates that all individuals be placed on correctional supervision in the community during the remaining one third of their sentence. Individuals leaving state correctional facilities often have strict limitations in where they can live because of their legal status and responsibilities to specific community supervision. If an individual with a disability is not connected with appropriate resources, they may fail their conditions of supervision and return to prison.

To address these challenges, actions are needed while an individual with disabilities is incarcerated and to prepare for their release:

[46] Lower-income households with more affordable housing costs are better able to meet other important basic needs such as food, clothing and transportation. A household with affordable housing is more likely to be able to avoid eviction or foreclosure and therefore avoid experiencing homelessness or institutionalization. Data from the American Communities Survey coupled with data from DHS can be used to show progress on this indicator. A comparison of the addresses of persons with disabilities who are using public funds for health care, social and supportive services with addresses of housing financed by Minnesota Housing will be another way to demonstrate progress on this indicator.

- Minnesota Department of Corrections (DOC) will identify and track individuals with disabilities when they enter a Minnesota correctional facility to ensure that they receive proper support during incarceration and to begin release planning at an early stage.
- As individuals with disabilities leave correctional facilities, DOC provides medical and mental health release planning to offenders who meet criteria outlined in DOC policy and state statute.

Timeline:

- By September 30, 2014 data gathering and detailed analysis of the demographic data on people with disabilities who use public funding will be completed. [HS 1A]
- By January 30, 2015 a timeframe for completing individual assessments and facilitating moves into more integrated settings will be completed. [HS 1B]
- Specific timelines related to Department of Corrections facilities:
  - For individuals entering Minnesota correctional facilities:
    - By July 1, 2015 Department of Corrections will begin identifying and tracking individuals with disabilities following initial intake into state correctional facilities. [HS 1C]
    - By January 1, 2016 analyze the data collected to identify trends and gaps in services and establish measurable goals related to demonstrating benefits to the individuals intended to be served. [HS 1D]
  - For individuals exiting Minnesota Correctional facilities:
    - 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. [HS 1E]
    - By June 30, 2015 analyze the data collected and establish measurable goals related to demonstrating benefits to the individuals intended to be served. [HS 1F]

Responsibility: The Commissioners of DHS and DOC will designate responsible persons.

Action Two: *Increase the number of affordable housing opportunities created.*

One of the barriers identified as being the most significant to increased integration is the lack of affordable housing. Persons with disabilities who do not have access to affordable housing in the community are forced into a more restrictive setting. An important action in the Olmstead Plan is to increase the number of affordable housing opportunities. Increase in housing opportunities that are affordable to persons with disabilities who rely on public funding for health care, social and supportive services will open up the prospect for more persons with disabilities living in integrated settings.

Additional affordable housing opportunities will be created through a combination of additions to the affordable housing stock and additional rental assistance. Resources will continue to be devoted to maintaining and preserving the existing affordable housing stock, including privately owned subsidized and unsubsidized housing and public housing. Consistent with Minnesota Housing's past practice,

housing opportunities will be created throughout the state. A portion of all newly created affordable rental housing will be fully accessible.

The state will also *pursue additional federal funding* as it becomes available, including Section 811 program funding, Veterans Affairs Supportive Housing (VASH) vouchers and other mainstream Housing and Urban Development (HUD) programs to increase the supply of affordable housing opportunities.

Specific targets will be identified (timeline below), but we anticipate that beginning in fiscal year 2018, and for each fiscal year thereafter, Minnesota will achieve a 10% annual increase in the number of newly created affordable housing opportunities. Minnesota Housing, on average, assists with providing approximately 1,000 new housing opportunities each year; so the anticipated 10% increase will result in at least another 100 units being created each year. The 2018 timeframe takes into account the state biennial budgeting process, the fact that program redesign will be a gradual process that builds on experience, and the time needed to create additional housing opportunities once additional funding is available. Additional resources will be necessary to achieve this goal, but a 10% annual increase is likely attainable.

The long-term goal will be re-examined as data is gathered and analyzed.

Timeline:

- 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.

[HS 2A]

Responsibility: The Commissioners of Minnesota Housing and DHS will designate a responsible person.

Action Three: *Increase housing options that promote choice and access to integrated settings by reforming programs that provide housing and supports to allow greater flexibility.*

Ensure income supplement programs can be used in the most integrated setting of a person's choice.
Minnesota has two income supplement programs for persons with disabilities, GRH and MSA Housing Assistance. Both programs are part of a Maintenance of Effort agreement with the Social Security Administration. Over the past several years, some pilot and demonstration projects have been implemented to use these income supplements in market rate housing as rental assistance and where the tenant holds their own lease. The results of these pilot and demonstration projects indicate that these income supplements could be changed to work better in non-congregate settings and that enabling people to live in the housing of their choice has been very successful. Thus DHS proposes

combining GRH and MSA Housing Assistance into one program and making changes to assure program integrity and simplify the program and administration. Allowing income supplements to be used in a broader range of settings will result in greater levels of choice in housing for persons with disabilities.

Provide access to housing independent of receiving services from a particular provider or receiving services at all.

The structural changes to the income supplements mentioned above will include de-linking housing and services for these programs. DHS will also review all housing and supports programs to determine whether similar structural changes need to be made to other programs.

Implement a Housing Stability Services option to those who need additional support to obtain housing or remain in the community.

Housing Stability Services will provide a flexible set of services to help individuals with accessing and staying in the housing setting of their choice. These services will be individualized through person-centered service plan development. Housing Stabilization Services may be short-term or on-going and vary in intensity depending on the needs of the individual. Housing Stabilization Services will incorporate elements of the Housing First model of supportive services, as recognized by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based best practice to end homelessness. The Housing First model is designed to help people move quickly into housing, regardless of other identified service needs that may need to be addressed longer-term, and remain as necessary to stabilize an individual in housing. The services will not be based solely on where the person lives (as they are today); they will be more responsive to the individual's needs and may change over time or can stay with them if their living situation changes.

Timeline:

- By January 6, 2015 prepare proposals for legislative changes for the 2015 session. [HS 3A]
- By December 31, 2015 program changes authorized by the legislature will be implemented. [HS 3B]
- By December 31, 2015 establish a baseline and targets for future years to measure how many people use financial incentives and/or income supplements for housing, how many people who move from institutions or congregate living settings to having their own lease, and how many people received housing versus how many were referred. [HS 3C]

Responsibility: The Commissioner of DHS will designate a responsible person.

Action Four: *Increase access to information about housing options.*

To achieve the goal in housing, the state must: increase access to information about housing options to highest risk populations; expand Housing Link and promote in conjunction with one-stop shops; and simplify, centralize, and streamline information and referral systems.

Minnesota has an affordable housing locator system with HousingLink.[47] This system provides current vacancy information for subsidized and unsubsidized affordable housing including information about accessible features in a building or unit. Knowledge of HousingLink's resources can be invaluable to

[47] Information about HousingLink is available at http://www.housinglink.org/Home.aspx.

persons with disabilities who are seeking to move into integrated settings as well as for providers, advocates, case managers and other helping individuals. HousingLink provides information on successful renting, including how to deal with credit and tenant history challenges, rights and responsibilities, fair housing and tenant services organizations. Access to this information can make for a more successful housing search.

A *supportive housing referral system* will be launched in October 2013. The supportive housing referral system will assist case managers in quickly identifying currently available supportive housing options for persons who are homeless and the specific housing features in order to provide an opportunity for informed choice. HousingLink is also working to expand the vacancy information for housing outside of the Twin Cities metropolitan area. Additional information useful to persons with disabilities will be identified through consultation with persons with disabilities.

Timeline:

- By September 30, 2014 persons with disabilities will be consulted to determine what features should be added to HousingLink's resources to improve its usefulness. [HS 4A]
- By September 30, 2014 a plan to inform and educate people with disabilities, case workers, providers and advocates about HousingLink will be developed. [HS 4B]
- By September 30, 2015 the plan will be implemented. [HS 4C]

Responsibility: The Commissioner of Minnesota Housing will designate a responsible person.

Action Five: *Actively promote and encourage counties, tribes, and other providers to implement best-practices and person-centered strategies related to housing.*

The state will identify practices and strategies that directly result in persons with disabilities having greater choice and control over their housing. The state will then promote these practices by:

- Ensuring that any existing policies in services and housing programs do not create barriers to implementing these strategies.
- Creating additional incentives for counties, tribes and providers to implement these strategies by directly tying funding availability to the successful use of these strategies.
- Providing training, education and technical assistance to providers on how to implement these strategies.

Two major examples include Individualized Housing Options and Supportive Housing as an Evidenced-Based practice for persons with a serious mental illness. These and other best practices that will increase choice and integration will be reviewed on an ongoing basis.

Timeline:

- By March 31, 2014 establish a baseline and set annual goals to increase the number of counties providing Individualized Housing Options[48] (thereby increasing the number of persons in

[48] Individualized Housing Options is a county-led initiative to help more persons with disabilities live in the community setting of their choice. Services and supports are designed on an individual basis to help persons live as independently as possible. The philosophy is that no matter where an individual lives, help and supports can be matched to their unique needs. It allows a person to stop services or change providers and continue living in their own home. The goals of the Individualized Housing Options initiative are achieved through two main tactics,

Individualized Housing Options). [As of March 2014, there were 14 counties participating in Individualized Housing Options. The number of people who had received Individualized Housing Options services was 162.] [HS 5A]

- 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. [HS 5B]
- By December 31, 2014 the number of counties participating will increase to 17. [HS 5B.1]
- By December 31, 2015 the number of counties participating will increase to 25. [HS 5B.2]
- By December 31, 2016 the number of counties participating will increase to 40. [HS 5B.3]
- By December 31, 2017 the number of counties participating will increase to 87. [HS 5B.4]

Responsibility: The Commissioner of DHS will designate a responsible person.

neither of which currently requires additional resources: using income supplements to help people afford housing in the community and enabling providers to provide services in a more flexible manner.

Transportation

Stakeholder Comments

The Department of Transportation should consider developing weekly direct transportation routes to some of the smaller rural areas in small towns that will allow individuals with disabilities, seniors, and families with limited or no transportation options access to shopping hubs, medical centers, recreation, social activities and the larger communities.	*Dalaine Remes*
When people are allowed to ride the bus with everybody else, then they're integrated into their community and they have relationships so I would hope that would continue to happen, specifically in rural areas.	*Mary Metzger*

Description: What this topic means

Transportation, in its broadest context, provides safe, convenient, efficient and effective movement of people and goods. Transportation however is also a key aspect in an individual's quality of life and recognizes and respects the importance, significance and context of place—not just as destinations, but also where people live, work, learn, and enjoy life regardless of socio-economic status or individual ability.

Minnesota has an extensive multimodal transportation system that requires substantial annual investment to operate and maintain. This is the shared responsibility of Minnesota Department of Transportation (MnDOT), in partnership and coordination with local, regional, state, tribal, federal, private sector, and other partners. In addition to freight rail systems, waterways, aeronautics, and 145,765 miles of roadway, the state and its transportation partners support a state trail system, passenger rail, and transit systems in the Minneapolis/St. Paul metropolitan area and Greater Minnesota. Program and service-based transit is supported by the state as well: the Department of Human Services (DHS) currently provides a portion of its clients' transit based on program enrollment, primarily for non-emergency medical transport. Some of the services overlap with traditional transit providers and provide critical access to services.

Unlike other states, Minnesota requires all operators of special transportation services to meet vehicle and other standards, and all drivers undergo training on first aid, abuse prevention, defensive driving, and passenger assistance.[49]

The transportation portion of the Olmstead Plan assumes that the availability and accessibility of transportation applies to all modes of travel, but recognizes that much of the transportation need relates to transit services administered by MnDOT, DHS, and Metropolitan Council and is focused accordingly.

[49] MnDOT, "Minnesota Commercial Truck and Passenger Regulations Fact Sheet, Special Transportation Service (STS)." Accessed October 17, 2013, http://www.dot.state.mn.us/cvo/factsheets/sts.pdf.

To integrate *Olmstead* principles in the state's transportation systems, the state will continue to focus on issues such as accessibility and ridership. The state will also ensure that transportation is as integrated as possible and that transportation allows people with disabilities to participate in integrated activities in the community.

Olmstead Plan goal: What we want

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.

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 individuals with disabilities with access to transit options and transportation modes.
- Increase in the ease of coordination of an individual's transportation.
- Decrease in transportation related obstacles that are barriers to competitive employment for individuals with disabilities.

In combination the population level indicators demonstrate that individuals have increasing access to the transportation needed to participate fully in the community.

Strategic actions: What we'll do

Action One: *Establish a baseline of transit expenditures and types of service provided across state agencies to better support people with disabilities.*

Understanding current resources gives policy makers better data and options on how to use transportation funding in different ways to support people with disabilities in their transportation needs. Coordination, cooperation, and consolidation of existing transit services are ways to increase access and capacity and increase the overall number of rides, and these actions lay the groundwork for systems to work across jurisdictional boundaries, including county to county rides.

Transit is provided by several agencies and paid for in numerous ways. Greater Minnesota transit is paid for through state and federal transportation funding administered by MnDOT. Transit in the seven county metropolitan area is paid for through state and federal funds administered by Metropolitan Council. DHS funding for transportation is allocated to specific programs while other transportation funds are embedded in different services. The *funding baseline* will include MnDOT's expenditures on transit in Greater Minnesota, Metropolitan Council, and transportation funded through DHS' services and programs and the number and types of vehicles in the system. The *service baseline* will identify the number of trips and mileage provided by transit services administered by MnDOT, Metropolitan Council, and DHS.

Some of the work necessary to establish these baselines includes potential adjustment of DHS tracking and budgeting mechanisms and developing shared methodology for counting trips.

Establishing a baseline of the resources available to support people with disabilities in transportation will show where resources in programs and services can be used more effectively to increase community participation and engagement in developing service needs and priorities.

Timeline:

- By September 30, 2014 the Department of Human Services, MnDOT and Metropolitan Council will establish a baseline of services and transit spending across public programs they administer. [TR 1A]
- By September 30, 2014 review administrative practices and implement necessary changes to encourage broad cross state agency coordination, including non-emergency protected transportation. [TR 1B]
- By October 31, 2014 using developed baselines from this action and Action Two (below), establish timelines and measures to demonstrate increased access to integrated transportation for people with disabilities. Measures will be implemented to assess transportation options for accessibility, cost effectiveness and reliability. [TR 1C]
  Current public transit meets 61 percent of total passenger demand and 57 percent of projected service hour needs statewide.
- By January 6, 2015 prepare proposals for legislative and fiscal changes for the 2015 legislative session; priority will be given to identifying changes that will increase funding flexibility to support increased access to integrated transportation. [TR 1D]

Responsibility: The Commissioners of DHS and MnDOT, in consultation with the Metropolitan Council, will designate responsible persons.

Action Two: *Engage community members to expand flexibility in transportation systems.*

Improving transportation access and supporting individuals with disabilities to be able to go where they want to go, when they want to, requires creative solutions and strategies. People with disabilities, state agencies, community organizations, faith communities and others will be engaged to determine strategies to support people with disabilities in accessing the community at their choosing. A baseline will be established to determine how people with disabilities are using existing transportation options. This information will inform where transportation options currently work well and where access to transportation can be enhanced.

Timeline:

- By March 31, 2014 community members will be convened by DHS to identify access issues and determine strategies to improve access and flexibility. [TR 2A]
- By March 31, 2014 develop a plan to work with transit providers to improve access and flexibility of transportation to meet the goal. [TR 2B]
- By October 31, 2014 using developed baselines from this action and Action One (above), establish timelines and measures to demonstrate increased access to integrated transportation for people with disabilities. Measures will be implemented to assess transportation options for accessibility, cost effectiveness and reliability. [Same as TR 1C]

Responsibility: The Commissioners of DHS and MnDOT, in consultation with the Metropolitan Council, will designate responsible persons.

Action Three: *Integrate Olmstead principles into existing transportation plans so that Minnesota's transportation policy supports integration and inclusion of people with disabilities*

MnDOT plays a significant role in influencing transportation policy and land-use patterns across the state; the inclusion of *Olmstead* principles in plans will inform transportation decisions through the next half century. In this context, *Olmstead* principles include ensuring that transportation is as integrated as possible and that transportation allows people with disabilities to participate in integrated activities in the community.

MnDOT's Statewide Multimodal Plan is a transportation policy framework for all Minnesota partners and transportation modes for the next 20 years that focuses on multimodal solutions that ensure a high return-on-investment while considering the context of place, and how land use and transportation systems should be better integrated. In addition to the statewide plan MnDOT also develops modal investment plans and supporting plans to inform specific program directions. The plans afford citizens and key transportation partners, like the Metropolitan Council, the opportunity to participate in developing investment priorities and guidance that is used to implement individual projects. Many of MnDOT's activities, current and planned, that contribute directly to integration of Olmstead principles are the Greater Minnesota Transit Investment Plan and MnDOT's ADA Transition Plan[50], which are scheduled for update in 2016 and 2014 respectively. Below is a list of plans that will be addressed as part of this strategy and an estimated completion of the revision. The time horizon to update all of the referenced plans and reports is 10 years.

Timeline:

- By August 31, 2014 complete MnDOT ADA Transition Plan. [TR 3A]
- By December 31, 2016 complete Greater Minnesota Transit Investment Plan. [TR 3B]
- By December 31, 2019 complete MnDOT Multimodal Plan. [TR 3C]
- By December 31, 2023 complete MnDOT 50 Year Vision. [TR 3D]

Responsibility: The Commissioner of MnDOT will designate responsible persons.

Action Four: *Minnesota Council on Transportation Access (MCOTA) Engagement*

To better coordinate public transit and human services transportation activities, Minnesota has created a state-level coordinating council, the Minnesota Council on Transportation Access (MCOTA). Established by the Minnesota Legislature in 2010 (Minnesota Statutes 2010 §174.285). MCOTA is to

[50] MnDOT's current ADA transition plan is available here: http://www.dot.state.mn.us/ada/pdf/mndotadatransitionplan.pdf. It contains information about MnDOT's actions to remove barriers and improve transportation access, such as improving intersections and sidewalks. Minnesota Statutes §169.212 permits the use of electric personal assistive mobility devices on roadways, sidewalks and bicycle paths.

"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." MCOTA is established as an advisory body and has no ability to enforce its recommendations.

The membership of MCOTA consists of 11 state agencies, the Metropolitan Council, and the Minnesota Public Transit Association; these entities have been identified as partners and key stakeholders in the delivery of transit in Minnesota. MCOTA and its membership are strategically well positioned to address many of the elements needed to create integrated transit in Minnesota. By utilizing and supporting existing multi-agency committees, planning processes, and coordination, agencies can provide significant focus to the continual improvement on the outcomes and impacts for Minnesotans accessing transportation. Some examples of these outcomes are: increase capacity to serve unmet needs, improve quality of service, improve understanding and access to services for Minnesotans, and achieve more cost-effective service delivery.

The legislation establishing MCOTA identified 20 duties related to five key issue areas:

- Vehicle and client sharing
- Cost sharing and purchasing
- Communication and coordinated planning
- Reporting and evaluation
- Research and demonstration projects

MCOTA's current workplan includes activities such as developing an inventory of funding programs, developing consistent approaches to transportation costs, creating maps of human services transportation providers, and collecting and analyzing data about vehicle sharing.

Timeline:

- By March 31, 2014 initiate discussions with MCOTA on how the MCOTA workplan can help achieve the Olmstead transportation goal. [TR 4A]
- 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. [TR 4B]

Responsibility: The Commissioner of MnDOT and DHS will designate responsible persons. (MnDOT and the DHS are legislatively required to staff MCOTA, and the entire membership is responsible for the outcomes of the committee.)

Supports and Services

Stakeholder Comments	
	We have a system that [forces] poverty on people with disabilities ... just to get the service they need…that's not freedom and that's not independence and that's not integration. *Galen Smith*
	I've lived in institutions, in group homes, crisis shelters, homeless shelters where I was told I was a drain on society, and I worked at shelters where I was told I was unfit for higher education and training and employment opportunities at anything more than subminimum wages. But I have navigated the system and I've achieved greater independence by advocating for my own person centered planning. *Bridget Riversmith*
	Time and again we have seen services developed from the perspective of serving people with developmental disabilities and physical disabilities fail to adequately meet the needs of people with mental illness. *Matt Burdick*

Description: What this topic means

Supports and services enable people with disabilities to live, learn, work and engage as fully participating members of the community. Supports and services include things like assisting a person to get dressed or do chores, assisting a person with paid work, explaining medical or other information, assisting a person understand choices before making a decision, teaching family members how to assist a person with a disability, providing respite for a parent or caregiver, or assisting a person to participate in community activities.

In order for 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, the state needs to better align the design and provision of supports and services with these outcomes. This will mean creating and expanding tools for understanding the available options, supporting individual planning and allowing people to have greater control over their resources.

It also requires a more holistic view of supporting people; moving from a "service" lens to an approach of working with all of the components of one's life, over time. For example, supporting a person to be successfully employed is not simply about employment services. It involves other factors, including: expectations and aspirations that develop early in life; skills a person acquires over many years; personal supports; the location of one's home; and, transportation options. All of the work described in this section requires collaboration among divisions within agencies, across state agencies, and with partners, including providers, businesses, and community organizations. It also means working directly with people with disabilities and their families to ensure that the voices of the people at the heart of the service system are heard.

Finally, to achieve all of these objectives, the state's resources need to be effectively and efficiently utilized. Increasing service flexibility and early access, and using approaches that deliver results, while reducing unnecessary use of more expensive and less integrated service are key strategies to creating equal opportunities for people who rely upon supports and services.

Olmstead Plan goal: What we want

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.

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.

Strategic actions:

Action One: *All individuals with disabilities will be offered supports and services in the most integrated settings.*

These principles will be incorporated into any individual planning processes that lead to supports and services administered across state agencies[51]:

1) Each person, the person's family and/or legal representative, and any others chosen by the person shall be permitted to be involved in any evaluation, decision-making and planning processes, to the greatest extent practicable, using whatever communication method the person prefers.
2) To foster each person's self-determination and independence, the state shall ensure the use of person-centered planning principles at each stage of the process to facilitate the identification of the resident's specific interests, goals, likes and dislikes, and abilities and strengths, as well as support needs.
3) Each person shall be given the opportunity to express a choice regarding preferred activities that contribute to a quality of life.
4) The state shall undertake best efforts to provide each person with reasonable alternatives for living, working, and education.
5) It is the state's goal that all persons be served in integrated community settings with adequate supports, protections, and other necessary resources which are identified as available by service coordination.

Timeline:

- By June 30, 2015, 600 people will be trained in 'person-centered thinking' and 100 of those will also receive training in 'person-centered planning.' An additional 1,600 people with receive 'person-

[51] The importance of this type of planning is described in Overarching Strategic Action One: Begin with the individual (page 26).

centered awareness' training via interactive television (iTV). Twenty people will be prepared to be trainers. Those trained will include staff from state agencies, providers, counties, health plans, tribes, and advocacy organizations. The state will adopt a plan and timeline to ensure that all state agencies, providers, counties, health plans, tribes, and advocacy organizations receive person-centered training. [SS 1A]

Responsibility: The Commissioner of the Minnesota Department of Human Services (DHS) will designate responsible persons.

- By January 1, 2015 the state will establish characteristics and criteria that define best practices in person-centered planning and the *Olmstead* requirements, to be used by state agencies to evaluate their current assessment and plan content and practices, and revise those practices accordingly. [SS 1B]

  Responsibility: The Olmstead Subcabinet will designate responsible persons.
- By June 1, 2015 the state will establish funding mechanisms to support person-centered planning. [SS 1C]

  Responsibility: The Olmstead Subcabinet will designate responsible persons.
- By July 1, 2017 the state will establish standards and outcomes for person-centered planning that can be accessed independently of a required assessment and support planning process. These will be reported to the Olmstead Subcabinet. [SS 1D]

  Responsibility: The Olmstead Subcabinet will designate responsible persons.

Action Two: *Support people in moving from institutions to community living, in the most integrated setting*

Over their lifetimes, people living with a disability will pass through a number of transition points, which shift the way supports and services are provided. These are critical junctures during which understanding options and assuring good coordination between all involved are necessary to avoid disconnects which could possibly put people at higher risk for going into more segregated and regimented settings. Leaving a hospital, nursing home, institution for mental disease (IMD), intermediate care facility for people with developmental disability (ICF/DD), Day Training and Habilitation Services (DT&H) or a Pre-Vocational setting are examples of transitions from segregated settings. Another transition is leaving the correctional system and going to community living. Desirable outcomes of effective transitions include: good planning to understand what is important *to* people as well as *for* people, and the future they would like; timely transitions; support to live in the most integrated and inclusive setting; and, the right services at the right time to support people in successfully implementing their plans.

There are challenges in assuring the availability of timely and appropriate community services at the time individuals are ready to leave prison. These challenges can include lack of housing, need for specialized provider resources and capacity, and community resistance. The DOC will identify individuals who are ready to leave prison and work with DHS and counties to develop appropriate transition plans as people are ready to move into the community. Another challenge for this population is the difficulty of sharing health information across systems to support continuity of care. All health care systems either have shifted or are shifting to electronic health records systems, and the Department of Corrections has

completed initial preparation for adoption of electronic health records to better support integration for people with disabilities leaving corrections facilities. An electronic health record will allow the efficient transfer of health care information between the prison system and community health care providers, and ensure continuity of care.

Timeline:

- Develop and implement protocols and processes to support individuals moving to the most integrated setting from Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD), people under 65 in nursing homes for more than 90 days, Anoka Metro Regional Treatment Center, Minnesota Security Hospital and Minnesota Specialty Health System (MSHS)-Cambridge:
    - By January 31, 2014 the state will create a team of state agency and community members to develop protocols and processes to facilitate successful transitions, problem-solve and reduce barriers that limit individuals' ability to live in the most integrated setting. These protocols and processes will include the five principles outlined on page 62~~61~~. . [SS 2A]
    - By June 30, 2014, the state will begin implementation of the protocols and processes. [SS 2A.1]
    - By January 1, 2015 for all individuals leaving for the most integrated settings, these protocols and processes will be used. [SS 2A.2]
    - By January 31, 2015 the state will develop a method to measure and track individuals transitioning from these settings to:
        - Identify whether individuals were able to access most integrated settings.
        - Identify whether they have achieved stability in most integrated settings.
        - Identify and propose resolution to problems. [SS 2A.3]
- By March 31, 2014 new community based services will be available for people with disabilities as an alternative to MSHS-Cambridge. [SS 2B]
- 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. [SS 2C]
- 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%. [SS 2D.1]
    - By December 31, 2015 the number will be reduced to 25%. [SS 2D.2]
    - By December 31, 2016 the number will be reduced to 20%. [SS 2D.3]
    - By December 31, 2017 the number will be reduced to 15%. [SS 2D.4]
    - By December 31, 2018 the number will be reduced to 10%. [SS 2D.5]

- For individuals in Minnesota Security Hospital:
    - By December 31, 2013 the Department of Human Services (DHS) will assess individuals at the Minnesota Security Hospital to determine the number of individuals who have been recommended for discharge and who do not oppose being discharged. [SS 2E]
    - By January 31, 2014 DHS will establish a timeline for transition to the most integrated setting for all individuals who have been recommended for discharge and who do not oppose being discharged. [SS 2F]
    - Beginning April 22, 2014 Minnesota Security Hospital will measure and report to the subcabinet every two months regarding progress on admissions, deaths, discharges, timeliness of discharge processes and readmissions within six months of discharge. [SS 2F.1]
    - Minnesota Security Hospital 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. [SS 2F.2]
        - By December 31, 2015, Increase average monthly discharge rates from 9 individuals per month, to 10 individuals per month. [SS 2F.3]
        - By December 31, 2016, increase average monthly discharge rates from 10 individuals per month, to 11 individuals per month. [SS 2F.4]
        - By December 31, 2017, increase average of monthly discharge rates from 11 individuals per month, to 12 individuals per month. [SS 2F.5]
- For individuals in other 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. [SS 2G]
    - By September 30, 2014 DHS will review this data and other states'[52] 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. [SS 2G.1]
    - By January 31, 2015 DHS will make a legislative request in support of the movement of the individuals in other segregated settings within the established timelines. [SS 2H]
- For individuals living in segregated residential settings:
  The current estimated number of individuals is 38,079.
    - By June 30, 2015, the number of individuals who move to the most integrated setting will be 50.
    - By June 30, 2016, the number of individuals who move to the most integrated setting will be 125.
    - By June 30, 2017, the number of individuals who move to the most integrated setting will be 300.

[52] In particular, DHS will review plans from Massachusetts, Oregon, and Rhode Island.

- By June 30, 2018, the number of individuals who move to the most integrated setting will be 350.
- By June 30, 2019, the number of individuals who move to the most integrated setting will be 400.

- For individuals in segregated day settings:
  The current estimated number of individuals with disabilities in segregated day settings is 20,055.
  - By June 30, 2015, the number of individuals who spend their days in more integrated settings will be 50.
  - By June 30, 2016, the number of individuals who spend their days in more integrated settings will be 150.
  - By June 30, 2017, the number of individuals who spend their days in more integrated settings will be 200.
  - By June 30, 2018, the number of individuals who spend their days in more integrated settings will be 500.
  - By June 30, 2019, the number of individuals who spend their days in more integrated settings will be 500.

- By September 30, 2015 DHS will initiate the movement of individuals in other segregated settings to the most integrated setting in accordance within the established timelines. Additionally the movement of individuals will be in accordance with the protocols and processes that developed using the five principles described on page 6261. [SS 2I]
- For individuals being released from a state correctional facility:
  - By January 6 2015, the DOC will develop a legislative initiative to fund an electronic health record system to assist with release to community settings with appropriate levels of support. [SS 2J]
  - By July 1, 2015 DOC, DHS, and community providers will begin to provide training to all DOC staff involved in release planning activities of programs and resources appropriate to individuals with disabilities. [SS 2K]
  - By July 1, 2015 DOC, DHS, and county social services will identify gaps and barriers to a more coordinated system of transition planning for individuals with disabilities exiting state correctional facilities. [SS 2L]
  - By January 1 2016, the DOC and DHS will identify solutions to gaps and barriers and establish measureable goals and timelines. [SS 2M]

  Responsibility: The Commissioners of DOC and DHS will designate responsible persons.

Responsibility: Except as noted, the Commissioner of the DHS will designate responsible persons.

Action Three: *Build effective systems for use of positive practices, early intervention, crisis reduction and return to stability after a crisis.*

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 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. [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, statewide 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.
- For individuals receiving Home and Community Based Services:
  The current baseline of people using mental health crisis services per year is 10,000. Of those, 85% or 8,500 remain in their homes. The current baseline of Emergency Department visits by these individuals is 61,000.
- 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. [SS 3J.1]
  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.

Action Four: *Provide access to the most integrated setting through the provision of supports and services*

While the goal is to support individuals in the most integrated community setting, the system provides an entitlement to institutional care. There are often competing priorities for home and community-

based supports and services and other services or supports that place limits on access. Supporting children at home with their families, addressing situations where people are at risk of homelessness, supporting people so they can leave a segregated setting when they wish to live in the community, and providing access to on-going support for competitive community employment are examples of where there are pressures on supports and services that provide alternatives to institutional care.

Sometimes, when the service that would best fit an individual's need is not available, that person will access an alternative service. This can then create pressure on the alternative service, making it difficult for people who need *that* service to get it. By understanding people's needs better, and distributing the resources effectively, more people should be able to be served, and served well. If service gaps are understood, effort can be made to address them. Encouraging innovations, such as the use of assistive technology, can contribute to increased outcomes and quality of life, and effectively use available resources.

Flexibility in services allows individuals and families with children with disabilities to best obtain their desired outcomes. By increasing flexibility in state medical assistance plan services, such as the conversion of the PCA program to a more flexible Community First Service and Supports, development of an autism early intervention benefit, and state wide availability of mental health services, there will be less pressure on services that have growth limits, such as home and community-based waiver supports and services.

Access to supports and services is often based on an individual's primary disability which means people with complex and/or co-occurring conditions often do not get connected with the appropriate supports and services. The state will continue to seek ways to assure that service access is based on an assessment process that reflects functional need rather than diagnosis or disability type.

Transition into the community from prison is difficult, much more so if the individual has a disability. A Forensic Assertive Community Treatment (FACT) team would work collaboratively with DOC Behavioral Health Release Planners and assist with a seamless transition into the community. 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, or bipolar disorder and who have significant and persistent functional impairments (homelessness, repeated hospitalizations, unemployment) which contribute to high system use. In the case of forensic assertive community treatment, individuals also have significant involvement in the corrections system. 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. The key to a successful FACT team is the monitoring of its fidelity to the ACT model, along with on-going technical assistance.

Timeline:

- Implement Community First Services and Supports: Within thirty days of federal approval, the state will establish an implementation plan including specific actions and timelines. [SS 4A]

Responsibility: The Commissioner of the Department of Human Services (DHS) will designate a responsible person.

- 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. [SS 4B]
- For individuals who have requested home and community-based waiver services, but are not yet receiving services:
  The current baseline of individuals who have requested a Developmental Disabilities (DD) waiver is 3,502 and a Community Alternatives for Disabled Individuals (CADI) waiver is 1,450.
  - By February 1, 2015, individuals who meet the "Immediate" criteria[53] will receive home-and-community-based supports and services within 90 days.
  - By February 1, 2015, individuals who meet the "Institutional Exit" criteria[54] will move at a reasonable pace by beginning service planning for home and community-based supports and services within 45 days. These individuals will begin services within 180 days of a completed service plan.
  - By June 30, 2015, 80 individuals residing in Intermediate Care Facilities/ Developmentally Disabled will receive home and community-based supports and services.

  Responsibility: The Commissioner of DHS will designate a responsible person.
- 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. [SS 4C]

  Responsibility: The subcabinet will designate responsible persons.
- Develop FACT team (described above):
  - 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. [SS 4D]
    For individuals receiving Forensic Assertive Community Treatment (FACT) team services:
    The current baseline is zero as this service has not yet been developed.
  - By January 6, 2015, DOC and DHS will develop a legislative initiative to build capacity and/or expand services. [SS 4E]

    Responsibility: The Commissioners of DOC and DHS will designate a responsible person.

[53] "Immediate" category includes individuals who are at imminent risk of being placed in an institutional setting.
[54] "Institutional exit" category includes individuals who need to exit an institutional setting.

Lifelong Learning and Education

Stakeholder Comments

Andrew was [in] regular education classrooms his whole 12 years of education because that's where he wanted to be and that's where he learned best.	*Karen Larson*
There should be more emphasis on reducing segregated school placements at an earlier age. These segregated placements at an earlier age sometimes funnel kids into segregated or center-based facility-placed employment situations later on.	*Dan Stewart*
Person centered planning could be a formative process implemented in transition planning services for students with any disability so that they may become active participants in determining their future in employment, housing, and community engagement. Teachers and service providers should have training to facilitate this process.	*Donna Atherton*

Description: What this topic means

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

The world is changing—as are the expectations for what students with disabilities need to be able to know and do to be successful in college, careers and life. 21st Century graduates need content knowledge and skills to succeed in an increasingly diverse and interdependent world. Minnesota's education and workforce systems are the cornerstone of our continued economic growth. For the purpose of the Minnesota Olmstead Plan, this section will focus specifically on Lifelong Learning and Education for students with disabilities.

The Individuals with Disabilities Education Act (IDEA) requires that students with disabilities receive special education services in the least restrictive environment, appropriate to meet their needs. This means that removal from regular education classes occurs only when a student cannot be successfully educated in regular classes, even with supplemental aids and services. When a student is removed from the regular educational environment for part of the day, the student must still be educated with non-disabled peers as much as possible.

The learning needs of the student and the services to be provided must be designated in an individualized education program (IEP). Under state law, all students with disabilities are provided the special instruction and services which are appropriate to their needs, and their individualized education program must address the student's needs for transition from secondary services to postsecondary education and training, employment, community participation, recreation, and leisure and home living.

In order to promote integration and provide students with disabilities educational services with their nondisabled peers, preventative approaches, such as Positive Behavioral Interventions and Supports

(PBIS) can be implemented at the school and district level.[55] Any and all prevention or intervention policies, programs, or procedures must be designed to enable a student to benefit from an appropriate IEP as well as develop skills to enable them to function as independently as possible in their communities.[56] Minnesota strives to ensure students with disabilities receive equal access to high quality education in the most integrated setting.

Olmstead Plan goal: What we want

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.

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 students with disabilities who are educated in the most integrated educational setting preschool through grade twelve.
- Increase in the number of students with disabilities who transition to the most integrated employment setting.
- Increase in the number of students with disabilities who transition to the most integrated postsecondary setting.

Strategic actions: What we'll do

Action One: *Reduce the use of restrictive practices*

Work with districts and other stakeholders to reduce the use of restrictive procedures and also provide further recommendations on how to further reduce these procedures and eliminate the use of prone restraints in schools. Minnesota Statutes §125A.0942 subdivision 3 (8) requires that school districts end the use of prone restraints with children ages five or older by August 1, 2015.

Timeline:

- By June 30, 2014 and each subsequent year, districts will report summary data on their use of restrictive procedures to the department, in a form and manner determined by the Commissioner of the Minnesota Department of Education (MDE) [ED 1A.1 - 1A.3]
  Responsibility: The director of MDE's Division of Compliance and Assistance is responsible.
- By June 30, 2014 Develop and maintain a list of training programs and identify and maintain a list of experts to help individualized education program teams reduce the use of restrictive procedures. [ED 1B]
  Responsibility: The directors of MDE's Divisions of Compliance and Assistance and Special Education, in collaboration with staff designated by the Commissioner of the Department of Human Services (DHS), are responsible.

[55] Minnesota Rules, part 3525.0850. Available at https://www.revisor.mn.gov/rules/?id=3525.0850.
[56] Ibid.

- By June 30, 2014 establish a process for school districts to ensure that students with complex disabilities can access crisis services. [ED 1C]
  Responsibility: The Commissioners of MDE and DHS will designate responsible persons.
- 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. [ED 1D]
  Responsibility: The Commissioner of MDE will designate responsible persons.
- By February 1, 2015 submit a report to the legislature on districts' progress in reducing the using of restrictive procedures in Minnesota schools. These stakeholder recommendations on revised statutory language will be included in the report. [ED 1E]
  Responsibility: The Commissioner of MDE will designate responsible persons.
- For students with disabilities whom school districts report experience restrictive procedures: The current baseline of students who experienced restrictive procedures was 2,707. The number of reported incidents was 19,409 which included 13,116 physical holds and 6,301 seclusions. The current baseline of prone restraints was 837 incidents. The number of students who experienced one or more prone restraints was 159.
  - By June 30, 2015
    - the number of students who experience a restrictive procedure will be reduced by 108.
    - the number of reported restrictive procedure incidents will be reduced by 776.
  - By August 1, 2015, the number of students who experience prone restraint will be zero.
  - By June 30, 2016
    - the number of students who experience a restrictive procedure will be reduced by 104.
    - the number of reported restrictive procedure incidents will be reduced by 745.
  - By June 30, 2017
    - the number of students who experience a restrictive procedure will be reduced by 100.
    - the number of reported restrictive procedure incidents will be reduced by 715.
  - By June 30, 2018
    - the number of students who experience a restrictive procedure will be reduced by 96.
    - the number of reported restrictive procedure incidents will be reduced by 687.
  - By June 30, 2019
    - the number of students who experience a restrictive procedure will be reduced by 92.
    - the number of reported restrictive procedure incidents will be reduced by 659.

  Responsibility: The Commissioner of MDE will designate responsible persons.

Action Two: *Build staff capacity for positive behavior interventions and supports*

Build staff capacity at the school level to effectively improve school-wide systems of positive behavior interventions and supports.

Timeline:

- By June 30, 2015 and each subsequent year, there will be a minimum of forty additional schools per year using the evidence-based practice of Positive Behavioral Interventions and Supports

(PBIS) so that students are supported in the most integrated setting. (423 schools have participated in this training, so this represents a 10% increase in the first year.) [ED 2A.1, 2A.2]

Responsibility: The director of MDE's Division of Special Education will designate responsible persons.

Action Three: *Support integrated employment options*

Students with disabilities will have interagency supports and services to access integrated employment options before exiting high school.

Timeline:

- By June 30, 2015 and each subsequent year, there will be a minimum of 20 additional schools per year adopting evidence-based practices that result in integrated competitive employment outcomes. (i.e., Customized Employment, Project SEARCH, etc.). [Same as EM 1C.1, 1C.2]
  Responsibility: The directors of MDE's Divisions of Special Education and College and Career Success, the Commissioner of DEED, and the Commissioner of DHS will designate responsible persons.
- By June 30, 2016 DEED, DHS and MDE will collaborate to review existing integrated competitive employment data and develop needed technical assistance materials that promote integrated competitive employment as the preferred outcome. [ED 3B]
  Responsibility: The directors of MDE's Divisions of Special Education and College and Career Success, the Commissioner of DEED, and the Commissioner of DHS will designate responsible persons.
- By June 30, 2016 a memorandum of understanding will be developed with DEED, DHS and MDE for the purpose of developing a Return on Investment (ROI) matrix which demonstrates that by using evidence-based employment practices such Customized Employment, Project SEARCH, etc., there will be an increase in integrated competitive employment outcomes for students with disabilities. [ED 3C]
  Responsibility: The directors of MDE's Divisions of Special Education and College and Career Success, the Commissioner of DEED, and the Commissioner of DHS will designate responsible persons.

Action Four: *Increase number of students enrolling in postsecondary education and training*

Using baseline data from the *Minnesota Post School Outcome Survey*[57] there will be an increase in the number of students with disabilities enrolling into postsecondary education and training programs. Resources will be developed and provided to parents, schools, and students with disabilities to facilitate and support enrollment in postsecondary settings.

[57] The most recent Post School Outcomes Survey is published in MDE's "2010-2011 Minnesota Annual Report on Special Education Performance." Accessed October 15, 2013, http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=005463&RevisionSelectionMethod=latestReleased&Rendition=primary The Post School Outcome Survey as outlined by Office of Special Education Programs (OSEP) for all states including MN includes information on students such as enrollment in higher education, enrollment in training programs, and employment in competitive settings. The report is available at http://www.psocenter.org/content_page_assets/content_page_3/What%20is%20I14.pdf

Timeline:

- Based on the Minnesota Post School Outcome Survey data, beginning September 1, 2014 and each subsequent year, there will be an increase of a minimum of 50 students with disabilities per year entering integrated postsecondary education and training programs within one year of exiting secondary education. [ED 4A.1 – 4A.3]
- For students with disabilities who entered integrated postsecondary education and training programs within one year of exiting secondary education:
  The baseline number of students is 254.
  - By September 1, 2015 the number will increase by 50 individuals.
  - By September 1, 2016 the number will increase by 50 individuals.
  - By September 1, 2017 the number will increase by 50 individuals.
  - By September 1, 2018 the number will increase by 50 individuals.
  - By September 1, 2019 the number will increase by 50 individuals.

Responsibility: The directors of MDE's Divisions of Special Education and College and Career Success, the Commissioner of DEED, and the Commissioner of DHS will designate responsible persons.

Action Five: *Return students with disabilities who are placed out of state or in juvenile corrections to resident district or most integrated setting*

Ensure that students with disabilities who are placed out of state by an agency or parent or who are in juvenile corrections are able to return to their resident district or most integrated setting when their noneducation program is completed and the IEP team determines that this transition is appropriate.

Timeline:

- By June 30, 2014 review current data on this student population and develop prototype reintegration plans to transition students to more integrated settings. Establish measurable goals and timelines for actions to be taken to benefit students [ED 5A]
- For students at the Minnesota Correctional Facilities at Red Wing and Togo:
  The baseline of students who have Individualized Education Programs (IEP)s is 180.
- By June 30, 2015 implement reintegration plan protocol statewide. [ED 5B]
- By June 30, 2016 and annually thereafter, report on the number of students who are placed out of state or in juvenile corrections. [ED 5C.1, 5C.2]

Responsibility: The Commissioners of MDE and Department of Corrections (DOC) will designate responsible persons.

Healthcare and Healthy Living

Stakeholder Comment

A coordinated system of health care and long term support services can more effectively identify high risk individuals, connect those individuals with needed services and provide follow-up improvement and overall quality.

Don Samuelson

Description: What this topic means

Healthcare is "the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions."[58]
Healthy living is making choices which are intended to improve a person's health. For example, healthy living includes having support to be active every day, to eat healthy foods, and to use medicine safely and as prescribed.

Health disparities are defined as significant differences in "the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates."[59] Health disparities for people with disabilities present barriers to full integration. Some problems with access to healthcare that exist for many Minnesotans have a significant impact on people with disabilities. For example, some people with disabilities may not be able to schedule dental appointments on a regular basis because there are not enough dentists and dental hygienists able to provide care. This is due to location (in parts of Greater Minnesota, there are not enough dental practitioners to serve all people); to affordability (not everyone has insurance coverage that includes dental care); and to some providers not knowing how to serve people with disabilities. Many individuals with disabilities develop other diseases (hypertension, heart disease, diabetes, stroke, cancer) at a higher frequency than persons without disabilities. Some people with disabilities die at a much younger age than persons without disabilities[60].

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

[58] American Heritage Medical Dictionary, "Healthcare." Boston: Houghton Mifflin Harcourt Publishing, 2008, 236
[59] Minority Health and Health Disparities Research and Education Act of 2000, United States Public Law 106-525, available at http://www.gpo.gov/fdsys/pkg/PLAW-106publ525/pdf/PLAW-106publ525.pdf
[60] As examples of studies showing health disparities for people with disabilities, review CDC "Disability and Secondary Conditions" in Healthy People 2010, http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review_focus_area_06.pdf and Goodell, Druss, and Walker. *Mental disorders and medical comorbidity*, Policy Brief No. 21, February 2011, Robert Wood Johnson Foundation. Accessed October 17, 2013, http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/02/mental-disorders-and-medical-comorbidity.html.

Olmstead Plan goal: What we want

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.

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

- Increasing health of people with disabilities so that the rates of secondary conditions (heart disease, diabetes, obesity, cancer and other health problems) are comparable to people without disabilities.
- Increasing longevity of people with disabilities so that death rates are comparable to people without disabilities.

Strategic actions: What we'll do

Action One: *Integrate primary care, behavioral health and long-term care/supports*

To successfully reduce secondary conditions and premature mortality for people with disabilities, we must integrate healthcare services including mental health and substance use treatment services. We must also integrate healthcare services with social services and public health. Integration occurs on a continuum, from improving integration capacity in a primary care setting to improving the medical care of individuals with serious mental health problems and substance abuse in behavioral health settings. Each is fundamental in creating greater access to a coordinated system of health care. Furthermore, achieving desired integration capacity occurs in the context of the healthy tension between independence and responsibility.

Increase the number of people served by an integrated primary care model; increase the number of providers who can participate in an integrated primary care model.

Minnesota is using the *health care home* model to achieve integrated primary care. By equipping primary care teams with the skills and resources necessary to provide person-centered, coordinated primary care, there will be strong partnerships among communities, other providers, patients and families.

Timeline:

- By January 1, 2015 establish baseline information about primary care teams across Minnesota that are able to provide integrated, person-centered primary care for persons with disabilities; establish timelines to increase the number. [HC 1A]
- By January 1, 2016 increase the number of clinics that are certified as *health care homes* from the current level of 35% of Minnesota clinics to 67%. (This will include rural and safety net clinics.) [HC 1B]

Responsibility: The Commissioner and Assistant Commissioner of the Department of Health and the Commissioner of Human Services and Assistant Commissioner of the Health Care Administration will designate responsible persons.

Develop a framework to provide services in a person-centered system of care that facilitates access to and coordination of the full array of primary, acute and behavioral health care.

For adults with serious mental illness and children with serious emotional disturbance who are Medicaid recipients and have complex, high-acuity chronic health conditions, there is a need for a framework that allows varying provider types to be at the center of providing care management.

Timeline:

- 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. [HC 1C]
- By July 1, 2015 the framework will be implemented. The following targets are set for this model: [HC 1D]
    - By July 1, 2016 15% of eligible individuals will choose to access care through this model.
    - By July 1, 2017 20% of eligible individuals will choose to access care through this model.
    - By July 1, 2018, 25% of eligible individuals will choose to access care through this model. [HC 1D.1 – HC 1D.3]
- By July 1, 2015 the state will develop the reporting mechanism necessary to require designated providers to report on all federally mandated quality measures and align these with the Olmstead Plan. In addition, the state will develop a patient experience of care survey to be administered to individuals served in a behavioral health home and begin developing baseline data [HC 1E]
- By December 31, 2015 the state will establish baseline data for federally mandated quality measures for beneficiaries enrolled in this model. [HC 1F]
- By December 31, 2015 establish measures to assess access and use of routine and preventive primary health care and dental care. [HC 1G]
- By July 1, 2016 utilizing baseline data gathered over the past year, establish measurable goals to improve patient experience of care. [HC 1E.1]
- By January 1, 2018 develop a sustainable funding source for the framework; develop system for collecting data on quality measures for which there are currently no reporting mechanisms in place; utilize findings from implementation to determine populations to serve under subsequent models; and, develop coordinated planning across partners (i.e., long-term services and supports and chemical and mental health) in developing additional models. [HC 1H]

Responsibility: The Commissioner of MDH and the Commissioner of the Department of Human Services, the Assistant Commissioner of the Health Care Administration and the Assistant Commissioner of the Chemical and Mental Health Services Administration will designate responsible persons.

Action Two: *Reduce gaps in access and outcomes*

Health messaging will specifically include people with disabilities

The state will develop targeted health promotion and disease prevention messaging for people with disabilities focusing on the prevention of fall injuries, sexual violence, assault and maltreatment, lead

poisoning and stroke; on smoking cessation and reducing alcohol consumption and obesity; on the control of diabetes, high blood pressure and weight; and on the promotion of exercise /physical activity, full immunization (especially influenza and pneumonia), and excellent nutrition.

Timeline:

- By May 31, 2014 develop a plan to ensure that health messaging is targeted to people with all types of disabilities; adopt timelines and measures to ensure ongoing progress. [HC 2A]
- By December 31, 2015 analyze impact / effectiveness of these efforts, using the impact measures developed for use in the whole population; provide a report to the subcabinet. [HC 2B]

Responsibility: The MDH Commissioner, Assistant Commissioner, Director of the Office of Statewide Health Improvement Initiatives and Health Promotion & Chronic Disease Division Director will designate responsible persons.

People with disabilities will have access to dental services.

Access to dental services has been a challenge for many people in Minnesota. Several changes have been implemented to encourage dental providers to treat recipients of the Minnesota Health Care Programs (MHCP), many of whom are persons living with disabilities. There have been changes to the dental services covered for adults, and changes to the rates paid to dentists. Many of these services are provided to recipients with disabilities, for whom dental visits and procedures are stressful or where their disability may make oral hygiene particularly challenging for them and their caregivers. These changes are expected to mitigate some of the challenges for people with disabilities in receiving quality dental care.

DHS will complete a legislatively mandated study of the Minnesota Health Care Program's dental program to improve access and ensure cost-effective delivery of services. The study reviews the program structure, including payment policies that compensate dental providers who serve underserved patients and treatment and workforce innovations that may improve access to dental care for recipients of MHCP.

Timeline:

- By June 30, 2014 using information from this study, develop a plan for implementation including timelines and measurable goals. [HC 2C]
- For adults with disabilities receiving Medicaid:
  The baseline number of individuals who did not receive at least one dental service during calendar year 2013 was 86,520.
  - By July 1, 2016 the number of individuals with disabilities who receive dental services will increase by 335.

Responsibility: The Commissioner of DHS will designate a responsible person.

Establish data collection systems to measure health outcomes for people with disabilities

As the specific efforts above are implemented, it is necessary to track their impact on health outcomes for people with disabilities. Additional coordination among agencies and integration of data sources will be necessary to measure health outcomes for people with disabilities. These efforts 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.

Timeline:

- 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. [HC 2D]
- By September 30, 2016 in partnership with the Centers for Disease Control and Prevention, disability advocates, and the academic community, develop, test, revise and implement the expanded "disability module" to better assess overall health status of people with disabilities in Minnesota. [HC 2E]
- By September 30, 2016 and annually thereafter, complete health status reports regarding health care outcomes and track policy and organizational practice changes at the community and state levels. [HC 2F.1, 2F.2]

Responsibility: The Commissioners of MDH and DHS will designate responsible persons.

The state will conduct a needs assessment to determine where people with disabilities do not have access to dentists, chiropractors, mental health counselors, or specialty providers

Some people with disabilities cannot readily access a dentist, chiropractor, mental health counselor, or specialty providers who can treat them. To make necessary changes, the state will conduct a needs assessment and develop concrete plans to improve healthcare access.

Timeline:

- 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. [HC 2G]
- By August 1, 2015 and biannually thereafter, measure how health care access and service are changing over time. Analyze the data to identify policy, practice and program changes that need to be made so that improvement happens more quickly; establish plans to make these changes. The focus will be on improving outcomes for people with disabilities. [HC 2H]

Responsibility: The Commissioners of MDH and DHS will designate responsible persons.

Youth with special health care needs will receive the services necessary to make transitions to adult health care.

As children with disabilities become young adults with disabilities, Minnesota must do a better system-wide job of helping youth with special health care needs receive the services necessary to make transitions to adult health care. With good transitions from youth to adult services, people receive ongoing access to coordinate care that can prevent institutionalization. According to the 2010 National Survey of Children with Special Health Care Needs nationally only 40% of youth with special health care needs receive the services necessary to make transitions to adult health care. In Minnesota in 2010, 47.1% of youth made this transition[61].

Timelines

- By September 30, 2014 complete a system analysis describing barriers that need resolution; develop a plan for addressing these barriers. [HC 2I]
- 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 [HC 2J.1, 2J.2]

Responsibility: The Commissioners of MDH and DHS and corresponding Assistant Commissioners will designate responsible persons.

[61] Data from National Survey of Children with Special Health Care Needs, Outcome #6: CSHCN youth receive services needed for transition to adulthood. 2009/2010. Accessed October 17, 2013, http://www.childhealthdata.org/browse/survey/results?q=2048&r=1&r2=25

Community Engagement

Stakeholder Comments

Give people a chance to show that we can do it, yes, we can. Everybody deserves a chance and everybody learns differently. Everyone has a dream where they want to live, work and be happy.	*Patricia Ann Wallace*
By including self-advocacy, peer-to peer support, and leadership training into the Olmstead Plan, self-advocates would have an increased ability to create change within the system that impacts their lives on a daily basis.	*Laura Birnbaum*
The right to association is the one most often abused. Their in-home provider would not allow former staff to visit their home.	*Lee Ann Erickson*
The possibility of physical harm, neglect and increasingly financial exploitation are issues that we need to have the capacity to address through adult protection.	*Mark Nelson*

Description: What this topic means

In the *Olmstead* decision, the United States Supreme Court ruled that states must eliminate unnecessary segregation of persons with disabilities and ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

Community engagement is one way to measure the level of integration. All Americans have a right to engage in activities of their choosing that help them connect with other people and give them greater control over their lives, such as building friendships and relationships with people they choose, joining a faith community, volunteering or taking on a leadership role with a neighborhood organization, attending cultural events, or participating in community decision-making (for example, voting).

The setting in which a person lives has a tremendous impact upon that person's ability to freely exercise his or her right to community participation. For over 40 years, Minnesota has continually moved away from providing long-term services and supports in segregated settings to home and community-based settings. Still, more work needs to be done to eliminate the unnecessary use of segregated settings and settings and policies that restrict individual choice and freedom, and to continue to create access to supports and services in the most integrated settings.

But setting by itself is not the only determinant of community engagement. The most powerful determinants of a person's integration in the community are discussed in other sections of this plan: access to affordable housing, transportation, supports and services, education, healthcare and employment. This section addresses support for community integration that not covered in other sections of the plan.

Olmstead Plan goal: What we want

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.

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 individuals with disabilities who report that they spend time with people they care about, doing things that are important to them. They report that they lead meaningful lives and they are members of a community. A discussion of the state's plans to measure quality of life, which will include these types of measures, can be found in the Quality Assurance section of this plan.

Strategic actions: What we'll do

Action One: *Support individuals to engage in their community in ways that are meaningful to them*

Using methods and models that are appropriate to individuals, Minnesota will support people with disabilities to exercise their rights and to participate in their communities.

Being fully engaged in one's life and community begins with setting one's goals, developing plans, choosing services, deciding how to spend one's time, choosing who to spend time with, and the like.

Community engagement often means assisting others in your community to have a better quality of life. One of the activities which people commonly identify as giving their life meaning is helping others. Engagement also means exercising leadership by contributing to group decisions that affect one's life, such as setting household rules, deciding vacation plans, picking the restaurant for a night out with friends, voting, participating on an advisory committee, or planning a neighborhood event.

Increasing the capacity of individuals to exercise their right to participate in their community addresses one part of the equation. There is also a need for communities to be accessible. Accessibility is central to the American with Disabilities Act and needs to be incorporated into all infrastructure built using public funds.

As discussed Overarching Strategic Action Four (page 32), the state will identify and adopt a systematic way to measure Quality of Life for individuals with disabilities. One of these quality of life areas is the measurement of community engagement by people with disabilities.

As referenced in Overarching Strategy Three (page 32) the state will develop opportunities for people with disabilities to serve in leadership roles in state policy development. This includes training in leadership and support for people with disabilities and family members to be successful in these leadership opportunities.

Timeline:

- 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. [CE 1A]
  Responsibility: The Olmstead Subcabinet will designate a responsible person.
- 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. [CE 1B]
  Responsibility: The Olmstead Subcabinet will designate a responsible person.
- The state will provide extensive training in person-centered planning statewide and establish protocols and processes for integrating person-centered practices for individuals desiring to move to the most integrated setting, as referenced in Overarching Strategy One (page 31) and further expanded on in Action One in the Supports and Services section (page 6261).

Action Two: *Provide access and opportunity for individuals to be full community participants*

Timeline:

- 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. [CE 2A]

  Responsibility: The Olmstead Subcabinet will designate a responsible person.

Financing Minnesota's Olmstead Plan

Subcabinet agency staff has considered financial impacts when developing the actions and timelines contained in this plan. (Appendix F has an example of this kind of analysis.)

Some of the actions described in this plan can be accomplished within existing resources, but many will require changes in how resources are allocated and will likely require additional resources. As discussed in Overarching Strategy Two (page 31), the Olmstead Subcabinet will identify fiscal changes that are necessary to accomplish the work outlined in the plan. In keeping with *Olmstead* principles, the subcabinet will identify and request resources, and will continue to apply reasonable modifications to programs where necessary (without fundamentally altering the nature of the program or service).

The subcabinet will work with other agencies and with legislators to identify funding solutions. The subcabinet will review strategies such as seeking expansion or amendment of Medicaid waivers, funding through federal grants and initiatives, legislation to allow flexibility in funding use, and legislative appropriation. If requested resources are not granted, the subcabinet will modify the Olmstead Plan.

Partners needed to implement the Olmstead Plan

Because we know the goals we've set can't be accomplished by one government agency or program (or even state government as a whole), the subcabinet has identified partners that we need to work with to meet the goals. This list is not exhaustive—it's just the start of the state's work to engage partners in implementing the plan.

First and foremost, the subcabinet plans to engage people with disabilities and their families in implementing and refining the Olmstead Plan.

Other important partners include:

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

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Definitions of key terms

§245D Standards: Many services for people with disabilities that are provided in people's home and/or in community settings and that are funded through Medicaid waivers are regulated under Minnesota Statutes §245D. (While Medicaid pays for the services covered by §245D, some people may receive these same services through other funding sources. The §245D standards apply to these services regardless of payment source.) The Minnesota Legislature created §245D in 2012 to establish standards for services that had previously been unlicensed. Additional services and standards were added to the statute in the 2013 session, including guidelines for the emergency use of manual restraint and requirements for positive support transition plans. The §245D standards will be implemented by January 1, 2014.

Adult foster care: An adult corporate foster care home licensed by DHS 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 provides services.

Behavioral health: The term "behavioral health" is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders. Behavioral health includes the identification, treatment of, and recovery from mental health and substance use disorders. It also increasingly refers to lifestyle changes and actions which improve physical and emotional health, as well as the reduction or elimination of behaviors which create health risks.

Benefit summary: A benefit summary is a personalized benefits report of an individual's current public benefits and potential eligibility.

Board and Lodge with Services: These facilities provide supportive or health supervision services such as assisting with preparation and administration of certain medications and assisting with dressing, grooming and bathing. They serve five or more people who need special services. These may include people who are frail elderly, mentally ill, developmentally disabled or chemically dependent.

Competitive Employment: Competitive employment is full-time or part-time employment, with or without supports, in an integrated setting in the community that pays at least minimum wage, as defined by the Fair Labor Standards Act, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by workers without a disability.

Customized Employment: Customized employment is a flexible process designed to personalize the employment relationship between a job candidate and an employer in a way that meets the needs of both. It is based on an individualized match between the strengths, conditions, and interests of a job candidate and the identified business needs of an employer. Customized Employment utilizes an individualized approach to employment planning and job development—one person at a time ... one employer at a time. [*Source*: US Department of Labor, Office of Disability Employment Policy http://www.dol.gov/odep/categories/workforce/CustomizedEmployment/what/]

DB101: Disability Benefits 101 or DB101 is a web-based interactive computer software program with Live Chat and support provided by the Disability Linkage Line that provides tools and information on employment, health coverage and benefits so that an individual can plan ahead and learn how employment and benefits can go together. [Information is available at: http://www.mn.db101.org/]

Day Training and Habilitation Services (DT&H): Activities in a non-residential setting, separate from the person's residence, such as assistance with self-help, socialization, and adaptive skills. Services focus on enabling the individual to develop and maintain skills in performing activities of daily living and community living. [A full definition is available from the US Department of Health and Human Services, Center for Medicaid, CHIP and Survey & Certification September 16, 2011 Informational Bulletin: http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf, page 6.]

Disability Employment Specialists: Department of Employment and Economic Development (DEED) employees that are experts in disability employment within the statewide service system who provide resources and strategic alliances to business and streamline the process of finding, recruiting and hiring workers with disabilities.

Employment First: A set of core values for persons with disabilities, including: a) employment is the first and preferred outcome for all working-age individuals with disabilities, including those with complex and significant disabilities, for whom working in the past has been limited or has not traditionally occurred; b) use typical or customized employment techniques to secure membership in the workforce, where employees with disabilities are included on the payroll of a competitive business or industry or are self-employed business owners; c) assigned work task offer at least minimum or prevailing wages and benefits; and d) typical opportunities exist for integration and interactions with co-workers without disabilities, with customers, and the public.

Employment community of practice: Employment Community of Practice is an intentional but voluntary network of persons engaged in providing employment services and supports that come together to share information, knowledge and practices to advance the progress of individuals with significant disabilities in achieving their goals for employment in the most integrated setting. Participants in the Employment Community of practice will include a diverse range of individuals from state/local social services agencies, community non-profit organizations, and research/training institutions engaged in practice and policy to support successful career and employment outcomes of people with disabilities.

Employment practice review panel: The Employment Practice Review Panel is a strategically selected representative group from county/local social services agencies, employment programs and non-profit organizations that work with multi-system funding and policy issues on a daily basis in service delivery. The panel will discuss and identify promising practices as well as cross agency barriers through individual case consultation. The panel will identify strategies and actions that promote competitive employment and address unintended consequences in the fiscal and service policies of DEED, DHS, and MDE in order

to fully align the efforts and resources of the state in support of individuals with disabilities in competitive employment.

Extended Employment: The Extended Employment (EE) Program is a performance-based state funded program administered by DEED that annually provides ongoing employment support services for nearly 5000 workers with the most significant disabilities. Services are provided through performance-based contracts with a statewide network of non-profit Commission on Accreditation of Rehabilitation Facilities (CARF) accredited Extended Employment Providers. Service payments are based on reported work hours and reimbursed at differing rates for supported, community and center-based employment. [Reference: Minnesota Statutes §268A.15 and Minnesota Rules parts 3300.2005 – 3300.2055]

Extended Employment (EE) Program Rule: Minnesota Rules parts 3300.2005-3300.2055 defines the certification, programmatic, service and funding requirements of the extended employment program under Minnesota Statutes §268A.15 and sets forth standards for the non-profit community rehabilitation programs that provide extended employment (EE) services in Minnesota.

Group Residential Housing: Group Residential Housing (GRH) is a state funded program that pays for room and board costs for low-income elderly and adults with disabilities living in some licensed or registered community-based settings. The program aims to reduce and prevent institutional residence or homelessness.

Health care home: A "health care home," also called a "medical home," is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.

Home and Community-Based Services: Home and community-based services (HCBS) are services and supports that are provided to people living in their communities who otherwise require the level of care provided in an institution, such as a nursing facility or a hospital.

HousingLink: A website that provides affordable housing resources and information for renters, landlords, researchers and policy makers. It also includes an affordable apartment search engine for Minnesota.

Housing with services: An establishment providing sleeping accommodations to one or more adult residents, at least 80% of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services.

Individual Placement and Supports (IPS): IPS is an evidence based approach to supported employment (SE) that helps people living with serious mental illnesses to identify, acquire and maintain competitive employment in their local community. IPS is different from a traditional brokered model of vocational rehabilitation. IPS emphasizes integration of employment within mental health treatment and utilizes rapid engagement in job search, individualized placement services, systematic job development and ongoing employment support services.

Individualized Education Program (IEP): An IEP is a formal written agreement and plan for provision of special education, including related services, to a child with a disability. It is developed, reviewed and revised through a team process in accordance with IDEA regulations. The required elements of an IEP are detailed in IDEA regulations and Minnesota Statutes §125A.08.

Informed choice: Informed choice includes: (a) informing individuals through appropriate modes of communication, about the opportunities to exercise informed choice, including the availability of support services for individuals who require assistance in exercising informed choice; (b) assisting individuals in exercising informed choice in making decisions; (c) providing or assisting individuals in acquiring information that enables them to exercise informed choice in the development of their individualized plans with respect to the selection of outcomes, supports and services, service providers, the most integrated settings in which the supports and services will be provided, and methods for procuring services; (d) developing and implementing flexible policies and methods that facilitate the provision of supports and services and afford individuals meaningful choices; and (e) ensuring that the availability and scope of informed choice is consistent with the obligations of the respective agencies. [*Source*: Based on 1998 Amendments to the Rehabilitation Act]

Interagency Employment Panel: The Interagency Employment Panel is the principal interagency leadership group responsible for the alignment of interagency policies and funding needed to meet the state's Olmstead goal in employment. Representatives from DEED, DHS, and MDE would be appointed by the Commissioners of the respective Departments.

Local education agencies: Local Education Agency (e.g., charter LEA, school district) is a public school district in the United States.

Local placement partnership model: The local placement partnership model is used by DEED-Vocational Rehabilitation Services. It is a unique collaboration of state, private and non-profit placement professionals that work together in an agreed-upon service or geographic area to connect the needs of employers and job seekers in a defined partnership that shares job leads to maximize possibilities for job seekers while creating an expanding and diverse talent pool for employers. This collaborative network of partners is team-based and uses a 'single point of contact' to bring together the needs of both job seekers and prospective employers in a business context.

Medical Assistance for Employed Persons with Disabilities (MA-EPD): MA-EPD is a work incentive that promotes competitive employment and the economic self-sufficiency of people with disabilities by assuring continued access to Medical Assistance for necessary health care services. MA-EPD allows working people with disabilities to qualify for MA under higher income and asset limits than standard MA. The goal of the program is to encourage people with disabilities to work and enjoy the benefits of being employed.

Minnesota Supplemental Aid (MSA) Housing Assistance: An income supplement for people who are eligible for Minnesota Supplemental Aid (MSA) and have high housing costs. MSA Housing Assistance provides $200 per month in 2013 for MSA participants who are age 18 – 64 and are relocating from an institution, or eligible for self-directed PCA services, or are receiving home and community based waiver

services and have monthly housing costs of more than 40% of their income and have applied for rental assistance, if eligible.

Most integrated setting: The "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." [*Source:* US Department of Justice, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C., Retrieved from http://www.ada.gov/olmstead/q&a_olmstead.pdf]

Motivational interviewing: Motivational interviewing is an evidence-based practice that has been shown to be effective in helping people work through the difficulties in achieving changes in their lives. It is a collaborative, goal oriented, person-centered style of communication to strengthen personal motivation and commitment to a specific goal.

Non-emergency protected transport: Secure transportation (that keeps the person and the driver safe) between facilities for people who would otherwise be transported in a law enforcement vehicle or ambulance because of their psychiatric symptoms.

Peer support: Peer support includes peer specialists and recovery coaches who play essential roles in a wide range of service environments. Their approach entails a fresh, more participatory role for people in recovery as well as the opportunity to advocate for and support their peers. This approach utilizes the unique contributions that those who have lived experience of mental health problems and addictions can make to another person's recovery process.

Person-centered: This concept is described in the section Person-Centered Planning in Minnesota's Olmstead Plan (beginning on page 27).

Person-centered awareness: Person-centered awareness is an understanding of the core concepts and principles behind a process-oriented approach to assist a person in defining the life that person wants to lead, rooted in values, goals and outcomes important to that person and developing meaningful life goals based on the person's strengths and talents, utilizing individual, natural and creative supports and services. A person-centered approach puts the person in charge of defining the direction of their lives and leads to greater inclusion as a valued member of both community and society.

Person-centered planning: Person-centered planning, based upon a set of core concepts and principles, is an on-going process of assisting someone to plan their life and supports. There is no one clearly defined process of person-centered planning, but many processes that share the same general philosophical background. (See "Person-centered awareness")

Person-centered thinking: Person-centered thinking is incorporating the core concepts and principles of person-centeredness into one's approach in working with people with disabilities. It is the foundation of person-centered planning. (See "Person-centered awareness")

Persons/people with disabilities: An individual with a disability is a person who: (1) has a physical or mental impairment that substantially limits one or more major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment.

Positive Behavior Interventions and Supports (PBIS): PBIS is a state-initiated project that provides districts and individual schools throughout Minnesota with the necessary training and technical support to promote improvement in student behavior across the entire school, especially for students with challenging social behaviors. It establishes clearly defined outcomes that relate to students' academic and social behavior, systems that support staff efforts, practices that support student success, and data to guide decision-making.

Positive practices: Positive practices are supports that treat people who receive services with respect and dignity, increase quality of life, build skills and decrease interfering behaviors. Programs and services licensed or certified by the Minnesota Department of Human Services must be positive with a focus on quality of life, including building skills people need to achieve their articulated desired life, self-management and self-efficacy, not just alleviating target symptoms. Positive support strategies incorporate person-centered planning, needs assessment, direct correspondence between the person's assessment and the person' positive supports, trauma-informed care, consultative and technical support for providers, and data, reporting and monitoring to ensure accountability.

Pre-Vocational services: Services that provide learning and work experiences (including volunteer work) to individuals to help them develop general workplace skills, such as communication, conduct, and problem solving skills. Competitive, integrated employment is the optimal outcome of these services. [A full definition is available from the US Department of Health and Human Services, Center for Medicaid, CHIP and Survey & Certification September 16, 2011 Informational Bulletin: http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf, page 7.]

Project SEARCH: Project SEARCH is an evidence-based internationally recognized employer-driven model that was developed at Cincinnati Children's Hospital Medical Center (CCHMC). The Project SEARCH High School Transition Program model is for students with developmental disabilities in their last year of high school eligibility.

Prone restraint: Prone restraint is a type of physical holding that places a person in a face down position.

Restrictive procedures: Restrictive procedure is a term used to describe physical holding or seclusion of children with disabilities in Minnesota schools. Minnesota Statutes §125A.0941 and §125A.0942 govern the use of restrictive procedures.

Return on Investment matrix: Return on investment (ROI) is a measure for evaluating the financial consequences of individual investments and actions. It measures the amount of money an investment will make relative to the initial cost of the investment.

Section 8: Also known as Housing Choice Vouchers. The housing choice voucher program is the federal government's major program for assisting very low-income families, the elderly, and people with disabilities to afford decent, safe, and sanitary housing in the private market. Since housing assistance is provided on behalf of the family or individual, participants are able to find their own housing, including single-family homes, townhouses and apartments.

Section 811: This program allows persons with disabilities who are low income to live as independently as possible in the community by subsidizing rental housing opportunities which provide access to appropriate supportive services. The newly reformed Section 811 program is authorized to operate in two ways: (1) the traditional way, by providing interest-free capital advances and operating subsidies to nonprofit developers of affordable housing for persons with disabilities; and (2) providing project rental assistance to state housing agencies.

Segregated settings: Segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with 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. [*Source*: "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C." http://www.ada.gov/olmstead/q&a_olmstead.htm]

Self-advocacy: Self-advocacy is a movement of individual and organizations working to empower people with intellectual and developmental disabilities to speak for themselves, make their own decisions and stand up for their own rights.

Self-Determination: Self-determination means the person makes decisions independently, plans for the person's own future, determines how money is spent for the person's supports, and takes responsibility for making these decisions. If a person has a legal representative, the legal representative's decision-making authority is limited to the scope of authority granted by the court or allowed in the document authorizing the legal representative to act.

Subminimum wage: A wage less than the established federal minimum wage that may be permitted under an exemption in the Fair Labor Standards Act (FLSA) that provides for the employment of certain individuals at wage rates below the minimum wage, including individuals whose earning or productive capacity is impaired by a physical or mental disability. In order to pay a subminimum wage to an individual with a disability, the employer must obtain a certificate from the U.S. Department of Labor and conduct periodic time and productivity studies to establish the rate of payment based on performance norms. [Information is available at http://www.dol.gov/compliance/topics/wages-subminimum-wage.htm]

Supportive Housing: Permanent rental housing affordable to the population served where support services are available to residents. Permanent supportive housing is available to individuals and families

with multiple barriers to obtaining and maintaining housing, including those who are formally homeless or at risk of homelessness and those with mental illness, substance abuse disorders, and/or HIV/AIDS.

Transition age youth/students: Transition age youth refers to students with disabilities in grades nine through twelve as well as students with disabilities age eighteen to twenty-one receiving secondary transition services.

Common Acronyms

ADA – Americans with Disabilities Act

AMRTC – Anoka Metro Regional Treatment Center

CFSS – Community First Services and Supports

DB101 – Disability Benefits 101

DEED – Minnesota Department of Employment and Economic Development

DHS – Minnesota Department of Human Services

DOC – Minnesota Department of Corrections

DOJ – United States Department of Justice

EE – Extended Employment

GRH – Group Residential Housing

HCBS – Home and Community-Based Services

HUD – Housing and Urban Development

ICF/DD – Intermediate Care Facility/Facilities for Persons with Developmental Disabilities

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IMD – Institution for Mental Disease

IPS – Individual Placement and Supports

iTV – Interactive television

MA-EPD – Medical Assistance for Employed Persons with Disabilities

MCOTA – Minnesota Council on Transportation Access

MDE – Minnesota Department of Education

MDH – Minnesota Department of Health

MDHR – Minnesota Department of Human Rights

MHCP – Minnesota Health Care Programs

MHFA – Minnesota Housing Finance Agency

MnDOT – Minnesota Department of Transportation

MOA/MOU – Memorandum of Agreement/Understanding

MSA – Minnesota Supplemental Aid

MSHS – Minnesota Specialty Health System

PBIS – Positive Behavioral Interventions and Supports

PCA – Personal care assistance

ROI – Return on Investment

SAMHSA – Substance Abuse & Mental Health Services Administration

SHIP – Statewide Health Improvement Program

SSI – Supplemental Security Income

VASH – Veteran Affairs Supportive Housing

VR – Vocational Rehabilitation

VRS—Vocational Rehabilitation Services

Appendix A. Demographics

The charts, tables, and maps in this appendix illustrate the demographics discussed on page 17.

Chart 1: 12% of all Minnesotans lived in poverty in 2011. By comparison, 22% of Minnesotans with disabilities lived in poverty in 2011. Poverty status in general has increased since 2008. *Source:* Minnesota Compass (image captured from website).

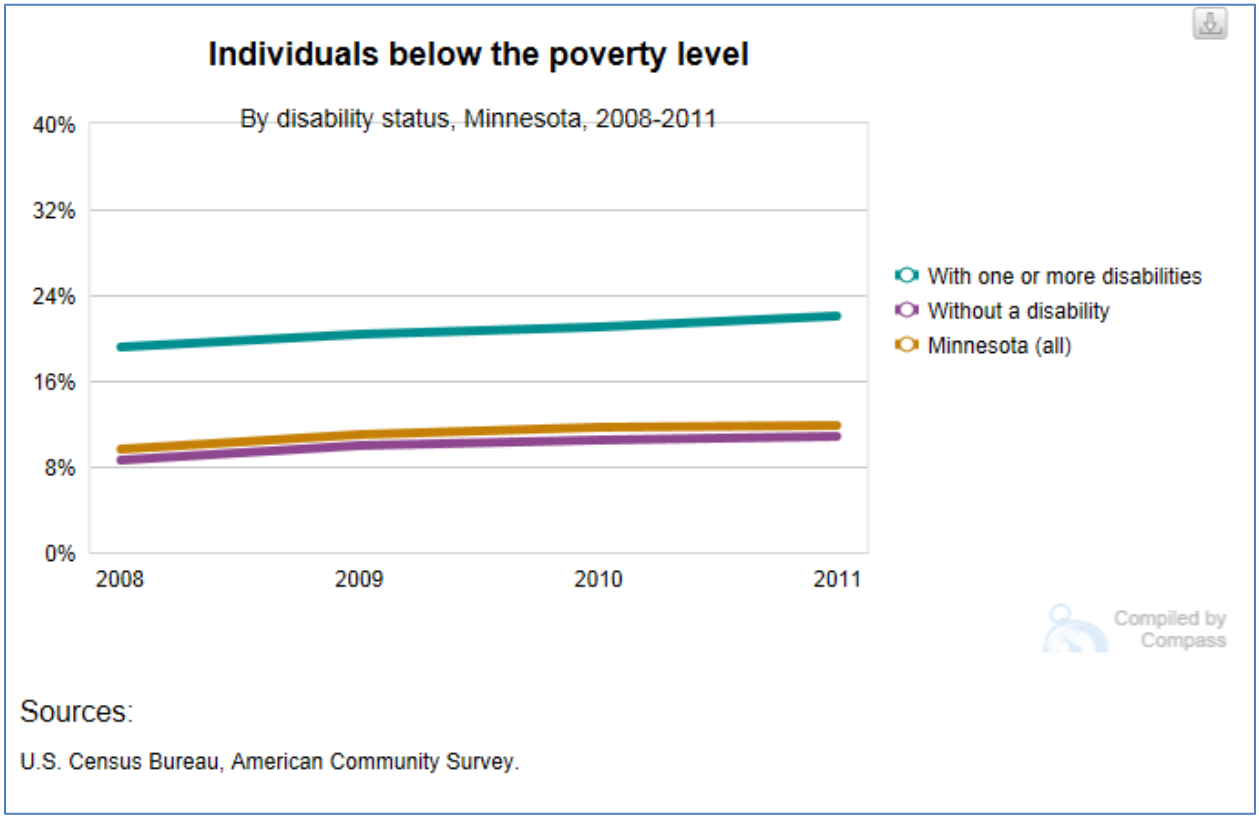


Chart 2: The highest rates of disabilities among working-age Minnesotans are American Indians (20%) and U.S.-born African Americans (17%). By comparison, the rates of disability among other populations are: about 5% of Southeast Asian people, about 4% of other Asian people, about 6% of foreign-born black people, about 7% of white (non-Hispanic) people; about 6% of Hispanic people, about 7% of people who identify as some other race or ethnicity, and about 10% of people who identify as two or more races. *Source:* Minnesota Compass (image captured from website).

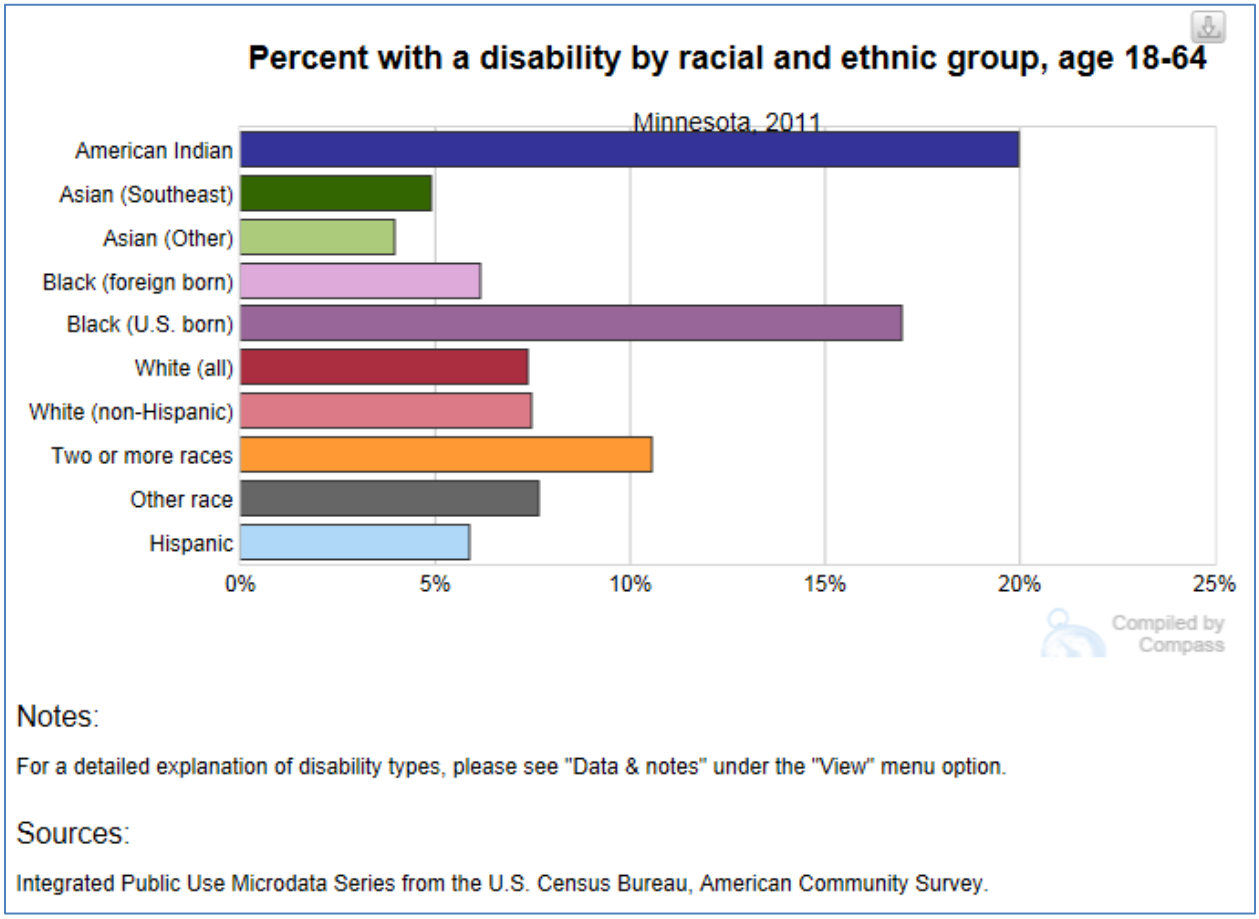


Chart 3: Working age Minnesotans experience different rates of disabilities—ambulatory (3.4%); cognitive (3.6%); hearing (2.0%); independent living (2.7%); self-care (1.4%); vision (1.0%) and one or more disabilities (8.1%). *Source:* Minnesota Compass (image captured from website).

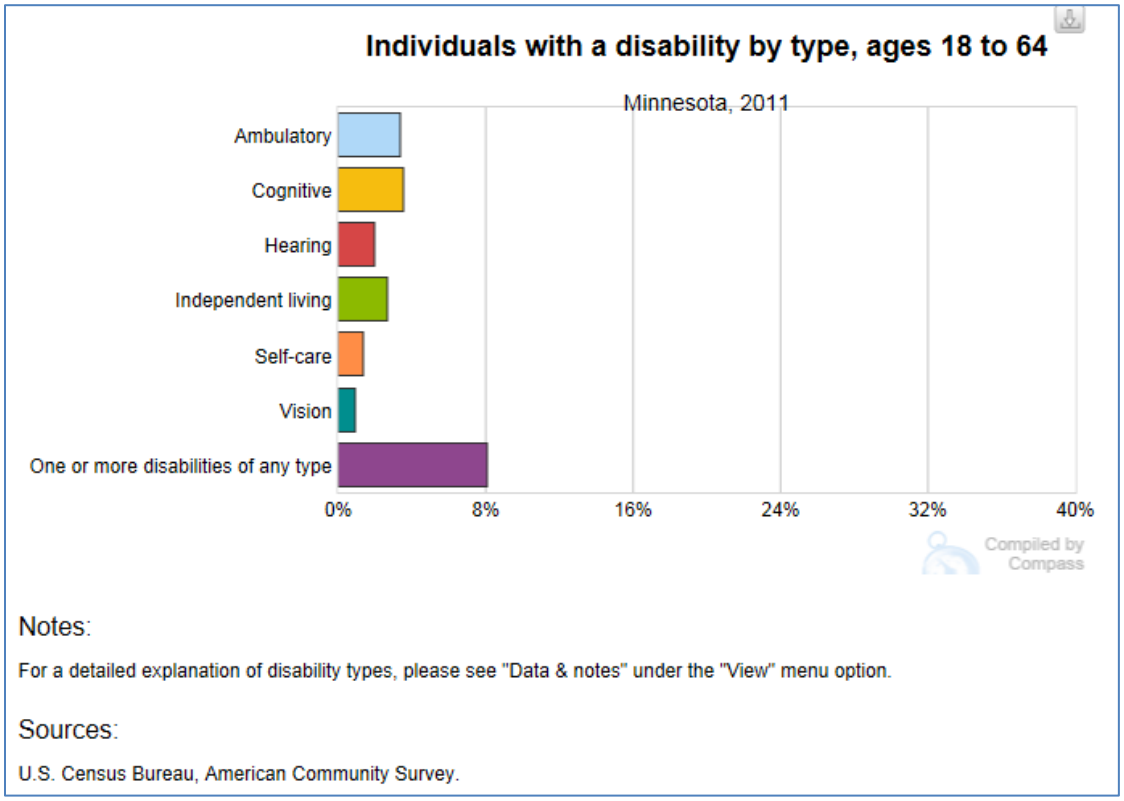


Chart 4a: Older Minnesotans (65 years +) experience different rates of disability–ambulatory (18.4%); cognitive (6.4%); hearing (15.0%); independent living (12.7%); self-care (6.8%); vision (4.9%) and one or more disabilities (32.0%). *Source:* Minnesota Compass (image captured from website).

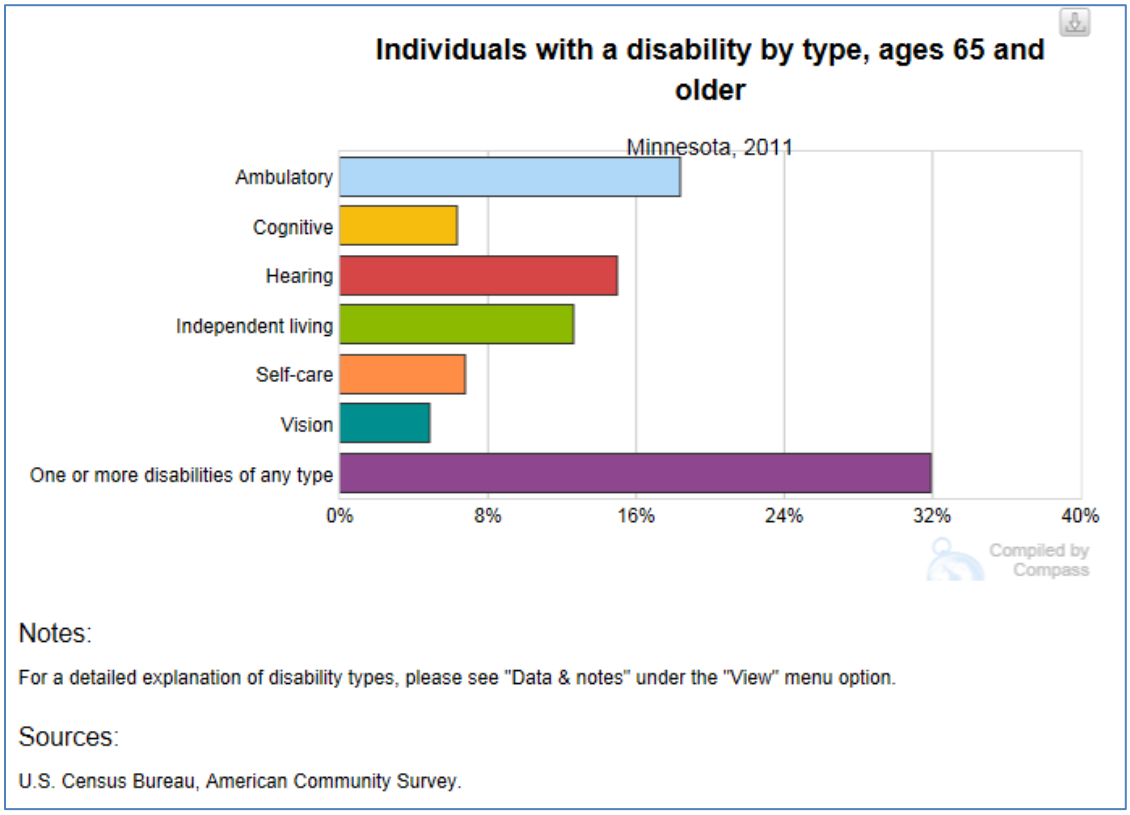


Chart 4b: Disability types vary among different age groups. *Source:* Chart created using data from Minnesota Compass

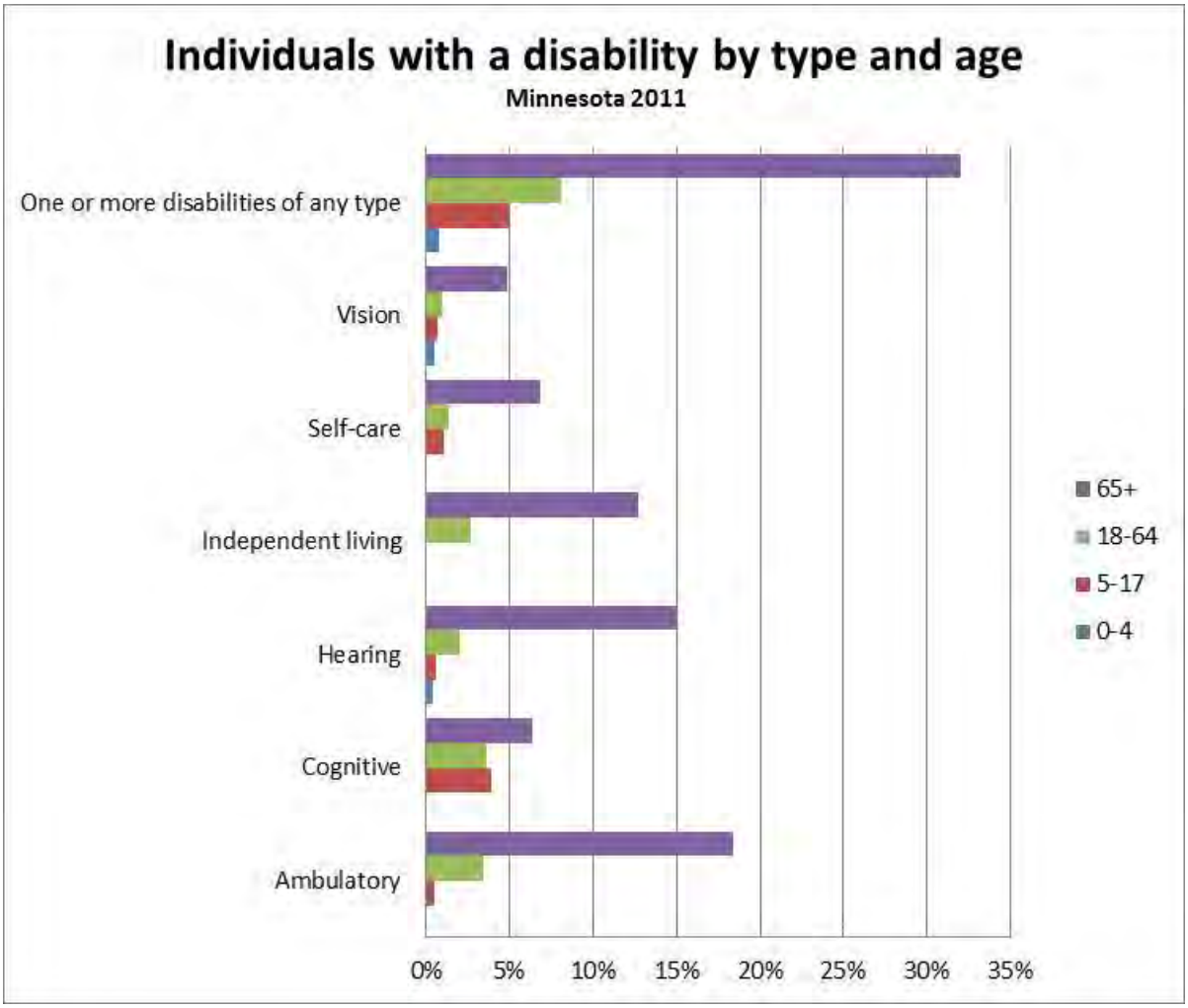


Chart 5a: There are regional differences in disability rates (which likely result from aging differences). The highest rates of disability are in the northern and western regions of the state (14%) and the lowest rate of disability is in the Twin Cities (8%). The rates of disability in the central and southwest parts of the state are about 11%, and the rate in the southern part of the state is about 9%. *Source:* Minnesota Compass (image captured from website).

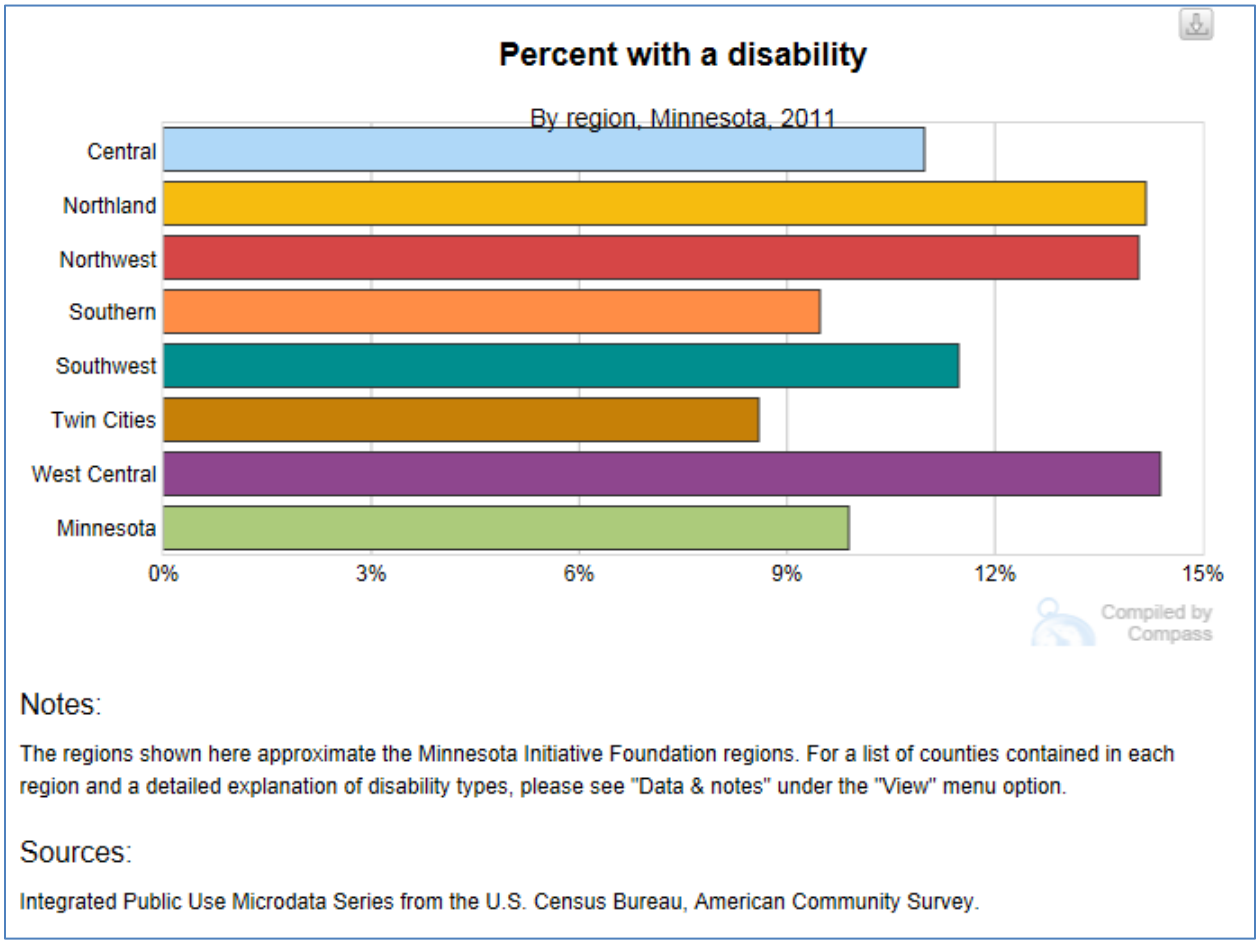


Chart 5b: Percent of the population with one or more disabilities – Minnesota. *Source:* Minnesota State Demographic Center, using Public Use Microdata from the American Community Survey 2009-2011. *Note:* Public Use Microdata Area (PUMA) is a statistical geographic area used by the United States Census.

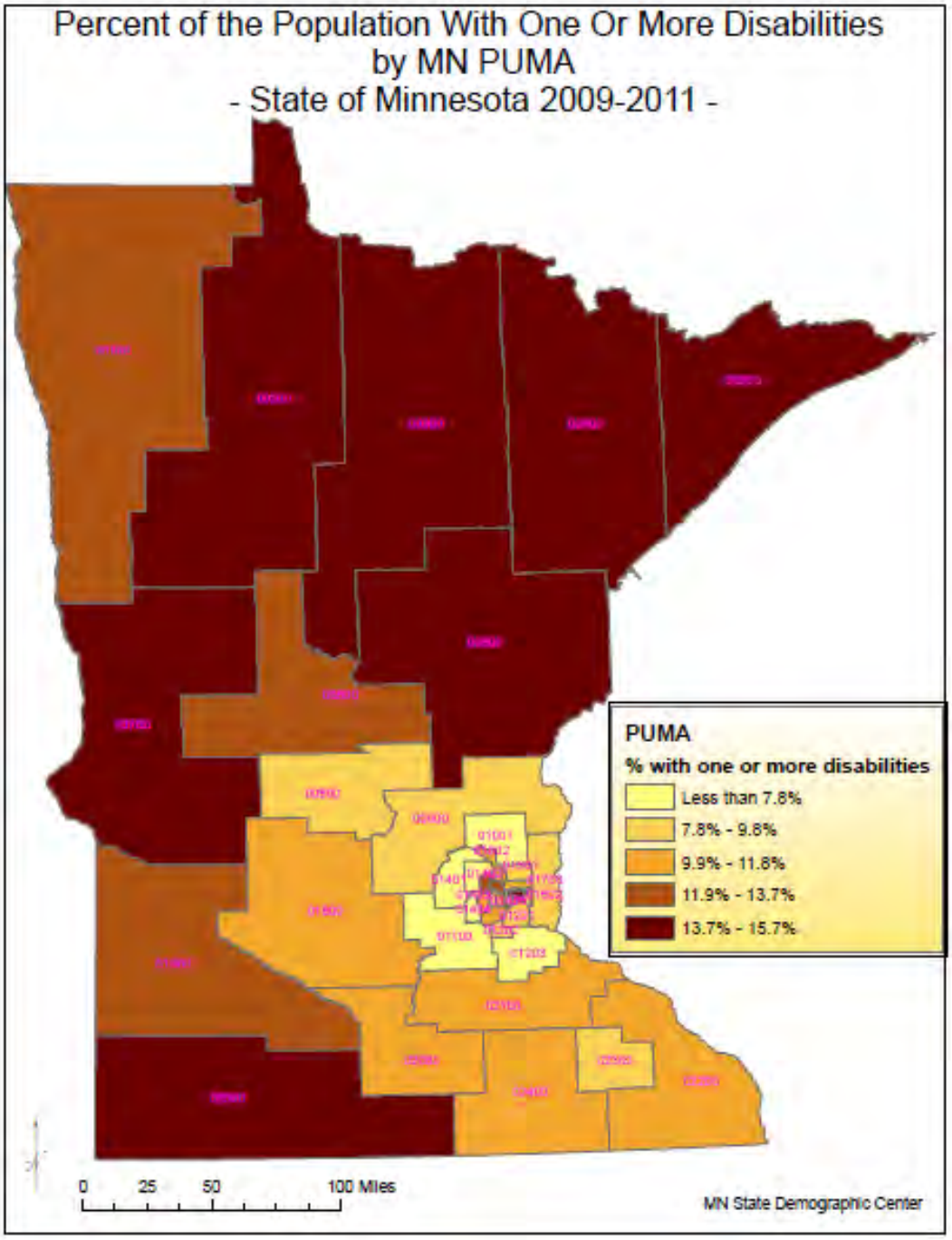


Chart 5c: Percent of the population with one or more disabilities—Twin Cities. *Source:* Minnesota State Demographic Center, using Public Use Microdata from the American Community Survey 2009-2011. *Note:* Public Use Microdata Area (PUMA) is a statistical geographic area used by the United States Census.

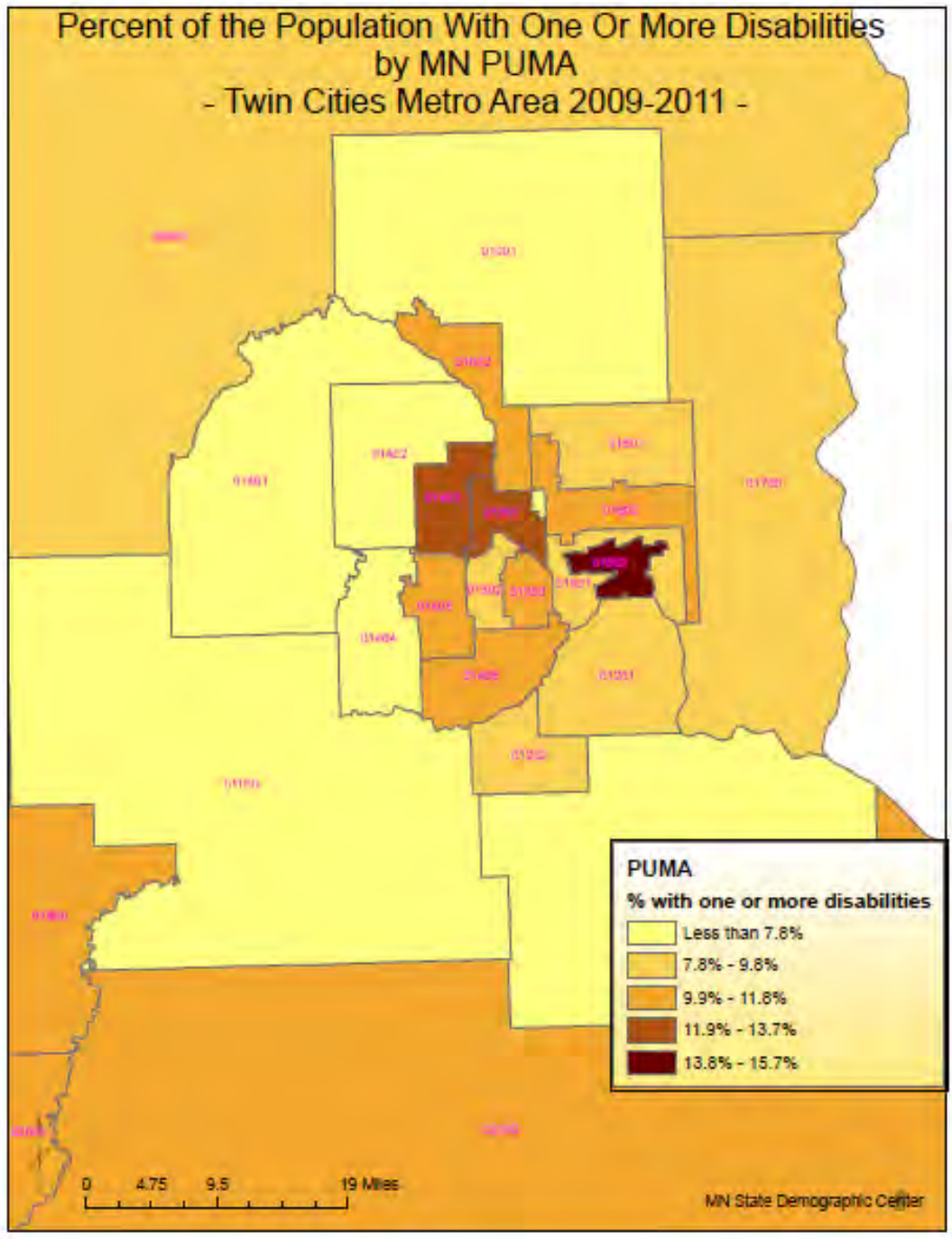


Table 5d: Data for Charts 5b & 5c. *Source:* Minnesota State Demographic Center, see other notes below table. *Note:* Public Use Microdata Area (PUMA) is a statistical geographic area used by the United States Census.

Geography number ("PUMA")	Counties and/or cities represented within this geography	% with one or more reported disabilities
100	Clay, Kittson, Marshall, Norman, Pennington, Polk, Red Lake, Roseau	12.7%
200	Becker, Beltrami, Clearwater, Hubbard, Lake of the Woods, Mahnomen	14.9%
300	Cass, Cook, Lake, Itasca and Koochiching	15.2%
400	St. Louis	14.2%
500	Aitkin, Carlton, Crow Wing, Kanabec, Mille Lacs, Pine	15.1%
600	Douglas, Morrison, Todd, Wadena	13.6%
700	Big Stone, Grant, Otter Tail, Pope, Stevens, Swift, Traverse, Wilkin	15.5%
800	Benton and Stearns	9.6%
900	Chisago, Isanti, Sherburne, Wright	8.6%
1001	Anoka	7.4%
1002	Anoka	11.0%
1100	Carver, Scott	6.3%
1201	Dakota	9.2%
1202	Dakota	9.3%
1203	Dakota	5.9%
1301	Hennepin: Minneapolis	12.0%
1302	Hennepin: Minneapolis	9.6%
1303	Hennepin: Minneapolis	11.4%
1401	Hennepin	7.8%
1402	Hennepin	7.3%
1403	Hennepin	12.4%
1404	Hennepin	7.8%
1405	Hennepin	9.9%
1406	Hennepin	10.9%
1501	Ramsey: St. Paul	9.3%
1502	Ramsey: St. Paul	15.7%
1601	Ramsey	8.2%
1602	Ramsey	11.0%
1700	Washington	8.4%
1800	Kandiyohi, McLeod, Meeker, Renville, Sibley	11.4%
1900	Brown, Chippewa, Lac Qui Parle, Lincoln, Lyon, Redwood, Yellow Medicine	12.7%
2000	Blue Earth, Nicollet, Waseca	9.9%
2100	Le Sueur, Rice, Goodhue	10.3%

Geography number ("PUMA")	Counties and/or cities represented within this geography	% with one or more reported disabilities
2200	Fillmore, Houston, Wasbasha, Winona	11.8%
2300	Olmsted	8.1%
2400	Dodge, Freeborn, Mower and Steele	11.4%
2500	Cottonwood, Faribault, Jackson, Martin, Murray, Nobles, Pipestone, Rock, Watonwan	14.1%

Notes from the Minnesota State Demographic Center:

Source: IPUMS version of the 2009-2011 American Community Survey, U.S. Census Bureau. Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. *Integrated Public Use Microdata Series: Version 5.0* [Machine-readable database]. Minneapolis: University of Minnesota, 2010. www.ipums.org .Tabulations by the MN State Demographic Center.

Notes: Error margins due to sampling error exist around data points but are not shown. Relates only to the civilian, non-institutionalized population with a serious difficulty in one or more of the following areas of functioning: hearing, vision, cognitive, ambulatory, or self-care, or independent living. Populations that were not asked about a particular type of disability where excluded from totals when calculating percentages.

Additional notes about types of disability asked about in this survey:

-Hearing limitations: Respondents were asked if they were “deaf or… [had] serious difficulty hearing." This question was asked of respondents of all ages.

-Vision limitations: Respondents were asked if they were “blind or… [had] serious difficulty seeing even when wearing glasses." This question was asked of respondents of all ages.

-Limitations in cognitive functioning: Respondents were asked if due to physical, mental, or emotional condition, they had “serious difficulty concentrating, remembering, or making decisions.” This question was asked of respondents 5 years and older.

-Ambulatory limitations: Respondents were asked if they had “serious difficulty walking or climbing stairs.” This question was asked of respondents 5 years and older.

-Self-care limitations: Respondents were asked if they had “difficulty dressing or bathing.” This question was asked of respondents 5 years and older.

-Independent living limitations: Respondents were if due to a physical, mental, or emotional condition, they had difficulty “doing errands alone such as visiting a doctor’s office or shopping.” This question was asked of respondents 15 years and older.

Chart 6: Minnesota's population is aging. The current retirement-to-working age ratio is about 22%, but by 2040, the retirement-to-working age ratio is projected to be almost 40%. *Source:* Minnesota Compass (image captured from website).

Chart 7: Recent data shows that 80% of Minnesotans with no disabilities are working, compared to only 43% of Minnesotans with disabilities. Rates of employment differ among different types of disability: about 60% of people with a hearing disability are working; about 45% of people with a vision disability are working; over 30% of people with a cognitive disability are working; about 30% of people with an ambulatory disability are working; about 25% of people with a self-care disability are working; and, about 30% of people with an independent living disability are working. *Source:* Minnesota State Demographic Center (image captured from PowerPoint presentation slide).

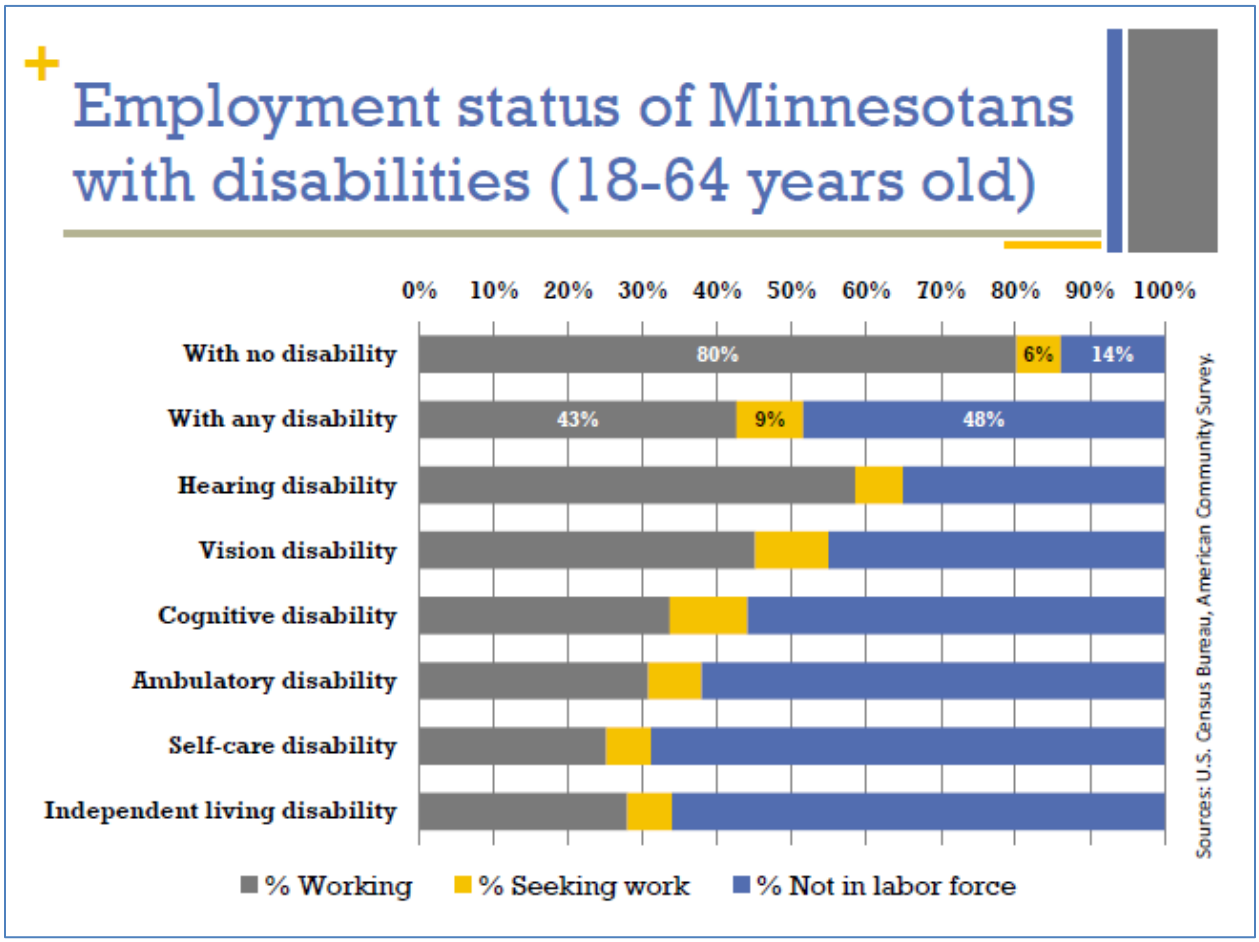
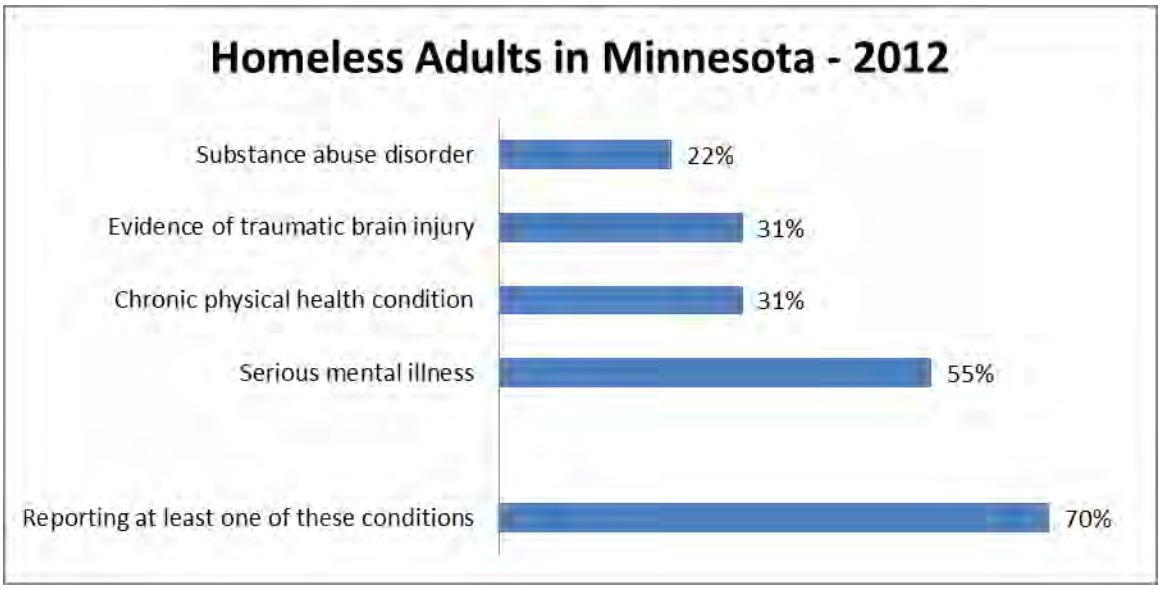


Chart 8: According to a 2012 study on homelessness in Minnesota, 55% of adults experiencing homelessness reported a serious mental illness, 51% reported a chronic physical health condition, 31% reported evidence of a traumatic brain injury, and 22% reported a substance abuse disorder. 70% (3,719 adults) reported at least one of these conditions. *Source:* Chart created with data from Wilder Research.



Appendix B. Subject matter experts

State agency staff consulted with several experts in developing the Olmstead Plan:

Employment
Karen Flippo
Program Director, Institute for Community Inclusion
University of Massachusetts/Boston

Employment/Customized Employment
Linda Rolfe
Independent Consultant

Education
Patrick Schwarz
Diversity in Learning and Teaching Department
National-Louis University

Family Supports and Health Care
Allan I. Bergman
CEO, HIGH IMPACT Mission-Based Consulting/Training

Housing
Ann O'Hara
Co-Founder, Director of TAC Housing Group
Technical Assistance Collaborative

Measurement/Data
James Conroy
Center for Outcome Analysis

Plan Development
Tony Records
Independent Consultant

Self-Determination
Michael Head
Independent Consultant

Appendix C. Selected stakeholder comments from listening sessions

Listening sessions were informally transcribed using Communication Access Real Time (CART) services. The comments below are taken from these transcripts, and may not be exact. Notes in parentheses show the topic area(s) that are connected to a particular comment.

St. Paul Listening Session – July 9, 2013

Steve Larson

"A concept to consider is for all of us to view the public dollars as an investment rather than an entitlement. Most investors expect a return, and the return expected is that individuals with disabilities will be able to build a life, a life which is fully integrated into the community, a life [in] which they attain services they choose at the right time in the right place in the right amount." (funding, supports and services)

Joe Cuoco

"Group Residential Housing covers many different types of programs within Minnesota [including] board and lodging programs for individuals in recovery from drugs and alcohol. I believe board and lodging programs do not meet the definition of an institution. This is not permanent housing. The average stay is three to six months. Congregate group residential housing settings play an important role in the continuum of care for the person coming off the street, out of detox, out of residential treatment programs as a place to continue recovery in the early stages and leading to stability and improved health outcomes." (housing, supports and services, health care)

Richard Hooks Wayman

"We are in full support of the goal that people with disabilities should choose where they live, with whom they live, and what type of housing. How do we know we're achieving that goal? What are the public data elements that we are collecting through the various agencies? And how is the information given to the public so that we can measure success moving forward?" (housing)

"Supportive housing is an evidence based practice and allows for integration. I think we have to have a balance between site-based supportive housing and scattered site supportive housing." (housing)

Jennifer Lewin

"I wanted to commend the Committee in looking at a continuum of choice but just wanted to make sure that it is a true choice, not a designated choice."

"Preserving that choice is also not limited by an arbitrary cap or denial to support services by choosing any one of those options, including a single-site setting." (housing)

"Integration is not inclusion. Integration is truly about demographic integration. Inclusion is about being welcomed and a sense of belonging into a community (housing, community engagement)

Ethan Roberts

"When you talk about future measures, to increase the percent of people with disabilities living within an integrated setting of their choice, that's tangible, that's real, it's thoughtful. I have my own lease. A roommate isn't forced on me; I can come and go as I please. That makes sense. That's real." (housing)

Al Hester

"Public housing isn't the problem and it's not the solution. Public housing is serving, providing good housing for a great many people with disabilities, but its capacity is very limited." (housing)

Matt Burdick

"Time and again we have seen services developed from the perspective of serving people with developmental disabilities and physical disabilities fail to adequately meet the needs of people with mental illness." (supports and services)

"We were really pleased to see that one of the goals under employment is increasing evidence based supported employment." (employment)

"We want to see a system that gives people comprehensive services when they first start experiencing mental illness so that it doesn't disrupt their life significantly down the line." (supports and services)

Don Lavin

"Employment is a critical gateway to the core goals of Olmstead and drives many individual choices associated with living and participating in the most integrated community setting. Without a competitive job, many of the goals of Olmstead are challenging, if not impossible to achieve." (employment, community engagement)

"We need a shared and uniform public policy statement that expects, encourages, provides and rewards integrated employment in a competitive workforce as the first and preferred option." (employment)

Linda Orrben

"A lot of individuals leaving high school don't have a whole lot of choices other than going to transition schools or day programs or work programs. If students are given the opportunity to learn these skills (social, vocational, independent living and academic), they may need less supports later on in life." (education, employment community engagement)

Mary Kay Kennedy

"The Olmstead decision creates some powerful opportunities to create change and the decision itself really has given self-advocates license to press for creation of new community accommodations." (community engagement)

"The plan has the potential to radically change the way people are included in their communities." (community engagement)

"If people have greatly limited life experiences, it's really not informed choice just to tell people what their options are."

Dan Stewart

"Ensure transition age students have opportunities to be fully integrated members in their community, especially in higher education and in competitive employment. A key to this, of course, is to ensure informed choice, having appropriate assessments and having access to a variety of different options and opportunities." (education, employment)

"There should be more emphasis on reducing segregated school placements at an earlier age. These segregated placements at an earlier age sometimes funnel kids into segregated or center- based facility-placed employment situations later on. " (education, employment)

Pamela Hoopes

"We strongly urge Minnesota to formally adopt an Employment First policy. Minnesota really must commit to collecting data about the number of individuals and hours that people are working in center-based or facility-based settings, enclave or work crew settings and integrated community or supportive employment settings." (employment)

"Minnesota really must commit to coordinating efforts across state and county agencies that provide funding for persons with disabilities in employment, and those agencies include Voc Rehab, State Services for the Blind, DHS Disability Services Division, Minnesota State Operated Services and also Children and Community Services Act county funding." (employment, funding)

The state must set goals and timelines for increasing opportunities for persons with disabilities to secure integrated competitive employment in the community." (employment)

Galen Smith

"As long as there's an institutional bias in Medicaid, there's not a real choice." (housing, community engagement)

"We have a system that [forces] poverty on people with disabilities... just to get the services they need and that's not freedom and that's not independence and that's not integration." (supports and services)

Dan Cain

"I believe Olmstead is about choice. And it's about a level playing field, and people being able to take control of their lives and make decisions that they believe are best for them.

"To borrow from the medical profession, [the] first rule should be to do no harm."

"It's very important that we not develop rules and guidelines that inhibit the good services that are being provided." (supports and services)

Moorhead Listening Session – August 2, 2013

Sue Humphers-Ginter

"A strong system of providing long-term options counseling to older adults and their family members is critical to helping older adults with disabilities and their caregivers make informed decisions about meeting long term service and support needs and remain in the community." (supports and services, housing)

"By supporting family caregivers, we enable them to sustain their care giving role for a longer period of time and reduce their reliance on more costly forms of care." (supports and services)

"We must ensure that older adults have access to proven interventions that will help them manage their chronic conditions." (health care, support and services)

"Successful transitions from nursing homes to home help to change the mindset that nursing homes are the best long term residence for older adults with disabilities and also respect people's preferences for living in care give arrangements." (housing, supports and services)

Donna Atherton

"Person centered planning could be a formative process implemented in transition planning services for students with any disability so that they may become active participants in determining their future in employment, housing, and community engagement. Teachers and service providers should have training to facilitate this process" (education, employment, housing, community engagement)

"It's so easy for people to get stuck working in an enclave or sheltered workshop and receiving subminimum wage. Vocational agencies are so entrenched with this model and people don't realize that they have choices to step outside and expand their horizons." (employment)

"I wholeheartedly embrace the concept of Employment First principles to make integrated employment the first employment option for people with disabilities." (employment)

My daughter, Nicole, is a strong advocate for herself and for others. She's competitively employed with two jobs in the community, volunteers, and is making plans to live independently." (employment, community engagement)

"Where people live is another area that needs examination." (housing)

Rebecca Melang

"To realize our full cost savings, we must stop people from entering institutions. We're not going to be able to realize that until we work with the people that are living in our shelters and our jails." (housing, supports and services)

"If we don't have a dedicated funding stream for housing and for housing vouchers, we will be basically taking away from other vulnerable populations that work to house people coming out of institutions." (housing, funding)

Jan Peterson

"Some of the folks I've been working with that are in nursing homes desperately want to return to the homes they've lived in most of their lives. One woman got a letter from the county saying that she had to put her house on the market. She had been in the nursing home for too long. She was transferred to an assisted living place and her house is for sale. A 62 year old Vietnam vet was placed in a nursing home last spring. He was told there were no other options for him. He sits in the nursing home room listening to his music every day, looking out the window." (housing, supports and services)

Nate Algaard

"In small town Minnesota, there are still a lot of physical barriers. Even when people renovate or build new, there are sometimes barriers. So what are our building inspectors doing to make sure that things are constructed accessible?" (housing)

Tom Holtgrewe

"My focus with my daughter is job searching and it's a challenge. We're just looking for other opportunities and we have got to create some of our own by going out and working with the agencies and the employers." (employment)

Sharon Grugel

"Two young men with disabilities have graduated for high school, are working in supported employment [jobs] in Roseau but the family would like them to be able to move into their own home setting. And there are absolutely no homes available. So the county, of course, wants to send them out, away from home, away from their support system, away from their friends, away from the community that has helped them grow up and accepts them. And I just think that's so unfair." (housing, supports and services)

Shannon Henrickson

"How do you keep those services available in those small communities when you can't even get people (direct care workers) to apply?"

Carolyn Strnad

"There doesn't seem to be a consistent way of determining who receives vocational rehabilitation services." (employment, supports and services)

Duluth Listening Session – August 13, 2013

Laurie Berner

"I think it's very, very important that people have those choices. I think people gain choices and learn how to make informed choices through being educated, hav[ing] experiences, real, personal experiences and opportunities so that they can explore and grow and be able to make decisions." (supports and services, community engagement)

"The UDAC (day training program) finally got a supported employment license. It took me months and months and months to get that so we would offer that opportunity to people we serve and people who will be coming in the future. It shouldn't be that hard." (employment)

Len Rothlisberger

"The state of Minnesota should encourage further development of the affirmative business enterprise model of employment services for people with disabilities." (employment)

Richard Wescott

"I'm here today to tell you how important having a good job [is and] has made a difference in my life. I have had a job in the past. However, the wages and hours were not what I need to pay my bills or to save for any extras." (employment)

Jon Nelson

"Unless you do something about a good, qualified workforce to support people in the community, everything else is going to be doomed for failure." (employment)

"We operate in eight counties and we experience what it's like to put technology in a variety of rural settings and it's very challenging. I can tell you right now that there are people who could live in the community with technology [but] who can't because we don't have the broadband capacity in those areas. (supports and services)

Roberta Cich

"You're really looking at the barriers that people with disabilities are facing and you're trying to address that at many levels." (supports and services, community engagement)

"The Olmstead decision, like the ADA, is a civil rights decision."

Bridget Riversmith

"I've lived in institutions, in group homes, crisis shelters, homeless shelters where I was told I was a drain on society, and I worked at shelters like Goodwill where I was told I was unfit for higher education and training and employment opportunities at anything more than subminimum wages. But I have navigated the system and I've achieved greater independence by advocating for my own person centered planning." (education, employment, community engagement)

"You're really focused on integration and I think that's great because I've gotten the message that, unless I can measure up to being normal, I can't be included."

"I notice that you focus on jobs, on employment first, and there's no mention of entrepreneurship or higher education, mentoring, apprenticeships, professions, business ownership, partnerships." (employment)

Laura Birnbaum

"By including self-advocacy, peer-to peer-support, and leadership training into the Olmstead Plan, self-advocates would have an increased ability to create change within the system that impacts their lives on a daily basis."

Employment opportunities are at the top of the list, often with the phrase, we want real work for real pay. We fully support the Olmstead Plan goal that people with disabilities will have choices for competitive, meaningful and sustained employment in the most integrated setting, but we advocate that these choices be informed, including increased opportunities for work experiences beyond the traditional custodial and food prep skill building experience for transition aged youth with disabilities." (employment)

Julie Jeatran

"I was reading the Olmstead Plan over and I read a lot of it but I had to skim some of it, seemed like this big kind of tin man, like an ironman kind of thing with a big heart and kind of bulky and all the agencies that are caring but like working from the top down versus the foundation up. I think it would just be great to build a foundation and maybe help the heart of this beast of the agencies to be effective."

Don Samuelson

"You captured many of the things that are important to people with disabilit[ies] of all ages in order for people to live in the way they want to live. This draft provides a solid foundation on which to build. Many older adults experience disabilities for the first time in the later years of their lives, often due to the progression of chronic illnesses. Thus the experience of older adults requires consideration in this plan" (supports and services)

"We must ensure that older adults who are experiencing disabilities have access to in-home supports regardless of their pay sources." (supports and services)

"In order for older adults to be able to live where they choose, including their own home and community, it is critical that these supports are available statewide." (supports and services)

"We need to ensure a strong transportation system statewide. Our transportation system must include a range of transportation options and must have a high degree of coordination in order to [make the] most efficient use of our resources." (transportation)

"We must support older adults who choose to age in place in order for people to continue living in their homes as their disability increase[s]. They must be able to have access to [a] cohesive system of home modifications." (housing, supports and services)

"We must continue our work to integrate health and long term services and supports." (health care, supports and services)

"A coordinated system of health care and long term support services can more effectively identify high risk individuals, connect those individuals with needed services and provide followup improvement and overall quality." (health care, supports and services)

Linda Sjoberg

"I believe we have felt all along that where people with disabilit[ies], and particularly people with mental illness, need to live and deserve to live is in the residence of their own choice." (housing)

"One thing that we are very much lagging behind on is the involvement of consumers and the development of peer supports." (supports and services)

"In order for people to have the opportunity to have stable lives in the community they need to be able to access a full continuum of services as they move through their treatment process." (supports and services)

"Beginning with inpatient hospitalization, we struggle sometimes to get people moved out because there is not the appropriate next level of care." (health care, supports and services)

Commissioner Chris Dahlberg

"Individuals with disabilit[ies] should live, work, and receive services in the greater community like individuals without disabilities. And so integration into the neighborhoods is key and we're seeing that." (housing, community engagement)

"Parkwood [is] a neighborhood with about a hundred homes, but in a hundred homes, there's six group homes and I think they're moving into eight. Olmstead talks about wanting to have integration so they're moving into communities with people without disabilities so what you're starting to do is have a concentration of homes and you're losing the effect." (housing)

Charlie Fedora

"I would implore you to consider how you concentrate these group homes and, if your focus is group homes, you're not integrating them, you're going right back to kind of an institutional atmosphere." (housing)

Mary Metzger

"As we're working for employment for people with disabilit[ies] across a broad spectrum, I would hope that you would have conversations with the Minnesota Chamber of Commerce. Oftentimes in smaller communities, it's very difficult to get into employment opportunities for people." (employment)

"When people are allowed to ride the bus with everybody else, then they're integrated into their community and they have relationships so I would hope that would continue to happen, specifically in rural areas." (transportation)

"I would ask that you would consider training for law enforcement across the state of Minnesota, not just for people with developmental disabilities but people with mental health issues."

"As a provider of services, I would hope that people, whether they're people with a disability or people who accompany them through life, actually have real pay for the real jobs that they do." (employment, supports and services)

Sherri Fedora

"The Parkwood development where I live was home to seven foster care homes that have now increased to nine. This is a newer subdivision of Duluth which has been overrun by foster home operations. Licenses and high density foster care areas should be rescinded. A fair ratio of one foster care home per 150 houses should be adopted. No new licenses should be approved in St. Louis County due to the saturation we are currently experiencing." (housing)

Mike Ryan

"When you start looking at employment, please remember that we also need transportation." (employment, transportation)

Rick Hammergren

"As we move into another generation of this huge systems change and as we look at the current evolution, we need to recognize that many people are served well where they are, sometimes we don't need to reinvent everything in order to improve it. Maybe we need additional options but we don't heed to abandon those models that are serving people well now." (supports and services)

"What we need is a diverse menu of openings for employment and training and community based supports to find jobs for people that work and endure, that aren't just a simple solution to go find a job [and] a placement but actually one that provides a solution for the long term (employment)

"Please let people who have disabilities and their families and their guardians make real choices about what the best model and design is to meet their needs. Please continue to listen to people who receive services. They know what they need. They know what works best for them." (supports and services)

Patricia Ann Wallace

"I work in recycling and sorting and shredding and we are paid by how many bags we sort and fill, we work at subminimum wage. I would like to get paid by the hour like you get paid by [the] hour." (employment)

"I think that everyone has rights to choose where they live and be happy. All kinds of people live in my community." (housing)

"Give people a chance to show that we can do it, yes, we can. Everybody deserves a chance and everybody learns differently. People just need to be shown how to do things. It can take a while but they can do it. Everyone has a dream where they want to live, work and be happy." (community engagement)

Nancy Cashman

"All of the people who live in our supportive housing programs are homeless upon entry into the housing and most have mental and /or chemical health issues and many have dual diagnosis. In our experience, homelessness is really not a good support plan or treatment plan for folks with disabilities." (housing, supports and services)

"It's really important that you understand how supportive housing works and, while we use some of the same funding tools as some of the other programs like group residential and foster homes, we really bring something different to the table." (housing)

"We're concerned about the 25% rule. If you build a new facility or only 25% of the units can be for [people with] disabilities, that completely collides with all of the capital funds that are out there. I don't know how we'll continue to get people off the streets if these policies and rules and laws really start to crash into each other." (housing, funding)

"Most of our supportive housing funds come from HUD and HUD requires that you be homeless upon entry and that you have a disability." (housing, supports and services)

"It's not cost effective to build a facility that only has four or ten units because then you end up scattering services all over and the model that we have found to be very successful has been congregate living with people having their own individual apartment but having high intense services and providing services in a philosophy that understands the barriers people have and helping them to maintain housing." (housing, supports and services)

Mark Nelson

"The adult protection system needs to be strengthened relative to the child protection system. Adult protection services are really funded on a fractional level and yet, the need is very substantial, especially as we seek to integrate people into the community." (supports and services)

"The possibility of physical harm, neglect and increasingly financial exploitation are issues that we need to have the capacity to address through adult protection." (supports and services, community engagement)

"There is a concentration of services in particular counties and so people really don't have a lot of choice in many, many counties." (supports and services)

"Housing is about where people live with their own family, on their own or with other people, and the goal is that people will choose where they live, with whom, and in what type of housing and, all too frequently, we have seen people who are either living in a home being introduced to people moving in, they don't have any say about that so there is a dignity piece there; nor do people often have a say about where they're going to be going, this is the only option." (housing, supports and services)

"Resident mix is a very important factor to consider over the potential for managing challenging behaviors and informing individual abuse prevention plans that each resident in foster care needs to

have. So keeping that option there for people to choose where they live and who they live with and how we put that together is going to be important for [the] dignity of people as well as safety for them and others." (housing, supports and services)

"It happens that people just will be placed at times and as much as licensing requires pre-placement, that doesn't always happen." (housing, supports and services)

"In developing individual abuse prevention plans, [we] need to know something about other people in the home in order for a case manager to say, yes, that individual abuse prevention plan will work for my client." (housing, supports and services)

John Hanson

"The use of waivers opened up many options for many consumers and, in particular, those with disabilities. (supports and services)

"A concern is how you would define 'community level settings.' There are indications that some factions feel some congregate settings including those with housing establishments are not personal homes. I would strongly disagree with that." (housing)

"People [who] can live in their own house with services brought in, that would be wonderful, that's what we should all shoot for but there are a broad range of people who need 24-hour care or monitoring or supervision. In this day of budget cuts and constraints, assisted living homes and housing with service establishments are one of the most cost effective options out there." (housing, supports and services, funding)

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Hiyas Quelle

"If you have good education and training, then you will have better opportunities with your employment." (employment)

"I want to see Mayo Clinic and Minnesota [have as] our goal, to be a trail-blazer and employ people with disabilities. "(employment)

"I see programs especially the high schools where they help students while they're in high school, they're being trained to work in the health care field but I haven't see that as a parent, I haven't seen a program training students with disabilities so that they can be qualified to work in the health care industry." (employment)

Lee Ann Erickson

"The cages are back but they're gilded now. Providers are investing [in] the lovely high-end homes so residents do have nice bedrooms but they're spending way too much of their free time in their bedrooms and not in the communities." (housing, community engagement)

"The right to association is the one most often abused. My two sons with disabilities own their own home. I'm their guardian. Their in-home provider would not allow former staff to visit their home." (community engagement)

"Staff at licensing made it clear they were not interested in [the] rights of individuals."

"When you are living in a home of your own, staff becomes more supportive and much less controlling. Many of the barriers created by corporate adult foster care liability issues are eliminated." (housing, supports/services)

"Quality of life improves when you're in a home of your own."

Tena Greene

"I know that the goal of the plan is that people [with] disabilities are living, learning, working, and enjoying life in the most integrated setting. I believe in order for this to happen, all children need to be [in an] inclusive setting for education." (education)

Children are born to be accepting of everyone and when we put individuals in self-contained classrooms, we're not only doing them an injustice but also all other individuals an injustice." (education)

"Everyone benefits through interacting with different people. Entering students with disabilities into the classroom may force teachers to leave their comfort zones and learn new techniques and become better instructors." (education)

"Diversity proves important in creating an open-minded society." (community engagement)

"If we do not start this early, it gets more and more distant and the chances are that our children will be included diminishes greatly." (education, community engagement)

"The struggles and challenges for inclusion [are} not a disability issue, it is a human issue." (community engagement)

Guy Finne

"We think it's very important to enhance interagency partnerships at the state and local levels." (employment)

"There are lots and lots of resources, lots of agencies and you can kind of get lost in that shuffle. The more connected we can make that, the better." (employment)

"Provide education to employers about how to improve their human resources practices about the benefits of hiring a diverse and inclusive workforce." (employment)

Martha Cashman

"One of the things we had to do from an employment standpoint was actually take a look at personal care attendants and bring that into the health benefits, that this was not something that was frivolous or

extra that this was a matter of life and death, and that it should be covered under the health care benefits." (employment, health care)

Bill Harreld

"Most organizations need help with establishing strategic plans, with specific strategic direction and measurable results."

Carrie Varner

"Because of self-advocacy, I didn't die in a group home. I'm not a ward of the state and I actually can be in [the] most integrated setting possible without fear of retribution or retaliation." (housing, community engagement)

"Because of providers and the fear they project toward their clients, they are unable to speak for fear of speaking due to retribution, retaliation and in some cases, even severe punishment, and that's not right for anyone. That's why self-advocacy is such a vitally important thing in everyone's life, not just those with disabilities but everyone's."

Betsy Spethman

"One size doesn't fit all. Developmental disability is different from physical disabilities. DHS has already combined licensing standards for Minnesotans with physical disabilities, developmental disabilities, and the elderly. This does all individuals a disservice because each population has strikingly different needs" (support and services)

"The issue is choice for each individual and appropriate levels of care." (supports and services)

"Do not restrict their choices in your effort to provide more independence for others." (funding, supports and services)

"Maintain funding for congregate care settings to serve the highest need individuals. Lift the moratorium on group homes. Give parents the tools to help you create capacity." (funding, housing, supports and services)

Karen Larson

"When Andrew was 5, his dream was to go to kindergarten with his peers at the same school as his big sister. That was a lot of work, a lot of planning and two lawyers and we made it happen." (education)

"Andrew was [in] regular education classrooms his whole 12 years of education because that's where he wanted to be and that's where he learned best." (education)

"Today, there are kids with disabilities who want to be in education, regular education classrooms, full time. They have been told because they [have a developmental disability] there isn't enough room or time for them to be in the regular education classroom. It's still happening today. I thought we resolved this long ago. When my son graduated, I thought I paved the nice road for kids to follow." (education)

"The purpose of education is to prepare, educate every student for the real world based on what that person needs and to make it happen." (education)

"After two years at working at the DT&H doing shredding, I asked when Andrew could start a community job. The staff said [that] Andrew would never be able to work in the community because [his disability was too severe]. Everyone should be able to work where they're happiest. Happy people make a happy Minnesota." (employment)

"Andrew's dream would be to have all blondes working with him and they should all be paid a million dollars an hour because that's what they're worth to him." (services and supports)

"Everyone should be able to work where they're happy." (employment)

"All direct care staff [should be] paid a salary that's worth the work that they do." (services and supports, funding)

"Base quality on what the person says quality is."

Derek Melby

My daughters' needs and wishes could not and would not ever be met by an institution, but their needs and wishes may be best service by group housing in Northfield. Don't let a bias towards provider group housing become a bias against provider group" (housing)

Robert Bonner

"The state's responsibility is to ensure that families and individuals have real choice." (supports and services)

"DHS promises at the same time to initiate a plan on a policy of restricting individual and family choice. They have laid out a campaign against what they call institutional-like settings. In Minnesota, that appears to mean defunding intermediate care facilities." (housing)

"The ICF in his parents' judgment is the most integrated alternative in which we think Tim could thrive." (housing)

Dalaine Remes

"The Olmstead Plan was to identify transportation as a barrier and develop solutions to group transportation to ensure that all people with disabilities, including our senior populations in small, rural areas, have equal access to rural communities on a regular basis." (transportation)

"The Department of Transportation should consider developing weekly direct transportation routes to some of the smaller rural areas in small towns that will allow individuals with disabilities, seniors, and families with limited or no transportation options access to shopping hubs, medical centers, recreation, social activities and the larger communities." (transportation)

"People with disabilities, even in the house right next door, continue to live in a very segregated, controlling environment." (housing, supports and services)

"Some people in southwest Minnesota are not allowed to form meaningful relationships with individuals who are outside their staff or outside that circle of people with disabilities that they live with, work with, and recreate with." (community engagement)

"As we think about what's meaningful in our own lives, it really is relationships that we build and we need those connections with people to give them true access to relationships and integration to community things that are of interest to the individual." (community engagement)

"I see on a consistent basis, people with higher abilities living in facilities where they do not need to have that level of care and, at the same time, individuals who have children at home who need more care, a residential setting but those setting are not available for them so [it] seems like there's barriers on both those levels. If you can remove those, live more independently and provide more options and maximize those options, it would increase the abilities for everyone."(supports and services)

Sandra Gerdes

"Families think it's normal for people to move out on their own. Finding way to provide gradual transitions, such as regular out-of-home respite with trusted providers is something that families want." (services and supports)

"It Isn't always more cost effective for people to live in the community. Sometimes it costs less and helps more to serve people with disabilities in congregate settings." (housing, supports and services)

"People need to have access to resources that give them the appropriate level of support and services for their needs and desires." (supports and services)

"One of the primary challenges is ensuring that we are not creating one-size-fits-all solutions. People have a full spectrum of needs. We must have a full spectrum of solutions." (supports and services)

Dan Zimmer

"The most important aspect is getting feedback from the individuals and their families as to what's important to them and what are their expectations of services. Who's better to say, are they giving good service, than the person actually receiving those services."

"One person's outcome is not going to be the same as another person's outcome, so you need to take time to really determine what [are] those outcomes that you're looking for and they need to be based on that individual and their families and [their] value system." (supports and services)

"If you don't continue to improve on the quality of a person's life, quality can be really affected and you might find that you're not meeting their needs." (supports and services)

"What goes on at work does affect home. What goes on at home does affect work and they need to be working together and being a true team, not just working in silos." (supports and services)

"We need to make certain that we're giving people real choices, real choices of where to live, how they're going to live, where they're going to work , and that's not always an easy thing." (housing, employment, supports and services)

Larry Lubbers

"I live in foster care where it's kind of hard for me to live in foster care because my rights were being taken away, and I'm kind of scared of it now and, plus, I can't even take a city bus anymore." (housing, transportation)(lives in an area not serviced well by public transit)

Rick Cardenas

"The expert is the individual with the disability and we just have to find a way for them to express that and make sure that other persons with developmental disabilities can also become a part of this society to the greatest extent possible."

Mary Ellen Mayo

"Folks who do in-home PCA services in Rochester get about $11 an hour. That comes to less than $25,000 a year and if you think about that, how can a person live." (supports and services, funding)

"Please think about workforce development because we need not only folks to do direct care in the home but if we think of the future for James, in a group home or in whatever setting he and we choose for him. We want people to give him good, direct care so we want not only caring people, we want people with skill, we want people who are accountable for their work, and we want more professionals." (supports and services)

Appendix D. Information from the federal government related to person-centered planning

Recovery

The Substance Abuse and Mental Health Services Administration[62] adopted a working definition of "recovery" that is relevant to person-centered planning in Minnesota's Olmstead Plan:

> *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*

SAMHSA also identified four major dimensions that support a life in recovery:

> ***Health**: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;*
>
> ***Home:** a stable and safe place to live;*
>
> ***Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and*
>
> ***Community:** relationships and social networks that provide support, friendship, love, and hope.*

And several guiding principles of recovery:

> ***Recovery emerges from hope:** The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.*
>
> ***Recovery is person-driven:** Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s).*
>
> ***Recovery occurs via many pathways:** Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—including trauma experiences—that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.*
>
> ***Recovery is holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.*
>
> ***Recovery is supported by peers and allies:** Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery*

[62] The information in this section is adapted from "SAMHSA announces a working definition of 'recovery' from mental disorders and substance use disorders" http://www.samhsa.gov/newsroom/advisories/1112223420.aspx

Recovery is supported through relationship and social networks: *An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.*

Recovery is culturally-based and influenced: *Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs —are keys in determining a person's journey and unique pathway to recovery.*

Recovery is supported by addressing trauma: *Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.*

Recovery involves individual, family, and community strengths and responsibility: *Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.*

Recovery is based on respect: *Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.*

Person-centered planning

The following text is an excerpt from rules issued by United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (42 CFR Part 430, 431 et al.)[63]

Sec. 441.725 Person-centered service plan.

(a) Person-centered planning process. Based on the independent assessment required in Sec. 441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The person-centered planning process is driven by the individual. The process:

(1) Includes people chosen by the individual.
(2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
(3) Is timely and occurs at times and locations of convenience to the individual.
(4) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with Sec. 435.905(b) of this chapter.
(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
(6) Offers choices to the individual regarding the services and supports the individual receives and from whom.

[63] The final rule is available online at: http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf

(7) Includes a method for the individual to request updates to the plan, as needed.
(8) Records the alternative home and community-based settings that were considered by the individual.

(b) The person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit, the written plan must:

(1) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
(2) Reflect the individual's strengths and preferences.
(3) Reflect clinical and support needs as identified through an assessment of functional need.
(4) Include individually identified goals and desired outcomes.
(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS.
(6) Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with Sec. 435.905(b) of this chapter.
(8) Identify the individual and/or entity responsible for monitoring the plan.
(9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
(10) Be distributed to the individual and other people involved in the plan.
(11) Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of Sec. 441.740.
(12) Prevent the provision of unnecessary or inappropriate services and supports.
(13) Document that any modification of the additional conditions, under Sec. 441.710(a)(1)(vi)(A) through (D) of this chapter, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
    (i) Identify a specific and individualized assessed need.

(ii) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(iii) Document less intrusive methods of meeting the need that have been tried but did not work.

(iv) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

(vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(vii) Include informed consent of the individual; and

(viii) Include an assurance that the interventions and supports will cause no harm to the individual.

(c) Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required in Sec. 441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

Appendix E. List of relevant Governor-appointed groups

The following list includes Councils, Committees, Commissions, and Boards that address aging or disability (Minnesota Secretary of State). These groups will receive copies of Olmstead implementation reports. More information is in the Quality Assurance and Accountability section (page 33).

- Board of the Minnesota State Academies
- Commission of Deaf, DeafBlind, and Hard of Hearing Minnesotans
- Governor's Interagency Coordinating Council on Early Childhood Intervention
- Governor's Task Force on the Prevention of School Bullying
- Governor's Workforce Development Council
- Maternal and Child Health Advisory Task Force
- Metropolitan Council (Metro Mobility and regular route)
- Minnesota Assistive Technology Advisory Council
- Minnesota Autism Spectrum Disorder Task Force
- Minnesota Board on Aging
- Minnesota Governor's Council on Developmental Disabilities
- Minnesota Resource Center Advisory Committee: Blind/Visually impaired
- Minnesota Resource Center Advisory Committee: Deaf/Hard of Hearing
- Minnesota State Council on Disability
- Ombudsman Committee for Mental Health and Developmental Disabilities
- Special Education Advisory Panel
- State Advisory Council on Mental Health
- State Quality Assurance Council
- State Rehabilitation Council
- State Rehabilitation Council for the Blind
- Statewide Independent Living Council
- Subcommittee on Children's Mental Health
- Traumatic Brain Injury Advisory Committee

Appendix F. Example of fiscal considerations

The Housing topic area drafting team considered a number of financial factors when developing the plan. The information below is provided as an example only—specific financial proposals will be developed by the subcabinet.

Fiscal impact – Affordable Housing Expansion:

Most of the new housing opportunities add units to the housing stock; a small portion is a result of turn-over in rental assistance participants. Capital cost subsidies range from $18,000 per unit to $50,000 per unit; annual rental assistance ranges from $5,400 to $6,700 annually per participant.

A number of factors influence the total cost of increasing the number of assisted affordable housing opportunities. These factors include the portion of housing opportunities provided through capital expenditures versus rental assistance, the incomes of the populations to be served and the location of the housing which influences the cost of developing the housing. Assuming that one-half of the opportunities are provided by adding new housing units, the state assistance costs for 50 additional units would range from $900,000 to $2.5 million. The availability of federal housing tax credits is one of the primary driver of levels of state assistance needed. Rental assistance costs for an additional 50 rental assistance vouchers would range from $270,000 to $335,000 annually. Depending on the incomes of the residents, rental assistance may be necessary for residents living in units that have benefited from a capital cost subsidy. The rental assistance costs are assumed to be ongoing costs. These costs are in addition to the amounts currently spent on the provision of affordable housing.

Long-term goals in housing can only be achieved with additional funding. Other potential funding sources include additional Section 811 program funding, VASH (Veterans Affairs Supportive Housing) vouchers and other mainstream HUD programs to increase the supply of affordable housing opportunities.

The availability of additional (new) resources is a barrier to achieving the goal. Minnesota Housing currently expends all available resources on affordable housing. A funding priority is given to proposals for housing that serves the lowest income households. Federal resources for affordable housing have been stagnant at best in recent years, with a few program exceptions. Sequestration will further reduce the availability of federal resources. While state appropriations to Minnesota Housing were increased for the current biennium, they have not rebounded to previous higher levels.

Appendix G. Chronological timetable for implementation, 2013-2016

[Note to readers: The timetable was temporarily removed to minimize the number of changes needed during the plan modification drafting process. The modified timetable will be finalized upon submission to the Court. You can review the timetable in the July 2014 Olmstead Plan, which is available on the Minnesota Olmstead Plan website.]

Minnesota Department of **Human Services**

November 10, 2014

David Ferleger, Esq. *By E mail*
Independent Consultant and Court Monitor
Archways Professional Building
413 Johnson Street, Suite 203
Jenkintown, PA 19046

Re: Response to Court's September 18, 2014 Order [Doc 344] Civil No.: 09-1775 (DWF/FLN)

Dear Mr. Ferleger:

We write in response to the Court's Order of September 18, 2014, to explain how we address the Court's requirements in the attached Revised *Olmstead* Plan and its Exhibits.

1. Establishment of Measurable Goals.

A. For the *Olmstead* Plan's First Year.

The Court has directed that the *Olmstead* Plan will "contain concrete, reliable, and realistic commitments, accompanied by specific and reasonable timetables, for which the public agencies will be held accountable." (Order, Doc 344, September 18, 2014, p. 5). We understand from this language that the Court is looking for "people goals," not "process goals," meaning that our goals should measure numbers of people affected and not steps in the process. To this end, and being mindful of making realistic commitments, we have established "people goals" on the items for which such goals had not yet been set but were due for establishment within the first year of the Plan, from October 31, 2013 through October 31, 2014.

We identified 15 such items, which are detailed in Exhibit 1.[1] We set these items out in a separate Exhibit for ease of identification and reading. We are also including these 15 items in the revised *Olmstead* Plan with track changes. As we explained in our November 6, 2014 letter to you we have divided the goals listed in Exhibit 1 into two categories: 1) For those that do not require additional funding we provide the baseline and the new goal. 2) For those requiring additional funding, we provide the baseline. We will provide an update to the Court Monitor in late January 2015, once the Governor's budget is public and a second update in June 2015, after the legislative session is over and actual funding appropriations are known.

[1] Exhibit 1 does not contain "people goals" previously set, such as numbers of people who will be moved from Intermediate Care Facilities for Developmentally Disabled, nursing facilities, Anoka Metro Regional Treatment Center, and the Minnesota Security Hospital. See Proposed *Olmstead* Plan, July 10, 2014 pp. 63 – 64.

B. For the *Olmstead* Plan's Subsequent Years.

We will establish goals required to be set after October 31, 2014 as they become due under the Plan. For ease of identification and forecasting, we have set those goals out in Exhibit 2. On or before the due dates, the baselines and proposed measurable goals will be submitted to the Monitor for approval. The subsequent bimonthly status report to the Court will include the baselines and measurable goals. This process will begin with the measurable goals due in December 2014.

2. Reporting on Measurable Goals.

The Court has directed our reporting to be "accurate, complete, and verifiable," and to include: "(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." (Order, Doc. 344, September 18, 2014, p. 6). We understand the Court's direction to report in a manner that reflects the movement of individuals through segregated settings so that the net number of people who have moved into more integrated settings can be determined; to evaluate whether people move off of the waiting list at a reasonable pace; and to analyze and explain quality of life measures submitted to the Court. We will meet these requirements in our future bi-monthly reports to the Court.

3. Quality of Life Measures.

Regarding the quality of life measures, the Court has directed us to "summarize and submit to the Court any available data and highlight any gaps in information." (Order, p. 7). We would like to take this opportunity to explain the existing tools available to us for measuring quality of life, the limitations of these tools, and the comprehensive tool we are currently piloting and will use as the *Olmstead* Plan moves forward, a quality of life measurement tool developed by the Center for Outcome Analysis ("The Quality of Life Measurement Tool").

We have identified several existing tools that contain quality of life measures. None, however, measure a broad and inclusive population of individuals with disabilities. In addition, existing measures have a limited sample size, an outdated survey period, and/or were designed to measure performance of programs, not an individual's overall quality of life over time.

Fortunately, however, we have identified and are piloting an instrument based on a tool originally developed by Jim Conroy, the national expert on quality of life measures in use for people with disabilities. Our Quality of Life Measurement Tool will measure how well people with a broad range of disabilities and ages are integrated into and engaged with their community; how much autonomy they have in day-to-day decisions-making, and whether they are working and living in the most integrated setting of their choosing.

a. Existing measurements.

We have identified the following existing measurement instruments:

1. The Elderly Waiver Statewide Consumer Experience Survey.

This survey, designed and administered to persons enrolled in Medical Assistance's Elderly Waiver program, was last conducted in 2009, and had 343 respondents. We do not regard it as a useful instrument for measuring integration, autonomy and choice for a broad range persons with disabilities across all age groups over time.

2. The Minnesota Participant Experience Survey.

This survey, conducted in 2010 and 2012 with a one-time legislative appropriation, was a random snapshot of the satisfaction of persons receiving one or more of four Home and Community-Based Services waivers with their case management services, case managers, community integration, relationships with family and friends, among other things. Due to its limited scope, we do not regard this survey as a useful instrument for measuring integration, autonomy and choice across a broad range of persons with disabilities of all ages over time.

3. Minnesota Department of Educations' Part B Annual Performance Report.

This report measures only children with disabilities, focusing on the performance of local schools and not on individual quality of life. We do not regard this survey as a useful instrument for measuring integration, autonomy and choice across a broad range of persons with disabilities of all ages over time.

Quality of Life Measurement Tool Developed by the Center for Outcome Analysis.

In contrast, the instrument we are piloting and will use is specifically designed to assess quality of life across a broad population, by focusing on salient components of life satisfaction, according to an individual's experience of his or her own life, and not according to the individual's experience of a government program. It is a valid and reliable instrument designed to reach individuals across all disabilities and age groups, which will measure individual housing settings, community integration and engagement during the day, integration in daily activities, autonomy over daily life, control over decision-making, and perceived qualities of life.

During 2014, the state has been developing and testing the instrument using 250 respondents. In the second phase of the survey, the sample size will increase to 5,000 persons and will begin during the 2015 state fiscal year. The same respondents will be followed over time and measured in 2016 and 2017. We will report the results of the Quality of Life Measurement Tool to the Court.

We look forward to discovering how people's lives are improved as we move forward with implementing the *Olmstead* Plan and we appreciate the efforts of the Court Monitor in our endeavor to achieve full realization of the *Olmstead* Plan in Minnesota.

Sincerely,

Lucinda E. Jesson
Commissioner

Cc: Shamus O'Meara, Attorney for Plaintiffs
Colleen Wieck, Executive Director for the Governor's Council on Developmental Disabilities
Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities
Scott Ikeda, Assistant Attorney General
Anne Barry, DHS Deputy Commissioner
Amy Akbay, DHS Chief General Counsel
Darlene Zangara, Executive Director, Olmstead Implementation Office

EXHIBIT 1

MEASURABLE GOALS

for action items

through October 31, 2014

INTRODUCTION

In response to the court order of September 18, 2014 that directed the State to submit measurable goals, this exhibit has been prepared by state agency personnel and approved by the Olmstead Subcabinet and is respectfully submitted to the court.

This Exhibit includes Olmstead Plan action items that measure impact on people that had deadlines between November 1, 2013 and October 31, 2014. The action items are categorized by topic area in the order they appear in the Plan.

Each set of measurable goals begins with the related action item from the Plan, followed by the baseline, the new measurable goals and a notes section. The notes are intended to provide background information on how the baseline was established and the source of the data.

For those goals requiring additional funding, the baseline is provided. There will be an update provided to the Monitor upon publication of the Governor's budget in late January 2015, with a second update in June 2015, after the legislative session is over and actual funding appropriations are known.

EMPLOYMENT GOALS

Action item EM 1A – Page 40

- By June 30, 2014 establish consistent baselines for measuring progress on increased employment of transition-age students; establish goals for annual progress. [EM 1A]

BASELINE: The number of students with disabilities in competitive employment within one year of leaving secondary education is 263.

MEASURABLE GOALS:

- By September 30, 2015 the number of students in competitive employment within one year of leaving secondary education will increase by 25
- By September 30, 2016 the number of students in competitive employment within one year of leaving secondary education will increase by 25
- By September 30, 2017 the number of students in competitive employment within one year of leaving secondary education will increase by 25
- By September 30, 2018 the number of students in competitive employment within one year of leaving secondary education will increase by 25
- By September 30, 2019 the number of students in competitive employment within one year of leaving secondary education will increase by 25

NOTES:

Minnesota Department of Education (MDE) collects outcome data from students with disabilities who within one year of leaving high school had Individualized Education Program (IEP)s in effect at the time they left school, graduated, aged out, or left school early (i.e., dropped out) to participate in the Federal Office of Special Education Programs (OSEP) approved Minnesota Post School Outcome Survey. This requirement is outlined in Indicator 14 within the Minnesota State Performance Plan. The 2005-2013 Part B State Performance Plan (SPP) sets targets in the state's efforts to implement the requirements and purposes of the Individuals with Disabilities Education Act 2004.

All of Minnesota's existing school districts and charter schools are assigned to one of five groups to participate in the Minnesota Post School Outcomes Survey on a five year cycle. Each year approximately 70-90 school districts and charter schools and 1,300 to 1,700 students are a part of the Minnesota Post School Outcome Survey process. Minnesota uses a randomized sampling process for this survey. This process is approved by the Office of Special Education Programs at the U.S. Department of Education. This process includes students from all disability categories as defined in Individuals with Disabilities Education Act (IDEA 2004). The annual survey is conducted by phone by school district staff.

Using post school outcome data from school year 2012-2013 for the baseline on this goal, a total of 74 districts and 1,529 students with disabilities who had graduated, aged out or dropped out could participate in the Minnesota Post School Outcome Survey. The number of completed surveys was 783. Of the 783 individuals, 33.6% or 263 students with disabilities were competitively employed one year

post graduation. Once the goals are achieved, the number of students who are competitively employed one year post graduation will have increased by 125 above the baseline of 263.

Certain items on the survey ask the student to respond to only one option that would indicate if the student was competitively employed within one year after leaving school. These results are then summarized and calculated and used for the measurement on this goal.

Survey results have been calculated for the school years 09-10 through 12-13. The percentage and number of youth who responded they were involved in competitive employment are as follows:

School Year	09-10	10-11	11-12	12-13
Percentage	32.9%	29.8%	39.1%	33.6%
Number	183	169	233	263
TOTAL Number Completed Surveys	557	567	596	783
TOTAL Number Leavers in Annual Sample	1,252	1,321	1,324	1,529
Response Rate	44.5%	42.9%	45.0%	51.2%

Minnesota uses the definition for competitive employment adopted from National Post School Outcome Center. Competitive employment means that youth have worked for pay at or above the minimum wage in a setting with others who are nondisabled for a period of 20 hours a week for at least 90 days at any time in the year since leaving high school. This includes military employment. This definition for competitive employment was derived from the database being used for this measure. It is similar but not identical to the definition in Minnesota's Olmstead Plan (page 89).

The number of completed annual surveys is not a static number. There will be fluctuation in the number of completed surveys from year to year. To date, the number of completed surveys has increased from 557 in 2010 to 783 in 2013 as noted above. As the number of completed surveys increases and the interagency collaboration between DEED and DHS improves, it is expected that the number of students in competitive employment will increase by 25 in 2015 and each subsequent year. The number of completed annual surveys will change over time which will affect the number/percent of the students having competitive employment. In addition, labor market trends and economic growth in Minnesota will impact transition-age youth competitive employment outcomes.

EMPLOYMENT GOALS

Action item EM 1B – Page 41

- By June 30, 2014 establish a baseline for measuring how many students with disabilities have at least one paid job before graduation; establish goals for annual progress. [EM 1B]

BASELINE: The number of students with disabilities who had paid employment by the age of 18 is 1,412.

MEASURABLE GOALS:

- By December 31, 2015, there is no projected increase
- By December 31, 2016, the number of students who have paid employment by the age of 18 will increase by 23
- By December 31, 2017, the number of students who have paid employment by the age of 18 will increase by 45
- By December 31, 2018, the number of students who have paid employment by the age of 18 will increase by 45
- By December 31, 2019, the number of students who have paid employment by the age of 18 will increase by 45

NOTES:

Once the goals are achieved, the number of students who have paid employment by the age of 18 will have increased by 158 above the baseline of 1,412. This baseline is derived from Department of Employment and Economic Development (DEED) data showing that DEED served 2,242 youth between ages of 14 and 17 in 2013. Of those individuals, 1,412 or 63% had paid employment by the age of 18.

This population includes individuals with all types of disabilities who were enrolled between the ages of 14-17, exited school in calendar year 2013, and lived in all 87 counties of the state. The data was obtained from DEED's Workforce One database and the Unemployment Insurance (UI) Wage Detail created on October 21, 2014.

The limitation of the baseline is that the social security numbers for all students are not available at this time. In addition, several types of employment are not covered in the UI Wage Detail Database. Most notably for these purposes, this would include employment of an individual in an internship or job re-training program, minors working in a family business, or youth who live in "border cities" and work in other states.

EMPLOYMENT GOALS

Action items EM 1G.1 and 1G.2 – Page 42

- By September 30, 2014 establish a baseline for the measures and establish measurable goals to demonstrate progress in increasing competitive employment for adults with disabilities. [EM 1G.1]
- By September 30, 2014 set annual deadlines beginning in 2015 to achieve goals for a defined significant portion of the population affected. The measureable goals will be related to demonstrating benefits to the individuals intended to be served. [EM 1G.2]

BASELINE: The number of working-age people with disabilities, receiving home and community-based long-term supports and services that are competitively employed is 4,609 individuals.

MEASURABLE GOALS:

For working-age people with disabilities, receiving home and community-based long-term supports and services:

- By June 30, 2015 the number of individuals who are competitively employed will increase by 380
- By June 30, 2016 the number of individuals who are competitively employed will increase by 553
- By June 30, 2017 the number of individuals who are competitively employed will increase by 638
- By June 30, 2018 the number of individuals who are competitively employed will increase by 801
- By June 30, 2019 the number of individuals who are competitively employed will increase by 1,006

NOTES:

Once the goals are achieved, the number of individuals who are competitively employed will have increased by 3,378 above the baseline of 4,609. This baseline is derived from the population of working-age people with disabilities who receive home and community-based long-term supports and services, a total of 53,689 people. Of that number 4,609 are competitively employed. Minnesota is using earned monthly income ≥$600 per month as an indicator of competitive employment. This definition for competitive employment was derived from the database being used for this measure. It is similar but not identical to the definition in Minnesota's Olmstead Plan (page 89).

The current database indicates a monthly earned income, but does not indicate the number of hours worked or the rate of pay. Monthly earned income can be tracked consistently over time and, it should be sufficient to show progress towards our goals. Data was collected using MMIS for Fiscal Year 2014 (July 1, 2013 - June 30, 2014). The total population consists of: individuals ages 18-64, on a home and community based waiver, receiving MA-funded Personal Care Attendant services, receiving Medical Assistance funded home care services, or on Medical Assistance for Employed Persons with Disabilities.

The annual analysis of this goal will also include any changes in the total population. The numbers of individuals competitively employed in the early years are lower while capacity is being built. The rate of growth is expected to increase over time as capacity is increased.

EMPLOYMENT GOALS

EM 1G.1 and EM 1G.2 - Page 42

BASELINE: The number of individuals served annually by the Workforce Development Unit (State Services for the Blind) that are competitively employed is 116 individuals.

MEASURABLE GOALS:

For individuals receiving services provided by the Workforce Development Unit (State Services for the Blind):

- By December 31, 2015 the number of individuals who are competitively employed will increase by 3
- By December 31, 2016 the number of individuals who are competitively employed will increase by 4
- By December 31, 2017 the number of individuals who are competitively employed will increase by 4
- By December 31, 2018 the number of individuals who are competitively employed will increase by 4
- By December 31, 2019 the number of individuals who are competitively employed will increase by 4

NOTES:

There are 1,000 Minnesotans served annually by the Workforce Development Unit (State Services for the Blind). This includes individuals who are blind, DeafBlind, and visually impaired aged 14 and up. During Federal Fiscal Year 2014, 116 individuals achieved competitive employment. Once the goals are achieved, the number of individuals who are competitively employed will have increased by 19 above the baseline of 116.

One limitation worth noting is that there is a disincentive to work because the eligibility requirement for Social Security Disability Insurance (SSDI) includes that a person cannot work due to a disability.

EMPLOYMENT GOALS

EM 1G.1 and EM 1G.2 - Page 42

BASELINE: The number of individuals receiving services from Vocational Rehabilitation Services (VRS) that are competitively employed is 2,738 individuals.

MEASURABLE GOALS:

For individuals receiving services provided by the Vocational Rehabilitation Services (VRS):

- By December 31, 2015 the number of individuals who are competitively employed will increase by 112
- By December 31, 2016 the number of individuals who are competitively employed will increase by 57
- By December 31, 2017 the number of individuals who are competitively employed will increase by 58
- By December 31, 2018 the number of individuals who are competitively employed will increase by 59
- By December 31, 2019 the number of individuals who are competitively employed will increase by 31

NOTES:

In FFY 2013 the total number of VRS clients with Employment Plans is 5,043. Of those individuals, 2,738 achieved Integrated Competitive Employment. This group includes individuals between 16 and 70 with all disability types from all parts of the state.

Once the goals are achieved, the number of individuals who are competitively employed will have increased by 317 above the baseline of 2,738.

EMPLOYMENT GOALS

EM 1G.1 and EM 1G.2 - Page 43

BASELINE:

The number of individuals with mental illness receiving Individual Placement and Supports (IPS) services that are competitively employed is 330 individuals.

MEASURABLE GOALS:

This is a goal that requires additional funding. An update will be provided to the Court Monitor upon publication of the Governor's budget in late January 2015. A second update will be provided in June 2015, after the legislative session is over and actual funding appropriations are known.

NOTES:

The targeted number that could be served through IPS services over the next five (5) years is 1,439. This includes individuals with Serious Mental Illness (SMI). The current number of individuals being served is 639. Of those 639 individuals there are 330 who are currently competitively employed. The expansion rates will be based on the placement rates and experiences of the existing IPS projects.

TRANSPORTATION GOALS

Action item TR 1C – Page 58

- By October 31, 2014 using developed baselines from this action and Action Two (below), establish timelines and measures to demonstrate increased access to integrated transportation for people with disabilities. Measures will be implemented to assess transportation options for accessibility, cost effectiveness and reliability.

BASELINE: Public transit currently meets 61 percent of total passenger demand and approximately 57 percent of projected service hour needs statewide.

MEASURABLE GOALS:

This is a goal that requires additional funding. An update will be provided to the Court Monitor upon publication of the Governor's budget in late January 2015. A second update will be provided in June 2015, after the legislative session is over and actual funding appropriations are known.

NOTES:

The public transit performance measure is to meet a percentage of the transit need. In order to satisfy the legislative mandate for determining transit needs and costs, Minnesota Department of Transportation developed models for calculating passenger demand, service levels needed to meet demand, and operating and capital costs of providing service. Using market research as a baseline, the models yield a reasonable foundation for quantifying Greater Minnesota's transit needs and costs in future years. In 2009, a total of $55.3 million was spent to provide 11.1 million passenger trips and 1.03 million service hours. Based on the need estimates conducted as part of this plan, 2009 services met approximately 61 percent of total passenger demand and approximately 57 percent of projected service hour needs statewide.

SUPPORTS AND SERVICES GOALS

Action items SS 2G and 2G.1 – Page 65-66

- For individuals in other 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. [SS 2G]
  - By September 30, 2014 DHS will review this data and other states'[1] 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. [SS 2G.1]

BASELINE: The estimated number of individuals with disabilities in segregated residential settings is 38,079.

MEASURABLE GOALS:

For individuals living in segregated settings:

- By June 30, 2015, the number of individuals who move to the most integrated setting will be 50
- By June 30, 2016, the number of individuals who move to the most integrated setting will be 125
- By June 30, 2017, the number of individuals who move to the most integrated setting will be 300
- By June 30, 2018, the number of individuals who move to the most integrated setting will be 350
- By June 30, 2019, the number of individuals who move to the most integrated setting will be 400

BASELINE: The estimated number of individuals with disabilities in segregated day settings is 20,055.

MEASURABLE GOALS:

For individuals who are in segregated day settings:

[1] In particular, DHS will review plans from Massachusetts, Oregon, and Rhode Island.

NOTES:

Once the goals are achieved, the total number of individuals who will have moved to the most integrated setting will be 1,225 and the total number of individuals who will be spending their days in more integrated settings will be 1,400. The baseline for individuals with disabilities in segregated residential and day settings was derived using two sets of billing data. In one set, numbers were derived by counting certain claims codes associated with delivery of long-term supports and services in settings with varying characteristics of segregation during fiscal year 2013 – 2014. The resulting list included specific waiver services and specific services commonly accessed by people with serious mental illness or serious and persistent mental illness.

Another set of billing data was used to identify numbers of individuals receiving group residential housing services, for which a disability criterion is required to qualify. This latter group was further narrowed to individuals who spent more than 90 days in a living arrangement matching certain segregation characteristics. This method yielded an estimated baseline of 38,079 individuals with disabilities in segregated residential settings and 20,055 in segregated day settings.

There are limitations to this data. The data does not specifically identify the degree of segregation as defined in the Department of Justice's 2011 Guidance on Most Integrated Setting. Nor can the data track moves between settings, particularly day/employment services settings. In addition, providers have up to 12 months to submit a claim, so claims data for fiscal year 2014 is subject to change through June 30, 2015.

Despite these limitations, billing data for items associated with varying characteristics of segregation is currently the most reliable data upon which to establish a baseline. The data will improve as the state implements the Centers for Medicaid Services' Home and Community Based services settings rule.

Residential settings/services delivered in segregated settings include:

- Adult foster care
- Assisted living residence (customized living service)
- Board and lodge (includes homeless shelters)
- Board and lodge with special services
- Boarding care
- Child foster care
- Children's residential care (children's residential facilities- Rule 5)
- Crisis respite (foster care)
- Housing with services establishment
- Supervised living facilities
- Supported living services

Day/employment services delivered in segregated settings:

- Adult day services
- Day training and habilitation center
- Family adult day services
- Pre-vocational service
- Structured day program
- Supported employment services

SUPPORTS AND SERVICES GOALS

Action item SS 3I –Page 68

- 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]

BASELINE: Approximately 10,000 people per year currently use mental health crisis services and approximately 85% of people who use them remain in their homes. There were 61,000 Emergency Department (ED) visits by individuals who were using Home and Community Based Services in 2010.

MEASURABLE GOALS:

This is a goal that requires additional funding. An update will be provided to the Court Monitor upon publication of the Governor's budget in late January 2015. A second update will be provided in June 2015, after the legislative session is over and actual funding appropriations are known.

NOTES:

Providing appropriate crisis intervention and a triage and hand off process may reduce the need for emergency department visits, loss of housing and allow more people to stay in their own homes. Annually, approximately 10,000 people with a range of disabilities currently use mental health crisis services and approximately 85% of people who use them to remain in their homes. There were 61,000 Emergency Department (ED) visits by individuals who were using Home and Community Based Services in 2010. Of these visits, "more than half" included mental health or behavioral crises. The source of the data is a 2012 report completed by Truven Analytics using 2010 data.

SUPPORTS AND SERVICES GOALS

Action item SS 4B – Page 70

- 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. [SS 4B]

BASELINE: As of August 2014, there were 4,952 people who have requested home-and-community-based waiver services, met eligibility criteria, but are not yet receiving services. Of this number there are 3,502 individuals requesting a Developmental Disabilities (DD) waiver and 1,450 individuals requesting a Community Alternatives for Disabled Individuals (CADI) waiver.

MEASURABLE GOALS:

- By February 1, 2015, individuals who meet the "Immediate" criteria will receive home-and-community-based supports and services within 90 days.

- By February 1, 2015, individuals who meet the "Institutional Exit" criteria will move at a reasonable pace by beginning service planning for home and community-based supports and services within 45 days. These individuals will begin services within 180 days of a completed service plan.

- By June 30, 2015, 80 individuals residing in Intermediate Care Facilities/ Developmentally Disabled will receive home and community-based supports and services.

NOTES:

As of August 2014, there were 4,952 people who have requested home-and-community-based waiver services, met eligibility criteria, but are not yet receiving services. Of this number there are 3,502 individuals requesting a Developmental Disabilities (DD) waiver and 1,450 individuals requesting a Community Alternatives for Disabled Individuals (CADI) waiver. These numbers do not currently reflect any priority based on immediate need for services.

A new system will prioritize and measure movement for individuals in these two groups: 1) "Institutional Exit" category includes individuals who need to exit an institutional setting; and, 2) "Immediate" category includes individuals who are at imminent risk of being placed in an institutional setting.

SUPPORTS AND SERVICES GOALS

Action SS 4D – Page 70

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, or bipolar disorder and who have significant and persistent functional impairments (homelessness, repeated hospitalizations, unemployment) which contribute to high system use. In the case of forensic assertive community treatment, individuals also have significant involvement in the corrections system. 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. The key to a successful FACT team is the monitoring of its fidelity to the ACT model, along with on-going technical assistance.

- Develop Forensic Assertive Community Treatment (FACT) team (described above)
    - 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. [SS 4D]

BASELINE: This service has not yet been developed, so the number of individuals enrolled in FACT services is zero.

MEASURABLE GOALS:

This is a goal that requires additional funding. An update will be provided to the Court Monitor upon publication of the Governor's budget in late January 2015. A second update will be provided in June 2015, after the legislative session is over and actual funding appropriations are known.

NOTES:

In the seven metro counties (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington) during 2013, there were 62 individuals released from custody with a diagnosis of Serious and Persistent Mental Illness (SPMI). These individuals were identified through a brief screening. It is anticipated that a more extensive screening evaluation process may identify a larger number of individuals over time who meet the SPMI criteria. Approximately 8 individuals are represented in the 62 count twice due to re-incarceration and subsequent release.

Because this is a new service, the baseline is zero. The goals will be based on best practices for starting a new high fidelity ACT program.

LIFELONG LEARNING AND EDUCATION GOALS

Action item ED 1A.1 – Page 73

Work with districts and other stakeholders to reduce the use of restrictive procedures and also provide further recommendations on how to further reduce these procedures and eliminate the use of prone restraints in schools. Minnesota Statutes §125A.0942 subdivision 3 (8) requires that school districts end the use of prone restraints with children ages five or older by August 1, 2015.

- By June 30, 2014 and each subsequent year, districts will report summary data on their use of restrictive procedures to the department, in a form and manner determined by the Commissioner of the Minnesota Department of Education (MDE) [ED 1A.1 - 1A.3]

BASELINE: During the 2013-2014 school year, the number of students with disabilities whom school districts reported experienced restrictive procedures was 2,707 students. The number of incidents of restrictive procedures school districts reported was 19,409. Of those, 13,116 were physical holds and 6,301 were seclusion.

During the 2013-2014 school year, there were 15 school districts that reported using prone restraint one or more times. There were 837 incidents of prone restraints. The number of students with disabilities who experienced one or more prone restraints was 159.

MEASURABLE GOALS:

- By June 30, 2015
  - the number of students who experience a restrictive procedure will be reduced by 108
  - the number of reported restrictive procedure incidents will be reduced by 776

- By August 1, 2015, the number of students who experience prone restraint will be zero

- By June 30, 2016
  - the number of students who experience a restrictive procedure will be reduced by 104
  - the number of reported restrictive procedure incidents will be reduced by 745

- By June 30, 2017
  - the number of students who experience a restrictive procedure will be reduced by 100
  - the number of reported restrictive procedure incidents will be reduced by 715

- By June 30, 2018
  - the number of students who experience a restrictive procedure will be reduced by 96
  - the number of reported restrictive procedure incidents will be reduced by 687

- By June 30, 2019
  - the number of students who experience a restrictive procedure will be reduced by 92
  - the number of reported restrictive procedure incidents will be reduced by 659

NOTES:

Once the goals are achieved, the number of students who experience a restrictive procedure will have been reduced by 500 below baseline to 2,207 students. The number of restrictive procedures will have been reduced by 3,589 below baseline to 19,402 restrictive procedures.

The number of prone restraints will have been reduced by 837 to 0 prone restraints. The number of students who experience one or more prone restraints will have been reduced by 159 to 0 students.

The baseline for these goals was determined by identifying both: 1) the number of students with disabilities whom school districts reported experienced restrictive procedures in the 2013-2014 school year, a baseline of 2,707 students; and, 2) the number of incidents of restrictive procedures school districts reported were used with students with disabilities in the 2013-2014 school year, a baseline of 19,409.

In addition during the 2013-2014 school year, there were 15 school districts that reported using prone restraint one or more times. There were 837 incidents of prone restraints. The number of students with disabilities who experienced one or more prone restraints was 159.

The goals were set based on: 1) the statutory prohibition against prone restraint going into effect August 1, 2015; and, 2) an existing $250,000.00 legislative appropriation for training and technical assistance to district staff. The goals may be affected by changing demographics in enrollment and movement of students between districts and out of state.

LIFELONG LEARNING AND EDUCATION GOALS

Action item ED 4A.1 - Page 75

- Based on the Minnesota Post School Outcome Survey data, beginning September 1, 2014 and each subsequent year, there will be an increase of a minimum of 50 students with disabilities per year entering integrated postsecondary education and training programs within one year of exiting secondary education. [ED 4A.1 – 4A.3]

BASELINE: The number of students with disabilities who entered integrated postsecondary education and training programs within one year of exiting secondary education is 254.

MEASURABLE GOALS:

The number of students with disabilities entering integrated postsecondary education and training programs within one year of exiting secondary education per year will increase

- By September 1, 2015 the number of individuals will increase by 50
- By September 1, 2016 the number of individuals will increase by 50
- By September 1, 2017 the number of individuals will increase by 50
- By September 1, 2018 the number of individuals will increase by 50
- By September 1, 2019 the number of individuals will increase by 50

NOTES:

Minnesota Department of Education (MDE) collects outcome data from students with disabilities who within one year of leaving high school had IEPs in effect at the time they left school, graduated, aged out, or left school early (i.e., dropped out) to participate in the Federal Office of Special Education Programs (OSEP) approved Minnesota Post School Outcome Survey. This requirement is outlined in Indicator 14 within the Minnesota State Performance Plan. The 2005-2013 Part B State Performance Plan (SPP) sets targets in the state's efforts to implement the requirements and purposes of the Individuals with Disabilities Education Act 2004.

All of Minnesota's existing school districts and charter schools are assigned to one of five groups to participate in the Minnesota Post School Outcomes Survey on a five year cycle. Each year approximately 70-90 school districts and charter schools and 1,300 to 1,700 students are a part of the Minnesota Post School Outcome Survey process. Minnesota uses a randomized sampling process for this survey. This process is approved by the Office of Special Education Programs at the U.S. Department of Education. This process includes students from all disability categories as defined in Individuals with Disabilities Education Act (IDEA 2004). The annual survey is conducted by phone by school district staff.

Using post school outcome data from school year 2012-2013 as a baseline, a total of 74 districts and 1,529 students with disabilities who had graduated, aged out or dropped out could participate in the Minnesota Post School Outcome Survey. The number of completed surveys was 783. Of the 783 individuals, 32.4% or 254 students with disabilities were enrolled in higher education one year post

graduation. Once the goals are achieved, the number of students who are competitively employed one year post graduation will have increased by 250 above the baseline of 254.

Certain items on the survey ask the student to respond to only one option that would indicate if the student was enrolled in higher education. These results are then summarized and calculated and used for the measurement on this goal.

Survey results have been calculated for the school years 09-10 through 12-13. The percentage and number of youth who responded they were enrolled in higher education are as follows:

School Year	09-10	10-11	11-12	12-13
Percentage	29.1%	33.0%	26.7%	32.4%
Number	162	187	159	254
TOTAL Number Completed Surveys	557	567	596	783
TOTAL Number Leavers in Annual Sample	1,252	1,321	1,324	1,529
Response Rate	44.5%	42.9%	45.0%	51.2%

Minnesota uses the definition for enrolled in higher education adopted from National Post School Outcome Center. Enrolled in higher education means youth have been enrolled on a full- or part-time basis in a community college (2-year program), or college/university (4- or more year program) for at least one complete term, at any time in the year since leaving high school.

The number of completed surveys is not a static number. There will be fluctuation in the numbers of completed surveys from year to year. To date, the number of completed surveys has increased from 557 in 2010 to 783 in 2013. As the number of completed surveys increases and the interagency collaboration between DEED and DHS improves, it is expected that the number of students enrolled in higher education will increase by 50 in 2015 and each subsequent year. The number of completed annual surveys will change over time which will affect the number/percent of the enrolled in higher education outcomes. Labor market trends and economic growth in Minnesota will impact transition-age youth enrolled in higher education.

LIFELONG LEARNING AND EDUCATION GOALS

Action item ED 5A - Page 75

- By June 30, 2014 review current data on this student population and develop prototype reintegration plans to transition students to more integrated settings. Establish measurable goals and timelines for actions to be taken to benefit students [ED 5A]

BASELINE: Work is currently underway to establish the baseline.

MEASURABLE GOALS:

This is a goal that requires additional funding. An update will be provided to the Court Monitor upon publication of the Governor's budget in late January 2015. A second update will be provided in June 2015, after the legislative session is over and actual funding appropriations are known.

NOTES:

There were 256 students at Minnesota Correctional Facilities at Red Wing and Togo (under age 21) in 2012 -2013. Of the 256 students at the two juvenile correctional facilities, 180 or 70% had an Individualized Education Program (IEP).

On December 1, 2014 the Department of Corrections (DOC) will begin collecting data on adolescents with IEPs in Minnesota Correctional facilities at Red Wing, Togo and Lino Lakes. This will include tracking individuals being released to determine if they return to their home school district.

HEALTHCARE AND HEALTHY LIVING GOALS

Action item HC 2C – Page 79

DHS will complete a legislatively mandated study of the Minnesota Health Care Program's dental program to improve access and ensure cost-effective delivery of services. The study reviews the program structure, including payment policies that compensate dental providers who serve underserved patients and treatment and workforce innovations that may improve access to dental care for recipients of MHCP.

- By June 30, 2014 using information from this study, develop a plan for implementation including timelines and measurable goals. [HC 2C]

BASELINE: The total number of adults with disabilities receiving Medicaid who did not receive at least one dental service during calendar year 2013 was 86,520 individuals.

MEASURABLE GOAL:

- By July 1, 2016 the number of individuals with disabilities who receive dental services will increase by 335.

NOTES:

The baseline for this goal was determined by identifying the total number of adults with disabilities receiving Medicaid who did not receive at least one dental service during calendar year 2013, a baseline of 86,520 individuals. Data was extracted from Medicaid billing systems. Confirmation of the number of individuals receiving dental services may not be available until at least December 31, 2016.

The goal was set based on a legislatively approved rate change for dental services that will take effect in 2016. The goal is reasonable because it is based upon trends experienced in other states that have raised dental payment rates.

At this time it is not clear of the actual impact of the rate changes. It is also not clear how the legislature will act during the 2015 session on the recommendations made in the legislative report of 2014. Therefore, goals will be set on an annual basis until these variables until these variables are better understood.

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EXHIBIT 2 –

PLAN FOR MEASURABLE GOALS

from November 1, 2014

to September 30, 2016

EXHIBIT 2

This exhibit includes Olmstead Plan action items that measure impact on people that have deadlines between November 1, 2014 and September 30, 2016. Baselines and proposed measurable goals for these items will be submitted to the Court Monitor for approval on or before the due dates prescribed in the Plan. Subsequently these baselines and measurable goals will be reported in the bimonthly Subcabinet Report to the Court. Measurable goals for each listed action item will be reported in accordance with the following schedule:

December 22, 2014 Subcabinet Report to the Court - Report 5

- None due

February 22, 2015 Subcabinet Report to the Court - Report 6

- CE 1A People with disabilities to participate in policy development
- CE 1B Set annual goals for peer support and self-advocacy programs
- CE 2A People with disabilities to participate in public planning processes
- HC 2G Baseline of current health care access for people with disabilities
- HC 2J.1 Transition 50 % of youth to adult health care
- HS 2A Baseline of need for affordable housing
- OV 3A Leadership opportunities for people with disabilities
- SS 4C Plan to expand assistive technology

April 22, 2015 Subcabinet Report to the Court - Report 7

- HC 1A Baseline and goals for increasing health care homes

June 22, 2015 Subcabinet Report to the Court - Report 8

- None due

August 22, 2015 Subcabinet Report to the Court - Report 9

- EM 1K Expand Individualized Placement and Supports statewide
- HS 1F Goals for individuals leaving correctional facilities to access services/supports

October 22, 2015 Subcabinet Report to the Court - Report 10

- HC 1D Implement framework for behavior health homes and set goals
- SS 3H.1 Recommendations to reduce restrictive procedures & increase positive practices
- SS 3L Baseline/goals regarding crisis episodes across state system

December 22, 2015 **Subcabinet Report to the Court - Report 11**

- QA 4B.1 Report on statewide levels of abuse, neglect, exploitation
- SS 3G.1 Report of incidents of emergency use of manual restraint, etc.

February 22, 2016 **Subcabinet Report to the Court - Report 12**

- HC 1G Measures to assess access and use of primary health care and dental care
- HS 3C Baseline/goals on people using income supplements, moving from segregated settings and where they are moving to
- QA 1D.1 Quality of life survey completed to establish baseline

April 22, 2016 **Subcabinet Report to the Court - Report 13**

- HS 1D Goals for individuals entering correctional facilities
- SS 2M Goals for identified gaps for individuals leaving correctional facilities

June 22, 2016 **Subcabinet Report to the Court - Report 14**

- None due

August 22, 2016 **Subcabinet Report to the Court - Report 15**

- ED 5C.1 Report on number of students placed out of state or in correctional facilities

October 22, 2016 **Subcabinet Report to the Court - Report 16**

- HC 1E.1 Goals to increase patient experience of care

December 22, 2016 **Subcabinet Report to the Court - Report 17**

- HC 2F.1 Report on health care outcomes

Future Action Items Requiring Measurable Goals
(Listed alphabetically)

Topic	Action #	Description from the Plan
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.
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.
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.
ED	5C.1	By June 30, 2016 and annually thereafter, report on the number of students who are placed out of state or in juvenile corrections.
EM	1K	By June 30, 2015 establish plan to expand Individual Placement and Supports (IPS) employment for Minnesotans with serious mental illness statewide.
HC	1A	By January 1, 2015 establish baseline information about primary care teams across Minnesota that are able to provide integrated, person-centered primary care for persons with disabilities; establish timelines to increase the number.
HC	1D	By July 1, 2015 the framework to provide services in a person-centered system of care that facilitates access to and coordination of the full array of primary, acute and behavioral health care will be implemented. The following targets are set:
HC	1E.1	By July 1, 2016 utilizing baseline data gathered over the past year, establish measurable goals to improve patient experience of care.
HC	1G	By December 31, 2015 establish measures to assess access and use of routine and preventive primary health care and dental care.
HC	2F.1	By September 30, 2016 and annually thereafter, complete health status reports regarding health care outcomes and track policy and organizational practice changes at the community and state levels.
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.
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
HS	1D	By January 1, 2016 analyze the data collected to identify trends and gaps in services and establish measurable goals related to demonstrating benefits to the individuals intended to be served.
HS	1F	By June 30, 2015 analyze the data collected and establish measurable goals related to demonstrating benefits to the individuals intended to be served.

Topic	Action #	Description from the Plan
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.
HS	3C	By December 31, 2015 establish a baseline and targets for future years to measure how many people use financial incentives and/or income supplements for housing, how many people who move from institutions or congregate living settings to having their own lease, and how many people received housing versus how many were referred.
OV	3A	By December 31, 2014 leadership opportunities will be identified and implemented.
QA	1D.1	By December 31, 2015 conduct the survey to establish a baseline, mechanisms will be designed and in operation.
QA	4B.1	By September 30, 2015 and annually thereafter, the subcabinet's designee will prepare a report on statewide levels and trends of abuse, neglect, exploitation, injuries, and deaths. The report will include analysis of trends in the amount of time to investigate allegations of abuse and neglect and quality of investigations (from complaint to disposition, recommendations, and follow-up).
SS	2M	By January 1 2016, the DOC and DHS will identify solutions to gaps and barriers and establish measureable goals and timelines.
SS	3G.1	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	3H.1	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	3L	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	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.

EXHIBIT 1

MEASURABLE GOALS

for action items

through October 31, 2014

(Amended December 1, 2014 in response to Court Monitor's 2014-23 request to include specific worksheets)

INTRODUCTION

In response to the court order of September 18, 2014 that directed the State to submit measurable goals, this exhibit has been prepared by state agency personnel and approved by the Olmstead Subcabinet and is respectfully submitted to the court.

This Exhibit includes Olmstead Plan action items that measure impact on people that had deadlines between November 1, 2013 and October 31, 2014. The action items are categorized by topic area in the order they appear in the Plan.

Each set of measurable goals begins with the related action item from the Plan, followed by the baseline, the new measurable goals and a notes section. The notes are intended to provide background information on how the baseline was established and the source of the data.

For those goals requiring additional funding, the baseline is provided. There will be an update provided to the Monitor upon publication of the Governor's budget in late January 2015, with a second update in June 2015, after the legislative session is over and actual funding appropriations are known.

EMPLOYMENT GOALS

Action item EM 1A – Page 40

- By June 30, 2014 establish consistent baselines for measuring progress on increased employment of transition-age students; establish goals for annual progress. [EM 1A]

BASELINE: The number of students with disabilities in competitive employment within one year of leaving secondary education is 263.

MEASURABLE GOALS:

- By September 30, 2015 the number of students in competitive employment within one year of leaving secondary education will increase by 25
- By September 30, 2016 the number of students in competitive employment within one year of leaving secondary education will increase by 25
- By September 30, 2017 the number of students in competitive employment within one year of leaving secondary education will increase by 25
- By September 30, 2018 the number of students in competitive employment within one year of leaving secondary education will increase by 25
- By September 30, 2019 the number of students in competitive employment within one year of leaving secondary education will increase by 25

NOTES:

Minnesota Department of Education (MDE) collects outcome data from students with disabilities who within one year of leaving high school had Individualized Education Program (IEP)s in effect at the time they left school, graduated, aged out, or left school early (i.e., dropped out) to participate in the Federal Office of Special Education Programs (OSEP) approved Minnesota Post School Outcome Survey. This requirement is outlined in Indicator 14 within the Minnesota State Performance Plan. The 2005-2013 Part B State Performance Plan (SPP) sets targets in the state's efforts to implement the requirements and purposes of the Individuals with Disabilities Education Act 2004.

All of Minnesota's existing school districts and charter schools are assigned to one of five groups to participate in the Minnesota Post School Outcomes Survey on a five year cycle. Each year approximately 70-90 school districts and charter schools and 1,300 to 1,700 students are a part of the Minnesota Post School Outcome Survey process. Minnesota uses a randomized sampling process for this survey. This process is approved by the Office of Special Education Programs at the U.S. Department of Education. This process includes students from all disability categories as defined in Individuals with Disabilities Education Act (IDEA 2004). The annual survey is conducted by phone by school district staff.

Using post school outcome data from school year 2012-2013 for the baseline on this goal, a total of 74 districts and 1,529 students with disabilities who had graduated, aged out or dropped out could participate in the Minnesota Post School Outcome Survey. The number of completed surveys was 783. Of the 783 individuals, 33.6% or 263 students with disabilities were competitively employed one year

post graduation. Once the goals are achieved, the number of students who are competitively employed one year post graduation will have increased by 125 above the baseline of 263.

Certain items on the survey ask the student to respond to only one option that would indicate if the student was competitively employed within one year after leaving school. These results are then summarized and calculated and used for the measurement on this goal.

Survey results have been calculated for the school years 09-10 through 12-13. The percentage and number of youth who responded they were involved in competitive employment are as follows:

School Year	09-10	10-11	11-12	12-13
Percentage	32.9%	29.8%	39.1%	33.6%
Number	183	169	233	263
TOTAL Number Completed Surveys	557	567	596	783
TOTAL Number Leavers in Annual Sample	1,252	1,321	1,324	1,529
Response Rate	44.5%	42.9%	45.0%	51.2%

Minnesota uses the definition for competitive employment adopted from National Post School Outcome Center. Competitive employment means that youth have worked for pay at or above the minimum wage in a setting with others who are nondisabled for a period of 20 hours a week for at least 90 days at any time in the year since leaving high school. This includes military employment. This definition for competitive employment was derived from the database being used for this measure. It is similar but not identical to the definition in Minnesota's Olmstead Plan (page 89).

The number of completed annual surveys is not a static number. There will be fluctuation in the number of completed surveys from year to year. To date, the number of completed surveys has increased from 557 in 2010 to 783 in 2013 as noted above. As the number of completed surveys increases and the interagency collaboration between DEED and DHS improves, it is expected that the number of students in competitive employment will increase by 25 in 2015 and each subsequent year. The number of completed annual surveys will change over time which will affect the number/percent of the students having competitive employment. In addition, labor market trends and economic growth in Minnesota will impact transition-age youth competitive employment outcomes.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
EM 1A
Description of Action item:
By June 30, 2014 establish consistent baselines for measuring progress on increased employment of transition-age students: establish goals for annual progress.
Agency/Agency Lead:
MDE/DEED/DHS/ MDE: Jayne Spain

Population Statement

1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item)

In school year 2012-2013, a total of 74 districts and 1,529 students with disabilities could participate in the Minnesota Post School Outcome Survey. Of that number 783 surveys were completed with a response rate of 51.2%. Of that number 33.6% or 263 students with disabilities were identified with competitive employment outcomes.

a. What is the source and date of that number?

MDE collects outcome data for students with disabilities who within one year of leaving high school had IEPs in effect at the time they left school, and graduated, aged out, or left school early (i.e., dropped out) to participate in the Minnesota Post School Outcome Survey. All of Minnesota's existing school districts and charter schools are assigned to one of five groups to participate in the Minnesota Post-School Outcomes Survey on a five year cycle. Districts are divided so that each of the five groups represents the state at large. The sampling frame is approved by the Office of Special Education Policy (OSEP).

Using school year 2012-2013 as our baseline, a total of 74 districts and 1,529 students with disabilities could take the survey. Of that number 783 surveys were completed with a response rate of 51.2%. Of that number 33.6% or 263 students with disabilities were identified with competitive employment outcomes.

b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.)

Each year, the census of leavers with IEPs are included in the survey. Leavers are youth who left school by graduating with a diploma, aged out, left school early (i.e., dropped out) or who were expected to return and did not. This includes all disability categories as defined in Individuals with Disabilities Education Act (IDEA 2004).

c. How is this number relevant to this part of the plan?

The MDE, DEED and DHS Olmstead baseline data team members learned that employment data collected within each agency is collected inconsistently and employment definitions vary between agencies. Therefore it was decided at this time to use the existing MDE Post School Outcome Survey process in establishing baseline employment data for transition-age students.

d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths).

This number may change over time depending on the percent/number of completed surveys from which to extract the competitive employment data. In addition current labor market trends and economic growth will impact transition-age youth competitive employment outcomes.

e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?)

These are not duplications in numbers. Using the MDE Minnesota Automated Reporting Student System (MARSS), participating districts are provided a list of students to be surveyed.

Current Status or Baseline

2. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)**

263 or 33.6% students with disabilities were identified with competitive employment outcomes.

a. Explain how this number was reached:

Minnesota uses the following definitions adopted from National Post School Outcome Center in determining post-school outcomes for students with disabilities one year upon exiting from special education:

- Competitive employment means that youth have worked for pay at or above the minimum wage in a setting with others who are nondisabled for a period of 20 hours a week for at least 90 days at any time in the year since leaving high school. This includes military employment.

b. Explain any weaknesses or limitations with this number

In mid-April, staff from sampled districts participated in training, and then completed telephone surveys. For the 2012-2013 school year district personnel attempted to contact an additional 756 students (49.1% of the total eligible sample) a minimum of three additional times but were unsuccessful in reaching them. Reasons include: moved, phone disconnected, contact information provided- message left, no return call, refused to answer survey, incarcerated or deceased youth. Repeated contacts are made with the districts by MDE staff to assist them in collecting data.

c. Explain plans to address these weaknesses/limitations

School districts have added contact information to their district Summary of Performance documents to increase the accuracy of contact information upon graduation. Presentations at Special Education Director's Forums and E-News articles for Special Education Directors have been done over the past few years to outline the importance of data collection, and we will continue to do so in the future.

Goal – Change in Baseline over time
3. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number) From 2015-2019, there will be an increase of 125 students with disabilities in competitive employment within one year of leaving secondary education from a baseline of 263 to 388 in 2019.
a. In 2015? By September 15, 2015 increase from 263 to 288.
b. In 2016? By September 15, 2016 increase from 288 to 313.
c. In 2017? By September 15, 2017 increase from 313 to 338.
d. In 2018? By September 15, 2018 increase from 338 to 363.
e. In 2019? By September 15, 2019 increase from 363 to 388.

Rationale
4. Why is the number in 3 reasonable?
a. Is the goal funded or resourced so that it is realistic? MDE staff are assigned to assist local education agencies in the Minnesota Post School Outcome Survey process.
b. Is this goal based upon past performance or historical trends? This goal is based on three years of prior Minnesota Post School Outcome data.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? Yes, there will be an increase in the number of students with disabilities in competitive employment within one year of leaving secondary education.
d. Why is this number not higher or lower? There is a specific requirement Indicator 14 outcome as outlined in the Minnesota State Performance Plan and approved by the Federal Office of Special Education Programs. 2005-2013 Part B State Performance Plan (SPP) sets targets in the state's efforts to implement the requirements and purposes of the Individuals with Disabilities Education Act 2004.

EMPLOYMENT GOALS

Action item EM 1B – Page 41

- By June 30, 2014 establish a baseline for measuring how many students with disabilities have at least one paid job before graduation; establish goals for annual progress. [EM 1B]

BASELINE: The number of students with disabilities who had paid employment by the age of 18 is 1,412.

MEASURABLE GOALS:

- By December 31, 2015, there is no projected increase
- By December 31, 2016, the number of students who have paid employment by the age of 18 will increase by 23
- By December 31, 2017, the number of students who have paid employment by the age of 18 will increase by 45
- By December 31, 2018, the number of students who have paid employment by the age of 18 will increase by 45
- By December 31, 2019, the number of students who have paid employment by the age of 18 will increase by 45

NOTES:

Once the goals are achieved, the number of students who have paid employment by the age of 18 will have increased by 158 above the baseline of 1,412. This baseline is derived from Department of Employment and Economic Development (DEED) data showing that DEED served 2,242 youth between ages of 14 and 17 in 2013. Of those individuals, 1,412 or 63% had paid employment by the age of 18.

This population includes individuals with all types of disabilities who were enrolled between the ages of 14-17, exited school in calendar year 2013, and lived in all 87 counties of the state. The data was obtained from DEED's Workforce One database and the Unemployment Insurance (UI) Wage Detail created on October 21, 2014.

The limitation of the baseline is that the social security numbers for all students are not available at this time. In addition, several types of employment are not covered in the UI Wage Detail Database. Most notably for these purposes, this would include employment of an individual in an internship or job re-training program, minors working in a family business, or youth who live in "border cities" and work in other states.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
EM 1B
Description of Action item:
Baselines & goals set for ensuring students with disabilities have at least one paid work experience
Agency/Agency Lead:
DEED/ Alyssa Klein

Population Statement
1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item) There were 2535 youth with disabilities served in DEED programs that were enrolled between the ages of 14-17 and were exited from these programs in calendar year 2013. Of these, 2242 had a valid social security number reported. The numbers with SSN's are broken down by program: • Vocational Rehabilitation Services: 571 • State Services for the Blind: 19 • Minnesota Youth Program: 949 • WIA Older and Younger Youth: 878
a. What is the source and date of that number? The source of the data is DEED's Workforce One database and the Unemployment Insurance Wage Detail. Date: The report was created on October 21, 2014. It includes data from the calendar year 2013.
b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.) The population includes individuals who were enrolled between the ages of 14-17, with all types of disabilities. DEED programs serve youth in all 87 counties of the state.
c. How is this number relevant to this part of the plan? This was the agreed upon proxy database to begin measurement of this goal.
d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths). The number of youth served in DEED programs may change due to the amount of funding the programs have to serve youth.
e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?) In the total number of youth in DEED programs, there is NO duplication. When the numbers are broken down by program, then there is duplication since some youth can be served in more than one program.

Current Status or Baseline
2. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)** Of the individuals with disabilities served by DEED programs who were ages 14-17 when enrolled, then exited in calendar year 2013, and had a valid social security number, 1412 (63%) had paid employment by the age of 18. This is broken down by program as follows: o Vocational Rehabilitation Services: 354 (62%) o State Services for the Blind: 8 (42%) o Minnesota Youth Program: 541 (57%) o WIA Older and Younger Youth: 623 (71%)
a. Explain how this number was reached This number was reached by using social security numbers to look up wages reported in the Unemployment Insurance Wage Detail Report.
b. Explain any weaknesses or limitations with this number We do not have the social security numbers of all youth. Vocational Rehabilitation Services only had SSN's of 66% of youth and SSB had 90%, while Minnesota Youth and WIA Youth had 100%. Finally, several types of employment are NOT covered in the UI Wage Detail Database. Most notably for these purposes, this would include employment of an individual in an internship or job re-training program, minors in a family business, or youth who live in "border cities" and work in other states.
c. Explain plans to address these weaknesses/limitations The item that we can most readily address is getting social security numbers of those served. We will work with VRS and SSB staff on reaching out to get more of these into the system.

Goal – Change in Baseline over time
3. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)
a. In 2015? No increase since no intervention will have been used on these exited individuals
b. **In 2016?** 64% or 1435
c. In 2017? 66% or 1480
d. In 2018? 68% or 1525
e. In 2019? 70% or 1569

Rationale
4. Why is the number in 3 reasonable?
a. Is the goal funded or resourced so that it is realistic? There are no additional funds or resources to support this item at this time, thus we had to keep the annual increases at a manageable rate.
b. Is this goal based upon past performance or historical trends? No.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? Yes.
d. Why is this number not higher or lower? This number is not higher for a few reasons. First, the baseline was higher than expected. Second, there are no additional funds or other resources to support this effort. We are going to be depending on the extra efforts and resourcefulness of DEED program staff to see increases in the numbers of youth with disabilities getting paid work prior to graduation.

EMPLOYMENT GOALS

Action items EM 1G.1 and 1G.2 – Page 42

- By September 30, 2014 establish a baseline for the measures and establish measurable goals to demonstrate progress in increasing competitive employment for adults with disabilities. [EM 1G.1]
- By September 30, 2014 set annual deadlines beginning in 2015 to achieve goals for a defined significant portion of the population affected. The measureable goals will be related to demonstrating benefits to the individuals intended to be served. [EM 1G.2]

BASELINE: The number of working-age people with disabilities, receiving home and community-based long-term supports and services that are competitively employed is 4,609 individuals.

MEASURABLE GOALS:

For working-age people with disabilities, receiving home and community-based long-term supports and services:

- By June 30, 2015 the number of individuals who are competitively employed will increase by 380
- By June 30, 2016 the number of individuals who are competitively employed will increase by 553
- By June 30, 2017 the number of individuals who are competitively employed will increase by 638
- By June 30, 2018 the number of individuals who are competitively employed will increase by 801
- By June 30, 2019 the number of individuals who are competitively employed will increase by 1,006

NOTES:

Once the goals are achieved, the number of individuals who are competitively employed will have increased by 3,378 above the baseline of 4,609. This baseline is derived from the population of working-age people with disabilities who receive home and community-based long-term supports and services, a total of 53,689 people. Of that number 4,609 are competitively employed. Minnesota is using earned monthly income ≥$600 per month as an indicator of competitive employment. This definition for competitive employment was derived from the database being used for this measure. It is similar but not identical to the definition in Minnesota's Olmstead Plan (page 89).

The current database indicates a monthly earned income, but does not indicate the number of hours worked or the rate of pay. Monthly earned income can be tracked consistently over time and, it should be sufficient to show progress towards our goals. Data was collected using MMIS for Fiscal Year 2014 (July 1, 2013 - June 30, 2014). The total population consists of: individuals ages 18-64, on a home and community based waiver, receiving MA-funded Personal Care Attendant services, receiving Medical Assistance funded home care services, or on Medical Assistance for Employed Persons with Disabilities.

The annual analysis of this goal will also include any changes in the total population. The numbers of individuals competitively employed in the early years are lower while capacity is being built. The rate of growth is expected to increase over time as capacity is increased.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
EM 1G.1
Description of Action item:
Baseline and goals set to demonstrate progress in increasing competitive employment for adults with disabilities.
Agency/Agency Lead:
DHS-DSD; Mary Alice Mowry 651-341-2384

Population Statement

1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item)

53,689 -- This is a calculation of the population of working-age people with disabilities, receiving home and community-based long-term supports and services, within the scope of Medicaid services. It does not reflect whether or not these people want to work, nor, the type or amount of work they might want to do, if they do have employment as a goal.

a. What is the source and date of that number?

This data was collected using MMIS. It is data for FY 2014 (July 1, 2013-June 30, 2014).

b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.)

The total population consists of:

a. Age 18-64, AND,
b. On a DD, CADI, CAC, or BI waiver (i.e., having a service agreement),AND/OR,
c. Receiving MA-funded PCA, AND/OR,
d. Receiving MA-funded home care services, AND/OR,
e. On MA-EPD

Key:

- DD = Developmental Disabilities
- CADI = Community Alternatives for Disabled Individuals
- CAC = Community Alternative Care
- BI = Brain Injury
- MA = Medical Assistance
- PCA=person care assistance
- MA-EPD=Medical Assistance for Employed Persons with Disabilities

c. How is this number relevant to this part of the plan?

The Olmstead goal is to increase the competitive employment of adults with disabilities. To find a population count that is measurable, as well as a group with which the state could intervene in order to achieve different outcomes, we chose the above group as the population marker.

- The population only includes working age people because it wouldn't be appropriate to include people who wouldn't be likely to be working due to age.
- They are people who have been determined disabled by the Social Security Administration or

the DHS-State Medical Review Team (SMRT) they are either enrolled in a program or receiving services for which having a disability is a requirement.

- They are people who receive home and community-based long-term supports and services Medicaid services because the state can identify them and potentially can influence their outcomes through program policy and service delivery.

d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths).

Between 2010 and 2030, the number of adults age 65 and older will grow by 620,000 people – over four times faster than the previous two decades. As many disabilities are acquired (as opposed to occurring from birth) and many conditions worsen over time, the longer people live, the more likely they are to have a disability.

At the same time, the number of people with disabilities under age 65 has been increasing by about 5% per year. There are many factors which contribute to this, among them, longer life expectancy of people with disabilities, increase rates of certain chronic diseases and increased poverty rates.

e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?)

No, the baseline data and the targets are all unduplicated numbers for the people who are enrolled in the DSD programs that are a part of the baseline. The people in the programs in our baseline may also be included in a DEED or MDE baseline numbers.

Current Status or Baseline

2. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)**

4,609 —This is the number we consider to be our baseline.

a. Explain how this number was reached

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 earned 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

Current Status or Baseline
measures, but a number we've been tracking since 2007, and used here just for illustrative purposes).
b. Explain any weaknesses or limitations with this number Our systems do not track "competitive employment". Therefore, we need to use an income measure as an indicator. There are variables which affect this number which are difficult, if not impossible to control. For example, our system records a monthly income and there is no way to discern the number of hours worked or the rate of pay. Also, income is tracked in our system in conjunction with determining a person's program eligibility. There are complex calculations as to how income is counted or disregarded in establishing program eligibility. The number recorded might not be the same thing as a person's actual income.
c. Explain plans to address these weaknesses/limitations There are no plans to address this weakness at this time. The indicator used is something that can be tracked consistently over time and, while it may not be entirely accurate, it should be sufficient to show progress towards our goals.

Goal – Change in Baseline over time
3. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)
a. In SFY 2015 Without additional resources: 380 With additional resources: [redacted]
b. In SFY 2016 Without additional resources: 553 With additional resources: [redacted]
c. In SFY 2017 Without additional resources: 638 With additional resources: [redacted]
d. In SFY 2018 Without additional resources: 801 With additional resources: [redacted]
e. In SFY 2019 Without additional resources: 1006 With additional resources: [redacted]

Rationale
4. Why is the number in 3 reasonable?
a. Is the goal funded or resourced so that it is realistic? We are submitting two sets of targets—one that we think we could reach with existing level of resources and another that we think we could reach with additional resources.

Rationale
We need both financial resources, as well as new waiver services, and service providers and other supports that will support individuals in their employment goals and incorporate employment planning into an integrated person centered planning process. The larger issue will be the ≥$600 per month marker. We may find that people are entering employment, are not in segregated settings, and are in a competitive job, but are not working at the number of hours needed to reach a ≥$600 threshold. We will need to continue to evaluate as we get better data on hourly wages and number of hours worked.
b. Is this goal based upon past performance or historical trends? This is indirectly based on past performance. These targets are not based upon a trend of past performance, but recognize that movement in this area has been very difficult to achieve. We created a target that has incremental change but is not so small that it inhibits momentum and a sense of expectation and possibility.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? Yes.
d. Why is this number not higher or lower? We believe there are some portions of the population that we can target and with which we can see success in the short run. The number is not higher in the early years because it will take some time to build capacity in the community to support people differently. We believe that, as there are viable alternatives widely available throughout the state that people will move into competitive employment at greater rates.

EMPLOYMENT GOALS

EM 1G.1 and EM 1G.2 - Page 42

BASELINE: The number of individuals served annually by the Workforce Development Unit (State Services for the Blind) that are competitively employed is 116 individuals.

MEASURABLE GOALS:

For individuals receiving services provided by the Workforce Development Unit (State Services for the Blind):

- By December 31, 2015 the number of individuals who are competitively employed will increase by 3
- By December 31, 2016 the number of individuals who are competitively employed will increase by 4
- By December 31, 2017 the number of individuals who are competitively employed will increase by 4
- By December 31, 2018 the number of individuals who are competitively employed will increase by 4
- By December 31, 2019 the number of individuals who are competitively employed will increase by 4

NOTES:

There are 1,000 Minnesotans served annually by the Workforce Development Unit (State Services for the Blind). This includes individuals who are blind, DeafBlind, and visually impaired aged 14 and up. During Federal Fiscal Year 2014, 116 individuals achieved competitive employment. Once the goals are achieved, the number of individuals who are competitively employed will have increased by 19 above the baseline of 116.

One limitation worth noting is that there is a disincentive to work because the eligibility requirement for Social Security Disability Insurance (SSDI) includes that a person cannot work due to a disability.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
Employment (EM) 1G.1 and 1G.2
Description of Action item:
• By September 30, 2014 establish a baseline for the measures and establish measurable goals to demonstrate progress in increasing competitive employment for adults with disabilities. [EM 1G.1] • By September 30, 2014 set annual deadlines beginning in 2015 to achieve goals for a defined significant portion of the population affected. The measureable goals will be related to demonstrating benefits to the individuals intended to be served. [EM 1G.2]
Agency/Agency Lead:
SSB/Ed Lecher

Population Statement
1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item) 53K
a. What is the source and date of that number? The article, Causes and Prevalence of Visual Impairment Among Adults in the United States (Congdon N, O'Colmain B, Klaver CC, Klein R, Muñoz B, Friedman DS, Kempen J, Taylor HR, Mitchell P; Eye Diseases Prevalence Research Group, 2004), estimates there are 937,000 Americans beyond the age of 40 who were blind (US definition). An additional 2.4 million Americans had low vision. Again, this equates to 1% of the general population. These numbers are very similar to those from NEI, and makes one wonder if this wasn't the source of that projection. Due to the aging of the baby boom generation, the number of blind persons in the US is projected to increase by 58% to 1.6 million by 2020, with a similar rise projected for low vision. Applying a percentage of 1% to Minnesota's population suggests 53,030 individuals may be eligible for SSB's services compared to approximately 1000 Minnesotans served annually by the Workforce Development Unit.
b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.) The group itself is represented by blind, DeafBlind, and visually impaired individuals aged 14 and up. Sub groups include: Native American, Asians, Black, and Hispanic individuals throughout the state. We do not have data at this time that reflects what number of blind, DeafBlind, and visually impaired individuals may be in segregated work settings
c. How is this number relevant to this part of the plan? This number clearly indicates that there are more people in the state who can benefit from SSB services and therefore underscores our approach to achieving greater numbers individuals in ICE.
d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths). This number is expected to change as people with age-related vision loss work longer and as the senior population increases due to the Baby Boomer wave.

e. **Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?)** No.

Current Status or Baseline
2. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)** The goal for FFY 2014 was to achieve 104 ICE outcomes. We actually achieved 116.
a. Explain how this number was reached This number is based upon individuals who received some level of service during FFY2014.
b. Explain any weaknesses or limitations with this number NA
c. Explain plans to address these weaknesses/limitations NA

Goal – Change in Baseline over time
3. **How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)** Our practice is to survey counselors and, using a probability formula, determine an ICE goal. For this worksheet, the numbers will be based upon a 3% increase set by our FFY2014 116 ICE outcomes.
a. In 2015? 119
b. In 2016? 123
c. In 2017? 127
d. **In 2018?** 131
e. **In 2019?** 135

Rationale
4. Why is the number in 3 reasonable? These numbers are based upon increasing our marketing and outreach activities that we expect to result in greater numbers individuals applying for and being determined eligible for our services. We also take into consideration the capacity of the resources we currently have available, and the unknown changes that may occur with future resources.
a. Is the goal funded or resourced so that it is realistic? Yes.
b. Is this goal based upon past performance or historical trends? Yes.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? Yes.
d. Why is this number not higher or lower? See above.

EMPLOYMENT GOALS

EM 1G.1 and EM 1G.2 - Page 42

BASELINE: The number of individuals receiving services from Vocational Rehabilitation Services (VRS) that are competitively employed is 2,738 individuals.

MEASURABLE GOALS:

For individuals receiving services provided by the Vocational Rehabilitation Services (VRS):

- By December 31, 2015 the number of individuals who are competitively employed will increase by 112
- By December 31, 2016 the number of individuals who are competitively employed will increase by 57
- By December 31, 2017 the number of individuals who are competitively employed will increase by 58
- By December 31, 2018 the number of individuals who are competitively employed will increase by 59
- By December 31, 2019 the number of individuals who are competitively employed will increase by 31

NOTES:

In FFY 2013 the total number of VRS clients with Employment Plans is 5,043. Of those individuals, 2,738 achieved Integrated Competitive Employment. This group includes individuals between 16 and 70 with all disability types from all parts of the state.

Once the goals are achieved, the number of individuals who are competitively employed will have increased by 317 above the baseline of 2,738.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
EM 1G, EM1G.1 and EM1G.2
Description of Action item:
o **EM 1G:** By June 30, 2014 identify consistent baseline measures to assess progress on increased competitive employment of adults with disabilities (including but not limited to people with mental illness and intellectual/developmental disabilities). o **EM1G.1:** By September 30, 2014 establish a baseline for the measures and establish measureable goals to demonstrate progress in increasing competitive employment for adults with disabilities. o **EM1G.2:** By September 30, 2014 set annual deadlines beginning in 2015 to achieve goals for a defined significant portion of the population affected. The measureable goals will be related to demonstrating benefits to the individuals intended to be served.
Agency/Agency Lead:
DEED/Vocational Rehabilitation Services/Terry Donovan

Population Statement
1. **What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item)** Baseline for the general services area of VRS is the number of VRS clients with Employment Plans whose cases are closed because they have found competitive employment. All employment outcomes for VRS are "integrated competitive employment (ICE)" as defined in Minnesota's Olmstead Plan. The total number of persons included in this action item are 5,043; this number represents the number of VRS clients who had Individual Employment Plans in FFY13.
a. **What is the source and date of that number?** VRS's database for recording client information (Workforce1) is the source of the data. The information is from validated reports sent to the Rehabilitation Services Administration for the period October 1, 2012 to September 30, 2013.
b. **What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.)** This group includes all disabilities – serious mental illness, cognitive disabilities, physical disabilities, developmental disabilities, etc. The group includes generally age ranges from 16 to 70. All clients have been in non-segregated settings and all employment placements are in Integrated Community Employment (ICE). The entire state of Minnesota is the geographic area for this population. All VRS clients must meet eligibility requirements set by federal regulations that prioritize services to individuals with the most significant disabilities (Order of Selection). Due to a combination of service needs and fiscal constraints during the last federal fiscal year, all but one category of eligibility has been closed and VRS is serving individuals with the most significant disabilities.
c. How is this number relevant to this part of the plan? The number measures how many individuals achieve Integrated Competitive Employment which is a key component Minnesota's Olmstead Plan.

d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths). Potentially two demographic trends which could affect this number would be: 1) an increase the number of academic mainstreaming of youth with disabilities which would increase the number of potential Transition cases for VRS and 2) gradual increase in the number of persons over the age of 60 who qualify for VRS services and wish to either remain in the work force or re-enter the work force.
e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?). There is not duplication in the numbers.

Current Status or Baseline
2. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)** Of the 5,043 consumers in FFY13 referenced in the Population Statement, 2,738 achieved Integrated Competitive Employment during FFY13.
a. Explain how this number was reached The number is the actual count of consumers who completed Individual Employment Plans and of the actual count of consumers who achieved Integrated Competitive Employment
b. Explain any weaknesses or limitations with this number No weaknesses or limitations with the number itself. Given our client information system, this number is relatively easy to track and collect each federal fiscal year.
c. Explain plans to address these weaknesses/limitations Not applicable

Goal – Change in Baseline over time
3. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)
a. **In 2015?** 2,850
b. **In 2016?** 2,907
c. **In 2017?** 2,965
d. **In 2018?** 3,024
e. **In 2019?** 3,055

Rationale
4. Why is the number in 3 reasonable? This projection aligns with the routine and regular projection for employment placements by VRS; by FFY 2015 there could be pilots/tests of referrals from DTH's which could have a dramatic impact on VRS's ability to both assess and determine the eligibility of the influx of DTH consumers and continue to offer services to existing VRS consumers.
a. **Is the goal funded or resourced so that it is realistic?** It is realistic within current funding constraints and referral patterns. As noted, if there is a substantial increase in referrals from DTH's as there is a move from segregated/non-integrated to integrated competitive employment, the goal would be underfunded and under resourced.
b. Is this goal based upon past performance or historical trends? Based on past performance and historical trends as well as assumptions of an increasing number of referrals of consumers from segregated/non-integrated employment.
c. **Over a five year period will this projection have significant impact on the lives of people with disabilities?** Yes. It will increase the number of persons with disabilities who work in integrated competitive employment and demonstrating different models that can be replicated by other programs striving to increase integrated competitive employment outcomes for their consumers.
d. Why is this number not higher or lower? Given the historical trends, financial constraints, closed VRS categories and unknown impacts of converting up to 50,000 consumers from segregated/non-integrated employment to integrated competitive employment, this number is realistic and within the expected range.

EMPLOYMENT GOALS

EM 1G.1 and EM 1G.2 - Page 43

BASELINE:

The number of individuals with mental illness receiving Individual Placement and Supports (IPS) services that are competitively employed is 330 individuals.

MEASURABLE GOALS:

This is a goal that requires additional funding. An update will be provided to the Court Monitor upon publication of the Governor's budget in late January 2015. A second update will be provided in June 2015, after the legislative session is over and actual funding appropriations are known.

NOTES:

The targeted number that could be served through IPS services over the next five (5) years is 1,439. This includes individuals with Serious Mental Illness (SMI). The current number of individuals being served is 639. Of those 639 individuals there are 330 who are currently competitively employed. The expansion rates will be based on the placement rates and experiences of the existing IPS projects.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
EM 1G, EM1G.1 and EM1G.2
Description of Action item:
• **EM 1G:** By June 30, 2014 identify consistent baseline measures to assess progress on increased competitive employment of adults with disabilities (including but not limited to people with mental illness and intellectual/developmental disabilities). • **EM1G.1:** By September 30, 2014 establish a baseline for the measures and establish measureable goals to demonstrate progress in increasing competitive employment for adults with disabilities. • **EM1G.2:** By September 30, 2014 set annual deadlines beginning in 2015 to achieve goals for a defined significant portion of the population affected. The measureable goals will be related to demonstrating benefits to the individuals intended to be served.
Agency/Agency Lead:
Vocational Rehabilitation Services/Terry Donovan

Population Statement
1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item) 1,439 is the targeted number that could be reached over the next five (5) years – this assumes increased funding to expand the program.
a. What is the source and date of that number? The source of the number is the projected number of clients who can be served in an IPS program which follows the fidelity protocols of Individual Placement and Support (IPS). These numbers were computed as of September 30, 2014.
b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.) This sub-group is comprised of individuals with Serious Mental Illness (SMI). All employment under this program is Integrated Competitive Employment. In the future, two related Olmstead Employment Action Items (EM1J and EM1K) require that DEED and DHS expand IPS services statewide. The estimates for that planning process will not be completed until June 1, 2015. This statewide expansion of IPS services, if funded by the legislature, would add 5 new IPS projects each year until statewide service availability is achieved.
c. How is this number relevant to this part of the plan? All IPS employment is in integrated competitive employment.
d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths). Demographics will have little impact on this number since demand for service currently exceeds supply and the rate of serious mental illness is projected to remain the same or possibly increase due to improved diagnostic methods, earlier identification and greater self-identification due to efforts to reduce the stigma of mental illness. The principle variable is legislative funding for expanding the program.

e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?) There is no duplication in the numbers

Current Status or Baseline
2. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)** 330
a. Explain how this number was reached An actual count of current employment placements for this population based on reports from the IPS sites.
b. Explain any weaknesses or limitations with this number There are no weaknesses or limitation of this number. It is an actual count.
c. **Explain plans to address these weaknesses/limitations** Not Applicable

Goal – Change in Baseline over time
3. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)
a. **In 2015?** 639 served/330 in ICE
b. **In 2016?** 839 served/430 in ICE
c. **In 2017?** 1039 served/530 in ICE
d. **In 2018?** 1239 served/630 in ICE
e. **In 2019?** 1439 served/730 in ICE

Rationale
4. Why is the number in 3 reasonable? Based on the placement rates and experiences of the existing IPS projects, the placement rates are reasonable if funding materializes.
a. Is the goal funded or resourced so that it is realistic? Expansion of IPS is directly dependent on the legislative state base appropriation for IPS expansion being increased to cover the costs of additional IPS projects. The effort to expand IPS Projects is set forth in Minnesota Olmstead Plan Action item EM-1J – "Expand Individual Placement and Supports employment for Minnesotans with serious mental illness (by 17 counties, 200 people)" and in Actin item EM-1K "By June 30, 2015 establish a plan to expand Individual Placement and Supports (IPS) employment for Minnesotans with disabilities statewide. "
b. Is this goal based upon past performance or historical trends? Goals are based on past performance and reasonable expectations for future placements if funding permits expansion.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? Yes, because all employment placements will be in ICE jobs and on average those jobs have an hourly wage of approximately $10/hour – based on VRS statistics.
d. Why is this number not higher or lower? This is a reasonable number given the IPS model, potential funding, and experience with current IPS projects.

TRANSPORTATION GOALS

Action item TR 1C – Page 58

- By October 31, 2014 using developed baselines from this action and Action Two (below), establish timelines and measures to demonstrate increased access to integrated transportation for people with disabilities. Measures will be implemented to assess transportation options for accessibility, cost effectiveness and reliability.

BASELINE: Public transit currently meets 61 percent of total passenger demand and approximately 57 percent of projected service hour needs statewide.

MEASURABLE GOALS:

This is a goal that requires additional funding. An update will be provided to the Court Monitor upon publication of the Governor's budget in late January 2015. A second update will be provided in June 2015, after the legislative session is over and actual funding appropriations are known.

NOTES:

The public transit performance measure is to meet a percentage of the transit need. In order to satisfy the legislative mandate for determining transit needs and costs, Minnesota Department of Transportation developed models for calculating passenger demand, service levels needed to meet demand, and operating and capital costs of providing service. Using market research as a baseline, the models yield a reasonable foundation for quantifying Greater Minnesota's transit needs and costs in future years. In 2009, a total of $55.3 million was spent to provide 11.1 million passenger trips and 1.03 million service hours. Based on the need estimates conducted as part of this plan, 2009 services met approximately 61 percent of total passenger demand and approximately 57 percent of projected service hour needs statewide.

SUPPORTS AND SERVICES GOALS

Action items SS 2G and 2G.1 – Page 65-66

- For individuals in other 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. [SS 2G]
  - By September 30, 2014 DHS will review this data and other states'[1] 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. [SS 2G.1]

BASELINE: The estimated number of individuals with disabilities in segregated residential settings is 38,079.

MEASURABLE GOALS:

For individuals living in segregated settings:

- By June 30, 2015, the number of individuals who move to the most integrated setting will be 50
- By June 30, 2016, the number of individuals who move to the most integrated setting will be 125
- By June 30, 2017, the number of individuals who move to the most integrated setting will be 300
- By June 30, 2018, the number of individuals who move to the most integrated setting will be 350
- By June 30, 2019, the number of individuals who move to the most integrated setting will be 400

BASELINE: The estimated number of individuals with disabilities in segregated day settings is 20,055.

MEASURABLE GOALS:

For individuals who are in segregated day settings:

- By June 30, 2015, the number of individuals who spend their days in more integrated settings will be 50
- By June 30, 2016, the number of individuals who spend their days in more integrated settings will be 150
- By June 30, 2017, the number of individuals who spend their days in more integrated settings will be 200
- By June 30, 2018, the number of individuals who spend their days in more integrated settings will be 500
- By June 30, 2019, the number of individuals who spend their days in more integrated settings will be 500

[1] In particular, DHS will review plans from Massachusetts, Oregon, and Rhode Island.

NOTES:

Once the goals are achieved, the total number of individuals who will have moved to the most integrated setting will be 1,225 and the total number of individuals who will be spending their days in more integrated settings will be 1,400. The baseline for individuals with disabilities in segregated residential and day settings was derived using two sets of billing data. In one set, numbers were derived by counting certain claims codes associated with delivery of long-term supports and services in settings with varying characteristics of segregation during fiscal year 2013 – 2014. The resulting list included specific waiver services and specific services commonly accessed by people with serious mental illness or serious and persistent mental illness.

Another set of billing data was used to identify numbers of individuals receiving group residential housing services, for which a disability criterion is required to qualify. This latter group was further narrowed to individuals who spent more than 90 days in a living arrangement matching certain segregation characteristics. This method yielded an estimated baseline of 38,079 individuals with disabilities in segregated residential settings and 20,055 in segregated day settings.

There are limitations to this data. The data does not specifically identify the degree of segregation as defined in the Department of Justice's 2011 Guidance on Most Integrated Setting. Nor can the data track moves between settings, particularly day/employment services settings. In addition, providers have up to 12 months to submit a claim, so claims data for fiscal year 2014 is subject to change through June 30, 2015.

Despite these limitations, billing data for items associated with varying characteristics of segregation is currently the most reliable data upon which to establish a baseline. The data will improve as the state implements the Centers for Medicaid Services' Home and Community Based services settings rule.

Residential settings/services delivered in segregated settings include:

- Adult foster care
- Assisted living residence (customized living service)
- Board and lodge (includes homeless shelters)
- Board and lodge with special services
- Boarding care
- Child foster care
- Children's residential care (children's residential facilities- Rule 5)
- Crisis respite (foster care)
- Housing with services establishment
- Supervised living facilities
- Supported living services

Day/employment services delivered in segregated settings:

- Adult day services
- Day training and habilitation center
- Family adult day services
- Pre-vocational service
- Structured day program
- Supported employment services

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
SS 2G.1 and SS 2G.2
Description of Action item:
• 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. [SS 2G] • By September 30, 2014 DHS will review this data and other states' 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. * other than 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
Agency/Agency Lead:
DHS/DSD, Paj Thao, 651.431.2433

Population Statement
1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item) Approximately 144,205 people received publicly-funded long-term supports and services and/or Group Residential Housing services within the study periods. It includes people with disabilities and people who are elderly. NOTE: The number represents data comes from two different sources from two different timeframes.
a. What is the source and date of that number? • MA number comes from state FY 2013 MMIS and MAXIS data • GRH number comes from FY 2014 MAXIS data
b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.) • 133,705 people who receive publicly-funded long-term supports and services • 10,500 people who are on GRH (without MA), in potentially segregated settings
c. How is this number relevant to this part of the plan? The population figure isn't an exact match to these "other segregated settings" but is as close as readily available data allows. The long-term care spending data includes, but is not limited to, residential treatment facilities, regional treatment centers, nursing facilities, ICF-DD, ICF/DT&H. The GRH data only includes people who we think may be in segregated settings and doesn't include people who pass through a potentially segregated setting on a short term basis.

d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths).

Between 2010 and 2030, the number of adults age 65 and older will grow by 620,000 people – over four times faster than the previous two decades. As many disabilities are acquired (as opposed to occurring from birth) and many conditions worsen over time, the longer people live, the more likely they are to have a disability.

At the same time, the number of people with disabilities under age 65 has been increasing by about 5% per year. There are many factors which contribute to this, among them, longer life expectancy of people with disabilities, increase rates of certain chronic diseases and increased poverty rates.

We may see fewer people moving into segregated settings as we develop new alternatives.

e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?)

We unduplicated the numbers within from each data source and unduplicated the MAXIS numbers against a different pull from MMIS so duplication, if it occurs, should be minimal. There may be some duplication however, because the runs were not pulled at the same time, against one another.

Current Status or Baseline

2. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)**

The original Olmstead Plan action item directed us to create a baseline number of people who are in (potentially) segregated settings so that is how it is calculated. We didn't calculate the way this question is posed (number of people who already meet the goal).

The number of people who are in *potentially* segregated residential and/or day settings is 53,291.

One contextual piece that will help put this number is perspective it to understand that 83.6% of people receiving LTSS in state fiscal year 2013 received HCBS. The 53,291 people in *potentially* segregated settings are all in HCBS, not in institutional settings. We do not believe all of these people are actually in segregated settings.

a. Explain how this number was reached

1. Data pull included anyone who met the criteria for any portion of the fiscal year.
2. Data used came from fiscal year 2014 (July 1, 2013 – June 30, 2014).
3. Data pull included people of any age.
4. To identify who a person would be counted as a person with a disability who might be in a segregated setting, using MMIS, we pulled data for individuals who had at least one claim in the fiscal year from a set of claims codes related to long-term supports and services that are potentially delivered in a segregated setting. This list included specific waiver services and specific services commonly accessed by people with serious mental illness or serious and persistent mental illness.
5. Because not all people with disabilities receive any of those services, we pulled data for any individual in the MAXIS system in the Group Residential Housing Program. A person needs to meet a disability criterion to qualify for this program.
6. We further narrowed the MAXIS group by only pulling data on people a *living arrangement* that matched out criteria of being "potentially segregated".
7. We further narrowed the GRH number by specifying that the person had to a potentially segregated residential setting for more than 90 days, to screen out people who only pass through a facility (e.g., homeless shelter) for a short stay.
8. 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.
9. For the people in the resulting pool, we pulled several demographic data points.

b. Explain any weaknesses or limitations with this number

1. Olmstead Plan does not provide measureable definition or criteria to identify what constitutes a segregated setting
2. Limited in ability to identify the setting in which a person receives services
3. Our philosophy is that anyone can be supported in the community, if that is their preference so we did not collect a number for "how many people can be supported in more integrated settings". Rather, we are interested in identifying those who want to making a change or who are unopposed to making a change to be in a more integrated setting. Our system does not currently track this consistently, across all affected populations.
4. No reliable way to track moves between settings, particularly day/employment services settings.
5. A setting type, as recorded in DHS data systems, represent a wide variety of actual places where people live, and do not necessarily indicate how "segregated" any particular setting is.
6. Providers have up to 12 months 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 in which they use. For example, people who apply for a Developmental Disability 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.

c. Explain plans to address these weaknesses/limitations

1. Develop criteria for measuring a setting's degree of segregation/integration based on Center for Medicare and Medicaid Services' Home and Community Based Services (HCBS) settings rule and Minnesota's transition plan.
2. Conduct survey of HCBS settings in conjunction with the CMS HCBS settings rule to determine how settings comport.
3. Explore options for interim data solutions while long-term data systems changes are put in place.
4. Build long-term systems solution for identifying, verifying, collecting and sharing information about degree of integration/segregation for HCBS.
5. Identify people not opposed to moving to a more integrated setting using MnCHOICES assessment and service planning system and targeted interviews.
6. Create long-term system for tracking numbers of people who move from to or from less integrated settings.

Goal – Change in Baseline over time

3. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)

RESIDENTIAL SETTINGS TARGETS	DAY SETTINGS TARGETS
a. In SFY 2015 Without additional resources: 50 With additional resources: [redacted]	**In SFY 2015** Without additional resources: 50 With additional resources: [redacted]
b. In SFY 2016 Without additional resources: 125 With additional resources: [redacted]	**In SFY 2016** Without additional resources: 150 With additional resources: [redacted]
c. In SFY 2017 Without additional resources: 300 With additional resources: [redacted]	**In SFY 2017** Without additional resources: 200 With additional resources: [redacted]
d. In SFY 2018 Without additional resources: 350 With additional resources: [redacted]	**In SFY 2018** Without additional resources: 500 With additional resources: [redacted]
e. In SFY 2019 Without additional resources: 400 With additional resources: [redacted]	**In SFY 2019** Without additional resources: 500 With additional resources: [redacted]

Rationale
4. Why is the number in 3 reasonable? We are submitting two sets of targets—one that we think we could reach with existing level of resources and another that we think we could reach with additional resources. These numbers are a base target, and 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 DHS will assess progress annually and will adjust targets as necessary to incent movement to the most integrated community living and employment. The residential settings targets for "without additional resources" reflect the rate at which we are moving people using existing programs such as the Housing Access Services and Tech for Home grants. Also, we are anticipating greater changes in 2017, if the proposed changes to GRH happen in the 2015 legislative session. The targets for "with additional resources" require additional waiver or service resources to accomplish.
a. Is the goal funded or resourced so that it is realistic? The residential settings "without additional resources" targets are realistic, but do depend on legislative action re: GRH in 2015. The "with additional resources" figures are only realistic if there are additional resources available. The day setttings targets are realistic as identified: with or without additional funds.
b. Is this goal based upon past performance or historical trends? The residential settings "without additional resources" targets are based in upon past performance of the Housing Access Services and Tech for Home grants.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? Yes.
d. Why is this number not higher or lower? For all the reasons outlined above.

SUPPORTS AND SERVICES GOALS

Action item SS 3I –Page 68

- 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]

BASELINE: Approximately 10,000 people per year currently use mental health crisis services and approximately 85% of people who use them remain in their homes. There were 61,000 Emergency Department (ED) visits by individuals who were using Home and Community Based Services in 2010.

MEASURABLE GOALS:

This is a goal that requires additional funding. An update will be provided to the Court Monitor upon publication of the Governor's budget in late January 2015. A second update will be provided in June 2015, after the legislative session is over and actual funding appropriations are known.

NOTES:

Providing appropriate crisis intervention and a triage and hand off process may reduce the need for emergency department visits, loss of housing and allow more people to stay in their own homes. Annually, approximately 10,000 people with a range of disabilities currently use mental health crisis services and approximately 85% of people who use them to remain in their homes. There were 61,000 Emergency Department (ED) visits by individuals who were using Home and Community Based Services in 2010. Of these visits, "more than half" included mental health or behavioral crises. The source of the data is a 2012 report completed by Truven Analytics using 2010 data.

SUPPORTS AND SERVICES GOALS

Action item SS 4B – Page 70

- 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. [SS 4B]

BASELINE: As of August 2014, there were 4,952 people who have requested home-and-community-based waiver services, met eligibility criteria, but are not yet receiving services. Of this number there are 3,502 individuals requesting a Developmental Disabilities (DD) waiver and 1,450 individuals requesting a Community Alternatives for Disabled Individuals (CADI) waiver.

MEASURABLE GOALS:

- By February 1, 2015, individuals who meet the "Immediate" criteria will receive home-and-community-based supports and services within 90 days.

- By February 1, 2015, individuals who meet the "Institutional Exit" criteria will move at a reasonable pace by beginning service planning for home and community-based supports and services within 45 days. These individuals will begin services within 180 days of a completed service plan.

- By June 30, 2015, 80 individuals residing in Intermediate Care Facilities/ Developmentally Disabled will receive home and community-based supports and services.

NOTES:

As of August 2014, there were 4,952 people who have requested home-and-community-based waiver services, met eligibility criteria, but are not yet receiving services. Of this number there are 3,502 individuals requesting a Developmental Disabilities (DD) waiver and 1,450 individuals requesting a Community Alternatives for Disabled Individuals (CADI) waiver. These numbers do not currently reflect any priority based on immediate need for services.

A new system will prioritize and measure movement for individuals in these two groups: 1) "Institutional Exit" category includes individuals who need to exit an institutional setting; and, 2) "Immediate" category includes individuals who are at imminent risk of being placed in an institutional setting.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
SS 4B
Description of Action item:
Report and recommendations on how to improve processes related to the home and community-based supports and services waiting list
Agency/Agency Lead:
DHS/DSD, Curtis Buhman, 651.431.2375

Population Statement

1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item)

4,952 on the DD, CADI, CAC or BI waiting list

- DD = Developmental Disabilities
- CADI = Community Alternatives for Disabled Individuals
- CAC = Community Alternative Care
- BI = Brain Injury

a. What is the source and date of that number?

Medicaid Management Information System (MMIS), August 2014

b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.)

Waiver type: DD, CADI, CAC, BI

c. How is this number relevant to this part of the plan?

This part of the plan is about improving processes to manage the waiver waiting lists, so the number on the waiting lists is the most relevant number to use.

d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths).

The number of people with disabilities under age 65 has been increasing by about 5% per year.

There is a concerted, stepped-up effort, through implementation of the Olmstead Plan, to decrease the number of people served in institutional settings. Doing so will put additional pressure on the waivers to serve more people with home and community-based services. If demand increases but resources do not increase, or re-directed existing resources are not sufficient, there is risk that the waiting lists will grow, despite efforts to manage them more efficiently.

e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?)

No.

Current Status or Baseline
2. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)** We do not currently have data that tracks what we hope to accomplish through this action item, which is to have people move off the waiting list and into waiver services at a reasonable pace, as dictated by an assessed urgency level.
a. Explain how this number was reached The number of people on the waiting list is derived by tracking the number of people who have been assessed for waiver services and met eligibility criteria, but who do not have a service agreement.
b. Explain any weaknesses or limitations with this number This number does not account for the level of the individual need, nor the urgency of their need, nor does it capture whether or not the individual is receiving services other than waiver services and the degree to which those services are meeting their needs. Wait list reporting is dependent on screening and authorization data from MMIS that may be entered into MMIS two or more weeks after the activity. This means that delayed MMIS entry by counties will cause waiver start numbers to change in future reports. The number does not reflect the number of people who are deemed to have high priority needs and who go directly into services. Sometimes that leads people reading the data to misinterpret it to mean that a person with urgent needs will have to wait until all the existing thousands "on the waiting list" to get served first; this is not the case.
c. Explain plans to address these weaknesses/limitations The plans to manage the wait list, which will change how the data is tracked, are outlined in the Olmstead HCBS Waiver Wait List Report. This was the deliverable for SS 4B that was submitted to the Subcabinet September 29, 2014.

Goal – Change in Baseline over time
3. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)
a. In 2015? • By 6/30/2015, move 80 people into waiver services. • Beginning February 1, 2015, individuals with the "Institutional Exit" categorization begin service planning within 90 days of an assessment. Individuals with the "Immediate" categorization receive services within 90 days to the extent that statewide resources are available to support them.
b. In 2016 and each subsequent year The new system for managing the wait list will be in place and people will move through the wait list at a reasonable pace, as defined in the September 2014 Olmstead HCBS Waiver Wait List Report, as resources are available.

Rationale
4. Why is the number in 3 reasonable? The target to move 80 people by 6/30/2015 is a reasonable number and is provided to show short-term measurable outcomes that are tied to specific individuals. This target is based on people who are currently in ICF-DDs who have expressed a desire to live in the community. The targets for making the proposed changes to the wait list is aggressive, but we believe doable. It could be slowed down by the other demands upon counties, as they are our partners in making these changes and are already under a lot of pressure to carry out multiple other reforms to the system. These targets are also dependent upon the availability of technology solutions for creating temporary, quick reporting on the acuity levels of people seeking services.
a. Is the goal funded or resourced so that it is realistic? All goals associated with this activity are covered under existing resource allocations.
b. Is this goal based upon past performance or historical trends? This goal is based on a real, current number of people with a desire to leave an ICF/DD and begin waiver services. Future activity will also draw from current numbers of people classified as having the most urgent needs.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? We will have a better idea of the scope of the problem—how many people with high, urgent needs are actually spending time waiting for services and, if so, how long are they waiting. We aren't sure of the scope of the problem now, so it is difficult to assess how many people will be affected and how, but we presume that by making sure people move into the system at pace that is reasonable, in accordance to their needs, that will have a significant impact on their lives. If we are better able to identify resource issues, through better management of the system, we will be better positioned to address those.
d. Why is this number not higher or lower? The short-term measurable target of 80 people is not higher or lower because it is based on an actual count of people who we know would likely meet the high need, high urgency criteria.

SUPPORTS AND SERVICES GOALS

Action SS 4D – Page 70

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, or bipolar disorder and who have significant and persistent functional impairments (homelessness, repeated hospitalizations, unemployment) which contribute to high system use. In the case of forensic assertive community treatment, individuals also have significant involvement in the corrections system. 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. The key to a successful FACT team is the monitoring of its fidelity to the ACT model, along with on-going technical assistance.

- Develop Forensic Assertive Community Treatment (FACT) team (described above)
    - 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. [SS 4D]

BASELINE: This service has not yet been developed, so the number of individuals enrolled in FACT services is zero.

MEASURABLE GOALS:

This is a goal that requires additional funding. An update will be provided to the Court Monitor upon publication of the Governor's budget in late January 2015. A second update will be provided in June 2015, after the legislative session is over and actual funding appropriations are known.

NOTES:

In the seven metro counties (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington) during 2013, there were 62 individuals released from custody with a diagnosis of Serious and Persistent Mental Illness (SPMI). These individuals were identified through a brief screening. It is anticipated that a more extensive screening evaluation process may identify a larger number of individuals over time who meet the SPMI criteria. Approximately 8 individuals are represented in the 62 count twice due to re-incarceration and subsequent release.

Because this is a new service, the baseline is zero. The goals will be based on best practices for starting a new high fidelity ACT program.

LIFELONG LEARNING AND EDUCATION GOALS

Action item ED 1A.1 – Page 73

Work with districts and other stakeholders to reduce the use of restrictive procedures and also provide further recommendations on how to further reduce these procedures and eliminate the use of prone restraints in schools. Minnesota Statutes §125A.0942 subdivision 3 (8) requires that school districts end the use of prone restraints with children ages five or older by August 1, 2015.

- By June 30, 2014 and each subsequent year, districts will report summary data on their use of restrictive procedures to the department, in a form and manner determined by the Commissioner of the Minnesota Department of Education (MDE) [ED 1A.1 - 1A.3]

BASELINE: During the 2013-2014 school year, the number of students with disabilities whom school districts reported experienced restrictive procedures was 2,707 students. The number of incidents of restrictive procedures school districts reported was 19,409. Of those, 13,116 were physical holds and 6,301 were seclusion.

During the 2013-2014 school year, there were 15 school districts that reported using prone restraint one or more times. There were 837 incidents of prone restraints. The number of students with disabilities who experienced one or more prone restraints was 159.

MEASURABLE GOALS:

- By June 30, 2015
  - the number of students who experience a restrictive procedure will be reduced by 108
  - the number of reported restrictive procedure incidents will be reduced by 776

- By August 1, 2015, the number of students who experience prone restraint will be zero

- By June 30, 2016
  - the number of students who experience a restrictive procedure will be reduced by 104
  - the number of reported restrictive procedure incidents will be reduced by 745

- By June 30, 2017
  - the number of students who experience a restrictive procedure will be reduced by 100
  - the number of reported restrictive procedure incidents will be reduced by 715

- By June 30, 2018
  - the number of students who experience a restrictive procedure will be reduced by 96
  - the number of reported restrictive procedure incidents will be reduced by 687

- By June 30, 2019
  - the number of students who experience a restrictive procedure will be reduced by 92
  - the number of reported restrictive procedure incidents will be reduced by 659

NOTES:

Once the goals are achieved, the number of students who experience a restrictive procedure will have been reduced by 500 below baseline to 2,207 students. The number of restrictive procedures will have been reduced by 3,589 below baseline to 19,402 restrictive procedures.

The number of prone restraints will have been reduced by 837 to 0 prone restraints. The number of students who experience one or more prone restraints will have been reduced by 159 to 0 students.

The baseline for these goals was determined by identifying both: 1) the number of students with disabilities whom school districts reported experienced restrictive procedures in the 2013-2014 school year, a baseline of 2,707 students; and, 2) the number of incidents of restrictive procedures school districts reported were used with students with disabilities in the 2013-2014 school year, a baseline of 19,409.

In addition during the 2013-2014 school year, there were 15 school districts that reported using prone restraint one or more times. There were 837 incidents of prone restraints. The number of students with disabilities who experienced one or more prone restraints was 159.

The goals were set based on: 1) the statutory prohibition against prone restraint going into effect August 1, 2015; and, 2) an existing $250,000.00 legislative appropriation for training and technical assistance to district staff. The goals may be affected by changing demographics in enrollment and movement of students between districts and out of state.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
ED 1A.1
Description of Action item:
By June 30, 2014 and each subsequent year, districts will report summary data on their use of restrictive procedures to the department, in a form and manner determined by the Commissioner and the Minnesota Department of Education (MDE).
Agency/Agency Lead:
MDE/ Marikay Litzau/Robyn Widley

Population Statement
1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item) • During the 2013/2014 school year, 2707 students with disabilities experienced one or more restrictive procedures. This was 1.95% of the number of students on IEPs reported by districts on the MDE restrictive procedure reporting form during the 2013/2014 school year. (Total reported was 138,541). • During the 2013/2014 school year, 2411 of those students were physically held (1.74%) and 815 of those students were placed in seclusion (.59%) (Note: Some students were reported as having experienced both procedures). • During the 2013/2014 school year, 244 school districts (i.e., traditional, charter, intermediate and cooperatives) reported using one or more restrictive procedures. • During the 2013/2014 school year, there were 19,409 incidents of restrictive procedures. Of those 19,409 incidents 13,116 were physical holds and 6,301 were seclusion.
a. What is the source and date of that number? Data is self-reported by school districts on the MDE Restrictive Procedure (RP) Summary Form that is to be submitted by June 30th of each school year. Beginning with June 30, 2015 school districts will be required to include in the MDE Restrictive Procedure Summary Form data on the use of reasonable force that is consistent with the definition of physical holding or seclusion for a child with a disability under Minnesota Statute section 125A.0942.
b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.) This group is solely comprised of students with disabilities who have an individualized education program (IEP).
c. How is this number relevant to this part of the plan? The population statements establish baseline data for future reporting and measurement. The reasonable force data will assist MDE and the Restrictive Procedures Work Group in determining if districts are using reasonable force in lieu of prone restraint, or to reduce the number of physical holding or seclusion incidents.
d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths). Movement of students between districts and in and out of state.

e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?)

One student may have multiple restrictive procedures (physical holding and or seclusion) incidents that stem from the same incident or different times of the day, or different days.

Current Status or Baseline

2. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)**

Based upon district self-reporting for the 2013/2014 school year, the number of students with disabilities (on an individual education program "IEP") experiencing the use of restrictive procedures (physical holding and/or seclusion) constituted 1.95% of the total enrollment of students with disabilities. This is down from 2% from the 2012/2013 school year.

a. Explain how this number was reached?

The number of students with disabilities is obtained from the MDE annual RP summary form submitted by districts (i.e. traditional, charter schools, intermediates and cooperatives/education districts) and then divided by the enrollment data that districts provide on the MDE annual RP summary form.

b. Explain any weaknesses or limitations with this number

Self-reported data by districts.

c. Explain plans to address these weaknesses/limitations

MDE staff contact the District if they have not submitted the annual RP summary form or if the data is incomplete.

Goal – Change in Baseline over time

3. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)

a. In 2015?

4% reduction in the number of students (108 fewer) experiencing a restrictive procedure and 4% reduction in the number of reported restrictive procedure incidents (776 fewer incidents).

b. In 2016?

4% reduction in the number of students (104 fewer) experiencing a restrictive procedure and 4% reduction in the number of reported restrictive procedure incidents (745 fewer incidents).

c. In 2017?

4% reduction in the number of students (100 fewer) experiencing a restrictive procedure and 4% reduction in the number of reported restrictive procedure incidents (715 fewer incidents).

Goal – Change in Baseline over time
d. In 2018? 4% reduction in the number of students (96 fewer) experiencing a restrictive procedure and 4% reduction in the number of reported restrictive procedure incidents (687 fewer incidents).
e. In 2019? 4% reduction in the number of students (92 fewer) experiencing a restrictive procedure and 4% reduction in the number of reported restrictive procedure incidents (659 fewer incidents).

Rationale
4. Why is the number in 3 reasonable?
a. Is the goal funded or resourced so that it is realistic? The $250,000 legislative appropriation to be expended by June 30, 2015 will provide additional training and technical assistance to district staff. It is unclear if the goals will continue to be funded after June 30, 2015 to provide ongoing technical assistance and training to staff. This is part of the Olmstead MDE funding proposal.
b. Is this goal based upon past performance or historical trends? There has been a reduction in the number of incidents and students who have experienced a restrictive procedure between FY 2013 and FY 2014. This data also includes prone restraint data, which is a physical hold. The reduction is in part due to the reduction in prone restraint incidents. Part of the incidents reduction may be due to more consistency in how incidents are reported.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? Yes
d. Why is this number not higher or lower? See b above.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
ED 1A.1
Description of Action item:
By June 30, 2014, and each subsequent year, districts will report summary data on their use of restrictive procedures to the department, in a form and manner determined by the Commissioner and the Minnesota Department of Education (MDE).
Agency/Agency Lead:
MDE – Marikay Litzau/ Robyn Widley

Population Statement
1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item) • During the 2013/2014 school year, 159 students with disabilities experienced one or more prone restraint. This was .1% of the number of students on IEPs reported by districts on the MDE data reporting form during the 2013/2014 school year. (Total number of students on IEPs reported was 138,541). • During the 2013/2014 school year, 15 school districts (tradition, charter, intermediate and cooperatives) reported using prone restraint one or more times. • During the 2013/2014 school year, there were 837 incidents of prone restraint. • Beginning with June 30, 2015 school districts will be required to include in the MDE Restrictive Procedure (RP) Summary Form data on the use of reasonable force that is consistent with the definition of physical holding or seclusion for a child with a disability under Minnesota Statute section 125A.0942.
a. What is the source and date of that number? Data is self-reported by school districts on the MDE RP summary form that is to be submitted by June 30th of each school year. Districts must report each incident of prone restraint to MDE within 5 working days of the incident. MDE staff checks to ensure that staff has been trained and seek clarification, as needed. The data collection of individual prone restraint incidents will be through incidents that occur on August 1, 2015. After that date, it will be prohibited by school staff to use prone restraint in the school setting.
b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.) This group is solely comprised of students with disabilities who have an individualized education program (IEP).
c. How is this number relevant to this part of the plan? It establishes the baseline for measurement and reporting. The reasonable force data will assist MDE and the Restrictive Procedure Work group in determining if districts are using reasonable force in lieu of prone restraint, or to reduce the number of physical holding or seclusion incidents. The prone restraint data reported through July 30, 2015, and broken out by quarter, will help us to see how well districts are doing in eliminating prone restraint.

d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths).

Movement of students between districts and in and out of state

e. **Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?)**

One student may have multiple prone restraint incidents that stem from the same incident or different times of the day, or different days.

Current Status or Baseline

1. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)**

Based upon district self-reporting for the 2013/2014 school year, the number of students with disabilities (on an individual education program "IEP") experiencing the use of prone restraint constituted .1% of the total enrollment of students with disabilities.

a. Explain how this number was reached

Self-reporting by districts – individual incidents of prone restraint, and then the enrollment data Districts provide on the MDE annual RP summary form.

b. Explain any weaknesses or limitations with this number

Self-reported by districts

c. Explain plans to address these weaknesses/limitations

MDE staff will continue to contact the district if there is an issue over whether staff are trained or if the report is incomplete.

Goal – Change in Baseline over time

2. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)

a. In 2015?

30 fewer students will experience prone restraint and there will be 200 fewer incidents.

b. In 2016?

As of August 2, 2015, 0 students and 0 incidents of prone restraint by school staff in the school setting.

Rationale
3. Why is the number in 3 reasonable?
a. Is the goal funded or resourced so that it is realistic? $250,000 was appropriated by the legislature to assist districts with students experiencing a high usage of prone restraint. $150,000 in grants are going to districts with a high usage of prone restraint. In addition, $100,000 is allocated for an RFP for the development of toolkits to provide technical support and training to assist staff in working with students with disabilities with the highest needs.
b. **Is this goal based upon past performance or historical trends?** Districts reduced the number of students by 30 and the number of incidents by 500 in comparing FY 2013 and FY 2014. Part of the incident reduction may be due to more consistency in how incidents are reported.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? It will if district staff are able to consistently implement strategies that will result in students experiencing less behavioral escalations which will result in less need for restrictive procedures and more time for students to spend ready to learn in the instructional setting.
d. Why is this number not higher or lower? Not applicable as the number will become 0.

LIFELONG LEARNING AND EDUCATION GOALS

Action item ED 4A.1 - Page 75

- Based on the Minnesota Post School Outcome Survey data, beginning September 1, 2014 and each subsequent year, there will be an increase of a minimum of 50 students with disabilities per year entering integrated postsecondary education and training programs within one year of exiting secondary education. [ED 4A.1 – 4A.3]

BASELINE: The number of students with disabilities who entered integrated postsecondary education and training programs within one year of exiting secondary education is 254.

MEASURABLE GOALS:

The number of students with disabilities entering integrated postsecondary education and training programs within one year of exiting secondary education per year will increase

- By September 1, 2015 the number of individuals will increase by 50
- By September 1, 2016 the number of individuals will increase by 50
- By September 1, 2017 the number of individuals will increase by 50
- By September 1, 2018 the number of individuals will increase by 50
- By September 1, 2019 the number of individuals will increase by 50

NOTES:

Minnesota Department of Education (MDE) collects outcome data from students with disabilities who within one year of leaving high school had IEPs in effect at the time they left school, graduated, aged out, or left school early (i.e., dropped out) to participate in the Federal Office of Special Education Programs (OSEP) approved Minnesota Post School Outcome Survey. This requirement is outlined in Indicator 14 within the Minnesota State Performance Plan. The 2005-2013 Part B State Performance Plan (SPP) sets targets in the state's efforts to implement the requirements and purposes of the Individuals with Disabilities Education Act 2004.

All of Minnesota's existing school districts and charter schools are assigned to one of five groups to participate in the Minnesota Post School Outcomes Survey on a five year cycle. Each year approximately 70-90 school districts and charter schools and 1,300 to 1,700 students are a part of the Minnesota Post School Outcome Survey process. Minnesota uses a randomized sampling process for this survey. This process is approved by the Office of Special Education Programs at the U.S. Department of Education. This process includes students from all disability categories as defined in Individuals with Disabilities Education Act (IDEA 2004). The annual survey is conducted by phone by school district staff.

Using post school outcome data from school year 2012-2013 as a baseline, a total of 74 districts and 1,529 students with disabilities who had graduated, aged out or dropped out could participate in the Minnesota Post School Outcome Survey. The number of completed surveys was 783. Of the 783 individuals, 32.4% or 254 students with disabilities were enrolled in higher education one year post

graduation. Once the goals are achieved, the number of students who are competitively employed one year post graduation will have increased by 250 above the baseline of 254.

Certain items on the survey ask the student to respond to only one option that would indicate if the student was enrolled in higher education. These results are then summarized and calculated and used for the measurement on this goal.

Survey results have been calculated for the school years 09-10 through 12-13. The percentage and number of youth who responded they were enrolled in higher education are as follows:

School Year	09-10	10-11	11-12	12-13
Percentage	29.1%	33.0%	26.7%	32.4%
Number	162	187	159	254
TOTAL Number Completed Surveys	557	567	596	783
TOTAL Number Leavers in Annual Sample	1,252	1,321	1,324	1,529
Response Rate	44.5%	42.9%	45.0%	51.2%

Minnesota uses the definition for enrolled in higher education adopted from National Post School Outcome Center. Enrolled in higher education means youth have been enrolled on a full- or part-time basis in a community college (2-year program), or college/university (4- or more year program) for at least one complete term, at any time in the year since leaving high school.

The number of completed surveys is not a static number. There will be fluctuation in the numbers of completed surveys from year to year. To date, the number of completed surveys has increased from 557 in 2010 to 783 in 2013. As the number of completed surveys increases and the interagency collaboration between DEED and DHS improves, it is expected that the number of students enrolled in higher education will increase by 50 in 2015 and each subsequent year. The number of completed annual surveys will change over time which will affect the number/percent of the enrolled in higher education outcomes. Labor market trends and economic growth in Minnesota will impact transition-age youth enrolled in higher education.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
ED 4A.1
Description of Action item:
Based on the Minnesota Post School Outcome Survey data, beginning September 1, 2014 and each subsequent year, there will be an increase of a minimum of 50 students with disabilities per year entering integrated postsecondary education and training programs within one year of exiting secondary education.
Agency/Agency Lead:
MDE/DEED/DHS/ MDE: Jayne Spain

Population Statement
1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item) In school year 2012-2013, a total of 74 districts and 1,529 students with disabilities could participate in the Minnesota Post School Outcome Survey. Of that number 783 surveys were completed with a response rate of 51.2%. Of that number 32.4% or 254 students with disabilities were identified as enrolled in higher education.
a. What is the source and date of that number? MDE collects outcome data for students with disabilities who within one year of leaving high school had IEPs in effect at the time they left school, and graduated, aged out, or left school early (i.e., dropped out) to participate in the Minnesota Post School Outcome Survey. All of Minnesota's existing school districts and charter schools are assigned to one of five groups to participate in the Minnesota Post-School Outcomes Survey on a five year cycle. Districts are divided so that each of the five groups represents the state at large. The sampling frame is approved by the Federal Office of Special Education Programs (OSEP).
b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.) Each year, the census of leavers with IEPs are included in the survey. Leavers are youth who left school by graduating with a diploma, aged out, left school early (i.e., dropped out) or who were expected to return and did not. This includes all disability categories as defined in Individuals with Disabilities Education Act (IDEA 2004).
c. How is this number relevant to this part of the plan? The MDE, DEED and DHS Olmstead baseline data team members learned that postsecondary education data collected within each agency is collected inconsistently and definitions vary between agencies. Therefore it was decided at this time to use the existing MDE Post School Outcome Survey process.
d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths). This number may change over time depending on the percent/number of completed surveys from which to extract enrolled in higher education data. In addition current labor market trends and the

economic state of Minnesota will impact transition-age youth enrollment in higher education outcomes.

e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?)

There are not duplications in numbers. Using the MDE Minnesota Automated Reporting Student System (MARSS), participating districts are provided a list of students to be surveyed. These are not duplicated child count.

Current Status or Baseline

2. **Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)**

Using school year 2012-2013 data as a baseline, 254 or 32.4% of the 783 students with disabilities were enrolled in higher education.

a. Explain how this number was reached:

Minnesota uses the following definitions adopted from National Post School Outcome Center in determining higher education outcomes for students with disabilities one year upon exiting from special education:

- Enrolled in higher education means youth have been enrolled on a full- or part-time basis in a community college (2-year program), or college/university (4- or more year program) for at least one complete term, at any time in the year since leaving high school.

b. Explain any weaknesses or limitations with this number

In mid-April, staff from sampled districts participated in training, and then completed telephone surveys. For the 2012-2013 school year district personnel attempted to contact an additional 756 students (49.1% of the total eligible sample) a minimum of three additional times but were unsuccessful in reaching them. Reasons include: moved, phone disconnected, contact information provided - message left, no return call, refused to answer survey, incarcerated or deceased youth. Repeated contacts are made with the districts by MDE staff to assist them in collecting data.

c. Explain plans to address these weaknesses/limitations

School districts have added contact information to their district Summary of Performance documents to increase the accuracy of contact information upon graduation. Presentations at Special Education Director's Forums and E-News articles for Special Education Directors have been done over the past few years to outline the importance of data collection, and we will continue to do so in the future.

Goal – Change in Baseline over time

3. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)

Goal – Change in Baseline over time
Beginning September 15, 2015 and each subsequent year, there will be an increase of a minimum of 50 students with disabilities per year entering integrated postsecondary education and training programs within one year of exiting secondary education.
a. In 2015? By September 15, 2015 increase from 254 to 304.
b. In 2016? By September 15, 2016 increase from 304 to 354.
c. In 2017? By September 15, 2017 increase from 354 to 404.
d. In 2018? By September 15, 2018 increase from 404 to 454.
e. In 2019? By September 15, 2019 increase from 454 to 504.

Rationale
4. Why is the number in 3 reasonable?
a. Is the goal funded or resourced so that it is realistic? MDE staff is assigned to assist local education agencies in the Minnesota Post School Outcome Survey process.
b. Is this goal based upon past performance or historical trends? This goal is based on three years of prior Minnesota Post School Outcome data.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? Yes, there will be an increase in the number of students with disabilities in higher education within one year of leaving secondary education.
d. Why is this number not higher or lower? There is a specific requirement Indicator 14 outcome as outlined in the Minnesota State Performance Plan and approved by the Federal Office of Special Education Programs. 2005-2013 Part B State Performance Plan (SPP) sets targets in the state's efforts to implement the requirements and purposes of the Individuals with Disabilities Education Act 2004.

LIFELONG LEARNING AND EDUCATION GOALS

Action item ED 5A - Page 75

- By June 30, 2014 review current data on this student population and develop prototype reintegration plans to transition students to more integrated settings. Establish measurable goals and timelines for actions to be taken to benefit students [ED 5A]

BASELINE: Work is currently underway to establish the baseline.

MEASURABLE GOALS:

This is a goal that requires additional funding. An update will be provided to the Court Monitor upon publication of the Governor's budget in late January 2015. A second update will be provided in June 2015, after the legislative session is over and actual funding appropriations are known.

NOTES:

There were 256 students at Minnesota Correctional Facilities at Red Wing and Togo (under age 21) in 2012 -2013. Of the 256 students at the two juvenile correctional facilities, 180 or 70% had an Individualized Education Program (IEP).

On December 1, 2014 the Department of Corrections (DOC) will begin collecting data on adolescents with IEPs in Minnesota Correctional facilities at Red Wing, Togo and Lino Lakes. This will include tracking individuals being released to determine if they return to their home school district.

HEALTHCARE AND HEALTHY LIVING GOALS

Action item HC 2C – Page 79

DHS will complete a legislatively mandated study of the Minnesota Health Care Program's dental program to improve access and ensure cost-effective delivery of services. The study reviews the program structure, including payment policies that compensate dental providers who serve underserved patients and treatment and workforce innovations that may improve access to dental care for recipients of MHCP.

- By June 30, 2014 using information from this study, develop a plan for implementation including timelines and measurable goals. [HC 2C]

BASELINE: The total number of adults with disabilities receiving Medicaid who did not receive at least one dental service during calendar year 2013 was 86,520 individuals.

MEASURABLE GOAL:

- By July 1, 2016 the number of individuals with disabilities who receive dental services will increase by 335.

NOTES:

The baseline for this goal was determined by identifying the total number of adults with disabilities receiving Medicaid who did not receive at least one dental service during calendar year 2013, a baseline of 86,520 individuals. Data was extracted from Medicaid billing systems. Confirmation of the number of individuals receiving dental services may not be available until at least December 31, 2016.

The goal was set based on a legislatively approved rate change for dental services that will take effect in 2016. The goal is reasonable because it is based upon trends experienced in other states that have raised dental payment rates.

At this time it is not clear of the actual impact of the rate changes. It is also not clear how the legislature will act during the 2015 session on the recommendations made in the legislative report of 2014. Therefore, goals will be set on an annual basis until these variables until these variables are better understood.

Olmstead Plan Measurable Goal Worksheet

Olmstead Plan Action item Code:
HC 2C
Description of Action item:
Current plan language: By June 30, 2014, using information from this study, develop a plan for implementation including timelines and measurable goals.
Agency/Agency Lead:
DHS/ Brownell Mack

Population Statement
1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item) The total number of disabled adults identified in Medicaid with continuous eligibility in calendar year 2013 was 167,448. Of this group, 80,928 received at least one dental service during calendar year 2013, leaving a total of 86,520 individuals who could benefit from the action item.
a. What is the source and date of that number? September 2014, Draft Report for Olmstead HC 2G, version 4
b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.) Individuals age 21-64 as of December 31, 2013 and continuously enrolled in Medicaid during calendar year 2013. This is a statewide survey in all settings and is intended to include a wide range of disabilities including blindness, loss of physical function, mental illness, and certain severe medical conditions. Continuous enrollment for this measure allows no more than a single 45 day gap in enrollment. This is a statewide number for all of Medicaid and includes people with eligibility types indicating disability and people whose claims history suggests disability. An algorithm is used to evaluate claims history. The algorithm takes into consideration a wide range of factors to capture many different types of disabilities, including severe mental health conditions, chemical dependency with mental illness, extended hospitalizations, blindness, physical disability, paralysis, development disability, living in a facility for adults with mental illness, end stage renal disease, HIV infection, and homelessness .
c. How is this number relevant to this part of the plan? This number provides a statewide look at adult dental utilization in Medicaid for persons with many different types of disabilities in both managed care and fee-for-service.
d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths). This number will change based on the number of people in the age range who are continuously enrolled in Medicaid during the measurement year. People age 64 in 2013 will age out in future measurement years. People under 21 not included in 2013 will be included in future years. People may not be included in future measurement years if their incomes increase and they are no longer eligible for Medicaid.

e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50 Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?)

We have no concerns with duplication.

Current Status or Baseline

2. Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide)

80,928

a. Explain how this number was reached

Dental utilization for the population described in item 1b was evaluated by applying the Healthcare Effectiveness Data and Information Set (HEDIS) to DHS claims data and encounter data. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Using the HEDIS measure allows comparison of performance to private health plans.

b. Explain any weaknesses or limitations with this number

The data is limited to Medicaid adult populations. HEDIS data represents utilization, not access. HEDIS data does not assess utilization in relationship to need. However, HEDIS data allows DHS to seek to improve performance relative to private health insurance.

c. Explain plans to address these weaknesses/limitations

As part of development of the report required by HC 2G by December 31, 2014, DHS will develop baselines and measurable goals for children and seniors.

Goal – Change in Baseline over time

3. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number)

a. In 2015?

The legislative change in rates is not likely to be implemented in time to affect 2015 utilization.

b. In 2016?

By July 1, 2016, provide Medicaid dental services to at least 335 more disabled adult enrollees than the baseline. (Due to claims processing timelines, confirmation may not be available until at least December 31, 2016).

c. In 2017?

Not yet determined

Goal – Change in Baseline over time
d. In 2018? Not yet determined
e. In 2019? Not yet determined.

Rationale
4. Why is the number in 3 reasonable?
a. Is the goal funded or resourced so that it is realistic? The 2015 legislature is expected to authorize an increase in dental payment rates.
b. Is this goal based upon past performance or historical trends? This goal is based upon trends experienced in other states that have raised dental payment rates.
c. Over a five year period will this projection have significant impact on the lives of people with disabilities? Not yet clear.
d. Why is this number not higher or lower?