Minnesota Department of **Human Services**

August 10, 2015

The Honorable Donovan W. Frank
United States District Court
724 Federal Building
316 North Robert Street
St. Paul, MN 55101

Re: *Jensen, et al. v. Minnesota Department of Human Services, et al.*
Court File No.: 09-CV-01775 DWF/FLN
Revised Olmstead Plan

Dear Judge Frank,

I am pleased to present the revised Olmstead Plan, as ordered by the Court on May 6, 2015 (Dkt. 435) and on July 9, 2015 (Dkt. 472). This morning, the Olmstead Subcabinet Executive Committee adopted this Plan on behalf of the Subcabinet.

As you know, this revised Plan is the result of many hours of hard work on the part of Plaintiffs' class counsel, the Executive Director of the Governor's Council on Disabilities, the Ombudsman for Mental Health and Disabilities, Olmstead Subcabinet members, and agency staff. I am sure you are also aware that the Plan presented to you today would not have been possible without the time and effort of Magistrate Judge Thorson, and I would like the Court to know that the State is most grateful to her and her staff for facilitating development of the Plan.

You will see that this is a very different Plan from previous versions. This Plan focusses on setting measurable goals to achieve defined outcomes, rather than on government processes and actions alone. The Plan has eleven topic areas; each one contains one or more measurable goals over a three to five-year period, with annual targets. Two additional topic areas are currently under development and will be added in 2016. We have chosen three to five years as the immediate strategic planning period, but we intend the Olmstead Plan to continue well into the future, as a dynamic roadmap, determining its direction from information gained by experience implementing the Plan.

Each measurable goal is accompanied by broad strategies for how the goal will be achieved, as well as by a "rationale" section explaining the reasons for the goal. Funding is

either addressed in the rationale section, or will be addressed in the relevant work plans. The detailed implementation of the strategies will be addressed in work plans. These will be developed by each responsible agency or agencies working with the staff of the Olmstead Implementation Office, reviewed and approved by the Subcabinet and submitted to the court within 60 days, as the court has ordered. The work plans will contain specific actions, timelines for completion, and persons or entities responsible. We include an example of a work plan with the Plan submitted to you today.

Care was taken to ensure that the Plan submitted today accounted for all content contained in the original and previous versions of the Plan. To verify this, a comparison document was created showing all of the action items from the March 20, 2015 Plan and where each is accounted for in the current Plan. (Document attached).

We established the measurable goals using a set of criteria derived from the language in the *Jensen* Settlement Agreement, the Court's previous Orders, *Olmstead v. L.C.*, 527 U.S. 581 (1999), and the Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the ADA and *Olmstead v. L.C.* Taking all of these together, we established a checklist of criteria for the Plan and its content. Following is a summary of these criteria:

- Comprehensive: the Plan must include commitments for each group of people who are unnecessarily segregated;
- Baseline: each goal must have a baseline analysis from which progress can be measured;
- Measurable: the goal must achieve a defined outcome;
- Concrete, reliable, and realistic: the commitments must be specific, and capable of achievement in the specified time period;
- Strategic: the goals must be important to initiation, conduct, or completion of the Plan within the first three to five-year time period;
- Timeframes: there must be specific and reasonable timeframes established;
- Responsibility: the Plan must indicate which agency or agencies are responsible for achieving the goal;
- Resources/funding: the Plan must indicate the extent to which funding exists to support the relevant goal, including consideration of reallocating existing service dollars.

Additionally, I would like to highlight an area in which the revised Plan respectfully, proposes procedures that are also the subject of a previous Court Order. Regarding amendments to the Plan, the revised Plan establishes annual Subcabinet review of the measurable goals, with proposed amendments posted for public review and comment before the Subcabinet acts upon them.[1] Please note that the Court's Order of August 28, 2013 establishes procedures by which Plan modifications must be submitted to the Court Monitor, subject to review by the Court.[2]

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[1] "Updating and Extending the Olmstead Plan," p. 97.

[2] Order, Dkt. 224, August 28, 2013, p. 6.

We submit this Plan with the understanding that all parties—plaintiffs' class counsel, the Ombudsman, the Executive Director of the Governor's Council on Disabilities, and DHS—are in agreement, except for certain features of the Positive Supports and Waiting List portions of the Plan, where plaintiffs' class counsel is not in full agreement. Additionally, we have heard from and met with the Minnesota Disability Law Center on the provisions for Employment, Housing and Services, and the Waiting List. We have taken MDLC's comments into consideration in these provisions.

Finally, the revised Plan addresses communications and public relations.[3] The Olmstead Implementation Office (OIO) is responsible for managing communications and is responsible for responding to communications from the public. If the Court receives communications about the Olmstead Plan, the Court is invited to forward those communications to the OIO, which will work with agency staff to respond directly. Items may be forwarded by email to MNOlmsteadPlan@state.mn.us.

This is a promising time for people with disabilities in Minnesota, and for all citizens of the State, as greater inclusion and integration begin to enrich Minnesota's many communities in ways both seen and unseen. With the submission of this Plan we now turn to the difficult but exciting work of achieving our goals.

Sincerely,

Lucinda E. Jesson
Commissioner, Minnesota Department of Human Services

cc: Shamus O'Meara, Attorney for Plaintiffs
Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities
Colleen Wieck, Executive Director for the Governor's Council on Developmental Disabilities
Mary Tingerthal, Chair, Olmstead Subcabinet

[3] "Communications and public relations," p.98.

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

August 10, 2015 Revision

Feedback

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

Method	**Steps to follow**
Online	1. Go to: Mn.gov/Olmstead 2. Click "Participate" and follow instructions for the online form
In an Email	Send an email to this address: MNOlmsteadPlan@state.mn.us
In the Mail	Send a letter to: Olmstead Implementation Office 400 Sibley Street, Suite 300 St. Paul, MN 55101
On the Phone	Speak to a staff member at the Olmstead Implementation Office, or leave your comment on voicemail. 651-296-8081

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Minnesota Olmstead Subcabinet

August 10, 2015

To the People of Minnesota,

On behalf of the Olmstead Subcabinet, I am pleased to present this new Olmstead Plan for the State of Minnesota. The title of the Plan – *Putting the Promise of Olmstead into Practice: Minnesota's Olmstead Plan* – speaks to our intentions and our commitment.

We are firmly committed to building a future where people with disabilities experience lives of inclusion and integration in the community – just like people without disabilities. We envision a Minnesota where people with disabilities have the opportunity to live close to their families and friends and as independently as possible, to work in competitive, integrated employment, to be educated in integrated schools and to participate fully in community life.

This Plan is about choice, not about closure. The goals in this Plan will pave the way for Minnesotans with disabilities to express their preferences for how they choose to live, learn, work and engage in community life, while receiving the supports they need. The goals are also focused on increasing the options available for people with disabilities when they express those choices.

We intend this Plan to be both a proclamation of our commitment to integration and inclusion and a vital, dynamic roadmap for making our vision a reality. Because we will learn by implementing the Plan, it cannot be a static document. We expect that people with disabilities and their families will tell us what is working – and what is not working – when it comes to improving the quality of their lives. We will ask and we will listen, and we have proposed how we will amend this Plan in the future to improve the outcomes of our actions. We see this as a starting point – not a final destination.

Thank you to the people with disabilities that helped us to be bold in the commitments we make in this Plan. Thank you to the staff of our agencies who have worked to create ambitious, but realistic goals. Thank you to the thousands of people around the state who will work together on the many actions that it will take to bring reality closer to the vision statements expressed in this Plan for more people with disabilities.

Mary Tingerthal, Chair
Olmstead Subcabinet

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INTRODUCTION AND BACKGROUND INFORMATION

Introduction

The State of Minnesota is firmly committed to ensuring that people with disabilities experience lives of inclusion and integration in the community, just like the lives of people without disabilities. We envision a Minnesota where people with disabilities have the opportunity, both now and in the future, to live close to their families and friends and as independently as possible, to work in competitive, integrated employment, to be educated in integrated settings, and to participate in community life.

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

Background Information

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

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

Olmstead v. L.C.

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

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

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[1] "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.,"* U.S. Department of Justice, Civil Rights Division, June 22, 2011, Question 12, p. 4 ("DOJ Statement"), last accessed August 6, 2015, http://www.ada.gov/olmstead/q&a_olmstead.htm.
[2] *Olmstead v. L.C.,* 527 U.S. 581 (1999).
[3] "DOJ Statement, p. 1, *citing* 42 U.S.C. §12101(a)(2).
[4] 42 U.S.C. §12132.
[5] 28 C.F.$. §35.130(d).
[66] 28 C.F.R. Pt. 35, App. A (2010)(addressing §35.130).
[7] *Olmstead v. L.C.,* 527 U.S. 581 (1999).

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

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

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

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

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 Department of Justice (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).[12] The DOJ has also issued guidance for government entities to help them comply with the principles of the ADA and the *Olmstead* decision. Minnesota consulted this guidance in developing its Olmstead Plan.[13]

[8] *Olmstead v. L.C.,* 527 U.S. at 607.
[9] 28 C.F.R. §35.130(b)(7).
[10] *Olmstead v. L.C.,*527 U.S. at 603.
[11] 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.
[12] For a list of recent DOJ enforcement actions, review US DOJ, "Olmstead: Community Integration for Everyone." Accessed August 5, 2015, http://www.ada.gov/olmstead/olmstead_enforcement.htm.
[13] 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 5, 2015, http://www.ada.gov/olmstead/q&a_olmstead.htm.

Why does Minnesota have an Olmstead Plan?

Minnesota has an Olmstead Plan to ensure that Minnesotans with disabilities have opportunities for lives of integration and inclusion. To this end, in both 2013 and 2015, Governor Mark Dayton issued Executive Orders forming an Olmstead Subcabinet and charged the subcabinet with developing and implementing an Olmstead Plan.[14] Moreover, we know that implementing a comprehensive, effectively working Plan will keep the state accountable to complying with the letter and spirit of the *Olmstead* decision and the ADA.

Beyond that, however, Minnesota has an Olmstead Plan to fulfill an agreement made in the settlement of a class action lawsuit in U.S. District Court in a case called *Jensen v. DHS.*[15] *Jensen* involved people with developmental disabilities who had been residents of a Department of Human Services (DHS) facility. In 2011, that case resolved in a settlement agreement, which included a provision for an Olmstead Plan. The settlement agreement stated: "the State and the Department shall develop and implement a comprehensive *Olmstead* plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs in the "most Integrated Setting," and is consistent and in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.,* 527 U.S.582 (1999).

Developing Minnesota's Olmstead Plan

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

In January, 2013, Governor Mark Dayton issued Executive Order 13-01 establishing a subcabinet to develop and implement a comprehensive plan supporting freedom of choice and opportunity for people with disabilities. The Olmstead Subcabinet, then 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 January 2015, Governor Dayton issued Executive Order 15-03 which further defined the role and nature of the Olmstead Subcabinet. He subsequently designated Commissioner Mary Tingerthal of the Minnesota Housing Finance Agency to be the chair of the subcabinet.

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[14] Executive Orders 13-01 and 15-03, available in Appendix A and at http://mn.gov/governor/images/EO-13-01.pdf

[15] *Jensen, et. al. v. Department of Human Services, et. al.,* Civil No. 09-cv-1775 (DWF/FLN).

Olmstead Subcabinet vision statement

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

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

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

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

Demographics & implications

To better understand how to make the subcabinet's vision a reality, demographic information was reviewed about the state's population of people with a disability. Although this Olmstead Plan applies to people with disabilities as defined in the ADA,[16] available demographic data used a different definition of disability, one that excluded persons living in congregate settings.[17] Nevertheless, the information we have still helps us understand essential features and trends about the populations of Minnesotans with disabilities.

For example, data shows that Minnesotans with disabilities live in poverty at a higher rate than Minnesotans without disabilities;[18] and that the highest rates of disabilities among working-age Minnesotans are American Indians and U.S.-born African Americans.[19]

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

According to a 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

[16] 42 U.S.C. §12102 The term "disability" means, with respect to an individual - (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.
[17] Data from the American Community Survey and Decennial Census and Population Estimates, via Minnesota Compass, http://www.mncompass.org/demographics/
[18] Ibid.
[19] Ibid.

evidence of a traumatic brain injury, and 22% reported a substance abuse disorder. 70% (3,719 adults) reported at least one of these conditions.[20]

Recent media attention has focused on one disability that has increased dramatically. According to the Centers for Disease Control, autism has increased from a prevalence rate of 1 in 1,000 in 1970, to 1 in 150 in 2000, to 1 in 88 in 2012.[21]

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

Public comments

Since drafting the original Olmstead Plan, the subcabinet and state agency staff members, have continued to accept and encourage public comments on the Olmstead Plan and its implementation. Between June, 2013 and June, 2015, over 400 public comments were received by the Olmstead Implementation Office. In addition, since the original plan was submitted, members of the Olmstead Subcabinet and the Olmstead Implementation Office have attended more than 100 public listening sessions, or information sessions with specific groups. We listened to these comments and used them to determine the scope of the Plan, the topics it contains, and what outcomes the Plan should achieve.

All public comments were reviewed and distributed to the appropriate State agencies so that the agency teams would consider them in the drafting and implementation of the Plan.

Several themes emerged from stakeholder comments[22] during the most recent comment period (April 24, 2014 to June 19, 2015). Of the 175 comments received, 80% of the comments related to 11 theme areas. Those themes are summarized below and indicate the number of comments related to the theme. The total comments exceed 175 because some individuals commented on more than one area.

[20] 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.

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

[22] These themes are based on a qualitative review of information from individuals who made comments online or at listening sessions from April 2014 – June 2015. We realize that these opinions may not reflect the opinions of all relevant stakeholders or Minnesotans in general.

Theme Definitions

1) **Options and Choices** (107 comments) – People expressed that a "one size fits all" plan will not work. An array of options needs to be funded and available for people to meet the needs and choices of individuals. An example would be providing opportunities for integrated housing and competitive integrated employment or intentional communities such as sober housing, or center based day activities.
   - Influence of comments in this theme can be seen in Person Centered Planning, Transition Services, Housing & Services, and Employment

2) **Financial Resources** (51 comments) – People noted that rates for reimbursement of service and affordability of service are important. They also noted that there should be adequate funding for services.
   - Influence of comments in this theme can be seen in Transition Services, Waiting List, Health Care & Healthy Living, and Crisis Services

3) **Quality Assurance/Accountability** (41 comments) – People expect agencies to be accountable for the goals within the Plan. Work needs to be transparent and consistent in order for the public to hold agencies accountable. People also expressed the need to resolve conflict with agencies in a more effective and efficient manner. Examples include having a clear understanding of who will monitor providers to ensure that they are implementing person centered plans and ensuring that individuals have opportunities to make informed choices.
   - Influence of comments in this theme can be seen in Person Centered Planning, Transition Services, and Plan Management & Oversight

4) **Access** (41 comments) – People shared that not everyone can access the programs/services. This may be physical access, lack of awareness about programs/services, and/or policy barriers that prevent access. For example a person may need services, but the types of services they need are not available in their area. Or they may need services but they do not meet the qualification criteria to enter a given program.
   - Influence of comments in this theme can be seen in Transition Services, Housing & Services, Employment, Lifelong Learning & Education, Waiting List, Transportation, and Crisis Services

5) **Risk** (35 comments) – People expressed concern about personal safety. People perceive the opportunity to try different things as a risk, particularly if there is no option to return to what they were doing previously. Making changes in our lives is always a risk and we need to understand how that change may impact us positively and/or negatively.
   - Influence of comments in this theme can be seen in Person Centered Planning and Transition Services

6) **Person-Centered** (28 comments) – People feel strongly that individuals should be able to make informed decisions in all areas of their lives. For example, people with disabilities should have opportunities to make informed decisions and not be told they only have one option available.
   - Influence of comments in this theme can be seen in Person Centered Planning, Transition Services, Housing & Services, Employment, and Lifelong Learning & Education

7) **Barriers/Disincentives** (24 comments) – People shared that there are many policies that prevent individuals, families and businesses from achieving the Olmstead vision. An example would be a policy that requires a person with a disability be determined unable to work in order to receive services that they need, when in fact they can work.
   - Influence of comments in this theme will be identified in workplans that correspond to the measurable goals.

8) **Engagement** (24 comments) – People said that individuals with disabilities should be meaningfully involved in the direction of those policies and other things that impact their lives. While each individual defines meaningful engagement differently their voice is important and needs to be heard more consistently. "Nothing about us, without us" is often quoted by people with disabilities seeking changes to policy.
   - Influence of comments in this theme can be seen in Community Engagement

9) **Data** (22 comments) – People are dissatisfied with many of the data sources being used. They expressed that data needs to be robust and understandable. . Many people feel that as a state we collect a great deal of data about our citizens. Based on comments received it has been difficult for people to understand why we used certain data in the past. Many people also shared that they felt some data was too limited and didn't represent enough people with disabilities to be impactful in making change.
   - Influence of comments in this theme can be seen in cross agency coordination of data strategies section and all topic areas

10) **Training and Technical Assistance** (22 comments) - People said that training and technical assistance is needed for everyone. An example would be training for creating person centered plans so that there is consistency in how plans are being developed statewide. This training should be available to providers, advocates, people with disabilities and their families.
   - Influence of comments in this theme can be seen in Person Centered Planning, Transition Services, Housing & Services, Employment, Lifelong Learning & Education, Positive Supports

11) **Accessible Communications** (22 comments) - People are dissatisfied with the current level of accessibility in state communications. Providing accessible communications will lead to transparency and awareness. An example would be documents that cannot be read with a screen reader, or only providing information through a website.
   - Influence of comments in this theme can be seen in the Communications and public relations section

The August 2015 Plan

The August 2015 Plan focuses on setting measurable goals to both: 1) increase opportunities for people with disabilities to receive services that best meet their individual needs in the most integrated setting; and, 2) improve service delivery to promote a better quality of life. In this way, the Plan differs from the original and other previous versions, which laid out processes to implement tasks, but in many areas lacked measurable goals to achieve defined outcomes.

Going forward, the Olmstead Plan will contain measurable goals and broad strategies to achieve them, but the detailed actions to implement the strategies will be contained in separate workplans created by the responsible agencies. In October, 2015, workplans will be posted on the Olmstead website and submitted to the U.S. District Court. The subcabinet will review progress on the workplans on a periodic basis. More information on the workplans is available in the Plan Management and Oversight section.

During the drafting of the current Plan, care was taken to make sure all content from the original and previous versions of the Plan was accounted for. To verify this, a comparison document was created showing all of the action items from the March 20, 2015 Plan and how they relate to the August 2015 Plan and agency workplans. The comparison document is posted on the Olmstead website and available to the public upon request.

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MEASURABLE GOALS

Topic Areas and Measurable Goals

The August 2015 Plan is organized into 13 topic areas that cover different aspects of improving the quality of life for people with disabilities as indicated in the table below.

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

Measurable goals

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

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

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

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

The following criteria were used for setting measurable goals:

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

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

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

- **Strategic**: Each measurable goal sets its outcomes and activities over a three to five-year period.

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

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

Format of topic areas

Each topic area contains eight sections as described below:

- **Stakeholder comments**
  This section includes comments from stakeholders that voice the thoughts of people with disabilities on the topic area.
- **What this topic means**
  This section provides a narrative description of the topic area.
- **Vision statement**
  This section contains a Vision Statement that describes the state's aspirations for the topic area.
- **What we have achieved**
  This section includes key accomplishments, important reports and documents related to the topic area that were either required by the Plan or related to and utilized in implementation of the Plan to date. The referenced reports are listed in Appendix A and are available on the Olmstead website.
- **Measurable goals**
  This section contains one or more measurable goals that meet the criteria described above.
- **Rationale**
  This section includes statements that support the reasons that the particular measurable goals were selected to be the appropriate measurements for the activities within the topic area and the status of funding for the goals in the topic area.
- **Strategies**
  This section contains several key strategies that will need to be implemented to accomplish the measurable goals in that area. Responsible agencies will develop workplans that will include steps for implementing these strategies. The workplans will be posted on the Olmstead website and reviewed regularly by the subcabinet.
- **Responsible agencies**
  This section lists the state agencies that will be primarily responsible for the implementation of the activities described in the topic area.

Measurable Goals at a Glance

The table below provides a summary of the measurable goals contained in the Plan that indicate targeted outcomes within three to five years. More information about the specific goals is included in the topic area sections of the Plan.

Topic	Goals	Agency*
Person-Centered Planning	**Goal One:** By June 30, 2020, plans for people using disability home and community-based waiver services will meet required protocols. Protocols will be based on the principles of person centered planning and informed choice. **Annual Goals** for the percent of plans that meet required protocols: • By June 30, 2016, the percent of plans will increase to 30% • By June 30, 2017, the percent of plans will increase to 50% • By June 30, 2018, the percent of plans will increase to 70% • By June 30, 2019, the percent of plans will increase to 85% • By June 30, 2020, any plans that do not meet the required protocols will be revised to contain required elements of person centered plans.	DHS, DEED, MDE
	Goal Two: By 2017, increase the percent of individuals with disabilities who report that they exercised informed choice, using each individual's experience regarding their ability: to make or have input into major life decisions and everyday decisions, and to be always in charge of their services and supports, as measured by the National Core Indicators (NCI) survey. **Annual Goals** for the percent reporting they have input into major life decisions: • By 2015, the percent will increase to > 45% • By 2016, the percent will increase to > 50% • By 2017, the percent will increase to ≥ 55% **Annual Goals** for the percent reporting they have input in everyday decisions: • By 2015, the percent will increase to ≥ 84% • By 2016, the percent will increase to ≥ 85% • By 2017, the percent will increase to ≥ 85% **Annual Goals** the percent reporting they are always in charge of their services and supports: • By 2015, the percent will increase to ≥ 70% • By 2016, the percent will increase to ≥ 75% • By 2017, the percent will increase to ≥ 80%	

* Agency acronyms are listed at the end of the table

Topic	Goals	Agency*
Transition Services	**Goal One:** By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings will be 7,138. **Annual Goals** for the number of people moving from ICFs/DD, nursing facilities and other segregated settings • By June 30, 2015, the number moving will be 874 • By June 30, 2016, the number moving will be 1,074 • By June 30, 2017, the number moving will be 1,224 • By June 30, 2018, the number moving will be 1,322 • By June 30, 2019, the number moving will be 1,322 • By June 30, 2020, the number moving will be 1,322	DHS, DOC, MHFA
	Goal Two: By June 30, 2019, the percent of people at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting will be reduced to 30% (based on daily average). **Annual Goals** to reduce the percent of people at AMRTC awaiting discharge: • By June 30, 2016 the percent will reduce to ≤ 35% • By June 30, 2017 the percent will reduce to ≤ 33% • By June 30, 2018 the percent will reduce to ≤ 32% • By June 30, 2019 the percent will reduce to ≤ 30%	
	Goal Three: By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital will increase to 14 individuals per month. **Annual Goals** to increase average monthly number of individuals leaving MSH: • By December 31, 2015 the number will increase to ≥ 10 • By December 31, 2016 the number will increase to ≥ 11 • By December 31, 2017 the number will increase to ≥ 12 • By December 31, 2018 the number will increase to ≥ 13 • By December 31, 2019 the number will increase to ≥ 14	
	Goal Four: By June 30, 2018, 50% of people who transition from a segregated setting will engage in a person centered planning process that adheres to transition protocols that meet the principles of person centered planning and informed choice. **Annual Goals** to increase the percent of plans that adhere to transition protocols: • By June 30, 2016, the percent will increase to 15% • By June 30, 2017, the percent will increase to 30% • By June 30, 2018, the percent will increase to 50%	

Topic	Goals	Agency*
Housing & Services	**Goal One:** By June 30, 2019, the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing will increase by 5,547 (from 6,017 to 11,564 or about a 92% increase). **Annual Goals** to increase the number living in the most integrated housing: • By June 30, 2015, the number will increase by 617 over baseline • By June 30, 2016 the number will increase by 1,580 over baseline • By June 30, 2017 the number will increase by 2,638 over baseline • By June 30, 2018 the number will increase by 4,009 over baseline • By June 30, 2019 the number will increase by 5,547 over baseline	DHS, MHFA
Employment	**Goal One:** By September 30, 2019 the number of new individuals receiving Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) who are in competitive, integrated employment will increase by 14,820. **Annual Goals** to increase the number in competitive, integrated employment**:** • By September 30, 2015, the number will increase by 2,853 • By September 30, 2016, the number will increase by 2,911 • By September 30, 2017, the number will increase by 2,969 • By September 30, 2018, the number will increase by 3,028 • By September 30, 2019, the number will increase by 3,059	DHS, DEED, MDE
	Goal Two: By June 30, 2020, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 5,015 or 10% in competitive, integrated employment. **Annual Goals** to increase the number in competitive, integrated employment • By June 30, 2017, a data system will be developed. • By June 30, 2017, the number will increase by 1,500 individuals • By June 30, 2018, the number will increase by 1,100 individuals • By June 30, 2019, the number will increase by 1,200 individuals • By June 30, 2020, the number will increase by 1,200 individuals	
	Goal Three: By June 30, 2020, the number of students with developmental cognitive disabilities, ages 19-21 that enter into competitive, integrated employment will be 763. **Annual Goals** for the number of students in competitive, integrated employment: • By June 30, 2016, the number will be 125 • By June 30, 2017, the number will be 188 • By June 30, 2018, the number will be 150 • By June 30, 2019, the number will be 150 • By June 30, 2020, the number will be 150	

Topic	Goals	Agency*
Lifelong Learning & Education	**Goal One:** By December 1, 2019 the number of students with disabilities, receiving instruction in the most integrated setting, will increase by 1,500 (from 67,917 to 69,417). **Annual Goals** for the number of students in the most integrated settings: • By December 1, 2015 the number will increase by 300 over baseline • By December 1, 2016 the number will increase by 600 over baseline • By December 1, 2017 the number will increase by 900 over baseline • By December 1, 2018 the number will increase by 1,200 over baseline • By December 1, 2019 the number will increase by 1,500 over baseline	MDE, DHS, DOC
	Goal Two: By October 1, 2020 the number of students who have entered into an integrated postsecondary setting within one year of leaving secondary education will increase by 250 (from 225 to 475). **Annual Goals** to increase the number of students entering an integrated postsecondary education setting are: • By October 1, 2016 the number will increase by 50 over baseline • By October 1, 2017 the number will increase by 100 over baseline • By October 1, 2018 the number will increase by 150 over baseline • By October 1, 2019 the number will increase by 200 over baseline • By October 1, 2020 the number will increase by 250 over baseline	

Topic	Goals	Agency*
Waiting List	**Goal One:** By October 1, 2016, the Community Access for Disability Inclusion (CADI) waiver waiting list will be eliminated.	DHS
	Goal Two: By December 1, 2015, the Developmental Disabilities (DD) waiver waiting list will move at a reasonable pace. **For persons exiting institutional settings** • Beginning December 1, 2015, as people residing in an institutional setting are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person makes an informed choice of alternative community services that are more integrated, appropriate to meet their individual needs, and the person is not opposed to moving, and would like to receive home and community based services. **For persons with an immediate need** • Beginning December 1, 2015, as people are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person meets criteria under Minn. Statutes, sections 256B.49, subdivision 11a(b) and 256B.092, subdivision 12(b)**.** **For persons with a defined need** • Beginning December 1, 2015, as people are assessed as having a defined need for waiver services within a year from the data of assessment, and within available funding limits, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days of determining the defined need.	
	Goal Three: By March 1, 2017, the DD waiver waiting list will be eliminated for persons leaving an institutional setting and for persons with immediate need as defined by Minn. Statutes, sections 256B.49, subdivision 11a(b) and 256B.092, subdivision 12(b).	
	Goal Four: By December 31, 2018, within available funding limits, waiver funding will be authorized for persons who are assessed and have a defined need on or after December 1, 2015, and have been on the waiting list for more than three years.	
	Goal Five: By June 30, 2020, the DD waiver waiting list will be eliminated, within available funding limits, for persons with a defined need.	

Topic	Goals	Agency*
Transportation	**Goal One:** By December 31, 2020 accessibility improvements will be made to 4,200 curb ramps (increase from base of 19% to 38%) and 250 Accessible Pedestrian Signals (increase from base of 10% to 50%). By January 31, 2016, a target will be established for sidewalk improvements. **Annual Goals** to increase the number of APS installations: • By December 31, 2015, there will be an additional 50 APS installations • By December 31, 2016, there will be an additional 50 APS installations • By December 31, 2017, there will be an additional 50 APS installations • By December 31, 2018, there will be an additional 50 APS installations • By December 31, 2019, there will be an additional 50 APS installations	MnDOT, Metro-politan Council
	Goal Two: By 2025, additional rides and service hours will increase the annual number of passenger trips to 18.8 million in Greater Minnesota (approximately 50% increase). **Annual Goals** to increase the annual number of passenger trips: • By 2015 the number of trips will increase to 13,129,593 • By 2020 the number of trips will increase to 16,059,797 • By 2025 the number of trips will increase to 18,800,000	
	Goal Three: By 2020, expand transit coverage so that 90% of the public transportation service areas in Minnesota will meet minimum service guidelines for access.	
	Goal Four: By 2020, transit systems' on time performance will be 90% or greater statewide.	

Topic	Goals	Agency*
Healthcare & Healthy Living	**Goal One:** By December 31, 2018, the number/percent of individuals with disabilities and/or serious mental illness accessing appropriate preventive care, focusing specifically on cervical cancer screening, and follow up care for cardiovascular conditions will increase by 833 people compared to the baseline. **Annual Goals** to increase the number of individuals accessing appropriate care: • By December 31, 2016 the number will increase by 205 over baseline • By December 31, 2017 the number will increase by 518 over baseline • By December 31, 2018 the number will increase by 833 over baseline	DHS, MDH
	Goal Two: By December 31, 2018, the number of individuals with disabilities and/or serious mental illness accessing dental care will increase by 1,229 children and 1,055 adults over baseline. **Annual Goals** to increase the number of **children** accessing dental care: • By December 31, 2016 the number will increase by 410 over baseline • By December 31, 2017 the number will increase by 820 over baseline • By December 31, 2018 the number will increase by 1,229 over baseline **Annual Goals** to increase the number of **adults** accessing dental care: • By December 31, 2016 the number will increase by 335 over baseline • By December 31, 2017 the number will increase by 670 over baseline • By December 31, 2018 the number will increase by 1,055 over baseline.	
Positive Supports	**Restrictive procedures for people with disabilities are prohibited except when used in an emergency situation. These goals seek reduction to the exceptions to restrictive procedures.** **Goal One:** By June 30, 2018 the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) who experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will decrease by 5% or 200. **Annual Goals** to reduce number of people experiencing a restrictive procedure: • By June 30, 2015 the number will be reduced by 5% or 54 • By June 30, 2016 the number will be reduced by 5% or 51 • By June 30, 2017 the number will be reduced by 5% or 49 • By June 30, 2018 the number will be reduced by 5% or 46	DHS, MDE, MDH, DOC

Topic	Goals	Agency*
Positive Supports	**Goal Two:** By June 30, 2018, the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) will decrease by 1,596. **Annual Goals** to reduce the number of reports of restrictive procedures: • By June 30, 2015 the number will be reduced by 430 • By June 30, 2016 the number will be reduced by 409 • By June 30, 2017 the number will be reduced by 388 • By June 30, 2018 the number will be reduced by 369	DHS, MDE, MDH, DOC
	Goal Three: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, with limited exceptions to protect the person from imminent risk of serious injury. (Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and safety clips for safe vehicle transport). By December 31, 2019 the emergency use of mechanical restraints will be reduced to $\leq$ 93 reports and $\leq$ 7 individuals. **Annual Goals** to reduce the use of mechanical restraints: • By June 30, 2015, reduce to 461 reports and 31 individuals • By June 30, 2016, reduce to 369 reports and 25 individuals • By June 30, 2017, reduce to 277 reports and 19 individuals • By June 30, 2018, reduce to 185 reports and 13 individuals • By June 30, 2019, reduce to 93 reports and 7 individuals	
	Goal Four: By June 30, 2017, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 316. **Annual Goals** to reduce the number experiencing restrictive procedures at school: • By June 30, 2015, the number will be reduced by 110 • By June 30, 2016, the number will be reduced by 105 • By June 30, 2017, the number will be reduced by 101	
	Goal Five: By June 30, 2017, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 2,251. **Annual Goals** to reduce number of incidents of restrictive procedures in school: • By June 30, 2015, the number will be reduced by 781 • By June 30, 2016, the number will be reduced by 750 • By June 30, 2017, the number will be reduced by 720	

Topic	Goals	Agency*
Crisis Services	**Goal One:** By June 30, 2018, the percent of children who receive children's mental health crisis services and remain in their community will increase to 85% or more. **Annual Goals** to increase the percent of children who remain in their community after a crisis: • By June 30, 2016, the percent will increase to 81% • By June 30, 2017, the percent will increase to 83% • By June 30, 2018, the percent will increase to 85%	DHS, MDE
	Goal Two: By June 30, 2018, the percent of adults who receive adult mental health crises services and remain in their community (e.g., home or other setting) will increase to 89% or more. **Annual Goals** to increase the percent of adults who remain in their community after a crisis: • By June 30, 2016, the percent will increase to 84% • By June 30, 2017, the percent will increase to 86% • By June 30, 2018, the percent will increase to 89%	
	Goal Three: By June 30, 2017, the number and percent of people who discontinue waiver services after a crisis will decrease to 45% or less. (Leaving the waiver after a crisis indicates that they left community services, and are likely in a more segregated setting.) **Annual Goals** to decrease the number who discontinue waiver services after a crisis: • By June 30, 2015, the number will decrease to no more than 60 people • By June 30, 2016, the number will decrease to no more than 55 people • By June 30, 2017, the number will decrease to no more than 45 people	
	Goal Four: By June 30, 2018, people in community hospital settings due to a crisis, will have appropriate community services within 30 days of no longer requiring hospital level of care, and will have a stable, permanent home within 5 months after leaving the hospital. • By February, 2016 a baseline and annual goals will be established.	
	Goal Five: By June 20, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary, placement within ten days. • By January 31, 2016, establish a baseline of the length of time it takes from referral for crisis intervention to the initiation of crisis services and develop strategies and annual goals to increase access to crisis services, including specific measures of timeliness.	

Topic	Goals	Agency*
Community Engagement	**Goal One:** By June 30, 2019, the number of individuals involved in their community in ways that are meaningful to them will increase to 1,992. **Annual Goals** to increase the number of self-advocates: • By June 30, 2016, the number will increase by 50 • By June 30, 2017, the number will increase by 75 • By June 30, 2018, the number will increase by 100 • By June 30, 2019, the number will increase by 150 **Annual Goals** to increase the number involved in public planning projects**:** • By June 30, 2016, the number will increase by 50 • By June 30, 2017, the number will increase by 75 • By June 30, 2018, the number will increase by 100 • By June 30, 2019, the number will increase by 150	OIO
Topic Areas Under Development		
Assistive Technology	By 2016, a baseline and measurable goals will be established for expanding the use of assistive technology to increase access to integrated settings.	ADM
Prevent Abuse & Neglect	By 2016, a baseline and measurable goals will be established on statewide levels and trends of abuse, neglect, exploitation, injuries, and deaths.	MDH

Agency Acronyms

ADM – Department of Administration	MDH – Minnesota Department of Health
DEED – Department of Employment and Economic Development	MHFA – Minnesota Housing Finance Agency
DHS – Department of Human Services	MnDOT – Minnesota Department of Transportation
DOC – Department of Corrections	OIO – Olmstead Implementation Office
MDE – Minnesota Department of Education	

Person-Centered Planning

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

What this topic means

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

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

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

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

centered service plan. The full rule, 42 CF.R. Pt. 430, 431 et al, is available at http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf (§441.725 contains the description of a person-centered service plan).

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

Definition of Person-Centered Planning

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

Statement of Core Values and Principles of Person-Centered Planning

Person-centered planning embraces the following values and principles:

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

- Services, treatments, interventions and supports honor what is important to people (e.g. their goals and aspirations for a life, overall quality of life) and promote dignity, respect, interdependence, mastery and competence.
- Plans include sufficient proactive support and organization to prevent unnecessary life disruption and/or loss especially during transition periods or crisis recovery.
- Community presence, participation, and connection are expected and supported through the use of natural relationships and community connections in all aspects of the plan to assist in ending isolation, disconnection and disenfranchisement of the individuals.
- The process is based on mutually respectful partnerships that empower the person who is the focus of the plan and is re 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.

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

Vision statement

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

What we have achieved

- Trained and provided technical assistance to 4,655 people on person centered thinking, and person centered planning since 2012. Developed a Person-Centered Organizational Development Tool for use by providers and trained 470 provider staff from across the state.
- In 2015, engaged four agencies in a yearlong training and technical assistance project with DHS and the Institute on Community Integration to create organizational and system change to support person centered practices.
- Adapted and tested a Person-Centered Plan Scoring Criteria and Checklist tool to assess whether plans contain characteristics of a person centered plan. Once approved by the subcabinet it will be made available on the Olmstead website and upon request in multiple formats.
- Over 1,300 people attended the two day 2015 Minnesota Age and Disability Odyssey conference which had as its theme "Person Centered Perspectives".
- 607 provider agencies received grant funding to further person centered practices.
- Selected a Quality of Life Survey Tool for implementation.
- Secured funding for and completed the pilot survey designed to test the effectiveness of the selected survey tool.

- Completed "Minnesota's Olmstead Plan Quality of Life Survey Pilot Study" Report
- Requested and received funding for the full implementation of the Quality of Life Survey for the 2016-2017 biennium.

Measurable goals

Goal One: By June 30, 2020, plans for people using disability home and community based waiver services will meet required protocols. Protocols will be based on the principles of person centered planning and informed choice.

Baseline: In state fiscal year, 38,550 people were served on the disability home and community based services. However, a baseline for the current percentage of plans that meet the principles of person centered planning and informed choice needs to be established.

Annual Goals to increase the percent of plans that meet the required protocol:

- By June 30, 2016, the percent of plans that meet the required protocols will increase to 30%
- By June 30, 2017, the percent of plans that meet the required protocols will increase to 50%
- By June 30, 2018, the percent of plans that meet the required protocols will increase to 70%.
- By June 30, 2019, the percent of plans that meet the required protocols will increase to 85%
- By June 30, 2020, any plans that do not meet the required protocols will be revised to contain required elements of person centered plans.

Goal Two: By 2017, increase the percent of individuals with disabilities who report that they exercised informed choice, using each individual's experience regarding their ability: to make or have input into major life decisions and everyday decisions, and to be always in charge of their services and supports, as measured by the National Core Indicators (NCI) survey.

- By 2017, increase the percent of people with intellectual and developmental disabilities (I/DD) who report they have input into major life decisions[23] to 55% or higher.

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

  Annual Goals to increase the percent of people reporting they have input into major life decisions:

  - By 2015, the percent will increase to > 45%
  - By 2016, the percent will increase to > 50%
  - By 2017, the percent will increase to ≥ 55%

[23] Of those not currently living with family, percentage who chose or had input into where they live; of those not currently living with family, percentage who chose or had some input in choosing their roommates; among those with a day program or activity, percentage who chose or had some input in where they go during the day. Calculation was made by totaling the number of responders who answered the three questions, and totaling the number of affirmative responses and calculating the percentage.

- By 2017, increase the percent of people with intellectual and developmental disabilities who make or have input in everyday decisions[24] to 85% or higher.

  Baseline: In the 2014 NCI Survey, 79% reported they had input into everyday decisions

  Annual Goals to increase the percent of people reporting they have input in everyday decisions:

  - By 2015, the percent will increase to ≥ 84%
  - By 2016, the percent will increase to ≥ 85%
  - By 2017, the percent will increase to ≥ 85%

- By 2017, increase the percent of people with disabilities other than I/DD who are always in charge of their services and supports[25] to 80% or higher.

  Baseline: In the 2014 NCI Survey, 65% reported they were always in charge of their services and supports.

  Annual Goals to increase the percent of people reporting they are always in charge of their services and supports:

  - By 2015, the percent will increase to ≥ 70%
  - By 2016, the percent will increase to ≥ 75%
  - By 2017, the percent will increase to ≥ 80%

Rationale

- The primary focus in this area is to assure that person centered planning principles, including meaningful informed choice, are included in the planning process for all persons. This will begin with those receiving disability home and community based service waivers because they are a known group and an evaluation system is in place to sample plans on a routine basis. This group of people would also be under the federal requirements for person centered planning for home and community based services which took effect in March 2014. The intent is to extend the person centered planning requirements across populations beyond those using home and community based services.
- No baseline exists for the quality of person centered plans or the degree to which plans contain required principles of person centered planning and the informed choice of individuals. The National Core Indicator survey is a **sample survey** and has been validated for people with developmental disabilities. The NCI survey has been expanded for use by older adults and people with disabilities at risk of nursing facility level of care. The NCI survey will be used as a proxy to measure informed choice until the Olmstead Quality of Life survey is implemented.
- The Quality of Life Survey, has been validated across, all ages, all settings, and all disability groups.
- There is sufficient funding to implement these goals.

[24] Among those with a paid community job, percentage who chose or had some input in where they work; percentage who choose or help decide their daily schedule; percentage who choose or help decide how to spend their free time. Calculation was made by totaling the number of responders who answered the three questions, and totaling the number of affirmative responses and calculating the percentage.

[25] The percent who respond "yes" they are in charge of the supports and services.

Strategies

Broaden the Effective Use of Person-centered Planning Principles and Techniques for People with Disabilities

- Define and initiate person centered planning services to assist people with disabilities in expressing their needs and preferences about quality of life.
- Expand person centered planning principles across more populations to include Medical Assistance recipients using mental health or home care services, those served through DEED, MDE, those leaving correctional facilities, and those requiring a coordinated plan between education, human services, and/or health. Provide training on person centered planning practices and informed choice to people with disabilities and their families, counties, tribes, and providers.
- Actively promote and encourage implementation of best practices and person-centered strategies that support individualized service and housing options through, for example, Housing Options Best Practices Forum and communities of practice on person centered planning and transition protocols.
- Evaluate progress towards goals, and determine if additional strategies will be necessary to provide everyone receiving services through one of the four disability home and community-based service waivers with person centered plans, that include meaningful informed choice.

Evaluate the Effectiveness of Person-Centered Planning Principles and Techniques

- Use the NCI survey for measuring progress and add the Quality of Life survey when available in 2016. See the Plan Management and Oversight section of the Plan for more information on the Quality of Life Survey.
- Using the established protocols, measure the quality of plans and the extent to which they contain required elements of person centered planning through regular county and state audits. These audits will include technical assistance and/or improvement plans as indicated.
- Evaluate the potential of a monitoring role by the State Quality Council in light of 2015 legislative appropriations.

Responsible Agencies

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

Transition Services

Stakeholder Comments

"There needs to be funding for people that are in a nursing facility less than 90 days who need new housing."	DebJo Sathrum (2014)

What this topic means

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

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

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

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

Vision statement

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

What we have achieved

- Since November 2013[26] the numbers of people exiting institutional settings are as follows: Intermediate Care Facilities for individuals with Developmental Disabilities (ICFs/DD) = 107; Nursing Facilities (for persons with a disability under age 65 in facility longer than 90 days) = 1,002; Anoka Metro Regional Treatment Center (AMRTC) = 398; and Minnesota Security Hospital = 150.
- The MSHS-Cambridge facility was closed and replaced by community services.
- Developed and began initial implementation of transition protocols that meet the principles of person centered planning and informed choice for individuals exiting segregated settings.
- Life Bridge, AMRTC and Minnesota Security Hospital (MSH) staff have been trained and are using the transition protocols. Implementation with counties is underway.

Measurable goals

Goal One: By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings[27] will be 7,138.

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

	Baseline*	6/30/15	6/30/16	6/30/17	6/30/18	6/30/19	6/30/20	Cumulative Total
Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72*	84	84	84	72	72	72	468
Nursing Facilities (NF) under age 65 in NF > 90 days	707*	740	740	740	750	750	750	4,470
Segregated housing other than listed above	Not Available[28]	50	250	400	500	500	500	2,200
Total		**874**	**1,074**	**1,224**	**1,322**	**1,322**	**1,322**	**7,138**

*Calendar year 2014

[26] As reported in subcabinet bimonthly reports to the Court November 2013 – March 2015.
[27]This goal measures the number of people exiting institutional and other segregated settings. Some of these individuals may be accessing integrated housing options being reported under Housing Goal One.
[28] A baseline is not available because there is no standardized informed choice process currently in place to determine how many individuals in segregated settings would choose or not oppose moving to an integrated setting. Once this baseline is established, the goals will be re-evaluated and revised as appropriate.

Goal Two: By June 30, 2019, the percent of people at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting[29] will be reduced to 30% (based on daily average).

Baseline: In State Fiscal Year 2014, the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting was 33% on a daily average. During State Fiscal Year 2015, a change in utilization of AMRTC (see Rationale section for description of change) caused an increase in the percent of the target population to 36% (above the 2014 level) which resulted in the need to adjust the goal over the next four years.

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

- By June 30, 2016 the percent awaiting discharge will be reduced to ≤ 35%
- By June 30, 2017 the percent awaiting discharge will be reduced to ≤ 33%
- By June 30, 2018 the percent awaiting discharge will be reduced to ≤ 32%
- By June 30, 2019 the percent awaiting discharge will be reduced to ≤ 30%

Goal Three: By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital will increase to 14 individuals per month.

Baseline: In Calendar Year 2014, the average monthly number of individuals leaving Minnesota Security Hospital was 9 individuals per month.

Annual Goals to increase average monthly number of individuals leaving Minnesota Security Hospital:

- By December 31, 2015 the average monthly number of discharges will increase to ≥ 10
- By December 31, 2016 the average monthly number of discharges will increase to ≥ 11
- By December 31, 2017 the average monthly number of discharges will increase to ≥ 12
- By December 31, 2018 the average monthly number of discharges will increase to ≥ 13
- By December 31, 2019 the average monthly number of discharges will increase to ≥ 14

Goal Four: By June 30, 2018, 50% of people who transition from a segregated setting will engage in a person centered planning process that adheres to transition protocols that meet the principles of person centered planning and informed choice.

Baseline: The baseline of the quality of transition plans will be established as the new transition protocols are implemented.

Annual Goals to increase the percent of plans that adhere to transition protocol standards:

- By June 30, 2016, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person centered planning and informed choice will increase to 15%.

[29] As measured by monthly percentage of total bed days that are non-acute. Information about the percent of patients not needing hospital level of care is available upon request.

- By June 30, 2017, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person centered planning and informed choice will increase to 30%.
- By June 30, 2018, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person centered planning and informed choice will increase to 50%.

Rationale

- Individuals exiting institutional settings may be included in the housing goal when they move into integrated housing.
- In 2014, due to a change in Minnesota law, the percent of individuals at AMRTC under criminal court jurisdiction for competency restoration increased. These individuals' discharges from the program are not governed by medical stability but by the criminal court process. This issue inflates the number and percent of individuals who do not meet hospital level of care and await discharge.
- It is projected that the census of ICFs/DD will decrease over time, therefore the number of people who leave an ICF-DD over time will also decrease.
- There is not a standardized informed choice process in place to determine how many individuals in segregated settings would choose or not oppose moving to a more integrated setting. In order to improve the accuracy of the baseline and measurable goals one and three, an informed choice process needs to be implemented and data on these choices will be collected and used to determine if adjustments to the goals are needed.
- There is no baseline against which to measure quality of transition planning and implementation because the protocols are currently being implemented for other segregated settings. After one year of data is collected, the degree to which the transition meets the transition protocols, goals will be adjusted.
- Data tracking to monitor moves to more integrated settings must be developed. It is known when people leave institutional settings, but additional data for reporting may be needed to track moves from a potentially segregating setting, such as foster care.
- Some settings in the Segregated Settings report are potentially segregating, and may in fact be an integrated option for the person, such as a foster care setting where one person lives with staff support and engaged with neighbors and friends, or where two roommates who have chosen to live together and be supported by a provider in a licensed setting. The informed choice process and implementation of the new federal standards on the characteristics of home and community based services will provide additional information over the next few years.
- Annual goals reflect a ramp up period to train, fully implement, and monitor the transition protocols. There are existing funds to support these goals.

Strategies

Improve Ability to Gather Information about Housing Choices

- By December 2016, an informed choice process will be implemented for all people who receive long-term services and supports to determine the number of individuals who would choose or do not oppose moving to an integrated setting. Once that information is known (projected to be in June 2017), the baseline and measurable goals in goals one and three will be reassessed.

Implement New Transition Protocols

- Test, refine and implement transition protocols for individuals moving to integrated settings from segregated settings to ensure that planning includes what's important to the individual as well as for the individual. Transition protocols must align with the Jensen Settlement Agreement, the five principles of transition planning, and relevant components of the final rule of Home and Community Based Services standards. Testing is occurring through August 2015, with implementation of the revised protocol and tools beginning in September, 2015. Final draft protocols will be submitted to the subcabinet for approval by February 1, 2016. Approved protocols will be posted on the Olmstead website and made available in other formats upon request.
- Implement the federal rule governing Home and Community-Based Services (HCBS) settings requiring assessment and person centered planning practices which are complementary to the transition protocols. The transition for full compliance with the rule will be completed by 2019.

Increase Service Options for Individuals Making Transitions

- Provide targeted technical assistance and mentoring to build statewide capacity with lead agencies and providers to successfully transition people to more integrated settings, and use innovative approaches to individualized housing and supports.
- Provide targets for service development, and support counties, tribes and providers in developing alternatives to segregated settings, such as alternatives to shift staff foster care.
- Evaluate the current range of services available, such as those through home and community based service waivers, and redesign services as necessary to make available flexible options to support transitions to more integrated settings.

Monitor and Audit the Effectiveness of Transitions

- Develop materials to help people with disabilities, families and guardians understand options, answer questions and connect with those who can assist them in making an informed choice and planning for a transition.
- Lead agencies and the state will conduct audits of transition planning done by counties and providers to determine and gather the degree to which the transition meets the transition protocols.
- Monitor both the number and percent of AMRTC patients under restore to competency orders and civil commitments for mental health treatment.
- DHS, DEED and DOC will work together to ensure efficient and successful transitions for people leaving DOC facilities and entering community services.

Responsible Agencies

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

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Housing and Services

Stakeholder Comments	
"I have been trying to get rental assistance since November 2013 and as of September 25, 2014, I still have not been able to get any help."	Susan Nelson (2014)
"Some of the folks I've been working with that are in nursing homes desperately want to return to the homes they've lived in most of their lives."	*Jan Peterson (2013)*
"[Use measures like] I have my own lease; a roommate isn't forced on me; I can come and go as I please. That makes sense. That's real."	*Ethan Roberts (2013)*

What this topic means

Housing and Services is about:

- People having meaningful options about where to live, and with whom.
- The state supports housing costs for people with disabilities who choose to live in integrated settings.

Housing and Services is not about closing potentially segregated settings. According to the Department of Justice, "Individuals must be provided the opportunity to make an informed decision. Public entities must take affirmative steps to remedy a history of segregation and prejudice in order to ensure that individuals have an opportunity to make an informed choice. Such steps include providing information about the benefits of integrated settings; facilitating visits or other experiences in such settings; and offering opportunities to meet with other people with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers. Public entities also must make reasonable efforts to identify and addresses any concerns or objections raised by the individual or another relevant decision-maker."

Vision statement

People with disabilities will choose where they live, with whom, and in what type of housing. They can choose to have a lease or own their own home and live in the most integrated setting appropriate to their needs. Supports and services will allow sufficient flexibility to support individuals' choices on where they live and how they engage in their communities.

What we have achieved

- Completed "A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report" to determine number of people who live in segregated settings.
- 2015 State legislative session authorized some initial policy changes to the Group Residential Housing (GRH) program. Once fully implemented these policy changes will increase flexibility of housing benefits to allow more individuals to move from segregated to integrated settings.
- 2015 State legislative session authorized an additional $2.5 million to support the expansion of the Bridges rental assistance program which is available to people with a mental illness who are at risk of or currently living in segregated settings.

- Applied for and received federal funding in 2014 and 2015 for 160 Section 811 housing vouchers for people with disabilities exiting out of segregated settings into their own homes.
- Engaged in strategic planning between MHFA and DHS as a means to align housing and service supports.

Measurable goals

Goal One: By June 30, 2019, the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing will increase by 5,547 (from 6,017 to 11,564 or about a 92% increase).

Baseline: In State Fiscal Year 2014, there were an estimated 38,079 people living in segregated settings[30]. Over the last 10 years, 6,017 individuals with disabilities moved from segregated settings into integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing[31].

Annual Goals to increase the number of individuals living in the most integrated housing with a signed lease:

- By June 30, 2015 there will be an increase of 617 over baseline to 6,634 (about 10% increase)
- By June 30, 2016 there will be an increase of 1,580 over baseline to 7,597 (about 26% increase)
- By June 30, 2017 there will be an increase of 2,638 over baseline to 8,655 (about 44% increase)
- By June 30, 2018 there will be an increase of 4,009 over baseline to 10,026 (about 67% increase)
- By June 30, 2019 there will be an increase of 5,547 over baseline to 11,564 (about 92% increase)

Rationale

- There were an estimated 38,079 people living in potentially segregated settings in SFY 2014.
- At this time it not known how many of those individuals would choose or not oppose living in an integrated setting. Until that information is available, a subset of the 38,079 will be engaged through a set of flexible housing programs.
- There is sufficient funding authorized and forecasted to meet the target in the goal.
- Individuals accessing these housing options may include those exiting segregated settings such as: Anoka Metro Regional Treatment Center (AMRTC), Minnesota Security Hospital (MSH), Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD), people with disabilities under age 65 in Nursing Facilities and other segregated settings. This number may also include people exiting the Department of Corrections facilities.
- DHS will monitor for unintended consequences to ensure appropriate new capacity is developed.

[30] Based on "A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report" and information from ICFs/DD and Nursing Facilities.

[31] The programs that help pay for housing included in this measure are: Group Residential Housing (three setting types which require signed leases), Minnesota Supplemental Aid Housing Assistance, Section 811, and Bridges.

Strategies

Create More Affordable Housing

- Increase the number of affordable housing opportunities for people with disabilities exiting segregated settings by re-allocating existing funding.

Improve the Ability to Gather Information about Housing Choices

- Implement a process to gather and measure choices made by people with disabilities regarding housing.
- Once a process for capturing and measuring choice is in place, analyze the data and report annually to the subcabinet on progress in meeting goals.

Implement Reform for Housing Assistance Programs

- Implement housing policy changes adopted in 2015 legislative session. These policy changes will promote choice and access to integrated settings by reforming programs that currently provide combined housing and supports to allow greater flexibility.

Improve Future Models for Housing in the Community

- Increase access to information about integrated housing for people with disabilities through outreach, technical assistance and improved technology.
- Actively promote and encourage counties, tribes, and other providers to implement best-practices and person-centered strategies related to housing.
- Develop policy recommendations and strategies to access Medicaid coverage for housing related activities and services for people with disabilities.
- Identify and assess barriers for individuals to obtain and maintain housing, and provide recommendations to the subcabinet of strategies to address policy and funding barriers.

Responsible Agencies

- Department of Human Services
- Minnesota Housing Finance Agency

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Employment

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

What this topic means

Employment is about:

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

Employment is not about eliminating certain service options or closing specific facilities, instead it is about the state taking affirmative steps that include providing information about the benefits of integrated settings; facilitating visits or other experiences in such settings; and offering opportunities to meet people with disabilities who live, work and receive services in integrated settings, with their families, and with community providers. Public entities also must make reasonable efforts to identify and addresses any concerns or objections raised by the individual or another relevant decision-maker.

Employment Statistics

According to the Cornell University Employment and Disability Institute's Disability Status Report (data for 2010, published in 2012)[32]:

- 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 people 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.

According to the 2014 State Rehabilitation Council Annual Report:

[32] Employment and Disability Institute conducts research and provides continuing education and technical assistance on many aspects of disability in the workplace. It is important to note that this information is based on US Census data which does not include information on people living in institutional settings.

- In FFY 2015, Vocational Rehabilitation Services (VRS) anticipates serving about 16,910 persons under Title I of the Rehabilitation Act, all of whom will be individuals with a significant disability.
- Estimate of the Number of Persons Potentially Eligible for Services. Of the approximately 225,000 Minnesotans between the ages of 16 and 64 with two or more long-lasting disabilities, it is estimated that approximately 150,000 are eligible for vocational rehabilitation services of which approximately 11% received State Vocational Rehabilitation Services. For comparison, according to DEED, in 2014, 13% of unemployed Minnesotans utilized the services of the State's Workforce Centers.

Vision statement

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

What we have achieved

- Adopted "Minnesota Employment First Policy" which promotes the opportunity for people with disabilities to make informed choices about employment. This policy views competitive, integrated employment as the first and preferred option for individuals with disabilities. It does not call for the elimination of certain service options or close specific facilities.
- Established two stakeholder groups that included people with disabilities to advise the Interagency Employment Panel, comprised of MDE, DEED and DHS.
- Completed "A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report" which identified settings that primarily provide segregated employment.
- DEED initiated changes in the state rule governing the Extended Employment (EE) program that cap non-integrated and subminimum wage subprograms and define procedures that shift funding to integrated competitive employment.
- In collaboration with DEED, DHS and MDE and individuals from the Employment First Coalition, technical assistance and training was provided to twelve local education agencies through the Employment Community of Practice during the 2014-2015 school years.
- As part of the "Olmstead Plan: Work and Benefits Family Outreach Plan", 1,115 youth with disabilities received benefit summaries and Disability Benefits estimator sessions to inform them of their employment planning choices and how integrated employment benefits work together. This was done through collaboration across DEED, DHS and MDE. Disability Benefits 101 (DB101.org) is a planning tool that provides information and resources on employment, health coverage and benefits. This is an on-going resource.
- The 2015 Minnesota legislature provided additional funding for the 2016-20117 biennium for programs that serve people with disabilities in integrated settings including: $2.0 million for Individual Placements and Supports (IPS) Employment under Minn. Stat. 265A.13-14; $.5 million for Extended Employment (EE) under Minn. Stat. 268A.15; and $2.0 million for deaf and hard of hearing services to youth and adults under Minn. Stat. 268A.16.
- DHS submitted a request to CMS to modify the Home and Community Based waiver to include services supporting integrated employment, informed by stakeholder input.

Measurable goals

Goal One: By September 30, 2019 the number of new individuals[33] receiving Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) who are in competitive, integrated employment will increase by 14,820.

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

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

- By September 30, 2015, the number of new individuals with disabilities working in competitive, integrated employment will be 2,853
- By September 30, 2016, the number of new individuals with disabilities working in competitive, integrated employment will be 2,911
- By September 30, 2017, the number of new individuals with disabilities working in competitive, integrated employment will be 2,969
- By September 30, 2018, the number of new individuals with disabilities working in competitive, integrated employment will be 3,028
- By September 30, 2019, the number of new individuals with disabilities will be working in competitive, integrated employment will be 3,059

Goal Two: By June 30, 2020, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 5,015 or 10% in competitive, integrated employment.

Baseline: In 2014, there were 50,157 people age 18-64 who received services from one of the following programs: Home and Community Based Waiver Services, Mental Health Targeted Case Management, Adult Mental Health Rehabilitative Services, Assertive Community Treatment and Medical Assistance for Employed Persons with Disabilities (MA-EPD).

Annual Goals to increase the number of individuals in competitive, integrated employment

- By June 30, 2017, a data system will be developed to measure the following: the number of individuals who are working in competitive, integrated employment; the number of individuals not working in competitive, integrated employment; and the number of individuals not working in competitive, integrated employment who would choose or not oppose competitive, integrated employment.
- By June 30, 2017[34], the number of individuals in competitive, integrated employment will increase by 1,500 individuals

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

[34] The projected increase of 1,500 individuals includes increases for 2016 and 2017. This is necessary as data for 2016 will not be available until 2017.

- By June 30, 2018, the number of individuals in competitive, integrated employment will increase by 1,100 individuals
- By June 30, 2019, the number of individuals in competitive, integrated employment will increase by 1,200 individuals
- By June 30, 2020, the number of individuals in competitive, integrated employment will increase by 1,200 individuals

Goal Three: By June 30, 2020, the number of students with developmental cognitive disabilities, ages 19-21 that enter into competitive, integrated employment will be 763.

MDE, DEED and DHS will focus efforts on two groups of students consecutively.

- The first group (2014 group) will be all students with developmental cognitive disabilities, ages 19-21 receiving special education services and included in MDE's December 1, 2014, Unduplicated Child Count.
- The second group (2017 group) will be those students with developmental cognitive disabilities, ages 19-21 receiving special education services and included in MDE's December 1, 2017, Unduplicated Child Count.

Through our collaborative work MDE, DEED, and DHS will develop and enhance interagency strategies that can be replicated across other populations of students with disabilities.

Annual Goals for the number of students that enter into competitive, integrated employment:

2014 group total in competitive, integrated employment = 313 (35%) (N=894)

- By June 30, 2016 (using FY 15 and FY 16 data), the number of students with Developmental Cognitive Disabilities (DCD) in competitive, integrated employment will be 125.
- By June 30, 2017, the number of additional students in competitive, integrated employment will be 188.

2017 group total in competitive, integrated employment = 450 (50%) (N=900)

- By June 30, 2018, the number of students in competitive, integrated employment will be 150.
- By June 30, 2019, the number of additional students in competitive, integrated employment will be 150.
- By June 30, 2020, the number of additional students in competitive, integrated employment will be 150.

Rationale

- The second goal targets 50,157 working age individuals with disabilities in certain Medicaid funded programs who are receiving Long Term Services and Supports and/or Mental Health treatment services. These are programs where there is the most opportunity for strategies to be carried out to increase competitive, integrated outcomes. Some individuals served in these programs also receive Extended Employment services under Vocational Rehabilitation Services.

- The DHS employment data system has limitations. The data system does not provide a way to measure an increase in competitive, integrated employment.
- The Post School Outcome is a sample survey and does not represent the entire population. This will be used until a broader set of measures is developed. At that time the baseline and measurable goals will be revised.
- Students with Developmental Cognitive Disability (DCD) are at the greatest risk of entering into a segregated employment setting after leaving high school. In setting the baseline and goal, a sample of post-school outcome data was used.
- Because of the limitations of the data, it is not possible to determine if the growth in the level of employment is reasonable, so a baseline will be established in 2017 using a new data system and annual goals may be revised.
- In the next five years, there is a projected increase in excess of 20,000 individuals seeking competitive, integrated employment through VRS. These individuals include students exiting school or DHS programs.
- There is existing funding to support these goals.

Strategies

Implement the Employment First Policy

- Implement Minnesota Employment First Policy which encourages competitive, integrated employment.

Develop an Interagency Data System to Improve Measurement of Integrated Employment

- DHS will establish a data collection system to measure movement into competitive, integrated employment. The data system will be compatible with the system used by VRS and will include: Employment Type/Work Setting (Facility-based, Crew, Competitive Employment, Self-employed); Hourly Wage; Number hours worked per week; Benefits provided (health care, dental, etc.); Employer of record (Provider or employer); Number of people currently in segregated settings who do not oppose moving into Competitive Employment; specific information on subpopulations; and Individual level identifying information to track outcomes over time.

Reform Funding Policies to Promote Competitive, Integrated Employment

- Beginning in the 2015-2016 school year any new Special Education Transition Disabled Funds for vocational evaluations, and/or employment placement will be used in competitive, integrated, employment settings.
- Redirect funds to follow and support an individual's informed choice for employment.

Develop Additional Strategies for Increasing Competitive, Integrated Employment among People with Disabilities

- Adopt the evidence-based practice of engaging youth in paid work before exiting school.
- Build capacity at state/regional levels by expanding evidence-based and promising practices, such as:
    - Project SEARCH (youth)
    - Individual Placements and Supports (IPS) Employment program (for adults with serious mental illness)

- Provide training, technical assistance, public information and outreach regarding competitive, integrated employment to individuals and families, providers, educators, vocational rehabilitation services, staff, county and tribal case managers and other stakeholders

Implement the Workforce Innovation and Opportunity Act (WIOA) and Section 503

- Implement federal requirements under Workforce Innovation and Opportunity Act (WIOA), the federal law governing publicly funded workforce development programs.
- Implement federal rule Section 503 that sets a hiring goal for federal contractors and subcontractors that 7% of each job group in their workforce be qualified people with disabilities.

Implement the Home and Community Based Services (HCBS) Rule in a Manner that Supports Competitive, Integrated Employment

- Implement federal requirements regarding employment under the Centers for Medicare and Medicaid Services Home and Community-Based Services Rule, the federal rule that governs waivered services for individuals with disabilities.
- Request modification of HCBS waiver plan to support competitive, integrated employment.

Responsible Agencies

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

Lifelong Learning and Education

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

What this topic means

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

The federal Individuals with Disabilities Education Act (IDEA) of 2004[35] requires that students with disabilities receive special education services in the least restrictive environment appropriate to meet their needs. This means that removal from regular education classes occurs only when a student cannot be successfully educated in regular classes, even with supplemental aids and services. When a student is removed from the regular educational environment for part of the day, the student must still be educated with non-disabled peers as much as possible.

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

Vision statement

People with disabilities will experience an inclusive education system at all levels and lifelong learning opportunities that enable the full development of individual talents, interests, creativity, and mental and

[35] IDEA is a federal law that governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

physical abilities. They will be educated in the most integrated educational setting from preschool through grade twelve and will transition to the most integrated post-secondary setting or employment.

What we have achieved

- A "Postsecondary Resource Guide – Successfully Preparing Students with Disabilities" and four training modules were created in collaboration between Minnesota Department of Education and the Minnesota State Colleges and Universities (MNSCU). The Resource guide can be viewed at www.normandale.edu/advising-and-services/students-with-disabilities/resources-and-links.
- Adopted a reintegration protocol to transition students placed at the Minnesota Corrections Facility (MCF) – Red Wing to more integrated settings. The protocol is a collaborative effort of the Minnesota Department of Education, MCF – Red Wing and Institute on Community Integration at the University of Minnesota.

Measurable goals

Goal One: By December 1, 2019 the number of students with disabilities[36], receiving instruction in the most integrated setting[37], will increase by 1,500 (from 67,917 to 69,417).

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

Annual Goals to increase the number of students receiving instruction in the most integrated settings:

- By December 1, 2015 there will be an increase of 300 over baseline to 68,217
- By December 1, 2016 there will be an increase of 600 over baseline to 68,517
- By December 1, 2017 there will be an increase of 900 over baseline to 68,817
- By December 1, 2018 there will be an increase of 1,200 over baseline to 69,117
- By December 1, 2019 there will be an increase of 1,500 over baseline to 69,417

Goal Two: By October 1, 2020 the number of students who have entered into an integrated postsecondary setting within one year of leaving secondary education will increase by 250 (from 225 to 475).

Baseline: Using the 2014 Post School Outcome Survey, of the 962 students with disabilities who participated in the survey, 225 (23.3%) entered into an integrated postsecondary setting within one year of leaving secondary education.

Annual Goals to increase the number of students entering an integrated postsecondary education setting are:

- By October 1, 2016 there will be an increase of 50 over baseline to 275
- By October 1, 2017 there will be an increase of 100 over baseline to 325
- By October 1, 2018 there will be an increase of 150 over baseline to 375
- By October 1, 2019 there will be an increase of 200 over baseline to 425

[36] "students with disabilities" are defined as students with an Individualized Education Program age 6 to 21 years;
[37] "most integrated setting" refers to receiving instruction in regular classes alongside peers without disabilities, for 80% or more of the school day

- By October 1, 2020 there will be an increase of 250 over baseline to 475

Rationale

Goal One

- In 2013, Minnesota schools identified and provided special education services to 109,332 students with disabilities ages 6 to 21, as reported on the IDEA Section 618 Data. Of that number, 67,917 students with disabilities (62.1%) received instruction in regular classes 80% or more of their school day. Of that number, 41,415 students with disabilities (37.9%) received instruction in regular classes less than 79% or less of their school day.
- A particular focus of attention includes students with Autism Spectrum Disorders or Developmental Cognitive Disabilities ages 6 – 18, who comprise 19.9% of students with disabilities. However, this same student group comprised 12.6% of students with disabilities receiving instruction in regular classes for 80% or more of their school day.
- The projected growth in the number of students in integrated classrooms (to 63.3% of the current base) is attainable given previous success in the application of the identified strategies.

Goal Two

- The Minnesota Post School Outcome Survey measures both competitive employment, enrollment in higher education as well as participation in other employment or postsecondary education training programs as defined by the National Post School Outcome Center.
- The Post School Outcome Survey provides information from a snapshot in time. It will be used as a short-term proxy measure to identify how many students with disabilities are enrolled in an integrated postsecondary setting. This methodology will be used until a broader data system is developed. At that time, the baseline and measurable goals will be reviewed and adjusted.

Strategies

Goal One

Improve and Increase the Effective Use of Positive Supports in Working with Students with Disabilities

- Continue the expansion of the Positive Behavioral Interventions and Supports (PBIS) which improves the capacity of school districts to include students in integrated classrooms. There are currently 479 schools implementing PBIS, with another 53 set to begin in fall of 2015. By the 2015-2016 school year there will be 532 or 26.5% of Minnesota schools implementing PBIS, impacting an estimated 247,009 students (30% of all students).

Continue Strategies to Effectively Support Students with Low-Incidence Disablities

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

Improve Graduation Rates for Students with Disabilities

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

Improve Reintegration Strategies for Students Returning Back to Resident Schools

- Continue collaboration between MDE and DOC at the Minnesota Correctional Facility in Red Wing. This project will improve reintegration of students with disabilities exiting the facility to their resident district or to a more integrated setting.
- Implement a reintegration protocol statewide for students placed out of state or in juvenile correctional facilities.

Goal Two

Increase the Number of Students with Disabilities Pursuing Post-Secondary Education

- Utilize the "Postsecondary Resource Guide- Successfully Preparing Students with Disabilities." This resource guide and training modules provide regional technical assistance to IEP teams including youth and families, to increase the number of students with disabilities who enter into integrated, postsecondary settings.
- MDE will continue working with the National Secondary Transition Technical Assistance Center (NSTTAC) to provide regional capacity building training for the purpose of increasing the number of students with disabilities who are in a postsecondary education setting by 2020.
- MDE will begin to explore a broader data system to measure how many students with disabilities are graduating from high school entering into an integrated postsecondary education setting after graduation.

Responsible Agencies

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

Waiting List

Stakeholder Comment	
"I believe that our waiver rules and systems are set up exactly the same way as organ transplants: you may have a high need, and be on an imaginary "list," but each time a new waiver opportunity – or a new organ in my example –is available, someone else may always be seen as needier than you and be put at the top of the list ahead of you."	Sharon Armus (2013)

What this topic means

In this topic, "waiver services" refers to two home and community-based service waiver programs for people with disabilities that have waiting lists: 1) Community Access for Disability Inclusion (CADI); and, 2) Developmental Disabilities (DD). Waivers are funded by a combination of federal Medical Assistance (MA) and state funds. They are called "waiver services" because the federal government waives the institutional requirements of MA to allow funds to be used for services in the home and community when people would otherwise require the level of care provided in institutional settings.

MA funding for institutional care is not an entitlement, but can be obtained through an application process through which a person with a disability becomes eligible for these services. This means that states can set limits on the growth of these programs. In Minnesota, waiver services waiting lists occur because the budgets for the waiver services are limited by: 1) the amount the federal government approves in the state waiver plans; and, 2) the amount the legislature appropriates for the state share of the service costs. A waiting list is created when people who are eligible for the service do not have immediate access to the service because of the funding limits. In addition to the waiver services, Minnesota may provide other services to people with disabilities while they are on the waiting list for waiver services.

The urgency of an individual's need for waiver services varies. Some people are waiting to exit institutional settings; some people are at serious risk of institutionalization because they lack supports to remain in the community; some people in the community are not at risk of institutionalization, but will need waiver services within a year in order to remain in the community. We will prioritize access to waiver funding and services according to these levels of urgency. Additionally, the waiver services waiting list will move at a reasonable pace, according to urgency of need, and not controlled by endeavors to keep institutions populated.

In this topic area, we will use statutory priorities for accessing waiver service planning and funding so that the waiver services waiting lists move at a reasonable pace according to urgency of need.

Vision statement

Individuals who qualify for home and community based waiver services will be approved for services at a reasonable pace, determined by the individual's urgency of need.

What we have achieved

- The Department of Human Services (DHS) worked with stakeholders to create four categories for individuals currently on the waiting list to indicate urgency for waiver services and reasonable pace standards for each category. The four categories are: institutional exit, immediate need, defined need, and future need. The categories, reasonable pace standards and recommendations were published in the Home and Community-Based Supports and Services Waiver Waiting List Report.
- DHS conducted an analysis of the waiver services waiting lists and funding that would be required to eliminate the waiting list and provided the information to the legislature in a "Report on Program Waiting Lists" in December 2014. In 2015, the legislature authorized changes to the management of the waiver services, including strategies that increase the state's ability to use funds to serve people on the waiting list. Under the new legislation, county and tribal agencies (lead Agencies) are required to spend at least 97% of their waiver services funding allocation while maintaining a list of persons waiting for waiver services, or the lead agency must submit a corrective action plan to DHS' Commissioner for approval stating actions the lead agency will take to assure reasonable and timely access to waiver services for persons waiting for services. Minn. Stat. §§ 256B.0916, subd. 12 and 256B.49, subd. 27.
- Technical assistance and communications have occurred with lead agencies to maximize funding utilization; increase numbers served, and redistribute funding across lead agencies where necessary to meet statutory priorities. Minn. Stat. § 256B.0916, subd. 12 and 256B.49, subd. 27
- In 2015, the legislature appropriated $300 million towards elimination of waiver services waiting lists.
- Truven Health Analytics September 2014[38] reports shows that Minnesota ranks number one in the country for serving people with a disability at home and in their communities as measured by home and community based service waiver recipients per 1,000 people based on CMS federal reporting, 2010-2011.

Measurable goals

Goal One: By October 1, 2016, the Community Access for Disability Inclusion (CADI) waiver waiting list will be eliminated.

Baseline: As of May 30, 2015, the CADI waiver waiting list was 1,420 individuals.

Goal Two: By December 1, 2015, the Developmental Disabilities (DD) waiver waiting list will move at a reasonable pace.

Baseline: In April 2015, there were 3,586 individuals on the DD waiver waiting list.

Persons exiting institutional settings will move off the waiting list at a reasonable pace, which means that:

[38] Truven Health Analytics. (September 2014). *Medicaid 1915(C) Waiver Data Based on the CMS 372 Report, 2010-2011*. Prepared for Centers for Medicare and Medicaid Services. Accessed July 16, 2014.

- Beginning December 1, 2015, as people residing in an institutional setting are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person makes an informed choice of alternative community services that are more integrated, appropriate to meet their individual needs, and the person is not opposed to moving, and would like to receive home and community based services.

Persons with an immediate need will move off the waiting list at a reasonable pace, which means that:

- Beginning December 1, 2015, as people are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person meets criteria under Minn. Statutes, sections 256B.49, subdivision 11a(b) and 256B.092, subdivision 12(b)**.**

  The current statutory criteria are: The person has an unstable living situation due to age, incapacity, or sudden loss of primary caregivers; is moving from an institution due to bed closure; experiences a sudden closure of their current living arrangement; requires protection from confirmed abuse, neglect, or exploitation; experiences a sudden change in need that can no longer be met through state plan services or other funding resources alone or meet other priorities established by DHS.

Persons with a defined need of requiring services within a year of assessment will move off the waiting list at a reasonable pace, which means that:

- Beginning December 1, 2015, as people are assessed as having a defined need for waiver services within a year from the data of assessment, and within available funding limits, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days of determining the defined need.

Goal Three: By March 1, 2017, the DD waiver waiting list will be eliminated for persons leaving an institutional setting and for persons with immediate need as defined by Minn. Statutes, sections 256B.49, subdivision 11a(b) and 256B.092, subdivision 12(b).

Goal Four: By December 31, 2018, within available funding limits, waiver funding will be authorized for persons who are assessed and have a defined need on or after December 1, 2015, and have been on the waiting list for more than three years.

Goal Five: By June 30, 2020, the DD waiver waiting list will be eliminated, within available funding limits, for persons with a defined need.

Rationale

- The Legislature authorized sufficient funding to end the CADI waiver waiting list over the 2016-2017 biennium by allowing previous legislative limits on growth to expire. The date for goal one is October 2016 because it is projected to take 15 months to complete assessments and funding authorizations. DHS will establish targets for lead agencies to expedite the process of authorizing funding.
- The reasonable pace standards outlined in goal two will be implemented on December 1, 2015, and planned new data systems and training will be provided on the new urgency categories and standards to lead agencies. Annual data will be available by December 2016, at which time a baseline will be established and the reasonable pace goals will be reevaluated, including reevaluation of sufficiency of funding and a determination of what funding would be needed to eliminate any remaining waiting list. An interim analysis of data will be conducted throughout the first year to monitor progress and assess targets.
- While it is anticipated that the waiting list for persons exiting an ICF/DD and persons with immediate need will be eliminated by January 15, 2017, which is 45 days from the completion of annual assessments of those on the waiting list, there is a lag in the data before analysis can be completed, which is why March 1, 2017, is the goal three date. The assumptions for this goal will be evaluated as the baseline of the number of people in these two urgency categories is obtained.
- Although there was a legislatively authorized increase in funding for DD waivers beginning July 1, 2015, due to the limits of the DD waiver plan, it may not be sufficient to completely eliminate the waiting list for persons in the "defined need" category. Limits on growth are based on legislative appropriations and the federally approved waiver plan. The federally approved DD waiver plan currently has a limit on funding growth of 300 persons/year.
- Individuals are considered as moving off the waiting list once they are authorized for funding.
- An individual will be identified as having a "future need" if, after assessment, the individual does not meet criteria for the other three categories (institutional exit, immediate need, and defined need) and instead identified a future need for services that is over a year from the assessment date. An individual with a future need will be placed on a waiver eligibility list, but will not be placed on the waiting list. People will be offered an assessment annually, or any time that their needs or situation change. At that point, the reasonable pace standards will be applied.
- Kentucky and Tennessee have implemented similar urgency categories for individuals on the waiting list. The experience from these states shows that people in the emergent categories move off the waiting list quickly. Those with planned needs tend to wait longer. DHS anticipates that the urgency category populations will be similar to the experience of those states.

Strategies

Reform Waiting List Protocols to Incorporate Urgency of Need

- Implement new urgency of need categorization system and report to the subcabinet as outlined in the Home and Community-Based Supports and Services Waiver Waiting List Report, dated March 3, 2015. Reporting on the new urgency categorization system, the new reasonable pace standards, and an estimate on funding needed to eliminate the waiting list will be reported to the legislature annually and to the subcabinet twice each year.

- Due process protections available to people with disabilities will be modified as necessary, to reflect new waiting list protocols.
- A workplan will be developed for the analysis of baseline data on urgency of need and reasonable pace as it becomes available to understand: the needs of persons waiting; identify potential options to meet their needs; complete evaluation of existing programs to determine if there are changes which would enable programs to be more effective; conduct analysis of options; and provide recommendations for a plan that will meet the needs of those with disabilities to receive needed services in the most integrated settings. This plan will be provided to the subcabinet.

Implement Initiatives to Speed up Movement from Waiting Lists

- Technical assistance will be provided to lead agencies to help them expedite required assessments and authorization of funding so people can begin services and come off the waiting list. This will include strategies such as allowing case managers to use the DD Screening and Long Term Care Consultation documents to begin planning for services, and completing required assessment updates, rather than limiting assessments to certified assessors. This draws on additional capacity of contracted private agency case managers in addition to lead agency staff, allowing planning to begin more quickly.
- Targets for progress will be given to lead agencies, particularly those with the highest numbers of people waiting, and their contracted case management providers, to assure progress. This will include data on those who have been waiting the longest, so that priority can be given to those waiting the longest within each category, in addition to those with a known urgent need. Technical assistance will be provided to these parties to streamline processes where appropriate to facilitate access to funding over the year.

Reform Management of Waiting List Management Systems

- The Waiver Management System, which is used with lead agencies and DHS to manage waiver funding, will be revised to gather needed data on waiting list categories of need, and the date when funding is authorized.

Responsible Agency

- Department of Human Services

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Transportation

Stakeholder Comments	
"There is a meager sidewalk along a portion of the highway through town. …the sidewalk and the crossing areas at major intersections adjacent to U.S. Highway 61 were clogged with snow and ice. A person with disabilities couldn't have gotten close enough to the crosswalk button to press it many days after a snow storm."	Mike Brooks (2015)
"The Department of Transportation should consider developing weekly direct transportation routes to some of the smaller rural areas in small towns that will allow individuals with disabilities, seniors, and families with limited or no transportation options access to shopping hubs, medical centers, recreation, social activities and the larger communities."	*Dalaine Remes (2013)*
"…in rural MN we do not have regularly scheduled Public Transportation. We have public transportation when we have enough volunteer drivers – and then only Monday through Friday and before 6 p.m."	Deanna Steckman (2013)

What this topic means

Transportation is a key aspect in an individual's independence and quality of life. Transportation is also part of a communities' foundation and recognizes the importance, significance and context of place—not just as destinations, but also where people live, work, learn, and enjoy life regardless of socio-economic status or individual ability.

The Minnesota Department of Transportation (MnDOT) in conjunction the Department of Human Services will integrate Olmstead principles in the state's transportation systems. The state will continue to focus on providing accessibility improvements in its right of way and improving transit access and ridership. The state will also ensure that transportation is as integrated as possible and that transportation allows people with disabilities to participate their communities.

Vision statement

People with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections. They will have increased access to transit options and transportation modes.

What we have achieved

- Completed the Minnesota Transit Funding Primer Technical Report which inventories transportation funding programs available in Minnesota from the federal and state governments, including funding levels and details about the administration of each program. The goal of the report is to identify opportunities for coordination and was completed through a partnership between MnDOT and the Minnesota Council on Transportation Access (MCOTA).
- Updated the MnDOT "ADA Transition Plan" to reflect changes in program delivery and facilities inventory.
- Published the "Olmstead Transportation Forum Final Report" which summarized a statewide open forum on transportation for people with disabilities facilitated by DHS and MnDOT.
- Inclusion of accessibility features in all transportation projects has been an ongoing commitment since 2009.

Measurable goals

Goal One: By December 31, 2020, accessibility improvements will be made to 4,200 curb ramps (increase from base of 19% to 38%) and 250 accessible pedestrian signals (increase from base of 10% to 50%). By January 31, 2016 a target will be established for sidewalk improvements.

Curb Ramps

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

- By December 31, 2020 accessibility improvements will be made to 4,200 curb ramps[39] bringing the percentage of compliant ramps to approximately 38%.

Accessible Pedestrian Signals

Baseline: In 2009: 10% of eligible state highway intersections with accessible pedestrian signals (APS) were installed.

- By December 31, 2019, an additional 250 Accessible Pedestrian Signals (APS) installations will be provided on MnDOT owned and operated signals bringing the percentage to 50%.

Annual Goals to increase the number of APS installations:

- By December 31, 2015 an additional 50 APS installations will be provided
- By December 31, 2016 an additional 50 APS installations will be provided
- By December 31, 2017 an additional 50 APS installations will be provided
- By December 31, 2018 an additional 50 APS installations will be provided
- By December 31, 2019 an additional 50 APS installations will be provided

Sidewalks

Baseline: In 2012: 46% of sidewalks on MnDOT right of way met 2010 ADA Standard and Public Right of Way (PROW) guidance.

- By January 31, 2016, an annual target for remaining un-remediated sidewalks will be established.

[39] ADA Title II Requirements for curb ramps at www.fhwa.dot.gov/civilrights/programs/doj_fhwa_ta_glossary.cfm

Goal Two: By 2025, additional rides and service hours will increase the annual number of passenger trips to 18.8 million in Greater Minnesota (approximately 50% increase).

Baseline: In 2014 the annual number of passenger trips was 12,543,553

Annual Goals to increase the annual number of passenger trips:

- By 2015 the annual number of passenger trips will increase to 13,129,593
- By 2020 the annual number of passenger trips will increase to 16,059,797
- By 2025 the annual number of passenger trips will increase to 18,800,000

Goal Three: By 2020, expand transit coverage so that 90% of the public transportation service areas in Minnesota will meet minimum service guidelines for access.

Transit access is measured against industry recognized standards for the minimal level of transit availability needed by population size. Availability is tracked as span of service, which is the number of hours during the day when transit service is available in a particular area. The measure is based on industry recognized standards and is incorporated into both the Metropolitan Council Transportation Policy Plan and the MnDOT Greater Minnesota Transit Investment Plan[40].

Baseline: A baseline for access will be established in 2016.

Goal Four: By 2020, transit systems' on time performance will be 90% or greater statewide.

Reliability will be tracked at the service level, and as reliability increases, the attractiveness of public transit for persons needing transportation may increase.

Baseline for on time performance in 2014 was:

- Transit Link – 97% within a half hour
- Metro Mobility – 96.3% within a half hour timeframe
- Metro Transit – 86% within one minute early – four minutes late
- Greater Minnesota – Baseline to be developed in 2016

Five year goals to improve on time performance:

- Transit Link – maintain current performance (97% within a half hour)
- Metro Mobility – maintain current performance (96.3% within a half hour timeframe)
- Metro Transit – improve to a service level of 90% or greater
- Greater Minnesota – To be developed in 2016

[40] Greater Minnesota Transit Investment Plan is available at www.dot.state.mn.us/transit/reports/investmentplan

Rationale

Goal One

- All of the goals focus on five year timelines and are consistent with MnDOT's project planning and programming based on anticipated funding with improvements to the accessibility of the system tracked on an annual basis. The annual tracking provides the status of the system and allows us to see emerging trends and needs in how accessibility is being provided.
- Accessibility improvements are required to be delivered as part of roadway projects rather than a standalone program to ensure that accessibility is routinely provided in all projects. The mix of roadway projects in a given fiscal year is dynamic, which is why we are unable to determine a precise number of curb ramp improvements in a given year. The goal has been based on historical averages and anticipated funding.
- The goal is constrained primarily by MnDOT's budget overseen by the legislature; however accessible pedestrian facilities are identified as a portion of MnDOT's budget in the Minnesota State Highway Investment Plan (MnSHIP). MnSHIP investment policy has allocated 1.6% of MnDOT's capital budget for the first 10 years and 1.8% of MnDOT's capital budget for years 11-20 to accessible pedestrian facilities, representing a rolling average investment of $12 million a year.

Goals Two - Four

- The goal appears in state statute and has a timeframe of ten years. Meeting the legislative goal is important to realizing the overarching vision of the Olmstead Plan because the availability of transit is consistently identified as important by the disability community as integral to living an independent, integrated life.
- The model to estimate transit need was developed during the 2011 Greater Minnesota Transit Investment Plan using demographic factors that can be updated with new estimates from the State Demographer's Office. This model will be re-evaluated when the Greater Minnesota Transit Investment Plan is updated in 2016.
- The measures that have been selected for this goal also allow for tracking of progress in the seven county Metro area in the areas of access and reliability, allowing for a more complete picture of how transit needs are being met for people with disabilities.
- Achieving the first four years of the goal is realistic based on current funding forecasts from Minnesota Management and Budget (MMB). In the fifth year and beyond, the goal will likely not be met without increased funding for Greater MN transit from the Minnesota legislature.
- The primary barriers that we face in achieving the goal are: (1) budgetary: (2) not being able to determine at a population level the degree to which meeting public transit goals provides benefit to the Olmstead population and (3) the impact of reduced capacity in program specific transportation to individuals' overall transportation access.

Strategies

Goal One

Increase the Number of Accessibility Improvements Made as Part of Construction Projects

- Accessibility improvements are included as part of any project meeting the alterations threshold, as required by the ADA, to ensure program consistency and ongoing investment. In general the alteration threshold is met when there is a pavement project such as a mill and overlay, bridge rehabilitation, or signal replacement. The four year schedule of projects is found in MnDOT's State Transportation Improvement Plan (STIP). [41]
- MnDOT will continue to work with our local partners though our project development process to encourage additional accessibility improvements whenever possible.

Increase Involvement in Transportation Planning by People with Disabilities

- MnSHIP is scheduled to be rewritten in 2016 and the investment levels will be reassessed as part of the plan update. MnSHIP is developed with significant public input and sets investment targets, including those for accessibility improvements, for the agency based on system conditions and revenue.

Goals Two - Four

Improve the Ability to Assess Transit Ridership by People with Disabilities

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

Improve Transit Services for People with Disabilities

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

Responsible Agencies

- Department of Transportation
- Metropolitan Council

[41] More information on STIP can be found at www.dot.state.mn.us/planning/program/stip.html

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Healthcare and Healthy Living

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

What this topic means

Healthcare is "the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions."[42]
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."[43] Health disparities for people with disabilities present barriers to full integration. Some problems with access to healthcare that exist for many Minnesotans have a significant impact on people with disabilities. For example, some people with disabilities may not be able to schedule dental appointments on a regular basis because there are not enough dentists and dental hygienists able to provide care. This is due to location (in parts of Greater Minnesota, there are not enough dental practitioners to serve all people); to affordability (not everyone has insurance coverage that includes dental care); and to some providers not knowing how to serve people with disabilities. Many people with disabilities develop other diseases (hypertension, heart disease, diabetes, stroke, cancer) at a higher frequency than people without disabilities. Some people with disabilities die at a much younger age than people without disabilities[44].

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

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[42] American Heritage Medical Dictionary, "Healthcare." Boston: Houghton Mifflin Harcourt Publishing, 2008, 236
[43] 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
[44] 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.

Vision statement

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

What we have achieved

- MDH and DHS established baseline information about primary care teams across Minnesota that are able to provide integrated, person-centered primary care for people with disabilities
- DHS published "Health Care and Community Supports Administrations Overview of Behavioral Health Homes" which described the extensive stakeholder involvement and progress toward implementing a framework developed to provide services in a person-centered system of care for Minnesotans with serious mental illness who are Medicaid consumers and have complex chronic health conditions.
- DHS conducted a study on dental access and reimbursement for Minnesota Health Care Programs (MHCP). The findings "Recommendations for Improving Oral Health Services Delivery System-February 2014" were reported to the legislature.
- DHS completed a dental study submitted to legislature entitled "Delivery System for Oral Health" which built on the February 2014 report referenced above.
- DHS completed a report entitled "Olmstead Plan: Baseline Data for Current Care" focusing on variations in utilization of primary care in Medicaid (including dental) by persons with and without disabilities.
- MDH completed a system analysis describing barriers that need resolution for transitioning youth with special health care needs to adult health care. This "Olmstead Benchmark Report" was completed October 2014 and includes a plan for addressing those barriers.
- MDH completed "The Status of Oral Health in Minnesota" September 2013 report describing the status of dental diseases and oral health conditions in the state. This report includes information related to disparities in the status of dental diseases and oral conditions among population groups.

Measurable goals

Goal One: By December 31, 2018, the number/percent of individuals with disabilities and/or serious mental illness accessing appropriate preventive care[45] focusing specifically on cervical cancer screening and follow up care for cardiovascular conditions will increase by 833 people compared to the baseline.

As specific indicators that individuals with disabilities are accessing appropriate care, cervical cancer screening and follow-up care for cardiovascular conditions will be tracked. These are two areas where health care outcome disparities have been identified.

- Cervical Cancer screening - Reduce disparities in cervical cancer screening by 10% (increase of 616 more women being screened).
- Follow-up care for cardiovascular conditions - Reduce disparities in appropriate follow-up care for cardiovascular conditions by 5% (increase of 217 more people receiving appropriate follow-up care).

[45] Appropriate care will be measured by current clinical standards.

Baseline: In 2013[46], the number of women receiving cervical cancer screenings was 21,393 and the number of individuals accessing follow up care for cardiovascular conditions was 1,589.

Annual Goals to increase the number of individuals accessing appropriate care:

- By December 31, 2016 the number accessing appropriate care will increase by 205 over baseline
- By December 31, 2017 the number accessing appropriate care will increase by 518 over baseline
- By December 31, 2018 the number accessing appropriate care will increase by 833 over baseline

Goal Two: By December 31, 2018, the number of individuals with disabilities and/or serious mental illness accessing dental care will increase by 1,229 children and 1,055 adults over baseline.

Baseline: In 2013, the number of children with disabilities continuously enrolled in Medicaid coverage during the measurement year accessing annual dental visits was 16,360.

Annual Goals to increase the number of children accessing dental care:

- By December 31, 2016 the number of children accessing dental care will increase by 410 over baseline
- By December 31, 2017 the number of children accessing dental care will increase by 820 over baseline
- By December 31, 2018 the number of children accessing dental care will increase by 1,229 over baseline

Baseline: In 2013, the number of adults with disabilities continuously enrolled in Medicaid coverage during the measurement year accessing annual dental visits was 21,393.

Annual Goals to increase the number of adults accessing dental care:

- By December 31, 2016 the number of adults accessing dental care will increase by 335 over baseline
- By December 31, 2017 the number of adults accessing dental care will increase by 670 over baseline
- By December 31, 2018 the number of adults accessing dental care will increase by 1,055 over baseline.

Rationale

- The "Baseline Data for Current Care" report identified health care disparities between people with disabilities and/or serious mental illness as compared to people without disabilities and/or mental illness in three areas. Those areas included cervical cancer screening for women; follow up care for cardiovascular conditions; and access to dental care for children. Data does not show disparities among adults in access to dental care. However, there is concern that there may be disparities in the intrusiveness of procedures for adults with disabilities (for example more tooth extractions versus preventive services).

[46] Baselines for these goals are from the 2013 "Olmstead Plan: Baseline Data for Current Care" Report.

- Achieving the cervical cancer screening goal, reduces the disparity by 10% (ensuring at least 616 more women have screenings over the 2013 baseline of 21,393).
- Achieving the follow up care for cardiovascular conditions goal, reduces the disparity (ensuring at least 217 more people receive appropriate follow-up care over 2013 baseline of 1,589).
- Achieving the accessing dental visits goal for children, reduces the disparity (ensuring at least 1,229 children over the baseline of 16,360).
- Measuring access to health care does not provide an indication of the health care outcome achieved for the individual. Measures for health care outcomes need to be established.

Strategies

Improve Dental Care for People with Disabilities

- Implement increase in dental payment rates in January 2016. Increase in dental rates has historically resulted in increased access to dental care for people with disabilities.
- Implement the recommendations from the "Recommendations for Improving Oral Health Services Delivery System" Report and the follow up report, "Delivery System for Oral Health."
- Implement "Minnesota Oral Health Plan."
- Increase the number of providers and the level of access of people with disabilities to providers.

Expand the Use of Health Care Homes and Behavioral Health Homes

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

Improve Access to Health Care for People with Disabilities

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

Develop and Implement Measures for Health Outcomes

- Develop and implement health outcome measures. Studying health outcomes will indicate the effectiveness of the health care delivery system and identify potential opportunities for improvement.

Responsible Agencies

- Department of Human Services
- Minnesota Department of Health

Positive Supports

Stakeholder Comment		
	Our child was removed from the school environment in November 2013 due to the excessive use of restrictive procedures and the harm done to him because of it. He has been on home bound services since then."	Sharon Kostiuk (2015)

What this topic means

An essential component of quality of life is being treated with dignity and respect. Minnesota is committed to supporting people through the use of positive practices, and prohibitions on use of aversive and restrictive procedures. There is no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques. There is strong evidence that positive approaches and planning that builds on the strengths and interests of the person are effective. Implementation of this vision will require a culture change throughout the service system, reinforcing positive skills and practices and replacing practices which may cause physical, emotional, or psychological pain or distress. This new culture and standards to evaluate it will include:

- Person-centered planning that includes a balance of what is important *for* the person with what is important *to* the person;
- Individual plans for services that reflect principles of the most integrated setting, consistent with Minnesota's Olmstead Plan;
- Types and use of positive and social behavioral supports;
- Prohibitions on use of restraints and seclusion; and,
- Requirement that care is appropriately informed by a recognition and understanding of past trauma experienced by an individual.

Department of Human Services (DHS)

Restrictive procedures for individuals with disabilities are prohibited except when used in an emergency situation[47]. The Legislature codified these requirements for providers of disability services when it passed Minn. Stat. Chapter 245D, which applies to the majority of disability services, including home and community based service waivers, and services provided in an Intermediate Care Facility for Persons with Developmental Disabilities. On August 31, 2015, with the adoption of the Positive Supports Rule, those same requirements will apply to all services and facilities licensed by the Commissioner of Human Services when provided to a person with developmental disabilities. The statute and the rule prohibit restrictive intervention, except for:

- Emergency use of manual restraint, which may be used only when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or

[47] Jensen Settlement Agreement definition of Emergency: Situations when the client's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Client refusal to receive/participate in treatment shall not constitute an emergency.

programming on their own do not constitute an emergency. This definition applies to DHS-licensed services and facilities. See Minn. Stat. §245D.02, subd. 8a.

- Transitions when providers begin working with an individual for whom the use of a restrictive procedure was used before admission and the team agrees that the procedure must be faded rather than immediately stopped to prevent injury to the person or others; and/or
- Limited exceptions for use of mechanical restraints when a person is at imminent risk of serious injury due to self-injurious behavior and less restrictive strategies would not achieve safety.

Reporting, clinical consultation, and oversight are required in those circumstances as specified by statute and rule.

Department of Education (MDE)

In the educational setting, restrictive procedures are prohibited except when used in an emergency situation. As defined in Minnesota Statutes section 125A.0941, in an educational setting, "emergency" means a situation where immediate intervention is needed to protect a child or other individual from physical injury. Emergency does not mean circumstances such as: a child who does not respond to a task or request and instead places his or her head on a desk or hides under a desk or table; a child who does not respond to a staff person's request unless failing to respond would result in physical injury to the child or other individual; or an emergency incident has already occurred and no threat of physical injury currently exists. See Minn. Stat. §125A.0941(b).

A restrictive procedure is defined in that statute as a physical hold or seclusion. In an educational setting, "seclusion" means confining a child alone in a room from which egress is barred. Egress may be barred by an adult locking or closing the door in the room or preventing the child from leaving the room. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion. See Minn. Stat. §125A.0941(g).

Training requirements for school staff and other requirements related to reporting are delineated in Minnesota statutes section 125A.0942. MDE will strive to ensure that students with disabilities receive evidence based positive supports to enable them to be educated in an inclusive setting, to have access and make progress in the general education curriculum and have improved educational outcomes.

Our goals for this topic area strive to reduce the overall incidence of emergency restrictive procedures in educational and in Department of Human Services settings.

Vision Statement

People with disabilities will be treated with respect and dignity. They will receive services that provide positive, therapeutic supports and practices; trauma-informed care; and person-centered thinking and planning. Physical intervention will occur only in an emergency when an individual's conduct creates an imminent risk of physical harm to self or another and less restrictive strategies will not achieve safety.

What we have achieved

- Implemented the new disability services provider Standards (Minnesota Statute 245D) which include positive support standards.
- Promulgated the Positive Supports Rule, Minnesota Rules Chapter 9544, which repeals Minnesota Rules, parts 9525.2700 to 9525.2810 (also known as Rule 40) and requires the use of positive supports. The Positive Supports Rule is on track to become effective on August 31, 2015.
- A "Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports" was completed. The plan initially is a collaboration between the Departments of Education and Human Services, and will expand in the future.
- Developed a list of Crisis Prevention/ Intervention Training Programs to help individualized education program teams reduce the use of restrictive procedures
- Prone restraint will be no longer be permitted by law as of August 1, 2015 in Minnesota school districts and will apply to children of all ages. (Statute 125A.0942)
- Completed annual Report to legislature "A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools."

Measurable goals

Minnesota Statute 245D, and Minnesota Rule part 9544 prohibit the use of restraint and seclusion except as authorized under limited circumstances for emergencies (Situations when a client's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Property damage, verbal aggression, or refusal to receive/ participate in treatment does not constitute an emergency.)

Goal One: By June 30, 2018 the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. rule, Part 9544, (for example, home and community based services) who experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will decrease by 5% or 200.

Annual Baseline: In 2014 the number of individuals who experienced a restrictive procedure was 1,076.

Annual Goals to reduce the number of people experiencing a restrictive procedure:

- By June 30, 2015 the number of people experiencing a restrictive procedure will be reduced by 5% from the previous year or 54 individuals
- By June 30, 2016 the number of people experiencing a restrictive procedure will be reduced by 5% from the previous year or 51 individuals
- By June 30, 2017 the number of people experiencing a restrictive procedure will be reduced by 5 % from the previous year or 49 individuals
- By June 30, 2018 the number of people experiencing a restrictive procedure will be reduced by 5% from the previous year or 46 individuals

Goal Two: By June 30, 2018, the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) will decrease by 1,596.

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

Annual Goals to reduce the number of reports of restrictive procedures:

- By June 30, 2015 the number of reports of restrictive procedure will be reduced by 430
- By June 30, 2016 the number of reports of restrictive procedure will be reduced by 409
- By June 30, 2017 the number of reports of restrictive procedure will be reduced by 388
- By June 30, 2018 the number of reports of restrictive procedure will be reduced by 369

Goal Three: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544[48], with limited exceptions to protect the person from imminent risk of serious injury. Examples of a limited exception include the use of a helmet for protection of self injurious behavior and safety clips for safe vehicle transport). By December 31, 2019 the emergency use of mechanical restraints will be reduced to ≤ 93 reports and ≤ 7 individuals.

Baseline: In SFY 2014, there were 2,038 BIRF reports of mechanical restraints involving 85 unique individuals.

Annual Goals to reduce the use of mechanical restraints:

- By June 30, 2015, reduce mechanical restraints to no more than
  - 461 reports of mechanical restraint
  - 31 individuals approved for emergency use of mechanical restraint
- By June 30, 2016, reduce mechanical restraints to no more than
  - 369 reports of mechanical restraint
  - 25 individuals approved for emergency use of a mechanical restraint
- By June 30, 2017, reduce mechanical restraints to no more than
  - 277 reports of mechanical restraint
  - 19 individuals approved for emergency use of a mechanical restraint
- By June 30, 2018, reduce mechanical restraints to no more than
  - 185 reports of mechanical restraint
  - 13 individuals approved for emergency use of a mechanical restraint
- By June 30, 2019, reduce mechanical restraints to no more than
  - 93 reports of mechanical restraint
  - 7 individuals approved for emergency use of a mechanical restraint

[48] Minnesota Security Hospital (MSH) is governed by the Positive Supports Rule when serving people with a developmental disability.

Goal Four: By June 30, 2017, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 316.

Annual Baseline: Use of restrictive procedures in schools is prohibited, except in the case of an emergency. In 2014 the number of students who experienced at least one restrictive procedure in a school setting was 2,740:

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

- By June 30, 2015, the number of students experiencing emergency use of restrictive procedures will be reduced by 110
- By June 30, 2016, the number of students experiencing emergency use of restrictive procedures will be reduced by 105
- By June 30, 2017, the number of students experiencing emergency use of restrictive procedures will be reduced by 101

Goal Five: By June 30, 2017, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 2,251.

Annual Baseline: In 2014, school districts (which include charter schools) reported to MDE that there were a total of 19,537 incidents which involved the emergency use of restrictive procedures occurring in schools.

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

- By June 30, 2015, the number of incidents of emergency use of restrictive procedures will be reduced by 781
- By June 30, 2016, the number of incidents of emergency use of restrictive procedures will be reduced by 750
- By June 30, 2017, the number of incidents of emergency use of restrictive procedures will be reduced by 720

Rationale

- Progress towards the goals will be measured through incident tracking from two sources:[49]

  Behavioral Intervention Reporting Forms (BIRFs) (Goals 1 – 3)
  Individuals who experience the use of a restrictive procedure while receiving services by a 245D licensed provider (a provider of disability services, for example: home and community based services) will be identified through submitted BIRFs. Providers are required to submit BIRFs to DHS and the Ombudsman for Mental Health and Developmental Disabilities for any sort of behavioral intervention, including all restrictive procedures, within 3-5 days of their use.

  For the purposes of Goal One and Goal Two, the baseline includes reports of mechanical restraints, self-injury protection equipment, seat belt restraints, time-out, seclusion and penalty consequences. For Goal Three, the baseline includes only reports about mechanical restraints, self-injury equipment and seat belt restraints.

[49] Restrictive procedures are defined differently by MDE and DHS, therefore there are two different reporting processes.

Providers are required to submit a single report for each use of manual restraint, emergency use of manual restraint and seclusion. For other practices, such as the use of seat belt clips or deprivation procedures, they may report multiple incidents in a week in one report. In order to understand the utilization trends it is important to know the number of individuals experiencing restrictive procedures and the number of incidents or application of emergency use of restrictive procedures. (Further information is available in the Positive Support Transition Plan Instructions[50], which implements the Minnesota Statute, Chapter 245D)

Annual restrictive procedure summary reports (Goals 4-5)
Baseline data includes students who experience the use of a restrictive procedure by school staff while in the school setting as well as the number of restrictive procedure incidents. A restrictive procedure includes physical holds and seclusions, as defined in Minnesota Statutes section 125A.0941. Summary student data will be identified by an annual restrictive procedure summary report submitted by school districts to the Minnesota Department of Education (MDE) on an annual basis. That data will be summarized in the annual legislative report submitted on February 1st of each year.

- These two measures are reasonable because they track every incident of restrictive procedures in their respective areas.
- Mechanical restraints are approved through a review process by a team of clinicians who also provide technical assistance and monitoring of the plans to reduce use of restraints.
- Note that when the new positive supports rule (Minn. Rule, part 6544) goes into effect in August 2015, providers with 245A licenses who serve people with developmental disabilities will also be reporting through the BIRF system, which may require a reassessment of the baseline and goals.
- We believe the targets to be realistic based upon the experience from other states and Minnesota's success following positive supports training.
- There is funding to support actions related to the current goals. The Governor proposed additional resources for the Department of Education for technical assistance, but it was not adopted by the 2015 legislature.

Strategies

Improve and Increase the Effective Use of Positive Supports in Working with People with Disabilities

- Implement the Positive Supports Rule (Minnesota Rules Chapter 9544) which becomes effective on August 31, 2015. This rule prohibits the use of restrictive procedures except in emergencies. The rule also requires training, technical assistance, and mentoring to disability service providers on positive support practices and the statutory and rule requirements.
- Continue the expansion of the Positive Behavioral Interventions and Supports (PBIS) which improves the capacity of school districts to include students in integrated classrooms. There are currently 479 schools implementing PBIS, with another 53 set to begin in fall of 2015. By the 2015-2016 school year there will be 532 or 26.5% of Minnesota schools implementing PBIS, impacting an estimated 247,009 students (30% of total students).
- Implement DHS's "Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports", which is a collaboration between DHS and MDE to build system capacity locally engaging with schools, providers, counties, tribes, people with disabilities, families, advocates, and

[50] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810B-ENG

community members. The strategies will be expanded across other agencies as applicable in the future. There will be regular reporting to the subcabinet on progress, and recommendations to address barriers and increase capacity.

- Continue implementation of training for the Department of Corrections staff on crisis intervention teams, motivational interviewing, traumatic brain injury, and Aggression Replacement Training (ART)[51]as appropriate for correctional settings.

Reduce the Use of Restrictive Procedures in Working with People with Disabilities

- Establish data systems to: (1) assess progress in the reduction of the emergency use of restrictive procedures; assess the number of individuals experiencing restrictive procedures and the number of incidents or applications of restrictive procedures; and (3) to identify situations to be targeted for technical assistance.
- Implement the statutory change that no longer permits the use of prone restraints in school settings by August 1, 2015.
- The advisory committee report as required by the Jensen Settlement Agreement and the Comprehensive Plan of Action (CPA) will be reviewed for possible additional recommendations that may be implemented.
- Annually evaluate progress and determine if there are additional measures to be taken to reduce the use of mechanical restraints that are used to prevent imminent risk of serious injury due to self-injurious behaviors. The external review committee provides oversight and technical assistance.
- Publish annual reports on the progress in reducing the use of restrictive procedures and recommendations.
- Work with the Department of Health to evaluate opportunities to coordinate tracking with DHS and reduce use of restrictive procedures for people with disabilities in MDH-licensed facilities.
- Implement MDE's Statewide Plan to Reduce the Use of Restrictive Procedures and Eliminate the Use of Prone Restraint. (Statewide Plan)If the legislature acts to eliminate the use of seclusion in schools, MDE will adjust goals four and five as needed to reflect the changes.
- MDE will document progress in Statewide Plan implementation and summarize restrictive procedure data in the annual legislative report submitted February 1st of each year. MDE will track individual uses of seclusion on students receiving special education services by requiring districts to submit individual incident reports of each use of seclusion. These reports will assist MDE and the Restrictive Procedures Work Group in identifying areas of concern and developing strategies for eliminating the use of seclusion.
- Restrictive procedures may only be used in the school setting in an emergency, by licensed professionals, who have received training which includes positive behavioral interventions, de-escalation, alternatives to restrictive procedures, and impacts of physical holding and seclusion.
- MDE contracted to develop three online training modules which contain evidence based strategies to use with students with disabilities who have significant needs that result in self-injurious or physically aggressive behaviors. These modules will be available for the 2015-2016 school year.

[51] ART is an evidence-based cognitive behavioral practice for working with youth who have a history of serious aggression and antisocial behavior. Multiple studies have shown ART's effectiveness for youth confined in juvenile correctional facilities.

Reduce the Use of Seclusion in Educational Settings

- Engage the Restrictive Procedures Work Group[52] at least annually to review restrictive procedure data, review progress in implementation of the Statewide Plan, and discuss further implementation efforts and revise the Statewide Plan as necessary.
- Engage the Restrictive Procedures Work Group to make recommendations to MDE and the 2016 legislature on how to eliminate the use of seclusion in schools on students receiving special education services and modify the Statewide Plan to reflect those recommendations. The recommendations shall include the funding, resources, and time needed to safely and effectively transition to a complete elimination of the use of seclusion on students receiving special education services.

Responsible Agencies

- Department of Human Services
- Department of Education
- Department of Health
- Department of Corrections

[52] Statute 125A.0942 states the Commissioner of MDE must consult with interested stakeholders, including representatives of advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, county social services, state human services staff, mental health professionals, and autism experts.

Crisis Services

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

What this topic means

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

Vison statement

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

What we have achieved

- Established a process for school districts so students with complex disabilities can access crisis services.
- "Crisis Triage and Handoff Process" Report was completed which summarized the crisis services currently available, barriers in accessing services, and recommendations to address the barriers.
- Secured $50 million in new funding from the state legislature for expansion of mental health services- inclusive of funds to prevent crisis from occurring and funds to address crisis when they do occur. Examples include:
    - Expanded crisis line to include consultations for people with traumatic brain injuries and developmental disabilities in crisis
    - Expanded mobile crisis teams, Assertive Community Treatment (ACT) capacity, and quality standards
    - Funded first episode psychosis initiative to ensure early intervention for individuals experiencing a psychosis as a means to minimize life disruption and maximize recovery.
    - Funded programming in schools to keep youth in schools and out of corrections (This program links mental health services, law enforcement and educational settings)

Measurable goals

Goal One: By June 30, 2018, the percent of children who receive children's mental health crisis services and remain in their community will increase to 85% or more.

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

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

- By June 30, 2016, the percent who remain in their community after a crisis will increase to 81%
- By June 30, 2017, the percent who remain in their community after a crisis will increase to 83%
- By June 30, 2018, the percent who remain in their community after a crisis will increase to 85%

Goal Two: By June 30, 2018, the percent of adults who receive adult mental health crises services and remain in their community (e.g., home or other settings) will increase to 89% or more.

Baseline: In State Fiscal Year 2014 of 5,051 episodes, the person remained in their community 82% of the time:

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

- By June 30, 2016, the percent who remain in their community after a crisis will increase to 84%
- By June 30, 2017, the percent who remain in their community after a crisis will increase to 86%
- By June 30, 2018, the percent who remain in their community after a crisis will increase to 89%

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

Baseline: State Fiscal Year 2014 baseline of 62 people who discontinued waiver services (3% of the people who received crisis services through a waiver):

Annual Goals to decrease the number of people who discontinue waiver services after a crisis:

- By June 30, 2015, the number will decrease to no more than 60 people (percent will adjust in relation to total number served in FY 15).
- By June 30, 2016, the number will decrease to no more than 55 people (percent will adjust in relation to total number served in FY 16).
- By June 30, 2017, the number will decrease to no more than 45 people (percent will adjust in relation to total number served in FY 17).

Goal Four: By June 30, 2018, people in community hospital settings due to a crisis, will have appropriate community services within 30 days of no longer requiring hospital level of care and, within 5 months after leaving the hospital, and they will have a stable, permanent home.

- By February, 2016 a baseline and annual goals will be established.

Goal Five: By June 20, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary placement within ten days.

- By January 31, 2016, establish a baseline of the length of time it takes from referral for crisis intervention to the initiation of crisis services and develop strategies and annual goals to increase access to crisis services, including specific measures of timeliness.

Rationale

- The State will reform crisis services across programs and funding sources to create a system that delivers timely responses to crisis and reduces the unnecessary use of restrictive and segregated settings. Crisis services will address any diagnosis, including complex or multiple conditions. The goals measure impact of reform of services in three areas: children's mental health; adult mental health; and disability home and community based waivers.
- Inadequate level of crisis services may result in people being unnecessarily hospitalized or placed in other segregated settings. Goal three measures the impact of improved crisis services on individuals receiving waiver services. Improvement in crisis services is projected to decrease the number of individuals who no longer receive waiver services. By expanding in home intervention and short term residential services, people will avoid unnecessary hospitalizations or other restrictive services.
- Baselines and measurement of progress is based on people who receive a crisis service for the count of incidents and individuals. Whether or not a person remains in their community is determined in one of three ways.
    - For children's mental health crisis services, where/how the incident is resolved is recorded and reported. Any resolution where the child remains at home or in school is considered "remaining in their community".
    - For adult mental health crisis services, outcome is determined by referrals made (either community-based provider or not community-based).
    - For waiver services, an analysis was performed to measure whether or not the crisis service in each episode was a residential or community-based service and whether or not the person left the waiver (stopped community-based services) following a crisis episode. A person could go to the emergency room, and maybe even have a short period of hospitalization, and still be counted as remaining in the community, as long as they return in a short period of time and do not lose home and community-based waiver services.
- Crisis services do three things: (1) stabilize a person in their current setting; (2) triage to determine if more intensive services are necessary; and (3) divert people from unnecessarily accessing segregated settings. The most effective measure for crisis services is maintaining stability in their current setting. This can be influenced by timely and appropriate crisis services and increased capacity of community providers delivering positive supports strategies.
- $50 million additional state investment for mental health expansion was authorized in the 2015 legislative session.
- Timely access to crisis services which are clinically appropriate is a best practice.

Strategies

Evaluate and Establish a Baseline and Measurements for the Effectiveness of Crisis Services

- Examine the utilization of crisis services by July 1, 2016 to determine:
    - the number of people who use crisis services
    - the number of individuals demitted from where they live/work after a crisis episode
    - single point of access
    - effectiveness of current crisis services for people with complex co-occurring conditions
    - timeliness of crisis interventions
    - length of time crisis services are used, and barriers to permanent, stable services, and housing.

- Establish a baseline for the length of time it takes to access crisis services by January 31, 2016, and establish annual goals.
- Evaluate the capacity (strengths and barriers) of the crisis system to provide timely access to in home intervention and residential crisis services and identify solutions, including development of additional crisis residential homes and mobile crisis services, increased specialized staffing and/or streamlined processes to efficiently authorize and access funding.
  Evaluate the length of time someone remains in a residential crisis setting when stable, and reasons for delay in moving back to their living situation. Identify solutions to expedite the development of permanent housing and service options to more quickly move people out of crisis homes when level of service no longer needed.

Implement Additional Crisis Services

- Implement the $50 million investment in mental health services for the 2016-2017 biennium
    - Increase access to children's mental health crisis services in schools (Goals 1, 2, 5)
    - Increase capacity of mental health crisis services providers to respond to the needs of people with complex needs (i.e., co-existing mental health and intellectual/ developmental disabilities) (Goals 1, 2, 5)
    - Expand and enhance Assertive Community Treatment (ACT) teams (Goal 4)
    - Expand housing with supports (Goal 4)
    - Expand mobile crisis teams (Goals 1, 2, 4)
- Implementation of recommendations from the Community-Based Services Steering Committee (DHS and stakeholder committee focused on safety net service infrastructure) which are due December, 2015, to close gaps in available state operated safety net and crisis capacity.
- Expand home and community-based crisis services
    - Develop residential crisis options throughout the state to have timely access to crisis services that are clinically appropriate.
        - By December 31, 2015, in collaboration with counties, develop a plan to increase in-home respite.
        - By August 2016, develop 20 additional crisis respite beds.
        - Annually evaluate and determine the number of crisis respite beds that are necessary to meet the needs and develop additional capacity if necessary.
    - Develop additional mobile crisis intervention and clinical expertise that supports providers and families so that people remain in their homes, jobs, and community.

- DHS will develop a single point of access and streamlined referral requirements to improve the quality of the crisis response outcomes for people with disabilities. The initial phase to start September 1, 2015 will be targeted to persons with developmental or intellectual disabilities in crisis and at risk of losing their current placement.

Develop a Set of Proactive Measures to Improve the Effectiveness of Crisis Services

- Train schools and providers, including child care centers, on positive practices and working with children who have experienced trauma in their lives. These practices have proven to reduce the use of emergency restrictive procedures and crisis episodes.
- Implement Behavioral Health Homes in July 2016. Behavioral Health Homes provide an array of primary care and mental health services which can be accessed in managing crisis episodes.
- Implement the Forensic Assertive Community Treatment (FACT) team model. This service focuses on individuals exiting correctional facilities with serious mental illness and provides a flexible set of community based mental health services to support the individuals in returning to the community.
- Build effective systems for use of positive practices, early intervention, crisis reduction and return to stability after a crisis.

Responsible Agencies

- Department of Human Services
- Minnesota Department of Education

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Community Engagement

Stakeholder Comments	
"Give people a chance to show that we can do it, yes, we can. Everybody deserves a chance and everybody learns differently. Everyone has a dream where they want to live, work and be happy."	*Patricia Ann Wallace (2013)*
"By including self-advocacy, peer-to peer support, and leadership training into the Olmstead Plan, self-advocates would have an increased ability to create change within the system that impacts their lives on a daily basis."	*Laura Birnbaum (2013)*
"Not enough mental health providers are employing certified peer specialists."	*NAMI Minnesota (2013)*

What this topic means

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

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

There are four main strategic actions to ensure community engagement is happening:

- Increase the number of employed certified Peer Support Specialists
- Increase the number of Self advocates
- Increase the number of people with disabilities involved in planning publicly funded projects
- Increase the number of leadership opportunities

Vision statement

People with disabilities will have the opportunity to fully engage in their community and connect with others in ways that are meaningful and aligned with their personal choices and desires.

What we have achieved

- The Olmstead Community Engagement Plan was approved by the subcabinet.
- 14 public listening sessions were held since 2013.
- The Olmstead Implementation Office presented 92 informational sessions between July 2014 and July 2015.
- The Olmstead Implementation Office had 7 meetings and appearances with key legislators before and during the 2015 legislative session.

Measurable goals

Goal One: By June 30, 2019, the number of individuals involved in their community in ways that are meaningful to them will increase to 1,992. (This includes increases in the numbers of: self-advocates; individuals involved in publicly funded projects; and Certified Peer Support Specialists.)

Baseline: As of June 30, 2014, the number of individuals engaged in their community is 1,242.

Self-Advocates

- **By June 30, 2019 the number of self-advocates will increase to 1,575.**

  Baseline: There are 1,200 active self-advocates involved in the Self Advocates Minnesota (SAM)[53] network statewide and participating in Tuesday's at the Capitol[54].

Annual Goals to increase the number of self-advocates:

- By June 30, 2016, the number of self-advocates will increase by 50 for a total of 1,250.
- By June 30, 2017, the number of self-advocates will increase by 75 for a total of 1,325.
- By June 30, 2018, the number of self-advocates will increase by 100 for a total of 1,425.
- By June 30, 2019, the number of self-advocates will increase by 150 for a total of 1,575.

Involvement in Publicly Funded Projects

- **By June 30, 2019, the number of people with disabilities involved in planning publicly funded projects at the subcabinet agency level will increase to 417.**

  Baseline: There were 42 individuals with disabilities involved in planning 6 publicly funded projects.

Annual Goals to increase the number of people involved in public planning projects**:**

- By June 30, 2016, the number people with disabilities involved in a publicly funded project will increase by 50 for a total of 92.
- By June 30, 2017, the number people with disabilities involved in a publicly funded project will increase by 75 for a total of 167.
- By June 30, 2018, the number people with disabilities involved in a publicly funded project will increase by 100 for a total of 267.
- By June 30, 2019, the number people with disabilities involved in a publicly funded project will increase by 150 for a total of 417.

[53] Self- Advocates Minnesota is a statewide network of regional self-advocacy groups coordinate through Advocating Change Together.

[54] Tuesday's at the Capitol is coordinated by the Minnesota Consortium for Citizens with Disabilities and brings together self-advocates, families, providers, law makers and agency staff for policy discussions every Tuesday during the legislative session.

Certified Peer Support Specialists

- By January 4, 2016, the initial Survey regarding employed Certified Peer Support Specialists will have been completed to establish a baseline and set measurable goals.

Rationale

- Meaningful community engagement is individual and can be difficult to define. Community engagement is a process that recognizes the value of creating ongoing, long-term relationships for the benefit of the greater community. It brings an interactive, collective problem-solving element into the process that capitalizes on the collective strengths of the various stakeholders.
- Self- Advocates - The baseline does not reflect the total number of active self-advocates. There are many self-advocacy groups however not all groups identify with the title of self-advocacy making identification more complex. Further data collection will be necessary to develop a more robust representation of what exists within the state.
- Public projects- There are hundreds of projects happening each year for which there is no current method of tracking. However, Minnesota has historically involved people with disabilities making sure that publicly funded projects are accessible and this continues as we move into the future.
- Peer Support Specialists -The Department of Human Services (DHS) provides funding for the peer support specialist certification course. A survey was conducted through a third party however; this data is more than two years old and the response rate was well under 40%. Based on the low response rate and time past since the survey was conducted it was determined that new data is needed to create a valid baseline from which to set goals. Anecdotal information received from DHS also identifies a range of barriers for this employment that need further exploration.

Strategies

Increase the Number of Leadership Opportunities for People with Disabilities

- Gather additional data and reassess goal within one year, through surveys, focus groups and other methods.
- Conduct a survey of all Governor appointed disability councils, boards, groups, etc. regarding existing leadership opportunities and capacity.
- Work with the Governor appointed councils, groups, boards, etc. to create plans that coordinate their goals with Olmstead goals.

Increase the Use of Self-Advocates in Implementing the Olmstead Plan

- Identify leadership and other training programs that can help develop self-advocates, such as Partners in Policy Making®[55] and the Olmstead Academy[56].
- Recommend the use of self-advocates as paid surveyors/auditors throughout implementation of the Olmstead Plan.
- Utilize self-advocates as trainers for the Olmstead Community Engagement Plan.
- Explore potential funding sources to enable support of self-advocates and their organizations, including but not limited to grants.

Increase the Use of Peer Support Specialists in Implementing the Olmstead Plan

- Survey those who have completed the Peer Support Specialist Certification program to get a baseline for how many have current employment in the field and what barriers may be preventing employment.
- Recommend utilizing Certified Peer Support Specialists as surveyors/auditors throughout implementation of the Plan.
- Review current reimbursement rates for the four services Certified Peer Support Specialists that are eligible to bill and make change recommendations, if needed.
- Survey service providers to get more information on use and employment of Certified Peer Support Specialists.

Increase Participation of People with Disabilities in Providing Input on Public Projects

- Design and deliver training programs for those who want to participate in providing input on publicly funded projects.
- Recommend inclusion of people with disabilities on decision making panels.

[55] Partners in Policymaking® is a training program created by the Minnesota Governor's Council on Developmental Disabilities. The program educates parents and self-advocates on the power of advocacy to influence public policy while building better inclusion and integration within the community.
[56] The Olmstead Academy is a training program offered by Advocating Change Together. The program is aimed at creating a culture in Minnesota where self-advocates play a meaningful role in the state's Olmstead Plan.

Topic areas under development

The following topics areas will be developed during the first year of implementation of this new Olmstead Plan and will be included in the Plan as modifications. They will contain the same items as the other topic areas as described above.

Assistive Technology

- By 2016, a baseline and measurable goals will be established for expanding the use of assistive technology to increase access to integrated settings.

Preventing Abuse and Neglect

- By 2016, a baseline and measurable goals will be established on statewide levels and trends of abuse, neglect, exploitation, injuries, and deaths.

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PLAN MANAGEMENT AND OVERSIGHT

Plan Management and Oversight

Olmstead Subcabinet and Olmstead Implementation Office

In 2013 Governor Dayton issued an Executive Order (13-01) that established the Olmstead Subcabinet to develop and implement a comprehensive Olmstead Plan. The original version of the Plan, drafted in 2013, established an Olmstead Implementation Office (OIO) to have day to day responsibility for overseeing implementation of the Plan.

In January of 2015, Governor Dayton issued a new Executive Order (15-03) that articulated the role of the subcabinet in more detail. Among other things, the order directed the subcabinet to oversee and monitor Plan implementation and modification; to appoint an Executive Director of the OIO; and to develop a quality improvement plan.

The Executive Order further directed the subcabinet to adopt procedures that would include clarifying and defining the role of the OIO. Accordingly, in March 2015, the subcabinet adopted procedures that established a dual role for the OIO: (1) quality assurance and accountability, including compliance evaluation, verification and oversight; and (2) engagement with the community, especially people with disabilities, including on-going management of communications and the Quality of Life survey.

As part of its primary role of providing direction and oversight of the development and implementation of the Olmstead Plan, the subcabinet has a particular responsibility to monitor the impact of the activities being undertaken by State agencies and delivery agents such as counties and providers. The subcabinet must be attentive to the possibility of unintended consequences of these actions, and should also watch for opportunities to simplify or change the delivery of services to achieve better results.

Quality assurance and accountability

Development and Oversight of Workplans

In order to achieve the measurable goals, the OIO and State agencies will need to develop specific strategies and workplans. Each measurable goal is supported by several key strategies. Key strategies will be supported by workplans.

Within 60 days of the publication of the new Olmstead Plan, the state agencies will develop a workplan for each of these strategies. The OIO compliance staff will oversee the development of the workplans. The workplans will be approved by the subcabinet and will be made available to the public on the Olmstead website.

The OIO compliance staff and the subcabinet will use the workplans throughout the year to review the progress of the work and to direct any adjustments to the work if progress is not timely, or if changes to the workplans are needed based on actual experience in the field, including results from the Quality of Life survey.

Following completion of the workplans, the OIO Director of Compliance will develop a schedule for reporting on the activities in the workplans. The frequency of reporting to the Olmstead Implementation and the subcabinet will be determined by taking into account specific deadlines that are critical to achieving the outcomes specified in the measurable goals. The reporting schedule will be provided to the subcabinet and will be made available to the public on the Olmstead website.

Compliance Evaluation, Verification and Oversight

The Director of Compliance will have the primary responsibility for overseeing the implementation and compliance activities undertaken by State agencies in the implementation of the Plan. Each State agency will be responsible for ensuring that its own activities are in compliance with state and federal law and regulations and any relevant court orders and are verifiable. The Director of Compliance will work with senior staff from each agency to develop protocols for periodic evaluation, verification and oversight of activities that are directly related to the implementation of the Plan.

The subcabinet will hold regular meetings at least six times per year and will schedule additional meetings as necessary to complete its work. The Director of Compliance will present a summary of compliance activities at each subcabinet meeting.

The subcabinet will provide periodic written reports to the public detailing progress on the measurable goals. These reports will also be provided to the Court by the Department of Human Services while the implementation of the Plan remains under the jurisdiction of the Court.

Quality of Life survey

The Executive Director will have primary responsibility for the oversight of 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.

In 2014, the Olmstead Implementation Office completed significant work that will allow it to move forward and complete the initial survey to establish the baseline data against which future surveys will be compared. Steps completed include:

- Selected a Quality of Life Survey Tool that is tested, reliable, validated, low cost, systematic, and repeatable, and it will apply to all people with disabilities.
- Secured funding for and completed the pilot survey designed to test the effectiveness of the selected survey tool
- Submitted “Minnesota’s Olmstead Plan Quality of Life Survey Pilot Study” Report
- Requested and received funding for the full implementation of the Quality of Life Survey for the 2016-2017 biennium

By June 30, 2016 the initial Quality of Life Survey will be completed to establish a sample baseline. The survey will be conducted annually for the next three years.

A critical piece of establishing the baseline will be the identification of 12,000 potential survey participants to develop a valid sample of 3,000 respondents.

The results of each annual Quality of Life survey will be shared with the subcabinet, and state agencies that are implementing the Plan so that they can evaluate whether changes should be made in these activities. The results of each annual Quality of Life survey will also be shared with the public.

Dispute resolution oversight

The Executive Director began work under the original Olmstead Plan to put in place a system for effectively working with people with disabilities that have a need for assistance in resolving disputes. Working with the State Department of Human Rights, the OIO identified those offices within State government that have formal dispute resolution processes in place, and established a set of protocols for referring people with disabilities to the most appropriate of these offices. These protocols are set forth in the "Olmstead Dispute Resolution Process Work Plan".

In 2016, the Olmstead Implementation Office will work with the State Department of Human Rights to develop a set of recommendations for any changes that may be necessary to improve performance under the Dispute Resolution process.

Updating and Extending the Olmstead Plan

The Olmstead Plan is not intended to be a static document that simply establishes a one-time set of goals for state agencies as they provide services for people with disabilities. Rather, it is intended to serve as a vital, dynamic roadmap that will help realize the subcabinet's vision of people with disabilities living, learning, working, and enjoying life in the most integrated settings.

As the subcabinet agencies work to accomplish the improvements described in the measurable goals, much will be learned regarding what practices are having a positive impact on the quality of life for people with disabilities. As improvements are made in the ability to gather and use better data, there will likely be opportunities to adjust the goals to accomplish improvements more quickly or in a better way. It will therefore be important that there is an established process for amending the Plan.

In addition to its on-going oversight of workplans, the subcabinet will establish an annual process for reviewing the measurable goals and evaluating whether the goals should be amended for future years. Based on these evaluations, the subcabinet will employ a formal process to amend the Plan. Any proposed amendments will be posted for review by the public and the court, and will allow for a specific public comment period of at least 30 days. Following the comment period, the subcabinet will consider whether any changes to the proposed amendments are warranted as a result of the public comments. Any subsequent changes to the proposed amendments will be posted for a brief public review period prior to adoption of the amendments to the Plan by the subcabinet.

Because many of the measurable goals have a time horizon of three to five years, the subcabinet will also put in place a strategic review of the Plan in 2018. The subcabinet will consider results of the Quality of Life survey, achievements under the measurable goals, and feedback from people with disabilities, families, providers, counties and tribal governments, and state agencies in establishing annual targets for the measurable goals for the subsequent three to five year period. This strategic review may also indicate that some goals should be replaced because they are not the most effective measure and/or that goals need to be added.

Communications and public relations

The Olmstead Implementation Office has primary responsibility for oversight and management of communications about the Olmstead Plan with the general public, and particularly with people with disabilities.

State agencies that are implementing activities as part of the Olmstead Plan have the responsibility to work with the Olmstead Implementation Office to ensure that materials developed to inform the public about these activities are developed within the principles of Olmstead. For example, one principle of this Olmstead Plan is to increase the number of individuals in the most integrated settings – and is not a plan to eliminate certain options or close certain facilities.

The Olmstead Implementation Office will develop a Communications Plan that will guide the direct communication messages and activities of the Office, but will also establish guidelines for materials that are developed by State agencies.

The subcabinet and Olmstead Implementation Office use relationships and tools to provide accurate, timely and useful information about the vision, goals and activities of the Olmstead Plan in ways that are accessible and effective. This will raise awareness and understanding in the Plan and increase long-term engagement with members of the public, including people with disabilities.

The Olmstead Implementation Office will also have primary responsibility for handling and tracking communications from and regarding individuals with disabilities that express concerns about services they are receiving from State or local agencies. Such communications may be initially delivered directly to the Office and to State agencies. The Office will track the receipt and handling of such communications and ensure that they are handled promptly and in accordance with the principles of the Plan.

Cross-agency coordination of data strategies

Within each of the Topic Areas in this Olmstead Plan, there is at least one Strategy that requires better and different collection and/or analysis of data in order to change certain key processes, to establish baselines against which progress can be measured or to measure outcomes. Because these strategies involving data are so pervasive within the Plan, it will be essential that the subcabinet and the Olmstead Implementation Office develop a means of promoting cross-agency collaboration around these strategies.

The Olmstead Implementation Office will develop a workplan within 60 days of the publication of this new Plan that will contain key activities necessary to ensure that this cross-agency collaboration will take place. The Office will consult with the Commissioner of MN.IT, which is the consolidated information technology office for the State of Minnesota, in the development of this workplan. This workplan will be approved by the subcabinet, and overseen and reviewed in the same manner described for the workplans described above.

Cross-agency coordination of legislative and funding strategies

Within each of the Topic Areas in this Olmstead Plan, there are activities described that are essential to the accomplishment of the outcomes described in the measurable goals. Each of these activities is subject to funding and policy directives that are the result of State or Federal appropriations and legislative and regulatory actions. In order for certain changes in activity to occur, it may be necessary for State agencies to propose and pursue statutory changes or regulatory waivers. It may also be necessary for State agencies to request authorization to redirect funding or to request additional funding in order to accomplish certain outcomes. The need for such statutory, regulatory and funding requests may become apparent as more and better data is available to analyze the outcome of the activities anticipated by the Plan.

The subcabinet will work to ensure the needs for statutory, regulatory, or funding changes that arise as a result of implementing the Olmstead Plan are fully considered as part of the biennial budget and legislative planning process.

Feedback

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

Method	**Steps to follow**
Online	3. Go to: Mn.gov/Olmstead 4. Click "Participate" and follow instructions for the online form
In an Email	Send an email to this address:
In the Mail	Send a letter to: Olmstead Implementation Office 400 Sibley Street, Suite 300 St. Paul, MN 55101
On the Phone	Speak to a staff member at the Olmstead Implementation Office, or leave your comment on voicemail. 651-296-8081

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Definitions of key terms

245A: The Human Services Licensing chapter of the Minnesota State Statutes.

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

Assertive Community Treatment: Assertive Community Treatment (ACT) is an intensive, comprehensive, non-residential treatment, rehabilitation, and supportive mental health service that uses a team approach. Services are consistent with Adult Rehabilitative Mental Health Services, except that ACT additionally provides services are (a) delivered by multidisciplinary, qualified staff who have the capacity to provide most mental health services necessary to meet the person's needs, using a total team approach; (b) directed to persons with a identified serious mental illness (i.e. primarily schizophrenia, schizoaffective disorder, bipolar disorder) who require intensive services; and (c) offered on a time-unlimited basis and available 24 hours per day, 7 days per week, 365 days per year.

Behavioral health home: Health homes services are comprehensive and timely high-quality services provided by a designated provider and specifically include: care management; care coordination; health promotion; transitional care; patient and family support; referral to community and social support services; and improved exchange of health information. [Reference Section 2703 of the Affordable Care Act]. DHS is developing behavioral health home services for adults and children with serious mental illness.

Behavior Intervention Reporting Form: The Behavior Intervention Reporting form (BIRF) is the form prescribed by the commissioner to collect data specific to incidents of emergency use of manual restraint and positive support transition plans for persons in accordance with the requirements of Minnesota Statutes, section 245.8251, subdivision 2.

Bridges: This program, operated by Minnesota Housing Finance Agency and implemented in collaboration with the Department of Human Services, is administered through local housing agencies. It provides rental assistance and access to support services for households in which at least one adult member has a serious mental illness and their income is below 50 percent of the area median income. Under the Bridges program, households are stabilized in the community until a Section 8 certificate or voucher becomes available for them to access. [Reference: Minnesota Statutes §462A.2097]

Certified Peer Specialist: An individual with a lived experience of mental illness who has been trained and certified by the State of Minnesota to provide Medicaid reimbursable rehabilitation services in Adult Mental Health Rehabilitation Services (ARMHS), Assertive Community Treatment Teams (ACT), Intensive Residential Treatment Services (IRTS) and Crisis services.

Competitive Integrated Employment: Competitive integrated employment means work: (1) performed on a full-time or part-time basis, with or without supports, including self-employment; (2) paying at least minimum wage, as defined by the Fair Labor Standards Act, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by workers without a disability; (3) paid by an employer who is not the individual's service provider; (4) performed in an integrated setting typically found in the competitive labor market where people with disabilities have the opportunity to interact with non-disabled co-workers during the course of performing their work duties to the same extent that non-disabled co-workers have to interact with each other when performing the same work; and (5) provides the employee with a disability with the same opportunities for advancement as employees without disabilities in similar positions.

Disability: See persons/people with a disability

Emergency: In an educational setting, "emergency" means a situation where immediate intervention is needed to protect a child or other individual from physical injury. Emergency does not mean circumstances such as: a child who does not respond to a task or request and instead places his or her head on a desk or hides under a desk or table; a child who does not respond to a staff person's request unless failing to respond would result in physical injury to the child or other individual; or an emergency incident has already occurred and no threat of physical injury currently exists. See Minn. Stat. §125A.0941(b).

Emergency use of manual restraint: means using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own do not constitute an emergency. This definition applies to DHS-licensed services and facilities. See Minn. Stat. §245D.02, subd. 8a.

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

Extended Employment: The Extended Employment (EE) Program is a performance-based state funded program administered by DEED that annually provides ongoing employment support services for nearly 5000 workers with the most significant disabilities. Services are provided through performance-based contracts with a statewide network of non-profit Commission on Accreditation of Rehabilitation

Facilities (CARF) accredited Extended Employment Providers. Service payments are based on reported work hours and reimbursed at differing rates for supported, community and center-based employment. [Reference: Minnesota Statutes §268A.15 and Minnesota Rules parts 3300.2005 – 3300.2055]

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

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.

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

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

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

Lead agencies: Lead agencies are counties, tribes and managed care organizations responsible to plan, provide, arrange and monitor services for eligible persons to ensure consistent delivery of supports and services.

Mechanical restraint: Mechanical restraint means the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. Restraints are used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury. It does not include use of devices that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement; or use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition.

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

Minnesota Supplemental Aid (MSA) Housing Assistance: A state-funded income supplement for people who are eligible for Minnesota Supplemental Aid (MSA) and have high housing costs. MSA Housing Assistance provides up to $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]

Person-centered: This concept is described in the Person-Centered Planning measurable goals section of the Plan (see page 31).

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 page 31)

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 page 31)

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

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

Positive practices: Positive practices are supports that treat people who receive services with respect and dignity, increase quality of life, build skills and decrease interfering behaviors. Programs and services licensed or certified by the Minnesota Department of Human Services must be positive with a focus on quality of life, including building skills people need to achieve their articulated desired life, self-management and self-efficacy, not just alleviating target symptoms. Positive support strategies are based on individualized assessment that emphasizes teaching a person productive and self-determined skill and behaviors without the use of restrictive interventions.

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

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

Restrictive procedures: Restrictive procedures, also referred to as "restrictive interventions", are procedures prohibited in Minnesota Statutes, section 245D.06, subdivision 5 and sections125A.0941 and 125A.0942; prohibited procedures identified in Minnesota Rules part 9544.0060; and the emergency use of manual restraint. They include, but are not limited to, actions that restrict a person's autonomy in some manner, including deprivation procedures, chemical restraint, seclusion and physical holding.

Seclusion: In an educational setting, "seclusion" means confining a child alone in a room from which egress is barred. Egress may be barred by an adult locking or closing the door in the room or preventing the child from leaving the room. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion. See Minn. Stat. §125A.0941(g).

Section 811: This program allows people with disabilities who are low income and between the ages of 18-62to live as independently as possible in the community by subsidizing rental housing opportunities with access to appropriate supportive services. The newly reformed Section 811 program is authorized to operate in two ways: (1) the traditional way, by providing interest-free capital advances and operating subsidies to nonprofit developers of affordable housing for persons with disabilities; and (2) providing project rental assistance to state housing agencies.

Segregated settings: Segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with people with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other people with disabilities. [*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.

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]

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.

Workforce Innovation and Opportunity Act (WIOA): WIOA is the federal Workforce Innovation and Opportunity Act signed into law on July 22, 2014. WIOA supersedes the Workforce Investment Act (WIA) of 1998 and amends the Rehabilitation Act of 1973, the Wagner-Peyser Act and the Adult Education and Family Literacy. Disability service and employment policy provisions that affect people with disabilities include a priority focus on youth with disabilities and their preparation for competitive, integrated employment. At a state level, memorandums of understanding must be developed between Vocational Rehabilitation, Education, Assistive Technology and the Medicaid agency. WIOA also sets limits on the use of the Special Subminimum wage including new requirements for oversight and review. Most of the provisions in WIOA became effective July 1, 2015. The WIOA provisions on Subminimum wage provisions will become effective 7/22/16. More information on WIOA can be found on the US Department of Labor website at: http://www.doleta.gov/wioa/

Common Acronyms

ACT - Assertive Community Treatment

ADA – Americans with Disabilities Act

ADM – Department of Administration

AMRTC – Anoka Metro Regional Treatment Center

APS – Accessible Pedestrian Signals

BIRF – Behavior Intervention Reporting Form

CADI - Community Access for Disability Inclusion

DCD – Developmental Cognitive Disabilities

DD – Developmental Disabilities

DEED – Minnesota Department of Employment and Economic Development

DHS – Minnesota Department of Human Services

DOC – Minnesota Department of Corrections

DOJ – United States Department of Justice

EE – Extended Employment

FACT - Forensic Assertive Community Treatment

GRH – Group Residential Housing

HCBS – Home and Community-Based Services

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

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IPS – Individual Placement and Supports

MA – Medical Assistance

MA-EPD – Medical Assistance for Employed Persons with Disabilities

MCF - Minnesota Correctional Facility

MCOTA – Minnesota Council on Transportation Access

MDE – Minnesota Department of Education

MDH – Minnesota Department of Health

MDHR – Minnesota Department of Human Rights

MHCP – Minnesota Health Care Programs

MHFA – Minnesota Housing Finance Agency

MMB - Minnesota Management and Budget

MnDOT – Minnesota Department of Transportation

MNSCU - Minnesota State Colleges and Universities

MnSHIP - Minnesota State Highway Investment Plan

MSA – Minnesota Supplemental Aid

MSH – Minnesota Security Hospital

MSHS – Minnesota Specialty Health System

NCI – National Core Indicators

OIO – Olmstead Implementation Office

PBIS – Positive Behavioral Interventions and Supports

SAM - Self-Advocates Minnesota

SSB – State Services for the Blind

SFY – State Fiscal Year

VR – Vocational Rehabilitation

VRS—Vocational Rehabilitation Services

WIOA – Workforce Innovation Opportunity Act

APPENDICES

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Appendix A – Governor's Executive Orders Related to Olmstead

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STATE OF MINNESOTA

EXECUTIVE DEPARTMENT

MARK DAYTON

GOVERNOR

Executive Order 13-01

Supporting Freedom of Choice and Opportunity to Live, Work, and Participate in the Most Inclusive Setting for Individuals with Disabilities through the Creation of Minnesota's Olmstead Plan

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, the State of Minnesota recognizes that such services advance the best interests of all Minnesotans by fostering independence, freedom of choice, productivity, and participation in community life of Minnesotans with disabilities;

Whereas, the unnecessary and unjustified segregation of individuals with disabilities through institutionalization is a form of disability-based discrimination prohibited by Title II of the American with Disabilities Act of 1990 (the ADA), 42 U.S.C. §§ 12101 *et seq.*, which requires that states and localities administer their programs, services, and activities, in the most integrated setting appropriate to meet the needs of individuals with disabilities;

Whereas, in *Olmstead v. L.C.*, 527 U.S. 581 (1999), the United States Supreme Court interpreted Title II of the ADA to require states to place individuals with disabilities in community settings, rather than institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonably accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities;

Whereas, the State of Minnesota has taken steps in response to the *Olmstead* decision through the past and current efforts of State agencies and the establishment and work of the Minnesota *Olmstead* Planning Committee, whose recommendations to the Commissioner of the Minnesota Department of Human Services are hereby acknowledged;

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, consisting of the Commissioner, or Commissioner's designees, of the following State agencies, shall develop and implement a comprehensive Minnesota *Olmstead* Plan: (i) that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the most integrated setting, and (ii) that is consistent and in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999):

    a) Department of Human Services;

    b) Minnesota Housing Finance Agency;

    c) Department of Employment and Economic Development;

    d) Department of Transportation;

    e) Department of Corrections;

    f) Department of Health;

    g) Department of Human Rights; and

    h) Department of Education.

    The Sub-Cabinet shall be chaired by Lieutenant Governor Yvonne Prettner Solon.

The Ombudsman for the State of Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities shall be *ex officio* members of the Sub-Cabinet.

The Sub-Cabinet shall allocate such resources as are reasonably necessary, including retention of expert consultant(s), and consult with other entities and State agencies, when appropriate, to carry out its work.

2. Each Commissioner, or Commissioner's designee, shall evaluate policies, programs, statutes, and regulations of his/her respective agency against the standards set forth in the *Olmstead* decision to determine whether any should be revised or modified to improve the availability of community-based services for individuals with disabilities, together with the administrative and/or legislative action and resource allocation that may be required to achieve such results.

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

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

This Executive Order shall remain in effect until rescinded by proper authority or until it expires in accordance with Minnesota Statutes, section 4.035, subdivision 3.

In Testimony Whereof, I have set my hand on this 28th day of January, 2013.

_____

Mark Dayton
Governor

Filed According to Law:

_____

Mark Ritchie
Secretary of State

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STATE OF MINNESOTA

EXECUTIVE DEPARTMENT

MARK DAYTON

GOVERNOR

Executive Order 15-03

Supporting Freedom of Choice and Opportunity to Live, Work, and Participate in the Most Inclusive Setting for Individuals with Disabilities through the Implementation of Minnesota's Olmstead Plan; Rescinding 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, the State of Minnesota recognizes that such services advance the best interests of all Minnesotans by fostering independence, freedom of choice, productivity, and participation in community life of Minnesotans with disabilities;

Whereas, the unnecessary and unjustified segregation of individuals with disabilities through institutionalization is a form of disability-based discrimination prohibited by Title II of the American with Disabilities Act of 1990 (the ADA), 42 U.S.C. §§ 12101 *et seq.*, which requires that states and localities administer their programs, services, and activities, in the most integrated setting appropriate to meet the needs of individuals with disabilities;

Whereas, in *Olmstead v. L.C.*, 527 U.S. 581 (1999), the United States Supreme Court interpreted Title II of the ADA to require states to place individuals with disabilities in community settings, rather than institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonably

accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities;

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

Whereas, the Olmstead Sub-Cabinet was created in Executive Order 13-01 to develop and implement a comprehensive Minnesota Olmstead Plan, which received provisional approval from the Court on January 9th, 2015;

Whereas, the Olmstead Implementation Office (OIO) was created as part of the Minnesota Olmstead Plan, to extend authority of the Sub-Cabinet to facilitate the implementation of the Plan, and is integral to the success of realizing the vision of *Olmstead*; and

Whereas, the work of the Olmstead Sub-Cabinet is ongoing, and further authority is needed by the Sub-Cabinet to effectively implement the Minnesota Olmstead Plan to 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, consisting of the Commissioner, or Commissioner's designees, of the following State agencies, shall implement Minnesota's Olmstead Plan:

    a) Department of Human Services;

    b) Minnesota Housing Finance Agency;

    c) Department of Employment and Economic Development;

    d) Department of Transportation;

    e) Department of Corrections;

    f) Department of Health;

    g) Department of Human Rights; and

    h) Department of Education.

    The Governor shall designate one of the members of the Sub-Cabinet to serve as chair.

The Ombudsman for the State of Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities shall be *ex officio* members of the Sub-Cabinet.

The Sub-Cabinet shall allocate such resources as are reasonably necessary, including retention of expert consultant(s), and consult with other entities and State agencies, when appropriate, to carry out its work.

2. The duties of the Sub-Cabinet are:

    a. Provide oversight for and monitor the implementation and modification of the Olmstead Plan, and the impact of the Plan on the lives of people with disabilities.

    b. To provide ongoing recommendations for further modification of the Olmstead Plan.

    c. Ensure interagency coordination of the Olmstead Plan implementation and modification process.

    d. Convene periodic public meetings to engage the public regarding Olmstead Plan implementation and modification.

    e. Engage persons with disabilities and other interested parties in Olmstead Plan implementation and modification and develop tools to keep these individuals aware of the progress on the Plan.

    f. Develop a quality improvement plan that details methods the Sub-Cabinet must use to conduct ongoing quality of life measurement and needs assessments and implement quality improvement structures.

    g. Establish a process to review existing state policies, procedures, laws and funding, and any proposed legislation, to ensure compliance with the Olmstead Plan, and advise state agencies, the legislature, and the Governor's Office on the policy's effect on the plan.

    h. Establish a process to more efficiently and effectively respond to reports from the Court and the Court Monitor.

    i. Convene, as appropriate, workgroups consisting of consumers, families of consumers, advocacy organizations, service providers, and/or governmental entities of all levels that are both members, and non-members, of the Sub-Cabinet.

3. The Sub-Cabinet shall appoint an Executive Director of the Olmstead Implementation Office (OIO), who will report to the Chair of the Sub-Cabinet. The OIO shall carry out

the responsibilities assigned to the Sub-Cabinet, as directed by the Chair of the Sub-Cabinet.

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

This Executive Order is effective fifteen days after publication in the State Register and filing with the Secretary of State, and shall remain in effect until rescinded by proper authority or until it expires in accordance with Minnesota Statutes, section 4.035, subdivision 3.

In Testimony Whereof, I have set my hand on this 28th day of January, 2015.

_____

Mark Dayton
Governor

Filed According to Law:

_____

Steve Simon
Secretary of State

Appendix B – Sample Workplan

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Sample Workplan

A sample of a completed workplan is included on the following pages. Each workplan will contain the following items for each strategy:

- **Key Activities** – Each strategy will have several key activities which will be measured. The activities will be selected because progress on these activities is critically important to implementation of a strategy. These activities may include identification of policy barriers, funding needs and communication plans.

- **Narrative Describing Expected Outcomes** – Each activity will have a narrative that describes why the activity is important and what outcomes are expected if the activity is completed.

- **Primary Measure** (Output, Outcome or Deadline) – Each activity will have one or more measurements in this section, such as a number of people served by a particular program or a date by which the activity must be completed.

- **Staff Lead(s) and Roles** – Each activity will have an identified lead person and their agency/department (some activities involved more than one agency may have more than one lead person) and their role(s).

- **Other Agencies, Partners and Roles** – Each activity may identify other agency(ies)/ department(s) or other parties (such as counties or people with disabilities) that will have a particular role in the activity.

- **Status Indicator** (On Track/Completed (Green), Delayed/Caution (Yellow), Corrective Action Needed (Red)) – The status indicator for each activity will be used by the activity lead person when they present their status report to the Olmstead Implementation Office and the subcabinet on a scheduled basis to indicate if the activity is on track or if it has issues that are causing problems or delays.

- **Status Notes** – The status notes will be used along with the status indicator to explain the status of each activity.

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Housing and Services Workplan - DRAFT

Executive Sponsor: Jennifer DeCubellis (DHS) and Ryan Baumtrog (MHFA)

Lead: Erin Sullivan Sutton (DHS) and xxx (MHFA)

Key Activity	Narrative Explaining Expected Outcome	Primary Measure (Output, Outcome or Deadline)	Staff Leads and Roles	Other Agencies, Partners and Roles	Status: • On Track / Completed • Delayed/ Caution • Corrective-Action	Status Notes
1. Create more affordable housing						
a) Fully utilize the new Section 811 Project Rental Assistance (811) funding	In the last two years, DHS and MHFA applied for and received 811 funding for a total of 160 people with disabilities who are exiting a segregated setting or who are at risk of segregation, and who have a signed lease and access to supportive services.	85 eligible households will have permanent affordable housing with 811 funding (10/30/2016) 75 additional eligible households will have permanent affordable housing with 811 funding (6/30/2019)	Vicki Farden, Minnesota Housing (MHFA), Program Manager Heidi Sandberg, Department of Human Services (DHS), Housing Coordinator	DHS – Tenancy Supports Coordination		
b) Fully utilize the re-allocated Regional Treatment Center (RTC) funding and the increased Bridges Rental Assistance base funding	MHFA re-allocated funds from the RTC to the Bridges rental assistance program, and the 2015 Legislature allocated additional funding for the Bridges program. Bridges supports the cost of housing for people with disabilities who are exiting a segregated setting or who are at risk of segregation, and who have a signed lease and access to supportive services.	Increase the number of eligible households who will have affordable, integrated housing under the Bridges program over the SFY14 baseline of 713: * SFY15: Increase by 35 * SFY16: Increase by 107 * SFY17: Increase by 173 * SFY18: Increase by 172 * SFY19: Increase by 134	Carrie Marsh (MHFA), Program Manager Gary Travis (DHS), Mental Health Housing Coordinator	DHS – Mental Health and Tenancy Supports Coordination		

Housing and Services Workplan - DRAFT

Executive Sponsor: Jennifer DeCubellis (DHS) and Ryan Baumtrog (MHFA)

Lead: Erin Sullivan Sutton (DHS) and xxx (MHFA)

Key Activity	Narrative Explaining Expected Outcome	Primary Measure (Output, Outcome or Deadline)	Staff Leads and Roles	Other Agencies, Partners and Roles	Status: • On Track / Completed • Delayed/ Caution • Corrective-Action	Status Notes
c) Measure and increase housing stability for people who move to more integrated settings using the new Bridges Rental Assistance funding	Affordable housing and supportive services will increase housing stability.	Increase the percent of people using the new Bridges rental assistance funding in affordable, integrated housing who stay in their housing for at least six months: * SFY15: 70% * SFY16: 70% * SFY17: 75% * SFY18: 75% * SFY19: 80%	Julia Welle Ayres (DHS), Project Manager Carrie Marsh (MHFA), Program Manager Gary Travis (DHS), Mental Health Housing Coordinator			
2. Improve the ability to capture information about housing choices						
a) Implement a process to capture and measure choices made by people with disabilities regarding housing.	At this time, it is not known how many people living in potentially segregated settings would choose or not oppose living in an integrated settings.	Implement through the Transition Protocols. See the Transition Section.	Alex Bartolic (DHS), Division Director			
b) Once a process for capturing and measuring choice is in place, analyze the data and report annually to the subcabinet on progress in meeting goals.	As people who choose or are not opposed to living in integrated settings are identified and supported to move, this number will decrease.	Implement through the Transition Protocols. See the Transition Section.	Alex Bartolic (DHS), Division Director			
3. Implement reform for housing assistance programs						

a) Implement housing policy changes adopted in 2015 legislative session.	Policy changes will promote choice and access to integrated settings by reforming programs that currently provide combined housing and supports to allow greater flexibility: * Give people more control regarding the county in which they prefer to live * Remove barriers to working * Separate the service payment from the housing payment so that people can choose providers In SFY14, approximately 29,400 people received GRH.	Implement new policies: * July 1, 2015: Issue Bulletin and new Forms ; complete statewide webinar and in-person trainings for counties, tribes and providers; establish process for responding to and publishing providers' frequently asked questions * January 30, 2016: Release GRH Orientation training * July 1, 2016: Add GRH Supplemental Services into DHS's Health Care Provider Manual, and complete trainings for counties and service providers in using DHS's service billing system. * July 1, 2016: Issue Bulletin and complete trainings for counties, tribes and providers in new work incentives. * December 30, 2016: All systems changes complete. Increase the number of people who will have affordable, integrated housing using GRH over the SFY14 baseline of 4,533: * SFY15: Increase by 474 * SFY16: Increase by 1,168 * SFY17: Increase by 1,874 * SFY18: Increase by 2,796 * SFY19: Increase by 3,817	Julia Welle Ayres (DHS), Project Manager Kristine Davis (DHS), GRH Lead			
4. Improve Future Models for Housing in the Community						

a) Increase access to information about integrated housing for persons with disabilities through outreach, technical assistance and improved technology solutions for accessing affordable housing.	There are currently people with disabilities who are eligible for supports to pay for the cost of housing, but who are not receiving them. MHFA contracted with HousingLink, a web-based tool to locate affordable rental housing openings, to * promote and increase access to HousingLink services in the disability community, and * add features that are most relevant to people with disabilities. DHS contracted with the World Institute on Disabilities to develop the Housing Benefits 101 website (mn.HB101.org) to makes housing information more accessible. Each Continuum of Care (CoC) will identify one "coordinated entry" point so that anyone wanting to access housing and supports designated for people experiencing homelessness knows where to go and only has to go to that one place to be served.	Market MSA to county financial workers (12/31/16), and increase the number of people who will have affordable, integrated housing using MSA Housing Assistance over the SFY14 baseline of 711: * SFY15: Increase by 108 * SFY16: Increase by 230 * SFY17: Increase by 496 * SFY18: Increase by 916 * SFY19: Increase by 1,436 Market new GRH policy changes that increase choice and access to contract managers and providers (6/30/2016) Launch new HousingLink website and fully market to the disability community (9/30/15) Promote and train providers, counties and tribes on HB101 (6/30/16) Develop the housing planning tool on HB101 to help people with disabilities explore their options (6/30/16) Each CoC will implement an initial Coordinated Entry system (10/30/2015)	Joel Salzer (MHFA), Manager Julia Welle Ayres (DHS), Project Manager Kristine Davis (DHS), GRH Lead Beth Grube (DHS), MSA and HB101 Lead Ji-Young Choi (MHFA), Housing Specialist Pat Leary (DHS), Housing	CoCs Minnesota Interagency Council on Homelessness		

Housing and Services Workplan - DRAFT

Executive Sponsor: Jennifer DeCubellis (DHS) and Ryan Baumtrog (MHFA)

Lead: Erin Sullivan Sutton (DHS) and xxx (MHFA)

Key Activity	Narrative Explaining Expected Outcome	Primary Measure (Output, Outcome or Deadline)	Staff Leads and Roles	Other Agencies, Partners and Roles	Status: • On Track / Completed • Delayed/ Caution • Corrective-Action	Status Notes
b) Actively promote and encourage counties, tribes and other providers to implement best practices and person-centered strategies related to housing.	Support communities in discovering, sharing and implementing successful practices in individualizing the process of helping a person access and maintain housing.	Implement Transition Protocols and Person-Centered Planning. See Transition Section and Person-Centered Planning Section. Continue to host statewide bimonthly Housing Options Best Practices Forums.	Alex Bartolic (DHS), Division Director Julia Welle Ayres (DHS), Project Manager			
c) Develop policy recommendations and strategies to access Medicaid coverage for housing related activities and services for individuals with disabilities.	The Centers for Medicaid and Medicare Services released guidance in June 2015 on using Medicaid funding for housing-related services for people with disabilities.	Preliminary recommendations proposed to DHS leadership (12/31/15)	Don Allen (DHS) Kristine Davis (DHS)			
d) Identify and assess barriers for individuals to obtain and maintain housing, and provide recommendations to the sub-cabinet of strategies to address policy and funding barriers.	As the state deploys strategies to help people move to more integrated housing, new barriers will emerge that need to be addressed.	Report policy and funding barriers to the subcabinet at the end of each fiscal year.				

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Appendix C – Index of Documents Related to Olmstead Plan Implementation

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Alphabetical Index of Documents Related to Olmstead Plan Implementation

Below is an alphabetical listing of reports and documents referenced in the August 2015 Olmstead Plan. The reports were either required by the Olmstead Plan or related to and utilized in the development of the August 2015 Plan.

Appendix C contains a compilation of these reports and is available on the Olmstead website. The list below provides information on each report including the page number where the report is referenced within the August 2015 Plan and the page number the report can be found in Appendix C.

Title of Report/Document	**Plan page**	**Plan Topic Area**	**Author***	**Date**	**Appendix C page #**
ADA Transition Plan	64	Transportation	MnDOT	January 2015	5
A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report	44, 49	Housing Services, Employment	DHS	September 2014	75
A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools	76	Positive Supports	MDE	February 2015	119
Crisis Prevention/Intervention Training Programs	76	Positive Supports, Crisis Services	MDE	June 2015	193
Crisis Triage and Handoff Process	82	Positive Supports, Crisis Services	DHS	February 2015	199
Delivery System for Oral Health	71, 72	Healthcare & Healthy Living	DHS	February 2015	223
Greater Minnesota Transit Investment Plan	66	Transportation	MnDOT	January 2011	237
Health Care and Community Supports Administrations Overview of Behavioral Health Homes	71	Healthcare & Healthy Living	DHS	January 2015	299
Home and Community-Based Supports and Services Waiver Waiting List Report	59	Waiting List	DHS	March 2015	325
Minnesota Employment First Policy	49	Employment	Olmstead SC	September 2015	345
Minnesota Oral Health Plan	73		MDH	January 2013	349
Minnesota Transit Funding Primer Technical Report	64	Transportation	MCOTA	January 2015	405
Minnesota's Olmstead Plan Quality of Life Survey Pilot Study	35, 96	Person Centered Planning, Quality Assurance	Improve Group	December 2015	415
Olmstead Benchmark Report (Barriers in Transitioning Youth to Adult Health Care)	71	Healthcare & Healthy Living	MDH	October 2014	493

Title of Report/Document	Plan page	Plan Topic Area	Author*	Date	Appendix C page #
Olmstead Community Engagement Plan	88	Community Engagement	OIO	March 2015	503
Olmstead Dispute Resolution Process Work Plan	97	Quality Assurance	OIO	February 2015	535
Olmstead Plan Baseline Data for Current Care	71, 72	Healthcare & Healthy Living	DHS	January 2015	541
Olmstead Plan: Work and Benefits Family Outreach Plan		Employment	DHS, DEED, MDE	July 2014	595
Olmstead Transportation Forum Final Report	64	Transportation	DHS, MnDOT	June 2014	615
Positive Support Transition Plan Instructions	79	Positive Supports	DHS		711
Postsecondary Resource Guide – Successfully Preparing Students with Disabilities	55, 57	Lifelong Learning & Education	MDE, MnSCU	2014	731
Recommendations for Improving Oral Health Services Delivery System- February 2014	71	Healthcare & Healthy Living	DHS	February 2014	775
Report on Program Waiting Lists	59	Waiting List	DHS	December 2014	853
Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports	76, 79	Positive Supports	DHS, MDE	October 2014	869
The Status of Oral Health in Minnesota	71	Healthcare & Healthy Living	MDH	September 2013	955

* Authors

DEED	Department of Employment and Economic Development
DHS	Department of Human Services
MCOTA	Minnesota Council on Transportation Access
MDE	Department of Education
MDH	Minnesota Department of Health
MnDOT	Minnesota Department of Transportation
MnSCU	Minnesota State Colleges and Universities
OIO	Olmstead Implementation Office

Appendix C

August 10, 2015
Olmstead Plan

Resource Documents

This packet is a compilation of reports and documents referenced in the August 2015 Olmstead Plan. The reports were either required by the Olmstead Plan or related to and utilized in the development of the August 2015 Plan.

Documents Related to Olmstead Plan Implementation (alphabetically listed)

Title of Report/Document	Plan page	Plan Topic Area	Author	Date	Appendix C page #
ADA Transition Plan	64	Transportation	MnDOT	January 2015	5
A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report	44, 49	Housing Services, Employment	DHS	September 2014	75
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ADA Transition Plan

Minnesota Department of Transportation

www.mndot.gov/ada

We all have a stake in A to B

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Minnesota Department of Transportation
395 John Ireland Boulevard
Saint Paul, MN 55155

January 20, 2015

Dear Citizens of Minnesota,

I am pleased to share with you the revised ADA Transition Plan for the Minnesota Department of Transportation. This plan demonstrates MnDOT's ongoing commitment to providing accessibility and continued collaboration between MnDOT and citizens, stakeholders, and partners throughout Minnesota. In addition to establishing a baseline of the accessibility of the State's transportation system, the plan tracks MnDOT's progress to ensure that transportation is accessible to all users.

As Minnesota's transportation leader, Mn/DOT will uphold the vision and policies presented in this plan. The success of making our transportation system fully accessible depends on the coordinated efforts of all levels of government, the public, and the policies and strategies outlined in this plan. Mn/DOT will continue to look for opportunities to involve citizens, stakeholders and partners in the implementation of this plan, future updates to the plan, and in policy decisions affecting accessibility. Together, we can realize a shared vision of an accessible, safe, efficient, and sustainable transportation system.

Sincerely,

(Original signed)

Susan Mulvihill P.E.

Deputy Commissioner/Chief Engineer

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Mn/DOT
ADA Transition Plan

Minnesota Department of Transportation

1/20/2015

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Introduction

MnDOT Vision

This document is intended to serve as a guide to further the vision, mission and core values for the Minnesota Department of Transportation (MnDOT) by outlining key actions for making the transportation system in Minnesota accessible. The Vision, Mission and Core Values for MnDOT are as follows:

Vision

Minnesota's multimodal transportation system maximizes the health of people, the environment and our economy.

Mission

Plan, build, operate and maintain a safe, accessible, efficient and reliable multimodal transportation system that connects people to destinations and markets throughout the state, regionally and around the world.

Core Values

- Safety
- Excellence
- Service
- Integrity
- Accountability
- Diversity and Inclusion

Transition Plan Need and Purpose

The Americans with Disabilities Act (ADA), enacted on July 26, 1990, is a civil rights law prohibiting discrimination against individuals on the basis of disability. The ADA consists of five titles outlining protections in the following areas:

- Employment
- State and local government services
- Public accommodations
- Telecommunications
- Miscellaneous Provisions

Title II of ADA pertains to the programs, activities and services public entities provide. As a provider of public transportation services and programs, MnDOT must comply with this section of the Act as it specifically applies to state public service agencies and state transportation agencies. Title II of ADA provides that, "…no qualified individual with a

disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." (42 USC. Sec. 12132; 28 CFR. Sec. 35.130)

As required by Title II of ADA, 28 CFR. Part 35 Sec. 35.105 and Sec. 35.150, MnDOT is conducting a self-evaluation of its facilities and developed this Transition Plan detailing how the organization will ensure that all of its facilities, services, programs and activities are accessible to all individuals.

Transition Plan Management

MnDOT's transition plan is a living document that will receive routine updates. Updates are scheduled to occur on a four year cycle. To streamline plan updates and keep the document current and relevant, appendices will be updated annually if new information is available and does not alter the intent of the transition plan. When an appendix update is found to alter the intent of MnDOT's Transition Plan the appendix and affected section(s) will be opened for public review and comment. The update schedule may be altered at the discretion of MnDOT based on changes in guidance from the United States Access Board, Federal policy, and MnDOT policy. MnDOT's Transition Plan is available for continual public inspection through MnDOT's website.

Relationship to Other MnDOT and State Plans

The transition plan does not function as an independent document and informs several planning documents owned by the Minnesota Department of Transportation, including but not limited to the our 50 year vision: Minnesota Go, our 20-year Statewide Multimodal Transportation Plan, and our 20 year investment plan MnSHIP. The development of the plans and their relationship to accessibility is an iterative process led by the goals of the transition plan. As MnDOT's long range plans have been developed they take into account the role of accessibility in meeting multimodal goals, creating livable communities, and identifying investment needs.

In addition to MnDOT's planning and investment documents the transition plan supports the outcomes of Minnesota's Olmsted Plan which focuses on ensuring that individuals with disabilities are living, learning, working, and enjoying life in the most integrated setting of their choice. The Olmstead Plan was published in 2013 and is part of a legal settlement with the state. As part of the eight agencies named to develop and implement the Olmsted Plan MnDOT is focused on how the needs of the Olmstead population affect the prioritization and delivery of our transportation system particularly in the area of Greater Minnesota transit.

Title II of ADA is companion legislation to two previous federal statutes and regulations: the Architectural Barriers Acts of 1968 and Section 504 of the Rehabilitation Act of 1973.

The Architectural Barriers Act of 1968 is a Federal law that requires facilities designed, built, altered or leased with Federal funds to be accessible. The Architectural Barriers Act marks one of the first efforts to ensure access to the built environment.

Section 504 of the Rehabilitation Act of 1973 is a Federal law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any Federal department or agency. Title II of ADA extended this coverage to all state and local government entities, regardless of whether they receive federal funding or not.

When addressing accessibility needs and requirements, it is important to note that ADA and Title II do not supersede or preempt state or local laws that may offer equivalent or greater protections, such as the Minnesota Human Rights Act.

Under Title II, MnDOT must meet these general requirements:

- Must operate their programs so that, when viewed in their entirety, the programs are accessible to and useable by individuals with disabilities (28 C.F.R. Sec. 35.150).
- May not refuse to allow a person with a disability to participate in a service, program or activity simply because the person has a disability (28 C.F.R. Sec. 35.130 (a).
- Must make reasonable modifications in policies, practices and procedures that deny equal access to individuals with disabilities unless a fundamental alteration in the program would result (28 C.F.R. Sec. 35.130(b) (7).
- May not provide services or benefits to individuals with disabilities through programs that are separate or different unless the separate or different measures are necessary to ensure that benefits and services are equally effective (28 C.F.R. Sec. 35.130(b)(iv) & (d).
- Must take appropriate steps to ensure that communications with applicants, participants and members of the public with disabilities are as effective as communications with others (29 C.F.R. Sec. 35.160(a).
- Must designate at least one responsible employee to coordinate ADA compliance [28 CFR § 35.107(a)]. This person is often referred to as the "ADA Coordinator."

The public entity must provide the ADA coordinator's name, office address, and telephone number to all interested individuals [28 CFR § 35.107(a)].

- Must provide notice of ADA requirements. All public entities, regardless of size, must provide information about the rights and protections of Title II to applicants, participants, beneficiaries, employees, and other interested persons [28 CFR § 35,106]. The notice must include the identification of the employee serving as the ADA coordinator and must provide this information on an ongoing basis [28 CFR § 104.8(a)].
- Must establish a grievance procedure. Public entities must adopt and publish grievance procedures providing for prompt and equitable resolution of complaints [28 CFR § 35.107(b)]. This requirement provides for a timely resolution of all problems or conflicts related to ADA compliance before they escalate to litigation and/or the federal complaint process.

MnDOT's Compliance History

Following the passage of ADA on July 6, 1990, MnDOT took initial steps to identify and address Title II requirements. In December of 1991 MnDOT received direction from the local Federal Highway Administration (FHWA) division to complete a curb ramp assessment and transition plan to comply with the new law. Based on direction from the FHWA and the requirements of the final rule passed on July 26, 1991 MnDOT developed the parameters to identify curb ramp needs and an investment plan which would be fully implemented by January 31, 1995. MnDOT records show that each district had completed a curb ramp inventory by December of 1992 and identified funding and a construction timetable that was to be completed by January 26, 1995.

During the same timeframe, the Minnesota Department of Administration conducted an assessment of all state owned and leased properties to identify barriers to be corrected by the individual agencies. According to available MnDOT records, all employee occupied buildings were retrofitted to meet the ADA requirements outlined in 1990 and all subsequent new construction has followed Minnesota Building Codes which meet or exceed ADA requirements. Construction plans and a timetable were developed in 1994 for barrier removal and accessibility improvement for all Class I and II rest areas with work to be completed at the end of 1995. MnDOT had begun barrier removal on rest areas when it was determined that funding administered by the Department of Administration could not be used on rest area improvements. A list of current barriers at MnDOT rest areas can be found in Appendix D.

From 1995 to 2001 MnDOT's ADA efforts were largely decentralized, focusing primarily on reasonable accommodation for employees and transit, with compliance and

oversight falling on individual offices and programs. In general, MnDOT had completed the retrofit requirements identified in ADA and was meeting compliance with new construction and reconstruction projects. During this time MnDOT did not maintain a centralized transition plan.

In 2001 ADA became a point of focus with the Access Board's issuance of the draft rules for public rights of way and the expiration of the moratorium on detectable warning surfaces. MnDOT provided comment to the draft rules in October of 2001, but only became aware of the detectable warning requirement in July of 2002 through an FHWA memo. A revised standard plan with truncated domes was issued in 2003 and has been required in new construction, reconstruction and alterations since 2003. In 2005 the Access Board issued a revision of the draft rules, titled Public Rights of Way Accessibility Guidance (PROWAG), to be utilized as best practices. The lifting of the detectable warning surfaces moratorium and the publication of PROWAG was the first new guidance affecting public rights of way since the initial passage of ADA in 1990.

In September 2006, MnDOT's Affirmative Action Office was asked to assess agency Title II compliance and determine needs in this area. As a result of the assessment, MnDOT took the following actions:

- Designated an ADA Coordinator.
- Drafted a Notice of Non-Discrimination to provide information about the rights and protections of ADA to employees and applicants, as well as participants and users of MnDOT services, programs and activities.
- Established a grievance/complaint process to address or correct user concerns related to inaccessible pedestrian and transportation facilities under MnDOT's jurisdiction.

In 2007, an internal MnDOT ADA Advisory Council was formed. The primary function of this council was to assess and determine accessibility program needs and provide guidance to MnDOT administrators. The group includes key staff from Technical Support, Design, Investment Management (Planning), Construction, Traffic Operations, Maintenance Operations, Transit, Aeronautics and State Aid.

Also in 2007, MnDOT updated its policy and procedures to more effectively respond to requests for Accessible Pedestrian Signals (APS). The policy and procedures require the installation of APS at every signalized intersection and at every pedestrian crossing in new and reconstruction projects.

MnDOT launched its ADA web pages for public use in the spring of 2008. The pages include MnDOT's Non-discrimination Notice, links to accessibility guidance and

information and an online grievance process for users to voice their concerns regarding barriers preventing access to MnDOT facilities, programs and services.

In 2008 MnDOT formed a standing external stakeholder advisory group, made up of citizens with disabilities and advocates for key disability groups in Minnesota. This committee provides important feedback and invaluable real-life experience regarding how persons with disabilities use MnDOT's facilities, programs and services. They also serve as a voice for members of Minnesota's disability community.

Technical Memorandum 08-13-TM-05 Pedestrian (Curb) Ramp Guidelines was adopted and issued by the Deputy Commissioner in 2008 to clarify pedestrian curb ramp installation requirements to MnDOT staff and city and county engineers.

In 2008, MnDOT contracted with an independent consultant to conduct an objective evaluation of the organization's current policies, procedures and practices regarding ADA and Title II. The evaluation analyzed the impact of MnDOT policies, procedures and practices on accessibility within our state, and how accessibility impacted people with disabilities. The report identified policies, procedures and practices potentially did not comply with Title II requirements. Please see Appendix E for the list of policies, procedure and practices and the action taken to address each.

MnDOT's Office of Affirmative Action, Office of Technical Support and Office of Transit began conducting ADA Title II training in 2008. The training provides an introduction to ADA Title II requirements and is offered to local partners and MnDOT engineers/employees in maintenance, design, construction and planning.

In 2009, as a part of the development of MnDOT's Transition Plan, MnDOT Issued Technical Memorandum 10-02-TR-01 *Adoption of Public Rights of way Accessibility Guidance* to MnDOT staff, cities and counties. The memo makes Public Rights-of-Way Accessibility Guidelines (PROWAG) the primary guidance for accessible facility design on MnDOT projects. MnDOT is currently beginning the integration of PROWAG into the Road Design Manual and other technical guidance.

Since the adoption of the transition plan and PROWAG guidance MnDOT has conducted numerous trainings for MnDOT staff and its contractors to raise awareness and provide specific technical knowledge on providing accessibility in the public right of way. The primary training was conducted in 2011 and 2012 for MnDOT employees, cities, counties and consultants to provide an overview of the ADA, MnDOT's compliance direction and design training. Over 600 individuals participated in the training which has provided a more universal understating of ADA needs and Title II obligation. In subsequent years MnDOT has run classes for its construction inspectors

improve the quality of accessibility features which MnDOT routinely provides on all projects that meet or exceed that alterations threshold.

Program Location and Staffing

Managing and implementing the MnDOT ADA Transition Plan requires a multidisciplinary approach encompassing policy development, outreach, technical support and oversight. These responsibilities, required by 28 CFR 35.107, are be managed by two peer positions: the Title II Coordinator/ADA Implementation Coordinator, and ADA Design Engineer in MnDOT's Operations Division

The Title II Coordinator/ADA Implementation Coordinator is responsible for addressing complaints as they are received and tracking the overall progress of the implementation of the MnDOT Transition Plan. The Title II coordinator is also responsible for the investigation of all formal grievances made against MnDOT. To ensure the obligations of ADA and the Transition Plan are met the Coordinator develops policy and procedures to integrate Title II requirements into MnDOT practices The Implementation Coordinator also functions as chair of the Internal ADA committee, the co-chair of ADA Stakeholders group, and the agency lead for implementing Minnesota's Olmstead Plan.

The ADA Design Engineer works with the ADA Implementation Coordinator to develop policy and provide technical support for design and construction at a project level. The position also oversees three full time staff that provides support and direction for project scoping and development, design, and construction oversight when necessary. Specifically, the unit works with districts to scope their projects for accessibility and conducts design review prior to final signature. In addition to providing support for projects, this position will also be available to assist districts in implementing design options that address accessibility complaints.

Please refer to Appendix B for contact information.

Committee Structure

Overview

Due to the far reaching and ongoing implications of the ADA, collaboration is an important tool for MnDOT to identify issues and solutions that reflects the needs of the agency and users. To ensure that stakeholders are represented MnDOT has established three committees, one external and two internal, to assist and advise on ADA policy development. The committees function independent of each other to, but their input is coordinated by ADA Implementation Coordinator who a co-chair on all of

the committees. Detail on the roles and membership of the individual committees follows.

MnDOT's ADA Accessibility Advisory Committee

The MnDOT ADA Accessibility Advisory Committee (MAAAC) was created in 2008 to begin a constructive dialogue on accessibility issues and advise MnDOT on compliance with Title II of the ADA. Since MAAAC's inception, the advisory role has expanded from a focus on achieving Title II compliance to providing input on prioritizing funds for ADA projects, design feedback and communication tools. The committee's current representation was identified and established by the Title II Coordinator. MAAAC's membership is composed of individuals with differing disabilities, MnDOT representatives from the Bicycle and Pedestrian section, the Commissioner's Office, and the Office of Policy, Analysis, Research and Innovation, and representatives from the Minnesota State Council on Disability and the Metropolitan Council Transportation Advisory Committee.

The MAAAC meets monthly in working session type meetings to provide feedback on policy development, including the Transition Plan, and learn about MnDOT operations and advise on accessibility issues. Meetings are co-chaired by the ADA Implementation Coordinator a member elected from the external representation. MnDOT is not a voting member of the committee. MAAAC is currently re-evaluating its structure to identify and recruit a broader cross-section to represent more types of disabilities and provide geographic balance. Expected outcomes of the re-evaluation include an application process for membership and an annual work plan.

Americans with Disabilities Act Advisory Committee (ADAAC) -Disbanded

In 2007 MnDOT convened an internal advisory committee with representation from a cross section of functional areas to assist in the development of policy and practice to integrate ADA into MnDOT project delivery and operations. ADAAC met on a bi-monthly basis, with additional meetings called as needed. The committee focused on issues with programmatic impact and identifies key resources for resolution. The ADA Implementation Coordinator was the ADAAC chair. Committee membership included the following offices and sections:

- Affirmative Action
- Aeronautics
- Maintenance
- Transit
- Traffic, Safety and Technology
- State Aid

- Information Resource Management
- Bridge
- Bicycle and Pedestrian Section
- Construction
- Pre-Construction
- Maintenance
- Technical Support

In 2010 it was determined that ADA integration was largely under way and that representation of the above groups would be met through other standing committees and ADAAC was no longer needed

ADA Implementation Committee – Disbanded

The ADA Implementation Committee was identified as a need during the development of the transition plan as an interim approach to develop and expand the agency's knowledge base and information sharing for ADA design and policy. The committee comprised of one design or traffic engineer from each MnDOT district and staff from the Office of Traffic Safety and Technology, Geometrics, Program Delivery and the Bicycle and Pedestrian Section and was co-chaired by The ADA Implementation Coordinator and the ADA Design Engineer. The members functioned as points of contact and were responsible for tracking ADA requests in their district, providing technical support for projects and providing feedback to ADA policy and practice. The committee met from in January 2010 until January 2011.

Grievance Procedure

Under the Americans with Disabilities Act users of MnDOT facilities and services have the right to file a grievance if they believe MnDOT has not provided reasonable accommodation.

The Grievance Procedure required by 28 CFR 35.107 can be found in Appendix A of this report or on MnDOT accessibility website provides details on how to file a complaint. Under the Grievance Procedure, a formal complaint must be filed within 180 calendar days of the alleged occurrence. MnDOT will act or respond only to complaints made through the grievance process identified in Appendix A.

Communications

Under Section 35.160(a) of ADA, "...A public entity shall take appropriate steps to ensure that communications with applicants, participants, and members of the public with disabilities are as effective as communications with others." This means that

MnDOT is required to provide equally effective communication to individuals with disabilities. Equally effective communication can be provided by offering alternative formats, auxiliary aid(s) and/or services upon request. For example, interpreters are hired as requested for the hearing impaired and text materials that are accessible by screen readers are made available to users.

Website Communications

Background

State Law requires that all of the State of Minnesota's information systems comply with the 2009 MN Law to incorporate Section 508 of the Rehabilitation Act and the Web Content Accessibility Guidelines 3.0.

Minnesota IT (MnIT) is responsible for the development and dissemination of standard state processes, tools, and guidelines in place. This will enhance end user accessibility to state information systems, and make sure that all Minnesota citizens have access to the information they need.

MnDOT will fully comply with or exceed the standards set by MnIT regarding compliance with this law. MnDOT is participating in a committee to set the state standard, and will participate in future committees advising on needs for training and oversight. We anticipate that MnIT will set the standard at WCAG 3.0, compliance level AA.

Current compliance actions

Several years ago MnDOT redesigned its internal and external Web templates to improve their overall accessibility. For example, templates are now controlled by style sheets and styles are set for headers and subhead navigation items. All Web editors are required to use these templates for new and revised pages.

Our Rules for the Web include several items relating to accessibility. For example, all images much include "alt tags" and blinking or scrolling script is not allowed. All Web editors are required to follow these rules; however, we know that some older pages are not in compliance.

We also have an internal Web site that includes additional resources for Web writers and developers, including links to the WCAG 3.0 standards and our Rules for the Web.

Communications is developing training for word processing and other staff about preparing accessible Word and PDF documents. We are also working with contractors to ensure that documents prepared as part of a contract with MnDOT are compliant.

We have developed an external page www.dot.state.mn.us/ada that includes a variety of information about MnDOT and the ADA. This includes our transition plan, a way to file complaints with MnDOT, links to other transportation-related resources and tips about how to use our pages. A link to this page is included in the footer of every MnDOT Web page.

2014-2018 Goals

- Develop contract language and training for our consultant contracts to ensure that accessible documents are a required part of the deliverables.

- Review the Rules for the Web and the templates for compliance with WCAG 3.0 and make revisions as necessary. This step includes educating Web writers and developers about changes to the current standards.

- Develop and implement a plan for spot checking and ensuring compliance with WCAG for all new or redeveloped pages.

- Continue to work provide training for those who develop content that is posted on the web, with the highest priority being given to those who develop content that is seeking comment form the public.

Public Involvement

MnDOT recognizes that broad public participation is essential to the development of Minnesota's transportation system. As required by the ADA and MnDOT's public participation guidance Hear Every Voice, any public meeting, hearing, or comment period held by MnDOT is accessible. MnDOT provides qualified interpreters upon request and will provide documents in an accessible electronic format or other alternative formats, such as large print or Braille. All public notices shall contain contact information for accommodation requests.

Public meetings, trainings, programs and other events must be in an accessible location and indicated on the meeting notice. Project managers and other MnDOT staff are directed to use the Department of Justice Guide to Conducting Accessible Meetings to assist in planning public meetings.

Self-Evaluation

MnDOT, as required by Title II of ADA, must conduct a self-evaluation of physical assets and current policies and practices. MnDOT has identified seven areas that will need to have and maintain inventories. As inventories are updated, they will be the transition plan will be updated accordingly.

Fixed Work Sites

MnDOT owns and leases numerous buildings throughout the state. MnDOT has identified 46 buildings that are routinely accessed by the public. The 46 buildings were re-evaluated in 2013 for potential accessibility improvements. The buildings have been divided into two categories; Priority One and Priority Two. Priority One buildings are those buildings that have employee use and a high potential for public use. Priority Two buildings are those buildings that employees use and have moderate potential for public use. The evaluation of the worksites found that there are no major barriers to public access however there are numerous recommendations for minor accessibility improvements as ongoing maintenance work and renovations are conducted.

The status of the individual worksites can be found in the district breakdowns in Appendix C

Rest Areas

All rest areas and their associated elements are required to adhere to the 2010 ADA Standards. Minnesota State Building Code, Chapter 1341 also includes specific requirements related to accessibility. Some State accessibility requirements in Chapter 1341 are more restrictive than the 2010 ADA Standards.

In addition to the 2010 ADA Standards, the Code of Federal Regulations (CFR) includes regulations related to accessibility that apply to Interstate rest areas and historic rest areas and waysides:

- Interstate Rest Areas: 49 CFR 27.75 requires States to make Interstate rest area facilities accessible whenever the State uses federal financial assistance to improve the rest area or whenever the State uses federal financial assistance to construct, reconstruct or otherwise alter the roadway adjacent to or in the near vicinity of the rest area.
- Historic Rest Areas & Waysides: Several State rest areas and waysides are historic properties listed in or eligible for listing in the National Register of Historic Places or are designated as historic under an appropriate State or local law. 28 CFR 35.151(d) requires alterations comply, to the maximum extent feasible, with Section 4.1.7 of ADAAG.

In 1990, the Minnesota Department of Administration (DOA) contracted with architectural consultants to survey all buildings and facilities owned and managed by the State. The survey included MnDOT rest areas and waysides. Unfortunately, DOA completed the survey before the Federal government finalized ADAAG in 1991. MnDOT staff resurveyed all Class I rest areas by 1994 using ADAAG and recorded actual conditions and identified corrective measures required to comply. (See Appendix D)

In March 1994, the DOA approved a priority listing of MnDOT facilities. Additionally, during FY 1993-04 the DOA distributed $1,700,000 in State funds to MnDOT for ADA improvements to buildings and facilities. Since Travel Information Centers, Class I and II rest areas in the southern portion of the state receive the highest public use, MnDOT considers these facilities the highest priority for rest area accessibility improvements. MnDOT took action to correct then-current deficiencies at the highest priority facilities, except those actions deemed technically infeasible or where MnDOT had identified and scheduled the facility for comprehensive replacement in the near future.

Since 1991, MnDOT has designed and built all new rest area facilities, including buildings, site features and parking areas in compliance with then current ADAAG and Minnesota State Building Codes. Also, since that time, MnDOT has completed rest area rehabilitation and reinvestment projects that included corrective action to bring facilities into compliance with ADAAG and Minnesota State Building Code requirements. MnDOT has not corrected deficiencies at all lower priority facilities.

In 2007, MnDOT retained a consultant to conduct a comprehensive assessment of the physical condition of (49) Class I rest areas. The consultant found accessibility deficiencies at (46) of the rest areas evaluated. MnDOT estimates it would cost $1.9M-2.5M to correct the accessibility deficiencies found at the 46 Class I rest areas.

Accessible Pedestrian Signals (APS)

In 2008, MnDOT completed a statewide inventory of all 1,171 signalized intersections with push buttons that are owned and operated by MnDOT. As part of the inventory each intersection received a rating to determine the priority for conversion to an APS signal. The ranking of the intersections was done utilizing the methodology laid out in the National Cooperative Highway Research Project 3-62 *APS Prioritization Tool.* In general the signalized intersections with higher scores are the ones with the greatest need for conversion to APS, but the rankings are always considered within context so that the greatest needs are served first. Factors outside the ranking that affect an intersection's priority for APS include the number of pedestrians at the intersection, the presence of nursing homes, hospitals, transit, and other public services, and requests for APS. Each district traffic engineer will be responsible for determining which

intersections are priorities in their district, taking the intersection score and other factors into consideration.

MnDOT's policy is to install APS at any eligible intersection where an existing traffic signal has aged to the point of needing replacement. APS is also required for all new signals installed at eligible locations. Based on normal replacement intervals for aging signals, MnDOT expects to achieve 100 percent statewide APS compliance by the year 2030. Since the 2009 publication of the transition plan MnDOT has increased the total number of intersections with APS installations from 120 to 330 or 28 percent of the total system.

Curb ramps and sidewalks

At the time of the 2010 transition plan MnDOT had not completed the self-evaluation for sidewalks and curb ramp. Over the course of three summers each MnDOT district has located and cataloged all sidewalks and curb ramps on MnDOT right of way. The inventory includes both an accounting of the facilities and their condition. The system at the time of this writing consists of 617 miles of sidewalk and 19,324 curb ramps. An analysis of the each system and their condition follows.

Curb Ramps

In determining the compliancy of curb ramps MnDOT inventoried the locations and five accessibility elements for each curb ramp:

- Presence of a landing
- Landing slope – no more than 2% in any direction
- Ramp running slope – 5% - 8%
- Cross slope – no more than 2%
- Presence of detectable warnings

To be compliant under PROWAG a curb must meet all five requirements so even if one element is non-compliant the ramp technically does not meet accessibility requirements even though it may be usable. In reporting on MnDOT's compliance level we include all ramps that meet all five requirements and those that meet all requirements with the exception of having truncated domes. The reason for including both types of ramps is that truncated domes were not introduced as a requirement until 2001 and they are not a retrofit requirement meaning that a compliant ramp built prior to the requirement is still compliant until the alterations threshold is met. Of the 19,324 curb ramps on MNDOT's right of way of those 3543 or 18% are compliant.

Sidewalks

During the summer of 2013 districts completed an inventory of their sidewalks. The total system consists of over 600 miles of sidewalk on MnDOT right of way. The inventory includes an assessment of width, cross slope, barriers, and general condition. The most common deficiency in our network is the violation of cross slope at driveway. The total number of miles of sidewalk in MnDOT's system that is fully compliant is 263.5 miles.

Pedestrian Bridge Inventory

MnDOT owns 170 pedestrian bridges and underpasses throughout the state. Any pedestrian bridge or underpass crossing an interstate or state highway is the responsibility of MnDOT, unless an agreement has been made with a local government agency. The location and condition of all pedestrian bridges within MnDOT's right of way can be found in the district inventory in Appendix C. To be accessible, pedestrian bridges and underpasses must have a ramp leading up to the overpass, the ramp must meet the PROWAG standards for ramps, railings must meet the requirements found in the MnDOT Bikeway Facility Design Manual, the bridges must have a cross slope of no more than 2 % and a running slope of no more than 5%. Those that do not meet accessibility requirements according to PROWAG will be replaced as necessary. Bridges and underpasses that are compliant with the standards in place when they were built will require further discussion to determine the feasibility of compliance with PROWAG and the future of the structure in general.

Greater Minnesota Transit

As the administrating agency for Federal Transit Administration grant programs, MnDOT is required to ensure that grant recipients comply with the Americans with Disabilities Act. Specific transit-related aspects of ADA fall into two distinct categories: (1) ensuring that transit services and facilities are designed to allow access by individuals with disabilities and (2) ensuring that transit vehicles purchased with federal funds meet the accessibility standards of ADA.

With respect to the first function, the Office of Transit has developed tools for MnDOT staff to use to monitor ADA compliance as part of grant oversight. This includes checking that the telephone reservation system is accessible to all; schedulers capture necessary passenger information to ensure that the person's trip needs can be fully accommodated; ADA trip requests in Duluth, East Grand Forks, La Crescent, Mankato, Moorhead, Rochester and St. Cloud are not denied at a higher rate than other trip requests; system advertising and information is produced in a variety of formats; transit facilities are laid out with appropriate clearances and accessibility; etc.

Some older bus garages and administrative facilities are not fully ADA accessible, but the noncompliant elements do not provide a barrier to the services provided to the general public. As facilities are replaced or receive major remodeling they will be required to be constructed to current ADA and Minnesota Building code standards. Reasonable accommodations will be provided at all locations as needs are identified.

With respect to vehicle purchases, the Office of Transit maintains a full array of vehicle specifications – all of which meet the accessibility standards of ADA. All transit vehicles acquired with grants through MnDOT are fully ADA-compliant. Because this policy has been in place for many years, the current fleet acquired through MnDOT is ADA-accessible.

MnDOT's inventory of right of way features will include an assessment of the accessibility of transit stops on MnDOT right of way that have received funding from MnDOT. To be accessible, bus stop boarding and alighting areas must provide a clear length of 8 feet minimum, measured perpendicular to the curb or street or highway edge, and a clear width of 5 feet minimum, measured parallel to the street or highway. Bus stop boarding and alighting areas must connect to streets, sidewalks, or pedestrian paths by a pedestrian access route. The grade of the bus stop boarding and alighting area must be the same as the street or highway, to the maximum extent practicable, and the cross slope of the bus stop boarding and alighting area must not be greater than 2 percent.

In addition to meeting the operations obligations of ADA MnDOT is reaching out to communities in the development of local service plans to ensure that as service is developed and expanded the needs of the Olmstead population are included.

Policies

In 2009, MnDOT contracted with an outside consultant to conduct an audit of its policies and procedures in order to identify areas where modifications may be needed to ensure full compliance with ADA Title II and Section 504. The study involved a review of over 200 policies and procedures that MnDOT uses to provide facilities, services, and programs to the public. Forty-one policies, primarily focused on project development and design, were identified as potentially needing improvement to integrate accessibility more consistently into MNDOT projects and operations. No policies were identified as a barrier to providing accessibility. MnDOT will be developing a systematic approach to ensure long-term compliance with ADA Title II and Section 504 for all policies and procedures. A listing of policies and procedures that MnDOT reviewed and their status can be found in Appendix E.

Maintenance

MnDOT is responsible for the seasonal and structural maintenance of its facilities. As part of the policy review identified in the Transition Plan, MnDOT is examining its current policies and procedures to improve maintenance for pedestrian facilities. MnDOT's Maintenance Office will be leading the policy development and is scheduled to have a policy identified by summer of 2011.

The policy will identify operation guidance for maintaining sidewalks. Guiding the discussion is Federal Code 23 U.S.C. § 116 which obligates a State DOT to maintain projects constructed with Federal-aid funding or enter into a maintenance agreement with the appropriate local official where such projects are located. The discussion will also address snow removal and ice treatment on sidewalks in accordance with 28 CFR § 35.133, which requires public agencies to maintain walkways in an accessible condition for all pedestrians, including persons with disabilities, with only isolated or temporary interruptions in accessibility. Part of this maintenance obligation includes reasonable snow removal efforts.

Correction Program

The Minnesota Department of Transportation is committed to addressing the barriers identified in the self-evaluation. Curb ramp improvements are required on all projects that meet the alteration thresholds. Facilities that are accessible, but do not meet PROWAG standards will continue to be improved through MnDOT's routine construction program. Facilities that are inaccessible and will not be improved in the course of a typical roadway project will be prioritized by districts as part of a separate barrier removal program. The funding and schedule of accessibility improvements that are being made as part MnDOT's routine construction program are determined through MnDOT's Statewide Transportation Improvement Plan (STIP).

Since 2010 MnDOT has improved numerous facilities around the state with a particular emphasis on curb ramps and during the last three construction seasons MnDOT has found that rote application of ADA policy and design does not immediately ensure accessible facilities. Emerging issues in our correction program include the role of right of way in alterations thresholds, the appropriate expansion of scope to ensure the right fix for achieving accessibility, and the quality of construction.

Much of MnDOT's construction program is focused on preserving our existing system and the project that we do typically have a very limited scope focused on working on pavement and working within our existing right of way. Often the improvement of accessible features requires that MnDOT obtain right of way or a temporary easement to construct the facility. Under Minnesota statues the process to obtain right of way

averages around eighteen months often longer than the project development time for the a pavement project. The ADA unit has been working with the districts at a project level to make certain that they are scoping projects with the entirety of ADA needs including right of way so that the proper facility can be built. Ensuring quality construction of accessible facilities is also an area of improvement for MnDOT. Under ADA the specifications provided for a facility do not include construction tolerances so it is important that facilities are built to design and are inspected to ensure that they meet our design requirements. MnDOT has developed contractor requirements and trains inspectors to address this issue, but we are still not at the performance level we desire.

Training

Part of MnDOT's adoption and implementation of Public Rights of Way Accessibility Guidelines and the Transition Plan, included agency-wide training on both design and policy. MnDOT has trained over 600 individuals which included MnDOT staff, cities and counties, and external partners on ADA and Title II in 2012 and 2013. MnDOT is looking at revising and resuming in 2015.

The training is based on policy, mobility needs and design. Modules identified for development and deployment in 2010 include:

- ADA and Title II overview and requirements
- Policy & Procedure
    - Public Involvement
    - Complaint Procedures
- Technical Training
    - PROWAG (Public Right OF Way Accessibility Guidelines)
    - Curb Ramps
    - APS (Accessible Pedestrian Signals)
    - Intersection Geometrics
    - Pedestrian Design & Planning
    - Maintenance, e.g., Inventory, Snow & Ice, Faulting, Maintenance Agreements
    - Bicycle & Pedestrian Planning

In addition to the ADA Overview training MnDOT's ADA Unit provides annual training to inspectors and presents at MnDOT's Signal Certification classes.

Appendix A

How to file a Grievance

The procedure to file a grievance is as follows:

1. A formal written grievance should be filed on ADA Grievance Form. An oral grievance can be filed by contacting ADA Title II Coordinator. The oral grievance will be reduced to writing by ADA Coordinator utilizing ADA Grievance Form. Additionally, individuals filing a grievance are not required to file a grievance with MnDOT, but may instead exercise their right to file a grievance with the Department of Justice.

    - The name, address, and telephone number of the person filing the grievance.
    - The name, address, and telephone number of the person alleging ADA violation, if other than the person filing the grievance.
    - A description and location of the alleged violation and the remedy sought.
    - Information regarding whether a complaint has been filed with the Department of Justice or other federal or state civil rights agency or court.
    - If a complaint has been filed, the name of the agency or court where the complaint was filed, and the date the complaint was filed.

2. The grievance will be either responded to or acknowledged within 10 working days of receipt. If the grievance filed does not concern a MnDOT facility, it will be forwarded to the appropriate agency and the grievant will be notified.

3. Within 60 calendar days of receipt, the ADA Title II Coordinator will conduct the investigation necessary to determine the validity of the alleged violation. If appropriate, ADA Title II Coordinator will arrange to meet with the grievant to discuss the matter and attempt to reach a resolution of the grievance. Any resolution of the grievance will be documented in MnDOT's ADA Grievance File.

4. If a resolution of the grievance is not reached, a written determination as to the validity of the complaint and description of the resolution, if appropriate, shall be issued by ADA Title II Coordinator and a copy forwarded to the grievant no later than 90 days from the date of MnDOT's receipt of the grievance.

5. The grievant may appeal the written determination. The request for reconsideration shall be in writing and filed with the Minnesota Department of Transportation Ombudsman within 30 days after the ADA Title II Coordinator's determination has been mailed to the grievant. MnDOT's Ombudsman shall

review the request for reconsideration and make a final determination within 90 days from the filing of the request for reconsideration.

6. If the grievant is dissatisfied with MnDOT's handling of the grievance at any stage of the process or does not wish to file a grievance through the MnDOT's ADA Grievance Procedure, the grievant may file a complaint directly with the United States Department of Justice or other appropriate state or federal agency.

   The resolution of any specific grievance will require consideration of varying circumstances, such as the specific nature of the disability; the nature of the access to services, programs, or facilities at issue and the essential eligibility requirements for participation; the health and safety of others; and the degree to which an accommodation would constitute a fundamental alteration to the program, service, or facility, or cause an undue hardship to MnDOT. Accordingly, the resolution by MnDOT of any one grievance does not constitute a precedent upon which MnDOT is bound or upon which other complaining parties may rely.

File Maintenance

MnDOT's ADA Coordinator shall maintain ADA grievance files for a period of three years.

Appendix B

ADA Program Contacts

Title II Coordinator

Lynnette M. Geschwind
395 John Ireland Blvd.
MS 200
St. Paul, MN 55155

Ph: 651-366-4717
Fax: 651-366-4155
E-mail: lynnette.geschwind@state.mn.us

ADA Implementation Coordinator

Kristie M. Billiar
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MS 670
St. Paul, MN 55155

Ph: 651-366-3174
Fax: 651-366-4155
E-mail: kristie.billiar@state.mn.us

ADA Design Engineer

Todd Grugel
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MS 670
St. Paul, MN 55155

Ph: 651-366-3531
Fax: 651-366-4155
E-mail: todd.grugel@state.mn.us

Appendix C

Inventory by MnDOT District

District 1 Asset Inventory

Buildings

T7910090221 - Duluth District Headquarters
T7915090143 - Grand Rapids Truck Station
T7915090123 - Virginia Maintenance Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	1755
Number of Non-Compliant Ramps	1445
Number of Compliant Ramps	310
Number of Compliant Ramps without Detectable Warnings	420
Number of Ramps with Compliant Slope and Cross Slope	892
Number of Ramps with Compliant Slope	1329

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
16006	PED-BIKE	TH 61	2009	Compliant
38014	SOIL	PED	2004	Compliant
5953	MN 23	PEDESTRIAN	1941	Excessive Running Grade on Bridge Deck

69122	MILLER CREEK	US 53	2003	Excessive Cross Slope on Bridge Deck and Approach Ramp
Asset Number	**Featured Intersected**	**Facility Carried by Structure**	**Year Built**	**Compliant Issues**
69804	EXCURSION TRACKS	PEDESTRIAN	1989	Excessive Running Grade on Bridge Deck
69805	EXCURSION TRACKS	PEDESTRIAN	1989	Excessive Running Grade on Bridge Deck and Approach Ramp
69811	PED WALK WAY	PEDESTRIAN	1967	Excessive Running Grade on Bridge Deck
69838	I 35	PEDESTRIAN AT 17TH AVE E	1988	Excessive Running Grade and Cross Slope on Bridge Deck
69843	I 35	PEDESTRIAN AT 25TH AVE	1990	Excessive Running Grade on Bridge Deck
69853	KEENE CREEK	PEDESTRIAN	1973	Excessive Running Grade on Bridge Deck and Excessive Cross Slope on Approach Ramp
69855	DITCH	PEDESTRIAN	1973	Excessive Running Grade on Bridge Deck and Approach Ramp
69858	EB I35 RAMP & MICH RAMP	PEDESTRIAN	1989	Excessive Running Grade on Bridge Deck and Approach Ramp
69885	I 35 & TWO RAMPS	PEDESTRIAN AT MESABA	1968	Stairs
69885A	FILL	BIKEWAY AT MESABA	1987	Compliant

Sidewalks

Total Miles of Sidewalks	55.27
Sidewalks < 48" (Miles)	0.38
Cross Slopes > 2% (Miles)	21.96
Condition 1 Sidewalks (Miles) (Best Rating)	0.32
Condition 2 Sidewalks (Miles)	37.77
Condition 3 Sidewalks (Miles)	14.76
Condition 4 Sidewalks (Miles) (Worst Rating)	2.44

Driveways > 2% (Number)	926

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	29
Driveway	0
Hand Hold	1
Hydrant	0
Light Post	29
Mailbox	0
Manhole	1
Minor Gap	2
Narrows to less than 48"	8
Other	5
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	0
Signs	0
Slope Issues	0
Stairs	0
Street Furniture	0
Traffic Poles	2
Trees	6
Utility Cabinet	0
Vegetation	36

Accessible Pedestrian Signals

APS Push Buttons	103
Non-Compliant APS Push Buttons	22
APS Complaint Push Buttons	81
Number of APS Intersections	15
Total Number of Signalized Intersections	83

District 2 Asset Inventory

Buildings

T7920090330 - Bemidji District Headquarters
T7925090530 - Crookston Maintenance Headquarters
T7925090533 - Thief River Falls Truck Station

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	1291
Number of Non-Compliant Ramps	1129
Number of Compliant Ramps	162
Number of Compliant Ramps without Truncated Domes	296
Number of Ramps with Compliant Slope and Cross Slope	776
Number of Ramps with Compliant Slope	949

Pedestrian Bridges

There are no MnDOT owned pedestrian bridges in District 2.

Sidewalks

Total Miles of Sidewalks	58.42
Sidewalks < 48" (Miles)	0.49
Cross Slopes > 2% (Miles)	28.77
Condition 1 Sidewalks (Miles)	17.29
Condition 2 Sidewalks (Miles)	35.87
Condition 3 Sidewalks (Miles)	7.06
Condition 4 Sidewalks (Miles)	2.61
Driveways > 2% (Number)	1009

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	54
Driveway	0
Hand Hold	0
Hydrant	2
Light Post	43
Mailbox	1
Manhole	1
Minor Gap	17
Narrows to less than 48"	4
Other	4
Power Poles	0
Railroad Crossing	3
Sand, Gravel Mud	0
Signs	4
Slope Issues	1
Stairs	1
Street Furniture	0
Traffic Poles	5
Trees	3
Utility Cabinet	2
Vegetation	5

Accessible Pedestrian Signals

APS Push Buttons	34
Non-Compliant APS Push Buttons	20
APS Complaint Push Buttons	14
Number of APS Intersections	26
Total Number of Signalized Intersections	61

District 3 Asset Inventory

Buildings

T7930090443 - Baxter District Headquarters
MnROAD (Monticello)
T7935090735 - St. Cloud Maintenance Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2249
Number of Non-Compliant Ramps	1748
Number of Compliant Ramps	501
Number of Compliant Ramps without Truncated Domes	582
Number of Ramps with Compliant Slope and Cross Slope	1053
Number of Ramps with Compliant Slope	1576

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
6847	MN 23	PEDESTRIAN	1958	Stairs
73029	MN 15	PEDESTRIAN	1987	Compliant
73871	I 94	PEDESTRIAN	1977	Compliant

Sidewalks

Total Miles of Sidewalks	67.71
Sidewalks < 48" (Miles)	1.21
Cross Slopes > 2% (Miles)	24.48
Condition 1 Sidewalks (Miles)	14.48
Condition 2 Sidewalks (Miles)	38.75
Condition 3 Sidewalks (Miles)	12.74
Condition 4 Sidewalks (Miles)	1.34
Driveways > 2% (Number)	937

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	52
Driveway	0
Hand Hold	0
Hydrant	2
Light Post	55
Mailbox	6
Manhole	0
Minor Gap	10
Narrows to less than 48"	11
Other	3
Power Poles	8
Railroad Crossing	1
Sand, Gravel Mud	0
Signs	9
Slope Issues	0
Stairs	4
Street Furniture	6
Traffic Poles	7
Trees	10
Utility Cabinet	1
Vegetation	4

Accessible Pedestrian Signals

APS Push Buttons	318
Non-Compliant APS Push Buttons	136
APS Complaint Push Buttons	182
Number of APS Intersections	67
Total Number of Signalized Intersections	174

District 4 Asset Inventory

Buildings

T7940090616 - Detroit Lakes District Headquarters
T7940090615 - Fergus Falls Truck Station
T7940090658 - Moorhead Truck Station
T7945090820 - Morris Maintenance Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	1381
Number of Non-Compliant Ramps	1151
Number of Compliant Ramps	230
Number of Compliant Ramps without Truncated Domes	324
Number of Ramps with Compliant Slope and Cross Slope	676
Number of Ramps with Compliant Slope	899

Pedestrian Bridges

There are no MnDOT owned pedestrian bridges in District 4.

Sidewalks

Total Miles of Sidewalks	45.71
Sidewalks < 48" (Miles)	0.1
Cross Slopes > 2% (Miles)	26.59
Condition 1 Sidewalks (Miles)	24.42
Condition 2 Sidewalks (Miles)	16.4
Condition 3 Sidewalks (Miles)	3.56
Condition 4 Sidewalks (Miles)	4.68
Driveways > 2% (Number)	861

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	129
Driveway	41
Hand Hold	0
Hydrant	5
Light Post	53
Mailbox	9
Manhole	3
Minor Gap	7
Narrows to less than 48"	22
Other	6
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	0
Signs	11
Slope Issues	0
Stairs	3
Street Furniture	3
Traffic Poles	9
Trees	4
Utility Cabinet	0
Vegetation	0

Accessible Pedestrian Signals

APS Push Buttons	7
Non-Compliant APS Push Buttons	4
APS Complaint Push Buttons	4
Number of APS Intersections	18
Total Number of Signalized Intersections	64

District 6 Asset Inventory

Buildings

Albert Lea Truck Station
T7965091327 - Owatonna Maintenance Headquarters
Wilson Truck Station (Winona)

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2122
Number of Non-Compliant Ramps	1584
Number of Compliant Ramps	539
Number of Compliant Ramps without Truncated Domes	882
Number of Ramps with Compliant Slope and Cross Slope	1404
Number of Ramps with Compliant Slope	1551

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
50802	I 90	PEDESTRIAN	1997	Compliant
55019	US 63	PEDESTRIAN	1963	Stairs
55044	TH 52, FRONT RD	PEDESTRIAN AT 16th ST NW	2004	Compliant
85003	US 14	PEDESTRIAN (ST MARYS)	1963	Stairs
9218	CEDAR RIVER	PEDESTRIAN	1958	Compliant

Sidewalks

Total Miles of Sidewalks	66.54
Sidewalks < 48" (Miles)	0.58
Cross Slopes > 2% (Miles)	24.02
Condition 1 Sidewalks (Miles)	5
Condition 2 Sidewalks (Miles)	32.88
Condition 3 Sidewalks (Miles)	21.2
Condition 4 Sidewalks (Miles)	6.8
Driveways > 2% (Number)	1010

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	30
Driveway	0
Hand Hold	0
Hydrant	0
Light Post	5
Mailbox	0
Manhole	0
Minor Gap	4
Narrows to less than 48"	4
Other	2
Power Poles	0
Railroad Crossing	7
Sand, Gravel Mud	0
Signs	0
Slope Issues	0
Stairs	2
Street Furniture	0
Traffic Poles	1
Trees	9
Utility Cabinet	0
Vegetation	0

Accessible Pedestrian Signals

APS Push Buttons	63
Non-Compliant APS Push Buttons	19
APS Complaint Push Buttons	44
Number of APS Intersections	31
Total Number of Signalized Intersections	102

District 7 Asset Inventory

Buildings

Mankato District Headquarters
T7980091523 - Marshall District Headquarters
T7975091614 - Windom Maintenance Headquarters
T7975032119 - Worthington Scale

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2568
Number of Non-Compliant Ramps	2160
Number of Compliant Ramps	408
Number of Compliant Ramps without Truncated Domes	541
Number of Ramps with Compliant Slope and Cross Slope	1167
Number of Ramps with Compliant Slope	1628

Pedestrian Bridges

There are no MnDOT owned pedestrian bridges in District 7.

Sidewalks

Total Miles of Sidewalks	76.49
Sidewalks < 48" (Miles)	4.76
Cross Slopes > 2% (Miles)	29.84
Condition 1 Sidewalks (Miles)	17.45
Condition 2 Sidewalks (Miles)	45.61
Condition 3 Sidewalks (Miles)	9.63
Condition 4 Sidewalks (Miles)	3.8
Driveways > 2% (Number)	1045

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	33
Driveway	0
Hand Hold	0
Hydrant	1
Light Post	6
Mailbox	0
Manhole	3
Minor Gap	17
Narrows to less than 48"	1
Other	7
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	4
Signs	1
Slope Issues	0
Stairs	0
Street Furniture	1
Traffic Poles	3
Trees	2
Utility Cabinet	2
Vegetation	1

Accessible Pedestrian Signals

APS Push Buttons	105
Non-Compliant APS Push Buttons	20
APS Complaint Push Buttons	85
Number of APS Intersections	18
Total Number of Signalized Intersections	59

District 8 Asset Inventory

Buildings

T7980091030 - Hutchinson Truck Station
T7980091036 - Litchfield Truck Station
T7980091023 - Willmar District Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2019
Number of Non-Compliant Ramps	1801
Number of Compliant Ramps	218
Number of Compliant Ramps without Truncated Domes	390
Number of Ramps with Compliant Slope and Cross Slope	926
Number of Ramps with Compliant Slope	1328

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
43006	US 212	PEDESTRIAN	1971	Stairs

Sidewalks

Total Miles of Sidewalks	58.67
Sidewalks < 48" (Miles)	0.38
Cross Slopes > 2% (Miles)	24.74
Condition 1 Sidewalks (Miles)	34.05
Condition 2 Sidewalks (Miles)	18.17
Condition 3 Sidewalks (Miles)	5.09
Condition 4 Sidewalks (Miles)	1.11
Driveways > 2% (Number)	970

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	10
Driveway	0
Hand Hold	0
Hydrant	4
Light Post	20
Mailbox	0
Manhole	1
Minor Gap	0
Narrows to less than 48"	3
Other	1
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	1
Signs	6
Slope Issues	0
Stairs	4
Street Furniture	0
Traffic Poles	3
Trees	5
Utility Cabinet	0
Vegetation	2

Accessible Pedestrian Signals

APS Push Buttons	23
Non-Compliant APS Push Buttons	0
APS Complaint Push Buttons	23
Number of APS Intersections	12
Total Number of Signalized Intersections	52

Metro District Asset Inventory

Buildings

T7906092055 - Aeronautics
T7902092039 - Arden Hills Training Center
T7990092139 - Daytonport Scale
T7990090931 - Golden Valley District Headquarters
T7990091138 - Oakdale District Headquarters
Office of Materials and Road Research
T7900092043 - Plymouth Driver's License
T7990091194 - Waters Edge

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	7800
Number of Non-Compliant Ramps	6040
Number of Compliant Ramps	1832
Number of Compliant Ramps without Truncated Domes	2439
Number of Ramps with Compliant Slope and Cross Slope	4596
Number of Ramps with Compliant Slope	6223

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
02017	MN 47	PED @ 49th Ave	1967	Stairs
02021	MN 65	PEDESTRIAN	1970	Compliant
02022	MN 65 & Frontage Rd	PED @ 80th Ave NE	1973	Stairs
02044	US 10	Pedestrian	1997	Compliant
10048	US 212	PED/BIKE	2007	Compliant
10531	TH 5	PED	1995	Compliant
19025	US 52	PED @ Lewis St	1973	Excessive Running Grade on Bridge Deck and Approach Ramp

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
27003	I 94, Lyndale & Henn Av	PED at Whitney	1988	Excessive Running Grade on Approach Ramp
27004	Mississippi River	Ped at St Anthony	1883	Compliant
27012	TH 100	Ped at 26th St	1978	Excessive Running Grade on Approach Ramp
27028	TH 77	PED AT 88TH ST	1978	Compliant
27038A	TH 100	Ped Brooklyn Blvd	1976	Compliant
27038B	TH 100	Ped Brooklyn Blvd	1976	Compliant
27061	TH 121	PED at 61st St	1962	Stairs
27105	TH 100 & Vernon Ave	PED at 41st St	1968	Stairs
27135	US 12 & Ridgeview Dr	PED at Ridgeview	1970	Stairs
27202	TH 55 & NB off ramp	PEDESTRIAN	1998	Compliant
27220	TH 610	Pedestrian	1998	Excessive Running Grade on Approach Ramps
27272	TH 12 & BNSF RR	Luce Line Trail	2003	Compliant
27278	TH 12 & BNSF RR	Trail A	2005	Compliant
27284	TH 100	PED at 39th Ave	2000	Excessive Running Grade on Approach Ramp
27407	LEGION LAKE	TRAIL	2008	Compliant
27520	TH 62 & W 64th St	PEDESTRAIN	1963	Stairs
27530	TH 62	PED at 40th Ave S	1966	Stairs
27535	TH 62	PED at 14th Ave	1967	Stairs
27615	TH 100 & SB off ramp	Ped at 59th Ave N	1980	Compliant
27649	TH 100	Pedestrian Bridge	1983	Compliant
27685	TH 252	PED AT 85th AVE	2003	Complaint
27710	I 394	PED @ Pennsylvania	1989	Excessive Running Grade on Approach Ramp
27711	I 394	PED @ Florida Ave	1989	Excessive Running Grade on Approach Ramp
27755	I 394 & 394R Frontage Rd	PEDESTRIAN	1989	Compliant

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
27757	I 394, I394R & Frontage	PED @ Cedar Lake Rd	1988	Excessive Running Grade on Approach Ramp
27864	I 94 & I 694	PED @ Shingle Creek	1980	Compliant
27866	UP RAIL	PED Linden Avenue	1972	Compliant
27868	I 35W NB, TH 65 & STS	PED @ 24th St E	1971	Excessive Running Grade on Bridge Deck and Approach Ramp and Stairs
27908	ELM CREEK	PEDESTRIAN	1973	Compliant
27955	I 94 On/Off Ramps-Huron	PEDESTRIAN	1965	Stairs
27958	I 94	PED @ Seymour	1967	Compliant
27985	I 35W & NB off ramp	PED @ Summer St	1973	Excessive Running Grade on Approach Ramp
27987	I 35W & off-on ramps	PED @ 5th St SE	1971	Excessive Running Grade on Approach Ramps
27B42	US 169	PED-BIKE	2008	Compliant
27R15	MN 610/CSAH 81 railroad	Pedestrian bridge	2005	Compliant
27R17	Wet Lands	Pedestrian TH 610	2005	Compliant
27R30	US 212	PED/BIKE	2006	Compliant
27V57	I 494	PED AT MAYWOOD LN	2005	Compliant
4175	County 101 Minnesota R	Pedestrian	1927	Compliant
5114	TH 7	Recreation Trail	1934	Compliant
62023	Lafayette Rd (US 52)	PED at Winifred St	1969	Excessive Running Grade on Bridge Deck and Approach Ramp
62096	MN 36	PEDESTRIAN	2007	Compliant
62804	I 35E & Thompson St	Ped at Walnut St	1987	Excessive Running Grade on Approach Ramp
62809	I 94 & RAMP 16A	GRIGGS ST PED	2009	Compliant
62822	I 694	RECREATION TRAIL	1966	Compliant
62849	I 94	PED at ALDINE	1966	Excessive Running Grade on Bridge Deck and Approach Ramps

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
62868	I 94, Hudson & Pacific	PED at Maple	1973	Excessive Running Grade and Cross Slope on Approach Ramp
62869	I 94 EB on ramp	PED at Hazelwood	1974	Stairs
62872	I 35E	PED at Bayard Ave	1984	Excessive Running Grade on Approach Ramps
62X02	Ped Trail	TH 35E	2001	Compliant
6402	TH 36	BN Regional Trail	1954	Compliant
6512	I 35E	GATEWAY TRAIL	1960	Compliant
70536	US 169	PED E OF CSAH 17	2002	Compliant
70539	US 169	PED W OF CR 79	2002	Compliant
82012	GORGE	PED	1968	Compliant
82028	US 61, Hasting Ave, 7th	PED	2003	Compliant
82032	US 61 7th Ave BN &CP RR	PED	2003	Compliant
9078	I 494 & N & S Front Rds	PED at 2nd Ave S	1960	Stairs
9600F	Minnesota River	Ped Trail	1980	Compliant
9618	I 35W	PED at 40th St	1965	Compliant
9714	US 10	Pedestrian	1963	Compliant
9736	I 94	PED at Chatsworth	1964	Compliant
9737	I 94	PED at Mackubin St	1963	Compliant
9773	I 94	PED at Grotto	1963	Compliant
9888	I 35W	PED at 73rd Ave	1960	Stairs
9892	I 94	PED at 22nd Ave	1962	Excessive Running Grade on Approach Ramp
9895	TH 100, Frontage Roads	PED at S View Lane	1971	Excessive Running Grade on Bridge Deck
9896	TH 100, Frontage Roads	PED at Windsor Ave	1971	Excessive Running Grade on Bridge Deck and Approach Ramp

Sidewalks

Total Miles of Sidewalks	188.24
Sidewalks < 48" (Miles)	3.79
Cross Slopes > 2% (Miles)	64.61
Condition 1 Sidewalks (Miles)	42.07
Condition 2 Sidewalks (Miles)	115.37
Condition 3 Sidewalks (Miles)	25.96
Condition 4 Sidewalks (Miles)	4.84
Driveways > 2% (Number)	1143

Sidewalk Barriers

Bridge Joint	551
Damaged Panel	3289
Driveway	12
Hand Hold	24
Hydrant	8
Light Post	93
Mailbox	1
Manhole	36
Minor Gap	22
Narrows to less than 48"	40
Other	48
Power Poles	19
Railroad Crossing	13
Sand, Gravel Mud	39
Signs	20
Slope Issues	22
Stairs	13
Street Furniture	17
Traffic Poles	5
Trees	31
Utility Cabinet	5
Vegetation	319

Accessible Pedestrian Signals

APS Push Buttons	1238
Non-Compliant APS Push Buttons	719
APS Complaint Push Buttons	519
Number of APS Intersections	227
Total Number of Signalized Intersections	675

Appendix D

Rest Area Facility Condition Assessment

Facility Location	Cost	System	Correction	Distress	Qty	Unit
Adrian EB						
Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
East Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$4,199	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Damaged	2	Ea
\Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Damaged	1	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$1,017	Fittings	Install grab bars in accessible stall.	Missing	6	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Inadequate	2	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$824	Plumbing Fixtures	Provide protective insulation for exposed piping.	Missing	6	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Adrian EB Total	$64,673					
Adrian WB						
Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$4,057	Slab on Grade	Remove and replace concrete sidewalk, 4" wide	Damaged	100	L.F.
Main Building	$4,199	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Damaged	1	Ea
Main Building	$749	Fittings	Install mirror at accessible height	Inadequate	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage	Inadequate	4	Ea
Main Building	$1,017	Fittings	Install grab bars in accessible stall	Missing	6	L.F.
Main Building	$824	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	6	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea

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Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Adrian WB Total	$65,379					

Anchor Lake

Site Features	$5,721	Site Development	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$749	Fittings	Install mirror at accessible height	Missing	2	Ea
Main Building	$2,280	Fittings	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$4,270	Fittings	Provide accessible service counter	Inadequate	14	L.F.
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$6,779	Communications & Security	Replace fire alarm control panel	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Anchor Lake Total	$75,341					

Baptism River

Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$2,880	Fittings	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$6,779	Communications & Security	Replace fire alarm control panel	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Baptism River Total	$63,572					

Beaver Creek

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
East Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Picnic Shelter East	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Picnic Shelter West	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Beyond Useful Life	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Main Building	$1,623	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	40	L.F.
Main Building	$24,345	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	600	L.F.
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Beaver Creek Total	$80,641					

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Big Spunk

Site Features	$3,136	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	2	Ea
Site Features	$31,527	Pedestrian Paving	Construct & provide ADA conc. ramp and steps	Missing	40	L.F.
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
Main Building	$1,425	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Auto Parking	$607	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Inadequate	100	L.F.
Big Spunk Total	$93,944					

Blue Earth EB

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
East Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Blue Earth EB Total	$11,561					
Blue Earth WB						
North Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
South Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$1,171	Communications & Security	Replace public telephone	Inadequate	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Blue Earth WB Total	$8,087					

Burgen Lake

East Picnic Shelter	$1,623	Slab on Grade	Remove and replace concrete sidewalk 4' wide	Damaged	40	L.F.
West Picnic Shelter	$1,623	Slab on Grade	Remove and replace concrete sidewalk 4' wide	Damaged	40	L.F.
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Beyond Useful Life	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea

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Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Burgen Lake Total	$47,302					

Cass Lake

Site Features	$3,136	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	2	Ea
Main Building	$1,190	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Cass Lake Total	$4,326					

Central Minnesota TIC

Site Features	$1,623	Slab on Grade	Remove and replace concrete sidewalk 4' wide	Damaged	40	L.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$1,566	Fittings	Replace directional signage	Inadequate	25	Ea
Main Building	$2,880	Fittings	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$4,270	Fixed Furnishings	Provide accessible service counter	Inadequate	14	L.F.
Central Minnesota TIC Total	$14,432					

Clear Lake

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$886	Plumbing Fixtures	Provide protective insulation for exposed piping	Inadequate	8	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Clear Lake Total	$68,935					

Dayton Port

Main Building Lobby	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building Men's Room	$8,497	Toilet Partitions	Replace toilet partitions	Damaged	3	Ea
Main Building Women's Room	$16,994	Toilet Partitions	Replace toilet partitions	Damaged	6	Ea

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Dayton Port Total	$27,293

Des Moines River

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
North Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
NW Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
South Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$4,199	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Beyond Useful Life	2	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$2,880	Plumbing Fixtures	Provide protective insulation for exposed piping	Inadequate	8	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Des Moines River Total	$56,306					

Dresbach TIC

Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Main Building	$1,624	Fittings	Toilet partitions laminate clad-overhead braced	Inadequate	1	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$13,004	Plumbing Fixtures	Replace drinking fountain	Inadequate	5	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$641	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	3	Ea
Auto Parking	$3,655	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Inadequate	910	L.F.
Dresbach TIC Total	$56,366					

Elm Creek

Site Features	$10,486	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	5	Ea
Patio Terrace	$6,524	Brick and Tile Plazas	Remove and replace asphalt sidewalk, 4' wide	Damaged	10	L.F.
Patio Terrace	$2,724	Brick and Tile Plazas	Replace expansion joints in concrete pavement	Damaged	50	L.F.
Main Building	$34,880	Slab on Grade	Mud jack floor slab.	Failing	500	S.F.
Main Building	$2,673	Exterior Doors	Repair aluminum frame and door	Inadequate	2	Ea
Elm Creek Total	$57,287					

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Enfield

Site Features	$12,584	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	6	Ea
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
Main Building	$15,279	Exterior Doors	Automatic door opener on existing door	Missing	2	Ea
Main Building	$1,498	Fittings	Install mirror at accessible height.	Inadequate	4	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Enfield Total	$31,301					

Enterprise

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Enterprise Total	$36,038					

Fishers Landing

Site Features	$1,568	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	1	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,186	Fittings	Install grab bars in accessible stall.	Missing	7	L.F.
Main Building	$406	Fittings	Replace accessible restroom signage.	Inadequate	2	Ea
Main Building	$24,395	Floor Finishes	Replace quarry tile floor	Damaged	800	S.F.
Main Building	$720	Plumbing Fixtures	Provide protective insulation for exposed piping	Inadequate	2	Ea
Main Building	$4,270	Fixed Furnishings	Provide accessible service counter	Inadequate	14	L.F.
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Fishers Landing Total	$92,638					

Forest Lake

Site Features	$5,704	Site Development	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Main Building	$15,379	Exterior Doors	Automatic door opener on existing door	Missing	2	Ea
Main Building	$3,105	Identifying/ Visual Aid Specialties	Renew System	Beyond Useful Life	1	Ea
Main Building Lobby	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Forest Lake Total	$25,890					

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Frazee

Main Building	$1,650	Exterior Doors	Repair aluminum storefront door	Damaged	3	Ea
Frazee Total	$1,650					

Fuller Lake

Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$15,709	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Beyond Useful Life	2	Ea
Main Building	$899	Fittings	Install mirror at accessible height	Missing	2	Ea
Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$2,439	Floor Finishes	Replace quarry tile floor	Damaged	80	S.F.
Main Building	$720	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Fuller Lake Total	$58,778					

General Andrews

Site Features	$6,292	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$275	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	2	Ea
Auto Parking	$2,413	Parking Lots	Re-Align & Re-stripe Parking Space for ADA Access	Inadequate	800	L.F.
Auto Parking	$2,204	Parking Lots	Replace Metal Reserved Parking Sign and Post	Missing	3	Ea
General Andrews Total	$11,184					

Goose Creek

Site Features	$4,704	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$6,086	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Inadequate	150	L.F.
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Inadequate	1	Ea
Main Building	$2,155	Identifying/ Visual Aid Specialties	Renew System	Beyond Useful Life	1	Ea
Main Building Lobby	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Auto Parking	$1,060	Parking Lots	Realign & Re-stripe Parking Space for ADA Access	Inadequate	264	L.F.
Goose Creek Total	$23,660					

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Gooseberry Falls

Site Features	$3,217	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$730	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Damaged	12	L.F.
Auto Parking	$3,956	Parking Lots	Re-Align & Re-stripe Parking Space for ADA Access	Inadequate	1120	L.F.
Gooseberry Falls Total	$7,906					

Hansel Lake

Site Features	$2,164	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Inadequate	200	S.F.
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building.	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Hansel Lake Total	$55,892					

Hayward

Site Features	$413	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	3	Ea
East Picnic Shelter	$507	Site Earthwork	Remove & Replace Concrete Sidewalk, 4' wide	Damaged	10	L.F.
West Picnic Shelter	$507	Site Earthwork	Remove & Replace Concrete Sidewalk, 4' wide	Damaged	10	L.F.
Main Building	$5,665	Fittings	Replace toilet partitions	Inadequate	2	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Hayward Total	$59,011					

Heath Creek

North Picnic Shelter	$10,052	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	15	C.S.F.
Main Building	$609	Fittings	Replace accessible restroom signage.	Inadequate	3	Ea
Heath Creek Total	$10,661					

High Forest

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
High Forest Total	$38,114					

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Kettle River

Site Features	$8,389	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	4	Ea
Auto Parking	$2,204	Parking Lots	Replace Metal Reserved Parking Sign and Post	Missing	3	Ea
Auto Parking	$2,413	Parking Lots	Realign & Re-stripe Parking Space for ADA Access	Missing	800	L.F.
Kettle River Total	$13,006					

Lake Iverson

Site Features	$6,872	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	3	Ea
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$25,492	Fittings	Replace toilet partitions	Damaged	9	Ea
Main Building	$812	Fittings	Replace accessible restroom signage	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Lake Iverson Total	$84,059					

Lake Latoka

Picnic Shelter East	$2,029	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	50	L.F.
Picnic Shelter West	$2,029	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	50	L.F.
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Lake Latoka Total	$5,860					

Lake Pepin

Site Features	$6,086	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Inadequate	150	L.F.
North Picnic Shelter	$1,420	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Inadequate	35	L.F.
South Picnic Shelter	$923	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Inadequate	35	L.F.
Auto Parking	$1,060	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Missing	264	L.F.
Lake Pepin Total	$9,489					

Middle Spunk

Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea

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Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$4,704	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$2,434	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Inadequate	60	L.F.
Auto Parking	$607	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Inadequate	100	L.F.
Middle Spunk Total	$66,281					

MN Valley

Main Building	$15,279	Interior Doors	Automatic door opener on existing door	Inadequate	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$1,017	Fittings	Install grab bars in accessible stall.	Missing	6	L.F
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$2,880	Plumbing Fixtures	Provide protective insulation for exposed piping.	Missing	8	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
MN Valley Total	$58,162					

Moorhead

Site Features	$1,845	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	1	Ea
Moorhead Total	$1,845					

New Market

Main Building	$609	Fittings	Replace accessible restroom signage.	Inadequate	3	Ea
Site Features	$3,275	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
West Picnic Shelter	$10,052	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	15	C.S.F.
New Market Total	$14,074					

Oak Lake

Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,186	Fittings	Install grab bars in accessible stall.	Missing	7	L.F
Main Building	$2,439	Floor Finishes	Replace quarry tile floor	Damaged	80	S.F.
Main Building	$720	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea

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Site Features	$3,136	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	2	Ea
East Picnic Shelter	$811	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Damaged	10	L.F.
Oak Lake Total	$47,914					

Oakland Woods

Main Building	$863	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$4,367	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	4	Ea
Oakland Woods Total	$58,737					

Rum River

Main Building	$2,339	Identifying/ Visual Aid Specialties	Renew System	Beyond Useful Life	1	Ea
Main Building	$1,042	Cabinets & Counters	Renew System	Beyond Useful Life	1	Ea
Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Inadequate	1	Ea
Main Building Men's Room	$5,665	Toilet Partitions	Replace toilet partitions	Damaged	2	Ea
Main Building Women's Room	$11,330	Toilet Partitions	Replace toilet partitions	Damaged	4	Ea
Main Building Women's Room	$6,479	Plumbing Fixtures	Replace lavatory vitreous china	Inadequate	8	Ea
Site Features	$6,292	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$4,057	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Missing	100	L.F.
Rum River Total	$46,278					

St. Croix TIC

Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Site Features	$10,486	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
St. Croix TIC Total	$11,921					

Straight River NB

Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$6,779	Communications & Security	Replace fire alarm control panel	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Main Building	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea

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East Picnic Shelter	$6,006	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	10	C.S.F
West Picnic Shelter	$8,828	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	10	C.S.F
West Picnic Shelter	$3,483	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Damaged	10	L.F
Straight River NB Total	$60,911					

Straight River SB

Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
East Picnic Shelter	$3,003	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$6,006	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	10	C.S.F
Straight River SB Total	$12,154					

Thompson Hill

Main Building	$13,556	Fittings	Install grab bars in accessible stall	Missing	80	L.F.
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Site Features	$2,097	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Missing	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Thompson Hill Total	$51,098					

Watonwan

Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$1,092	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Missing	1	Ea
Site Features	$3,289	Water Supply	Install Domestic Water Faucet Piping and Drain	Missing	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Watonwan Total	$57,861					

Worthington TIC

Main Building	$431	Exterior Doors	Repair aluminum door	Damaged	1	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$3,660	Fittings	Provide accessible service counter	Inadequate	12	L.F.

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Main Building	$812	Fittings	Replace accessible restroom signage	Inadequate	4	Ea
Main Building	$25,492	Fittings	Replace toilet partitions	Damaged	9	Ea
Main Building	$1,073	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$3,604	Communications & Security	Replace public telephone	Inadequate	2	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Worthington TIC Total	$94,354					

Grand Total	**$1,942,175**

Note: The following Rest Areas have no ADA Deficiencies: Brainerd Lakes Welcome Center, Albert Lea TIC, and Marion Rest Area

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Appendix E

Policies and Procedures under Review by MnDOT

2008 Signal & Lighting Certification Manual	Revised 2010
60% REVIEW CHECKLISTS	N/A
95% REVIEW CHECKLISTS	N/A
Accessibility Grievance Procedure	Revised
ADA Checklist	Revised
ADA IMPLEMENTATION PLAN FOR METRO DESIGN	Revised
D-7 PRESERVATION PROJECT GUIDELINES	N/A
Design Layout Checklist	N/A
GDSU Process of Layout Review	N/A
Guidebook for Minnesota Public Transit Providers	Retired
Guideline for the Application of Tubular Markers and Weighted Channelizers	No impact to accessibility
Guidelines for Changeable Message Sign (CMS) Use	No impact to accessibility
Hear Every Voice (HEV): MnDOT Public and Stakeholder Participation Guidance	Compliant
Hear Every Voice II: Public Involvement Guidance 2008	Compliant
HPDP Accessibility Requirements	Revision in 2015
HPDP Geometric Layouts	N/A
Layout Approval Process	Not found
Maintenance Manual	Revision pending
Minnesota Manual on Uniform Traffic Control Devices (Mn MUTCD) CH 4E	Revised
MnDOT Road Design Manual (RDM)	Chapter 11-3 Revised 2010
MnDOT Traffic Signal Timing and Coordination Manual	
No Passing Zone Workbook	No impact to accessibility
Off-site accessibility checklist	Not found
OLM's Right of Way Manual section 5-491.810	N/A
Scoping and Cost Estimating	Compliant
Scoping Worksheets	Compliant
Standard Plan - Acceleration and Deceleration Lane (Urban) Rigid Design (5-297.210)	No impact to accessibility
Standard Plate 7105C	No impact to accessibility
Standard Plate 7107H	No impact to accessibility
Standard Plate 7108F	No impact to

	accessibility
Standard Plate 7109C	No impact to accessibility
Standard Plate 7113A	No impact to accessibility
Standard Plate 8400E Pipe Railing	Needs revision
Standard Plate 8401 At grade pipe railing	Needs revision
Standard Plate Pedestrian installation	Not Found
Standard Sign Summary	Compliant
Standard Signs Manual	Compliant
Tech. Memo. Minnesota Work Zone Safety and Mobility Policy	Revised 2010
Tech. Memo. Pedestrian Countdown Signals (PCSs) Usage.	No impact to accessibility
TRAFFIC ENGINEERING MANUAL	Revised
Work Zone Field Handbook	Revised

Appendix F

Inventory Attributes for Sidewalks, APS Signals, and Curb Ramps

Below is listing of the data that was collected for determining the accessibility of sidewalks, signals, and curb ramps in MnDOT's right of way.

Sidewalk Attributes

Pedestrian Activity

Sidewalk Width

Sidewalk Material

Boulevard Width

Boulevard Material

Cross Slope

Condition Rating

Signal Attributes

Intersection ID

APS Present

Walk Signal Present

Countdown Present

Pedestrian Phase Activation

Push Button Location

Push Button on correct side

Push Button Landing Area

Push Button Landing Slope

Push Button Landing Location

Push Button Height

Push Buttons 10' Apart

Photo

Curb Ramp Attributes

Intersection ID

Pedestrian Activity

Ramp Type

Location

Truncated Domes

Pedestrian Landing Area

Pedestrian Landing Slope

Ramp Width

Running Slope

Cross Slope

Condition Rating

Gutter In Slope

Gutter Flow Slope

Photo

Appendix G

Glossary of Terms

ABA: See Architectural Barriers Act.

ADA: See Americans with Disabilities Act.

ADA Transition Plan: MnDOT's transportation system plan that identifies accessibility needs, the process to fully integrate accessibility improvements into the Statewide Transportation Improvement Program (STIP), and ensures all transportation facilities, services, programs, and activities are accessible to all individuals.

ADAAG: See Americans with Disabilities Act Accessibility Guidelines.

Accessible: A facility that provides access to people with disabilities using the design requirements of the ADA.
Accessible Pedestrian Signal: A device that communicates information about the WALK phase in audible and vibrotactile formats. Also known as APS.

Alteration: A change to a facility in the public right-of-way that affects or could affect access, circulation, or use. An alteration must not decrease or have the effect of decreasing the accessibility of a facility or an accessible connection to an adjacent building or site.

Americans with Disabilities Act: The Americans with Disabilities Act; Civil rights legislation passed in 1990 and effective July 1992. The ADA sets design guidelines for accessibility to public facilities, including sidewalks and trails, by individuals with disabilities. Also known as ADA.

Americans with Disabilities Act Accessibility Guidelines: ADAAG contains scoping and technical requirements for accessibility to buildings and public facilities by individuals with disabilities under the Americans with Disabilities Act (ADA) of 1990.

APS: See Accessible Pedestrian Signal.

Architectural Barriers Act: Also known as ABA.

Class I Rest Areas: Rest area buildings are open 24 hours per day and offer modern facilities, drinking fountains, display case maps, travel displays, vending machines and public phones. They feature picnic facilities; lighted walkways; and lighted car, recreational vehicle and commercial truck parking lots.

Class II Rest Area: Class II rest areas feature vault toilet facilities with separate facilities for men and women, a water well, picnic facilities, paved parking lots and other site amenities. They are seasonally operated.
Detectable Warning: A surface feature of truncated domes, built in or applied to the walking surface to indicate an upcoming change from pedestrian to vehicular way.

DOJ: See United States Department of Justice
Federal Highway Administration (FHWA): A branch of the US Department of Transportation that administers the federal-aid Highway Program, providing financial assistance to states to construct and improve highways, urban and rural roads, and bridges.

FHWA: See Federal Highway Administration

PROWAG: An acronym for the *Guidelines for Accessible Public Rights-of-Way* issued in 2005 by the U. S. Access Board. This guidance addresses roadway design practices, slope, and terrain related to pedestrian access to walkways and streets, including crosswalks, curb ramps, street furnishings, pedestrian signals, parking, and other components of public rights-of-way.

Right of Way: A general term denoting land, property, or interest therein, usually in a strip, acquired for or devoted to transportation purposes. "Right of way" also may mean the privilege of the immediate use of the highway. (MN 169.01 Subd. 45)

Section 504: The section of the Rehabilitation Act that prohibits discrimination by any program or activity conducted by the federal government.

Travel Information Centers: Travel Information Centers (TICs) and Regional Welcome Centers are Class I rest areas that offer expanded customer services and feature a staffed travel information counter. The TICs offer a broad range of statewide travel information while the Welcome Centers provide more regional travel information.

Statewide Transportation Improvement Program: The Statewide Transportation Improvement Program (STIP) is Minnesota's four year transportation improvement program. The STIP identifies the schedule and funding of transportation projects by state fiscal year (July 1 through June 30). It includes all state and local transportation projects with federal highway and/or federal transit funding along with 100% state funded transportation projects. Rail, port, and aeronautic projects are included for information purposes. The STIP is developed/updated on an annual basis.

STIP: See Statewide Transportation Improvement Program

Uniform Accessibility Standards (UFAS): Accessibility standards that all federal agencies are required to meet; includes scoping and technical specifications.

United States Access Board: An independent federal agency that develops and maintains design criteria for buildings and other improvements, transit vehicles, telecommunications equipment, and electronic and information technology. It also enforces accessibility standards that cover federally funded facilities.

United States Department of Justice: The United States Department of Justice (often referred to as the Justice Department or DOJ), is the United States federal executive department responsible for the enforcement of the law and administration of justice.

Minnesota Olmstead Plan: Demographic Analysis, Segregated Settings Counts, Targets and Timelines

Continuing Care Administration

Children and Family Services Administration

September 30, 2014

For more information contact:

Minnesota Department of Human Services
Disability Services Division
St. Paul, MN 55101
651-431-4262

This information is available in accessible formats to individuals with disabilities by calling 651-431-4262,
Or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

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Olmstead Plan Language

Housing section

Action One: Identify people with disabilities who desire to move to more integrated housing, the barriers involved, and the resources needed to increase the use of effective best practices

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

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 50.

Supports and Services section

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

For individuals in other[1] segregated settings:

- *By September 30, 2014 DHS will identify a list of other segregated settings, how many people are served in those settings, and how many people can be supported in more integrated settings.*
- *By September 30, 2014 DHS will review this data and other states[2] plans for developing most integrated settings for where people work and live. Based on this review DHS will establish measurable goals related to demonstrating benefits to the individuals intended to be served and timelines for moving those individuals to the most integrated settings.*

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 64.

Introduction

Minnesota's Olmstead Plan goal is to ensure that Minnesota is a place where people with disabilities live, learn, work and enjoy life in the most integrated setting. Services and supports that enable people to exercise their right of self-determination, to live in the most-integrated settings and to be able to freely participate in their communities will be appropriate to their needs and of their choosing.

To achieve this, the Olmstead Plan sets goals and identifies strategic actions in the following areas: employment, housing, transportation, supports and services, lifelong learning and education, healthcare and health living, and community engagement.

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[1] In the Olmstead Plan, immediately preceding this quoted section, is a list of actions and measures related to certain segregated settings: Intermediate Care Facilities for Persons with Developmental Disabilities, nursing facilities (specifically for people under 65 who are there more than 90 days), Anoka Metro Regional Treatment Center, Minnesota Security Hospital and Minnesota Specialty Health System-Cambridge. The term used here, "other segregated settings", refers to places other than these previously listed five settings.

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

This report focuses on moving people on increasing the number of people living in the most integrated settings and decreasing the number of people living unnecessarily in segregated settings.

The State must better align the design and provision of supports and services with these outcomes. The culture surrounding the delivery of supports and services will be based on a holistic approach to supporting people. Many factors influencing quality of life will have to come together, such as expectations and aspirations, skills developed over a lifetime, personal supports, location of one's home and transportation options.

Increasing flexibility and options in all of these areas will require collaboration among divisions within state agencies, across state agencies, with providers, businesses, community organizations and, of course, people with disabilities and their families.

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

- Increase in the number of people living in most integrated settings
- Decrease in people living unnecessarily in segregated settings
- Increase in the quality of life as reported by people with disabilities, using indicators described in the Quality Assurance section of the plan
- People will have timely transitions back to their community from hospital care or short-term institutional care

Background Information

People with disabilities in Minnesota receive long-term supports and services either in what we consider an institutional setting or through home and community based services. Home and community based services include home care and personal care assistant services covered through the Medicaid state plan, the Alternative Care program, the Elderly Waiver and the disability waivers.

In state fiscal year 2013, 93 percent of people with disabilities and 68 percent of older adults received their long-term supports and services through home and community based services (83 percent across both populations combined). Of those, 73 percent of people with disabilities and 76 percent of older adults received those services in their own homes.

Related Olmstead actions

This report was produced in conjunction with the Olmstead Plan actions cited on page one. There are several other closely related Olmstead Plan actions. This report includes demographic and baseline data about people receiving services in potentially segregated settings and lays out targets and timelines for moving people to more integrated settings. The related actions are what the state is planning to do, or currently implementing, to achieve those goals.

The plan lays out several actions to promote person-centered practices which identify people who would like to move to a more integrated setting, and those who would not be opposed to such a move. The plan includes actions to support people in more integrated settings and improve the quality of life of people with disabilities.

The plan includes developing and implementing transition protocols to support successful transitions. There are specific, measurable targets for transitioning individuals from Intermediate Care Facilities for

Developmental Disabilities (ICF-DDs), nursing facilities, the Minnesota Specialty Health System facility in Cambridge, the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital.

There are several actions in the plan that will identify people with disabilities who are exiting state correctional facilities, including youth who are leaving juvenile facilities, and connect them with appropriate services and supports upon release.

There are several actions in the plan related to increasing the use of positive practices. The plan also includes actions to increase planning in order to reduce crises and to respond quickly and effectively when crises do occur.

The plan directs the state to change the way prioritization for accessing limited services (waiver wait list) so that those who want to move to a more integrated setting will be able to access the necessary home and community-based supports in a reasonable amount of time.

The plan includes actions to increase flexibility of and access to certain services and supports.

The state has developed plans to provide training and technical assistance to services providers who have business models structured around segregated and non-competitive employment to transition their service delivery model to integrated, competitive employment models.

There are several Olmstead Plan actions related to housing that will facilitate meeting the state's targets and timelines for transitioning people from segregated to more integrated settings. One strategic action is to increase housing options that promote choice and access to integrated settings by reforming the Group Residential Housing (GRH) and Minnesota Supplemental Aid (MSA) Housing Assistance programs. The goal of the reform is to allow income supplement programs that typically pay for room and board in congregate settings to be more easily used in non-congregate settings. It is expected that this change would result in more people with disabilities transitioning from the potentially segregated settings identified in this report to more independent housing.

The plan also calls for increasing the availability of affordable housing. Another is to increase access to information about housing options. And, the plan includes actions to promote counties, tribes and other providers to use best-practices and person-centered strategies related to housing.

HCBS Settings Rule

Simultaneous to Minnesota's Olmstead Plan implementation, the Centers for Medicare and Medicaid Services (CMS) published a rule, effective March 17, 2014, outlining new requirements for states' Medicaid home and community-based services.

The intent of the rule is to ensure that individuals receiving long-term services and supports through home and community-based services programs have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate to meet the needs of the individual. The rule is designed to enhance the quality of home and community-based services and provide protections for people who use those services. The rule defines, describes and aligns requirements across the home and community-based services programs. It defines person-centered planning requirements for persons in home and community-based settings.

States have until March 17, 2019, to bring existing programs into compliance with the rule and must submit a plan to transition their existing home and community-based services waiver programs services

by that date. In Minnesota, this impacts the Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Individuals with Disabilities (CADI), Developmental Disabilities (DD), and Elderly Waiver (EW) programs. New programs under 1915(i), 1915(k) and any new 1915(c) will be required to be in full compliance from the date of implementation. In Minnesota, the new Community First Services and Supports (CFSS) program must meet this requirement.

The new federal HCBS rules require that individuals be afforded a real choice between settings in which they receive services. Minnesota's implementation of these rules will further the state's progress in implementing its Olmstead goals.

Process

Internal work groups

Two groups were convened to work on this project, one to develop the data set for measuring people in potentially segregated settings and another to analyze the data from a policy perspective and set the targets and timelines. The groups included data and policy experts from the Minnesota Department of Human Services Adult Mental Health, Children's Mental Health, Economic Assistance and Employment Support, Disability Services Division, Compliance Monitoring, and Chemical Health Divisions. The Department of Health and the Department of Employment and Economic Development also participated. This work has a direct link to the Olmstead Plan action to develop additional affordable housing and, therefore, included participation by the Minnesota Housing Finance Agency.

How people with disabilities were/will be involved in planning for community integration

Individuals can have significant impact on realizing their personal goals when their preferences as well as their needs are incorporated into assessment and service planning . Minnesota is currently rolling out MnCHOICES, which continues and enhances Minnesota's person-centered approach tailoring services to individual's strengths, preferences and needs. This major reform has been underway for several years and is now in the final stages of its staged roll-out.

People with disabilities also have the opportunity to participate as advocates and planning partners in shaping the future of Minnesota's HCBS system. A series of meetings and input sessions around the state were held as part of the preliminary planning for the HCBS settings rule implementation. Meetings specifically targeted for self-advocates were held to seek input in addition to other forums.

DHS also engaged stakeholders in providing input to the GRH/MSA reform efforts. This effort focused on receiving feedback regarding current housing options and barriers and comments on proposed future directions for this program. For this effort, six listening sessions were held throughout the state with over 450 participants, including people with disabilities and their families.

The Minnesota Department of Human Services conducts a biennial process to gather information about the current capacity and gaps in services and housing needs to support people with long-term care needs in Minnesota. The gaps analysis was originally focused on the needs of older persons but in 2011 the needs of children and adults with disabilities and/or mental illness were added to the study. As part of this process, people with disabilities, people with mental illness, older people and their families participated in focus groups to provide insights about long-term services and supports, based upon their personal experience. For the 2012/2013 study, focus groups were held in 16 communities across the state, with 260 individuals taking part. There were 110 people who participated by completing a short

on-line survey. Twenty-three percent of survey respondents identified as having a disability and 23 percent as parents and caregivers.

As part of the six-year Pathways to Employment initiative, the Department of Human Services, in conjunction with other state agencies, engaged people with disabilities and other stakeholders in a public process to identify what it will take to increase the employment of people with disabilities in Minnesota. Pathways supported three summits which brought together people with disabilities and other stakeholders with one focus—how to make employment the first and preferred choice of youth and adults with disabilities. Pathways also supported a series of events around the state, conversations with various disabilities sub-populations, that yielded nine policy briefs in the following areas: brain injury, mental health, Deaf-blindness, Deaf and hard of hearing, blindness, Autism Spectrum Disorder, intellectual/developmental disabilities, and physical disabilities.

Review of other state's plans (Olmstead Plan item SS 2G.2)

The policy work group that developed targets and timelines reviewed initiatives to reform state employment and day support services in Massachusetts, Oregon and Rhode Island. A chart showing their analysis of those plans is included in Appendix A.

The strategies that are being used by other states informed the development of Minnesota's implementation plans for increasing competitive employment and those plans informed the process for setting targets for competitive employment. The effort to support people to be competitively employed intersects with the targets to support people receiving day services in more integrated settings.

The strategies that Minnesota are pursuing include:

- Adopting an Employment First Policy
- Training and technical assistance to support day service providers to convert their service models from congregate and segregated, "sheltered workshop" day services to more individualized, person-centered approaches of community supports and competitive employment services
- Interagency collaboration to promote promising practices and coordinate services for transition-age youth
- Increasing expectations and work experiences
- Improved data system for tracking employment outcomes for students and adults with disabilities
- Documenting informed choice to enable tracking individuals' decisions and potential barriers to employment
- Service enhancements for people who are seeking competitive employment at minimum wages or higher
- Expanding self-advocacy and peer networks

Minnesota is using earned monthly income ≥$600/month as an indicator of competitive employment.

Our data base contains information about individuals' income, including what is earned income and what is the amount and type of unearned income. We recognize that many people have earned income, but would not necessarily be employed in what we consider "competitive employment"—that is, employment that is part of the regular workforce, not in a segregated setting, and which is compensated at a market rate. Minnesota is setting a relatively high threshold of monthly earned income to separate

those who have jobs that pay sub-minimum wages (more likely to be in segregated settings) from those who have jobs that pay at least a minimum wage.

This is an important distinction to keep in mind, particularly when comparing Minnesota to other states which may be using another benchmark, such as having *any* earned income as an indicator of employment. To illustrate this point, in 2013, 15.8 percent of people on a disability waiver have earned income over $250/month. (This is not the exact same population as used for the rest of our measures, but a number we've been tracking since 2007, and used here just for illustrative purposes).

Methodology

Available data sources

That data that is available comes from existing data systems that were designed for specific purposes. Therefore, there are many shortcomings with the data we have to inform and track our Olmstead implementation.

- Some data can only partially get at some questions
- Some data available for some of the people in the system but not for everyone
- Data fields that could be used, but which aren't reliably used or updated by the people who populate the data base.
- No data available to address some questions or track certain outcomes

MAXIS
MAXIS is a computer system used by state and county workers to determine eligibility for public assistance and health care. For cash assistance and food support programs, MAXIS also determines the appropriate benefit level and issues benefits.

For the purposes of this report, data from MAXIS were used to identify people with disabilities who receive benefits through the Group Residential Housing (GRH) program. This program pays for room and board costs related to living in a licensed or registered setting, as well as services for some people. GRH recipients were included in this report if they reside in one of the following settings: adult foster care, boarding care, board and lodge, board and lodge with special services, homeless shelter, housing with services establishment, or supervised living facility. For settings other than adult foster care, the individual had to be on the program for at least 90 days to be counted. This control sorted out people who are more likely to be living in a segregated setting, rather than passing through one on a temporary basis.

MMIS
Health care providers throughout the state – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in a Minnesota Health Care Program. These programs provide health care services to low-income families and children, low-income elderly people and individuals who have physical and/or developmental disabilities, mental illness or who are chronically ill.

For the purposes of this report, data from MMIS were used to identify people with disabilities who received long-term supports and services typically provided in licensed, and potentially segregated, settings.

Data limitations specific to this project

1. Olmstead Plan does not have measureable definitions or criteria to identify segregated settings
2. Current data bases have limited information regarding the type of settings in which people receive services
3. Current databases do not identify people who want to move to a more integrated setting
4. Current databases lack information required to indicate the type of setting in which the individual is being served (e.g., day/employment services settings). Therefore, it is also difficult, if not impossible, to track movement between settings with current databases.
5. Setting types, as recorded in DHS data systems, represent a wide variety of actual places where people live, and do not necessarily indicate how "integrated" a person in any particular setting is. For example, a person may receive customized living services in an assisted living residence which is comprised entirely of older adults, being in this residence may give the individual more access to community life than the person may have had in their own home.
6. Providers have up to 12 months through MMIS to submit a claim so the claims data for fiscal year 2014 is subject to change through June 30, 2015
7. There is different data kept for people depending on the program they use. For example, people who apply for a Developmental Disabilities waiver will have extensive assessment information in their records. People who are in a nursing facility also have assessment data, but from a different assessment tool with different data points. People who are in the Group Residential Housing program may not have any assessment data.

Data development plan

Because of the data which is currently available does not fully answer questions that could guide us in the process of assisting people move to the most integrate setting, we need to develop additional ways to get information. MMIS and MAXIS are large data bases that are central to the state's operations in administering public programs. The demands upon them are great and changes are not easily made. It is not practical to build additional statewide data systems so we need to work with our existing systems. MnCHOICES is a new assessment system, currently being rolled out, which will provide much more person-centered data in the future.

We are taking short-term and long-term approaches to improving our data. The HCBS segregated settings transition plan will provide the basis for most of the short-term improvements.

1. Develop criteria for measuring a setting's degree of segregation/integration.
2. HCBS waiver providers in potentially segregated settings will complete a self-assessment.
3. Develop a method for rating site-specific "integration-based" criteria using data from provider assessments.
4. Create short-term system for tracking numbers of people who make a move to more integrated setting.
5. Build long-term systems solution for identifying, verifying, collecting and sharing information about degree of integration/segregation.
6. Create long-term system for tracking numbers of people who move from to or from less integrated settings.

Data pull

The baseline and demographic data were compiled using the following process.

1. Data used came from fiscal year 2014 (July 1, 2013 – June 30, 2014).
2. Data included all people, irrespective of age.
3. MMIS data was queried using claim codes of services that are delivered in a potentially segregated setting. Individuals were included in the counts if there was at least one claim meeting criteria within fiscal year 2014. This list included specific waiver services and services commonly accessed by people with serious mental illness or serious and persistent mental illness.
4. Data from MMIS does not include data about Group Residential Housing (GRH). GRH recipients must meet disability criteria to qualify for this program. Therefore, data was pulled from MAXIS to capture people receiving GRH.
5. Some people are only on GRH for a short stay in a temporary setting and therefore would not be considered someone living in a segregated setting. To control for that, we narrowed the MAXIS group, for every setting except adult foster care, to only include people who were in the setting for at least 90 days.
6. We combined the MAXIS group and the MMIS group to arrive at the people that we consider to have been in potentially segregated settings in fiscal year 2014.

List of potentially segregated settings (requires further analysis)

Criteria

There is nothing in current state statute, policy or rule that defines what constitutes a segregated setting in Minnesota. The Olmstead Plan provides the following definition of 'segregated setting', taken from the *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.*[3]

> **Segregated settings:** Segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.

This definition needs to be broken down into measurable criteria, e.g., what constitutes "lack of privacy or autonomy."

The state will develop ways to measure these qualities. In the meantime, we identified settings that are *potentially segregating.* It is important to note that, in addition to developing measurable criteria, data, over and above that currently available to the State, will required in order to identify segregated settings. Additionally, our current data systems do not necessarily identify the setting in which a person receives a service.

In light of these limitations, this is where we are starting the task of identifying people in segregated settings, recognizing that this work will need further analysis, including possibly looking at other settings that weren't included in this first analysis.

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[3] www.ada.gov/olmstead/q&a_olmstead.htm

The group divided settings into residential settings and day/employment services settings. The logic is that strategies for transitioning people to more integrated settings will be similar within those categories and different outside those categories. In other words, a strategy to help people change residence will likely be useful across residential settings but not necessarily in helping people change their day/employment services settings. Likewise, strategies to make day service settings more integrated will likely work across day/employment services but not necessarily with transition out of residential settings.

We included people who are homeless in the count of people living in segregated settings for two reasons. First, according to the U.S. Department of Housing and Urban Development, over 40 percent of America's homeless population is people with disabilities[4]. Second, we consider our goal to be not only decreasing the number of people living unnecessarily in segregated settings but also increasing the number of people living in the most integrated settings. From a quality of life perspective, the people who are homeless have fewer opportunities to participate in community life. Therefore, we chose to look for indicators of homelessness and include people who are likely to be homeless in the counts of being in potentially segregated settings.

The group then developed criteria to use to identify if settings and services in each group will be considered potentially segregated.

Residential – potentially segregated/not integrated criteria

- The setting is controlled by the service provider
  - The exception to this criterion is private family settings (i.e., family foster care)
- There are no limits to length of stay
- A person who is likely to be homeless is considered not well-integrated in their community

Day/employment services settings – potentially segregated criteria

- Services which are often delivered in a provider-controlled setting
- Services which are often delivered in settings with a predominance of other people with disabilities

List of potentially segregated settings

Figure 1: List of potentially segregated settings and services (See Appendix B for definitions)

Residential settings/services delivered in potentially segregated settings	Day/employment services delivered in potentially segregated settings
Adult foster care	Adult day services
Assisted living residence (customized living service)	Day training and habilitation center
Board and lodge (includes homeless shelters)	Family adult day services
Board and lodge with special services	Pre-vocational service
Boarding care	Structured day program
Child foster care	Supported employment services
Children's residential care (children's residential facilities- Rule 5)	
Crisis respite (foster care)	

[4] U.S. Department of Housing and Urban Development, 2013 Continuum of Care Homeless Populations and Subpopulations Report (See www.hudexchange.info/reports/CoC_PopSub_NatlTerrDC_2013.pdf).

Residential settings/services delivered in potentially segregated settings	Day/employment services delivered in potentially segregated settings
Housing with services establishment	
Supervised living facilities	
Supported living services	

Data analysis

Residential services/settings

Figure 2: Residential settings by age and gender, fiscal year 2014

	Setting	Recipient	Age Group 0-13	Age Group 14-18	Age Group 19-26	Age Group 27-35	Age Group 36-64	Age Group 65+	Gender Female	Gender Male
MAXIS	Adult Foster Care	873	-	30	198	161	444	40	413	460
	Boarding Care	521	-	4	63	67	368	19	231	290
	Board and Lodge	3,070	-	36	616	758	1,627	33	765	2,305
	Board and Lodge w/ Special Serv	5,003	-	76	817	1,021	3,017	72	1,207	3,796
	Homeless Shelter	4,715	-	79	890	1,034	2,683	29	1,308	3,407
	Housing w/ Services Establ	2,690	-	21	340	401	1,832	96	920	1,770
	Supervised Living Facility	1,046	-	17	257	257	508	7	371	675
	Unduplicated	**10,562**	**-**	**152**	**1,804**	**2,079**	**6,281**	**246**	**3,132**	**7,430**
Claims	Adult Foster Care	5,318	-	97	910	813	2,821	677	2,255	3,063
	Assisted Living	2,610	-	-	38	62	945	1,565	1,685	925
	Assisted Living w/ 24 Hr Care	8,282	-	-	43	98	1,264	6,877	6,017	2,265
	Child Foster Care	187	55	124	8	-	-	-	62	125
	Crisis Respite	188	34	30	64	25	33	2	56	132
	Children's Residential Care	462	221	241	-	-	-	-	174	288
	Supported Living Services	10,470	45	225	1,510	2,079	5,657	954	4,468	6,002
	Unduplicated	**27,517**	**355**	**717**	**2,573**	**3,077**	**10,720**	**10,075**	**14,717**	**12,800**
Total Unduplicated		**38,079**	**355**	**869**	**4,377**	**5,156**	**17,001**	**10,321**	**17,849**	**20,230**

- A total of 38,079 individuals resided in other potentially segregated setting at some point during fiscal year 2014.
    - Of the GRH-only recipients, the largest group (47 percent) was in Board and Lodge with Special Services facilities. Of those with MA claims, the largest group (30 percent) was in Assisted Living with 24 hour care.
- Of the total, 72 percent were over the age of 35.
- Of the total number in all settings combined, nearly 47 percent were female; however, among the GRH-only recipients 70 percent were male.

Figure 3: Residential settings by race/ethnicity, fiscal year 2014

	Setting	Recipient	Race White	Race Black	Race Am Indian	Race Asian	Race Pac Island	Race Hispanic	Race 2+	Race Unknown
MAXIS	Adult Foster Care	873	697	89	29	25	2	15	6	10
	Boarding Care	521	391	82	12	11	1	14	4	6
	Board and Lodge	3,070	1,858	805	153	45	4	84	50	71
	Board and Lodge w/ Special Serv	5,003	3,048	1,256	324	60	2	133	77	103
	Homeless Shelter	4,715	2,375	1,653	322	51	4	129	90	91
	Housing w/ Services Establ	2,690	1,196	1,207	147	18	1	66	27	28
	Supervised Living Facility	1,046	666	228	59	15	4	27	22	25
	Unduplicated	**10,562**	**6,300**	**2,895**	**599**	**141**	**11**	**271**	**147**	**198**
Claims	Adult Foster Care	5,318	4,533	344	137	91	6	91	38	78
	Assisted Living	2,610	2,263	173	38	59	-	26	6	45
	Assisted Living w/ 24 Hr Care	8,282	7,458	308	69	91	2	54	13	287
	Child Foster Care	187	116	24	13	1	-	14	12	7
	Crisis Respite	188	126	32	5	9	-	7	4	5
	Children's Residential Care	462	278	54	53	2	-	29	31	15
	Supported Living Services	10,470	9,528	424	181	123	1	109	26	78
	Unduplicated	**27,517**	**24,302**	**1,359**	**496**	**376**	**9**	**330**	**130**	**515**
Total Unduplicated		**38,079**	**30,602**	**4,254**	**1,095**	**517**	**20**	**601**	**277**	**713**

- Of individuals residing in other potentially segregated setting, blacks were overrepresented (11 percent versus 6 percent of Minnesota's entire population). This disparity increased in the GRH-only group, where 27 percent were black.
- American Indians were overrepresented among those residing in Children's Residential Care and Board and Lodge with Special Services (11 percent and 6 percent, respectively, versus 1 percent of Minnesota's entire population).

Figure 4: Residential settings by diagnosis, fiscal year 2014

	Setting	Recipient	Acquired Cognitive Disability	Austism Spectrum Disorder	Blind	IDD	Deaf	Hard of Hearing	Mental Illness	SMI	SPMI	Substance Abuse
MAXIS	Adult Foster Care	873	611	111	11	365	5	243	808	245	204	469
	Boarding Care	521	387	14	1	77	1	127	517	190	142	449
	Board and Lodge	3,070	2,017	64	3	157	3	544	2,695	633	447	2,736
	Board and Lodge w/ Special Serv	5,003	3,500	95	11	265	-	979	4,563	944	660	4,540
	Homeless Shelter	4,715	3,286	79	8	191	-	916	4,238	778	493	4,260
	Housing w/ Services Establ	2,690	1,928	41	6	147	-	596	2,432	260	158	2,310
	Supervised Living Facility	1,046	845	52	2	86	-	260	1,037	575	490	967
	Unduplicated	**10,562**	**7,304**	**298**	**28**	**914**	**9**	**2,177**	**9,534**	**1,958**	**1,418**	**9,053**
Claims	Adult Foster Care	5,318	4,675	918	124	2,814	25	2,163	5,180	1,538	1,148	3,164
	Assisted Living	2,610	2,203	77	57	518	13	1,006	2,112	282	193	1,026
	Assisted Living w/ 24 Hr Care	8,282	7,280	119	179	966	17	2,665	6,511	408	277	2,100
	Child Foster Care	187	146	85	6	109	-	79	187	116	93	29
	Crisis Respite	188	134	125	1	186	2	85	181	30	6	24
	Children's Residential Care	462	309	119	1	78	-	165	459	424	414	155
	Supported Living Services	10,470	8,049	3,452	311	10,417	123	5,899	9,762	604	45	1,417
	Unduplicated	**27,517**	**22,796**	**4,895**	**679**	**15,088**	**180**	**12,062**	**24,392**	**3,402**	**2,176**	**7,915**
Total Unduplicated		**38,079**	**30,100**	**5,193**	**707**	**16,002**	**189**	**14,239**	**33,926**	**5,360**	**3,594**	**16,968**

- Individuals with an Intellectual/Developmental Disability were more likely to have an MA claim than were GRH-only recipients (55 percent versus 9 percent).
- Individuals with substance abuse issues were more likely to be GRH-only recipients (86 percent versus 28 percent of those with MA claims).
- Nearly all of the GRH-only recipients living in a Boarding Care facility had some history of mental illness, and 21 percent had a serious mental illness.

Figure 5: Residential settings by mobility, fiscal year 2014

	Setting	Recipient	No Impairment	Walks Aided (i.e. walker)	Uses Wheelchair	Not Mobile	Unknown
MAXIS	Adult Foster Care	873	369	81	30	13	380
	Boarding Care	521	291	15	2	-	213
	Board and Lodge	3,070	362	59	28	7	2,614
	Board and Lodge w/ Special Serv	5,003	655	117	23	5	4,203
	Homeless Shelter	4,715	433	98	20	6	4,158
	Housing w/ Services Establ	2,690	307	117	17	7	2,242
	Supervised Living Facility	1,046	285	30	6	1	724
	Unduplicated	**10,562**	**1,791**	**353**	**88**	**26**	**8,304**
Claims	Adult Foster Care	5,318	3,520	723	576	498	1
	Assisted Living	2,610	833	1,286	327	164	-
	Assisted Living w/ 24 Hr Care	8,282	1,849	3,500	2,137	796	-
	Child Foster Care	187	170	1	15	1	-
	Crisis Respite	188	113	70	4	-	1
	Children's Residential Care	462	81	1	1	-	379
	Supported Living Services	10,470	5,868	3,861	624	110	7
	Unduplicated	**27,517**	**12,434**	**9,442**	**3,684**	**1,569**	**388**
Total Unduplicated		**38,079**	**14,225**	**9,795**	**3,772**	**1,595**	**8,692**

- 40 percent of individuals residing in other potentially segregated setting were assessed to have some sort of mobility impairment (15,162 individuals), indicating a *potential* need for a physically accessible unit.
- Nearly half of the individuals receiving assisted living services were assessed to need assistance with walking.

Figure 6: Residential settings by income source, fiscal year 2014

	Setting	Recipient	Earned Income	Unearned Income	Earned or Unearned Income	Income Unknown	Unearned Subgroup: RSDI	Unearned Subgroup: SSI	Unearned Subgroup: RSDI or SSI	Unearned Subgroup: Other
MAXIS	Adult Foster Care	873	384	614	728	145	421	284	601	50
	Boarding Care	521	87	369	421	100	269	157	366	19
	Board and Lodge	3,070	842	733	1,495	1,575	407	380	656	200
	Board and Lodge w/ Special Serv	5,003	1,075	1,368	2,378	2,625	797	726	1,278	299
	Homeless Shelter	4,715	1,046	995	2,045	2,670	469	600	900	286
	Housing w/ Services Establ	2,690	345	784	1,095	1,595	380	481	700	135
	Supervised Living Facility	1,046	262	479	681	365	272	289	462	65
	Unduplicated	**10,562**	**2,426**	**3,524**	**5,491**	**5,071**	**2,082**	**1,867**	**3,297**	**607**
Claims	Adult Foster Care	5,318	2,197	4,966	5,238	80	3,707	2,049	4,959	229
	Assisted Living	2,610	209	2,503	2,598	12	2,214	598	2,501	93
	Assisted Living w/ 24 Hr Care	8,282	317	7,917	8,256	26	7,478	1,125	7,915	333
	Child Foster Care	187	16	86	119	68	23	73	86	28
	Crisis Respite	188	64	156	170	18	64	117	156	14
	Children's Residential Care	462	12	184	280	182	84	124	184	92
	Supported Living Services	10,470	7,626	10,043	10,430	40	8,025	3,834	10,030	342
	Unduplicated	**27,517**	**10,441**	**25,855**	**27,091**	**426**	**21,595**	**7,920**	**25,831**	**1,131**
Total Unduplicated		**38,079**	**12,867**	**29,379**	**32,582**	**5,497**	**23,677**	**9,787**	**29,128**	**1,738**

- Around one-third of individuals residing in other potentially segregated setting reported some amount of earned income.
- 26 percent (9,787 individuals) reported only receiving income from SSI. The maximum monthly benefit for SSI is $721; hence, people who receive SSI are likely to have limited ability to afford housing in the community.
- An additional 20 percent (10,968 individuals) were General Assistance recipients. This group has even less income. The General Assistance benefit for individuals living in the community is $203 per month.

Figure 7: Residence by region, fiscal year 2014

	Setting	Recipient	1 North West	2 Head-waters	3 Arrow-head	4 West Central	5 North Central	6 South West Central	7 East Central	8 South West	9 South Central	10 South East	11 Twin Cities	Unkn	Frontier
MAXIS	Adult Foster Care	873	2	14	56	18	15	10	241	8	45	133	318	13	4
	Boarding Care	521	3	1	9	4	5	4	70	1	1	25	396	2	3
	Board and Lodge	3,070	4	7	142	65	90	46	159	39	75	336	2,076	31	7
	Board and Lodge w/ Special Serv	5,003	20	19	615	111	129	51	278	54	108	246	3,338	34	29
	Homeless Shelter	4,715	8	18	326	76	44	28	166	13	39	229	3,707	61	9
	Housing w/ Services Establ	2,690	3	9	111	14	39	4	37	1	58	41	2,363	10	1
	Supervised Living Facility	1,046	11	14	68	19	7	29	67	30	32	35	722	12	9
	Unduplicated	**10,562**	**37**	**54**	**833**	**191**	**204**	**100**	**676**	**87**	**258**	**669**	**7,361**	**92**	**44**
Claims	Adult Foster Care	5,318	107	134	470	469	199	231	637	135	261	505	2,166	4	56
	Assisted Living	2,610	105	64	268	230	146	142	170	49	151	234	1,046	5	37
	Assisted Living w/ 24 Hr Care	8,282	134	141	1,162	404	317	235	829	148	489	920	3,499	4	71
	Child Foster Care	187	6	1	26	14	8	8	27	9	14	11	62	1	6
	Crisis Respite	188	1	1	6	8	2	3	18	-	-	7	142	-	-
	Children's Residential Care	462	9	26	103	27	13	24	59	11	41	28	120	1	4
	Supported Living Services	10,470	286	163	920	520	338	505	856	396	587	1,253	4,643	3	174
	Unduplicated	**27,517**	**648**	**530**	**2,955**	**1,672**	**1,023**	**1,148**	**2,596**	**748**	**1,543**	**2,958**	**11,678**	**18**	**348**
Total Unduplicated		**38,079**	**685**	**584**	**3,788**	**1,863**	**1,227**	**1,248**	**3,272**	**835**	**1,801**	**3,627**	**19,039**	**110**	**392**

- Half (50 percent) of individuals residing in other potentially segregated setting were in the Twin Cities Metro Area.
- Of GRH-only recipients, however, nearly three-quarters (70 percent) were in the Twin Cities Metro Area.

Figure 8: Unduplicated provider count by setting/service type (residential), fiscal year 2014

Residential setting/service	Unduplicated provider count
Adult Foster Care (MMIS)	1,074
Adult Foster Care (MAXIS)	491
Assisted living Residence (customized living service)	664
Assisted living Residence (24-hour customized living service)	1,047
Board and Lodge	173
Board and Lodge w/ Special Services	167
Boarding Care	18
Child Foster Care	91
Children's Residential Care (Children's Residential Facilities-Rule 5)	69
Crisis Respite (Foster Care)	18
Housing w/ Services Establishment	992
Supervised Living Facility (SLF)	31
Supported Living Services	708

Day/employment services

Figure 9: Service utilization by age, fiscal year 2014

	Setting	Recipient	Age Group 0-13	Age Group 14-18	Age Group 19-26	Age Group 27-35	Age Group 36-64	Age Group 65+
Day	Adult Day Center	5,782	0	6	119	140	1271	4246
	Day Training & Habilitation	10,135	0	34	1940	2383	5134	644
	Family Adult Day Servcies	46	0	0	2	0	6	38
	Prevocational Services	2,556	0	23	539	461	1464	69
	Structured Day Program	182	0	0	13	39	123	7
	Supported Employment Services	2,827	0	15	719	721	1324	48
	Unduplicated	20,055	0	70	3033	3411	8557	4984

- The data pull included people of all ages and therefore included older Minnesotans using long-term supports and services whose need for those services may have resulted from conditions acquired as they aged and/or conditions that were disabling, independent of their aging.

Figure 10: Service utilization by diagnosis, fiscal year 2014

	Setting	Recipient	Acquired Cognitive Disability	Austism Spectrum Disorder	Blind	IDD	Deaf	Hard of Hearing	Mental Illness	SMI	SPMI	Substance Abuse
Day	Adult Day Center	5,782	4,780	232	129	1,338	32	2,724	5,043	261	160	1,230
	Day Training & Habilitation	10,135	7,302	3,363	287	10,135	124	5,352	9,095	394	13	963
	Family Adult Day Servcies	46	39	-	-	6	-	18	44	3	2	10
	Prevocational Services	2,556	2,175	557	66	1,733	34	1,104	2,449	596	400	1,261
	Structured Day Program	182	181	28	1	121	1	65	177	13	6	100
	Supported Employment Services	2,827	2,195	826	39	2,242	12	1,182	2,645	455	284	1,115
	Unduplicated	20,055	15,461	4,634	497	14,467	194	9,788	18,066	1,466	698	4,084

- Individuals may have more than one diagnosis so these are not unduplicated counts. The service called day training and habilitation is only covered under the Developmental Disabilities waiver, so everyone receiving that service had that diagnosis. Individuals may have had additional diagnoses, as well.

Figure 11: Service utilization by source of income, fiscal year 2014

	Setting	Recipient	Earned Income	Unearned Income	Earned or Unearned Income	Income Unknown	Unearned Subgroup: RSDI	Unearned Subgroup: SSI	Unearned Subgroup: RSDI or SSI	Unearned Subgroup: Other
Day	Adult Day Center	5,782	427	4944	5663	119	2036	3371	4933	717
	Day Training & Habilitation	10,135	8079	9794	10127	8	7395	4165	9785	300
	Family Adult Day Servcies	46	6	42	44	2	19	26	42	2
	Prevocational Services	2,556	2229	2445	2550	6	1839	956	2443	80
	Structured Day Program	182	121	175	182	0	139	65	175	7
	Supported Employment Services	2,827	2483	2669	2824	3	2122	925	2665	94
	Unduplicated	20,055	12008	18666	19919	136	12437	9022	18641	1156

- The chart shows only the source of income, not the amount of income. The 'earned income' category does not distinguish between competitive employment and earnings at sub-minimum wages.
- Individuals could have multiple sources of income so counts are not unduplicated, unless specified.

Figure 12: Service utilization by living arrangement, fiscal year 2014

	Setting	Recipient	Home	Family Foster Care	Corp Foster Care	ICF-DD	NF	Board and Lodge	Housing with Services	Corr Facility	Hospital	Unknown
Day	Adult Day Center	5,782	4,656	119	597	3	80	116	185	-	9	17
	Day Training & Habilitation	10,135	2,879	582	6,549	29	32	2	-	-	-	62
	Family Adult Day Servcies	46	36	-	5	-	1	4	-	-	-	-
	Prevocational Services	2,556	1,022	153	1,147	1	29	92	80	1	10	21
	Structured Day Program	182	36	4	118	-	3	12	9	-	-	-
	Supported Employment Services	2,827	1,423	155	1,090	1	23	53	43	-	6	33
	Unduplicated	20,055	9,427	937	8,814	34	158	248	291	1	25	120

Figure 13: Unduplicated provider count by service type (day/employment), fiscal year 2014

Day/employment services	Unduplicated provider count
Adult day services center (EW) & Adult Day Care	229
Family adult day services setting	14
Structured Day Program	57
Day Training and Habilitation center	246
Pre-Vocational Service	177
Supported Employment Services (SES)	187

Targets and timelines

There are initiatives across the state agencies to support people moving to more integrated settings. While some are smaller in scale and targeted, others are larger and geared to systems-level changes. The systems changes take longer to implement and longer to see results, and will ultimately have a larger impact. The smaller projects will impact the lives of individuals quickly.

The targets given here set a base, but do not limit the number of people that can move. As strategies outlined in the Olmstead Plan, and reforms by DHS are implemented, such as those to promote community living and employment options, shift provider business models, peer mentoring to share their stories of moving to homes of their own or working, manage waiver resources differently, and support experiential learning of options to inform choice, momentum will build, needed community capacity and infrastructure will expand, and increasingly more people every year will seek and obtain community living and employment options.

The ability to transition people to more integrated settings will be affected by the availability of resources to support this work. The DHS will assess progress annually and will adjust targets as necessary to incent movement to the most integrated community living and employment.

These are targets for the settings identified in this report, and do not reflect targets that have been set elsewhere for Anoka Metro Regional Treatment Center, the Minnesota Security Hospital in St. Peter, Intermediate Care Facilities for Developmental Disabilities and nursing facilities.

These are some of the strategies the state is pursuing to reduce the number of people in segregated settings.

Residential interventions

- Continuing moratoriums on development of new ICF-DDs and corporate adult foster care beds
- Reforms to the Group Residential Housing (GRH) and Minnesota Supplemental Assistance (MSA) programs
- Expansion of Housing Access Services
- Technology grants to assist people in developing ways to use technology to support them in the homes and to otherwise meet their needs and goals
- Local planning grants to counties to develop alternatives to corporate foster care
- Providing technical assistance to service providers
- Quality improvement processes
- Transition protocols
- New and modified services
- Changes in payment for services
- HCBS transition plan

Day services interventions

- Working with school districts (Minnesota Department of Education to lead effort)
- Continue to develop and promote the use of Disability Benefits 101 (DB101), a benefits and work planning tool
- Provide technical assistance to providers
- Family outreach

- Develop opportunities for youth work experiences
- New and modified services
- Changes in payment for services
- HCBS transition plan
- Developing standards and managing capacity for day services

Figure 14: Targets and timelines for "other segregated settings"

RESIDENTIAL SETTINGS TARGETS	DAY SETTINGS TARGETS
In SFY 2015 Without additional resources: 50	In SFY 2015 Without additional resources: 50
In SFY 2016 Without additional resources: 125	In SFY 2016 Without additional resources: 150
In SFY 2017 Without additional resources: 300	In SFY 2017 Without additional resources: 200
In SFY 2018 Without additional resources: 350	In SFY 2018 Without additional resources: 500
In SFY 2019 Without additional resources: 400	In SFY 2019 Without additional resources: 500

Appendix A: Analysis of State Plans from Massachusetts, Oregon and Rhode Island

KEY ELEMENTS LEADING TO COMPETITIVE, COMMUNITY SUPPORTED EMPLOYMENT and COMMUNITY-BASED DAY SUPPORT SERVICES:

A Summary of Rhode Island, Oregon and Massachusetts State Reform Initiatives

KEY ELEMENTS LEADING TO COMPETITIVE, COMMUNITY SUPPORTED EMPLOYMENT and DAY SUPPORT SERVICES REFORM	RI Settlement Agreement	OR Governors Executive Order *(Lawsuit Pending)*	MASS Blue Print For Success
Response to U.S.D.O.J. litigation of Title II-ADA, Olmstead.	Y (reactive)	Y (preemptive)	Y (proactive)
Response to CMS' HCBS Final Rule Regulation and Requirements.	Y (reactive)	N	Y (proactive)
Parties Involved in the Plan.	Human Services, VR & Education	ODHS-ODDS, ODE & ODVR	MADDS, MASS ARC MA Provider Org.
Develop and conduct a comprehensive, statewide educational outreach campaign directed at state and local government agencies, providers, schools, people with disabilities and their families.	Y	Y	Y
Close new referrals to congregate, segregated sheltered workshops and facility-based day service programs providers.	Y	Y	Y
Discontinue the purchase of congregate, segregated sheltered workshop services and facility-based day services.	Y	N	Y (within 5 years)
Require providers to convert from congregate, segregated sheltered workshop programs and facility-based day service providers to community-based, competitive employment service providers and day support service providers.	Y	N	Y
Provide comprehensive training, business consultation, strategic planning and technical assistance support to providers on redesigning services and restructuring organizations to convert from congregate, segregated sheltered workshop programs and facility-based day service providers into individualized, community-integrated employment service providers and individualized, community-integrated day support service providers.	Y	Y	Y
Adopt Employment First Policy, and align all provider service and support practices with Employment First Policy.	Y	Y	Y
Create a financial system or service rate structure that incentivizes integrated, community-based, competitive employment services, supports and outcomes.	Y	Y	Y
Develop transition or action plans for people to move from congregate, segregated sheltered workshops and facility-based day service programs to individualized, community-based, competitive employment services and supports or individualized, community-based day services and supports.	Y	Y	Y
Design and implement a community-based, competitive employment services and support plan that gradually phases out special/subminimum wage work and increases minimum wage or higher jobs for people.	Y (Variances are allowable)	N	Y
Construct a comprehensive, compendium of community-based services and supports that produce an individualized employment plan for assessing, exploring, acquiring and maintaining community-based, competitive employment.	Y	Y	Y
Construct a set of community-based services and supports that assist people in other supportive activities such as transportation training, learning independent living skills, teaching personally-effective social skills, recreation and leisure assistance.	Y	N	Y
Identify and implement services and supports for transition age school students and young adults that produce individualized employment plans for assessing, exploring, acquiring and maintaining community-based, competitive employment as well as other supportive activities that assist with life skills instruction.	Y	Y	N
Build a comprehensive employment database system to track community-based, competitive employment and progress on system reforms.	Y	Y	Y

Establish and finance oversight positions that monitor outcomes and quality.	Y	Y	Y
Fund system transformation by converting existing funding, which supports congregate, segregated sheltered workshops programs and facility-based day service, to support individualized, community-based employment service and individualized, community-integrated day support services.	Y	Y	Y
Fund system reform and transformation initiatives with increased state dollars to possibly receive matched by federal financial participation money.	Y	N	Y

RHODE ISLAND

RHODE ISLAND SETTLEMENT

(Rhode Island Consent Decree)

BACKGROUND

On January 14, 2013, the United States Department of Justice initiated an investigation into whether the State has violated Title II of the Americans with Disabilities Act and Olmstead v. L.C. through its administration and operation of its day activity services system, including employment, vocational, and sheltered workshop day services for individuals with intellectual and developmental disabilities.

FINDINGS

1.) Approximately 80 percent of the people with I/DD (about 2,700 individuals)receiving state services are placed in segregated, sheltered workshops or congregate, facility-based, day service programs.
2.) Only about 12 percent (approximately 385 people) participate in individualized, community-integrated employment.
3.) Only about five percent of students with disabilities transitioned into jobs in community-integrated settings.
4.) Placement in segregated settings is frequently permanent:

A.) nearly half (46.2 percent) of the individuals in sheltered workshops have been in that setting for ten years or more, and

B.) over one-third (34.2 percent) have been there for fifteen years or more.

5.) Individuals with I/DD in sheltered workshops reportedly earn an average of about $2.21 per hour.

AGREEMENTS and ACTIONS

1.) Permanently stop placements and funding into sheltered workshops and facility-based, day service programs.
2.) On a scheduled basis, conduct supported employment placements of about 2,000 individuals between January 2015 and January 2024, including:

A.) at least 700 people currently in sheltered workshops;

B.) at least 950 people currently in facility-based non-work programs; and

C.) approximately 300-350 students leaving high school.

3.) Adults transitioning to supported employment services (SES) will receive:

A.) Person-centered career planning process that includes asset-based vocational assessments such as discovery, situational assessments and time-limited, trial work exploration experiences;

B.) Supports Intensity Scale ("SIS") assessment;

C.) Benefits analysis and planning;

D.) Medicaid Buy-In program information and counseling; and an

E.) array of other vocational services and supports to ensure that they have meaningful opportunities to live and work in the community (***Appendix # 1, item # 1***).

4.) School youth in transition (ages 14 – 21 years old), approximately 1,250 students, will receive:

A.) Person-centered, individual learning plans;

B.) Person-centered, school-to-work transition career plans;

C.) Integrated vocational and situational assessments including discovery, vocational assessment, situational assessment and time-limited trial work exploration experiences; and an

D.) array of other transitional services and supports to ensure that they have meaningful opportunities to live and work in the community after they exit school (***Appendix # 1, item # 2***).

5.) SES placement in community integrated employment settings must:

A.) pay at least minimum wage;

B.) allow the person to work the maximum number of hours consistent with their abilities and preferences;

C.) allow the person interact with peers without disabilities to the fullest extent possible;
D.) average 20 hours of work per week in integrated employment settings;
E.) allow access to community-integrated work and non-work day services and supports for a total of 40 hours per week; and
F.) receive transportation and other direct (face-to-face) and indirect (not-face-to-face) employment services and supports.

6.) Supported employment placements cannot be in group job enclaves, mobile work crews and time-limited work experiences.
7.) No vocational or situational assessments shall be conducted in segregated, sheltered workshops and congregate day service program settings.
8.) Employer-sponsored training or provider-subsidized trial work exploration experiences can only occur for 4 – 8 weeks prior to job placement.
9.) Work compensated by any other entity than the employer of record will not qualify as a job placement.
10.) Community-integrated, (non-work) day services and supports shall not be services provided as part of a sheltered workshop, day services facility, group home, or residential program service provider.
11.) Develop an informational outreach campaign for schools and the general public that educates about the benefits of supported employment, and addresses families' concerns about supported employment.
12.) Create an employment first advocacy task force of local stakeholders, advocacy organizations, business networks, individuals with I/DD and family representatives for oversight and monitoring.
13.) Develop Interagency MOU Collaboration Agreements among human services, VR and education.
14.) Adopt an Employment First Policies and presumptions that all people with disabilities can competitively work at jobs in the community given proper services and support.
15.) Variances to SES placements can occur if the eligible person:

A.) makes a voluntary, informed choice for placement in a group work arrangement (e.g., enclaves, crews, etc.), segregated sheltered workshop facility, congregate day services program;
B.) receives one vocational or situational assessment;
C.) receives one trial work exploration experience, except when a documented medical condition poses an immediate and serious threat to their health or safety, or the health or safety of others;
D.) receives outreach educational information and counseling about SES;
E.) receives benefits planning;
F.) annual re-assessment for SES; and
G.) elects an integrated day supports-only placement in lieu of a SES placement.

FUNDING and FINANCING PROJECT INITIATIVES

1.) Establish a Sheltered Workshop Conversion Institute and Trust Fund ($800,000) to assist providers of sheltered workshop services to convert to SES.
2.) Pursue and fund a contract for training and technical assistance vendors to provide leadership, competency and value based training and TA to state staff, employment, sheltered workshop and day service providers.
3.) Reallocate financial resources now spent on segregated sheltered workshop and congregate day service programs to instead fund SE and/or community-integrated day services. Allow funding to follow the person without an increase in cost (maintaining budget neutrality).
4.) Develop and implement performance-based contracts for SES providers to meet goals and objectives.
5.) Provide ongoing funding sources to sufficiently support a competent and qualified system of providers with the capacity to deliver effective SES and Integrated Day Services.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

1.) Identify information and data elements to measure and collect for the U.S. DOJ and the court monitor:

A.) number of individuals in segregated sheltered workshop programs, congregate day services facilities, group job enclaves, mobile work crews and time-limited trial work exploration experiences

B.) number of completed career development plans

C.) number of individuals referred to and receiving SES

D.) number of transition youth exiting or graduating from school with career planning goals, and where they are transitioning to following their graduation or exit from school

E.) number and client capacity of supported employment providers

F.) number of qualified and trained SES professionals

G.) number of qualified and trained vocational counselors and assessment professionals

H.) number of hours worked per week, hourly wages paid, and job tenure in a community integrated employment setting

I.) number and reason(s) for lost jobs and/or terminations from employment along with plans for re-employment

J.) number and client capacity, hours per week, and tenure within community integrated day services providers, including the number of individuals participating in Integrated Day-Only Services

K.) number of variances granted

L.) number of outreach educational information campaign efforts performed

2.) Public reports to the U.S. DOJ and the selected court monitor on identified information and data elements also include:

A.) findings and results of regularly conducted on-site reviews of converting sheltered workshops and day service programs;

B.) identified program service provider deficiencies and required corrective action plans;

C.) employment service and support outcomes and recommendations; and

D.) compliance with the consent decree

Appendix # 1: Services and Supports

1. Vocational services and supports

job discovery and development, job-finding, job carving, job coaching, job training, job shadowing, co-worker and peer supports, reemployment supports, benefits planning and counseling, transportation services, environmental modifications and accessibility adaptations, behavioral supports, personal care services, case management services, assistive technology, social skills training, self-exploration, career exploration, career planning and management, job customization, time management training, self-employment opportunities and supports, adaptive behavior and daily living skills training.

2. Transitional services and supports

career instruction, employment preparation training, school-based preparatory job experiences, integrated work-based learning experiences, business site visits, job shadowing, work skill development, internships, part-time employment, summer employment, youth leadership, self-advocacy, peer and adult mentoring, living skills training, teaching community services, post-secondary school educational opportunities, transportation instruction, benefits planning, and assistive technology.

Appendix # 2: Supported Employment and Integrated Day Services Placements Schedule

Rhode Island Sheltered Workshop and Rhode Island Youth Exit Target Populations

a. By January 1, 2015, the State will provide Supported Employment Placements to at least 50 individuals in the Rhode Island Youth Exit Target Population who left during the 2013-2014 school year.

b. By July 1, 2015, the State will provide Supported Employment Placements to all remaining individuals in the Rhode Island Youth Exit Target Population who left, or will leave, school during the 2013-2014 and 2014-2015.

c. By January 1, 2016, the State will provide Supported Employment Placements to at least 50 individuals in the Rhode Island Sheltered Workshop Target Population.

d. By July 1, 2016, the State will provide Supported Employment Placements to all individuals in the Rhode Island Youth Exit Target Population who left school during the 2015-2016 school year.

e. By January 1, 2017, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.

f. By January 1, 2018, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.

g. By January 1, 2019, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.

h. By January 1, 2020, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

i. By January 1, 2021, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

j. By January 1, 2022, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

k. By January 1, 2023, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

l. By January 1, 2024, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

Rhode Island Day Target Population

a. By January 1, 2016, the State will provide Supported Employment Placements to at least 25 individuals in the Rhode Island Day Target Population.

b. By January 1, 2017, the State will provide Supported Employment Placements to at least an additional 25 individuals in the Rhode Island Day Target Population.

c. By January 1, 2018, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Day Target Population.

d. By January 1, 2019, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Day Target Population.

e. By January 1, 2020, the State will provide Supported Employment Placements to at least an additional 75 individuals in the Rhode Island Day Target Population.

f. By January 1, 2021, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Day Target Population.

g. By January 1, 2022, the State will provide Supported Employment Placements to at least an additional 200 individuals in the Rhode Island Day Target Population.

h. By January 1, 2023, the State will provide Supported Employment Placements to at least an additional 200 individuals in the Rhode Island Day Target Population.

i. By January 1, 2024, the State will provide Supported Employment Placements to at least an additional 225 individuals in the Rhode Island Day Target Population.

OREGON

OREGON EXECUTIVE ORDER
(Oregon Executive Order)

BACKGROUND

On January 25, 2012, the first class action lawsuit case in the nation that challenges sheltered workshops as a violation of the integration mandates in Title II of the Americans with Disabilities Act and Olmstead v. L.C was filed. The case, ***Lane v. Kitzhaber***, was filed on behalf of eight named plaintiffs who are:

1.) stuck in sheltered workshops;
2.) spending years, and often decades in these congregate, segregated settings;
3.) qualified and prefer to work at real jobs in the community; and
4.) often paid less than a $1.00/hour for their labor in the workshops.

The class action lawsuit case is brought on behalf of thousands of similarly situated and qualified persons with disabilities placed in Oregon's sheltered workshop system. The class action lawsuit case seeks an injunction to require the State of Oregon, and its' Department of Human Services, to end the segregation of persons with intellectual and development disabilities, and to assist them in obtaining integrated employment opportunities with supported employment services. The case is pending and proceeding to court, unless a settlement can be reached.

FINDINGS

1.) In October 2011, the United States Department of Justice concluded via a lengthy investigation that the State of Oregon has violated Title II of the Americans with Disabilities Act and Olmstead v. L.C. by funding, structuring, and administering its disability employment services system in a manner that segregates persons with intellectual and developmental disabilities in sheltered workshops.

2.) The U.S. DOJ determined that segregated workshops constitute an ADA violation and a Rehabilitation Act violation, and that the state's employment service system must be reformed in order to expand integrated employment opportunities.

3.) The DOJ claims that Oregon's disability employment service system perpetuates segregation of individuals with disabilities by unduly relying upon sheltered workshops rather than providing employment services in integrated settings, thus causing the unnecessary segregation of individuals who are capable of, and not opposed to, working at jobs in the community.

4.) 2,691 persons receive employment and vocational services. 1,642 – 61% – received at least some of those services in sheltered workshops. By contrast, only 422, or less than 16%, of these persons received services at any time in individual supported employment settings.

5.) The average hourly wage for sheltered workshop participants is currently $3.72. Over 52% of participants earn less than $3.00 per hour. By contrast, the overwhelming majority of persons with disabilities in individual supported employment earn Oregon's minimum wage of $8.80 or above.

6.) The DOJ recommended that Oregon implement certain remedial measures, including the development of sufficient supported employment services to enable those individuals who are unnecessarily segregated, or at risk of unnecessary segregation, in sheltered workshops to receive services in individualized, integrated employment settings in the community.

7.) The DOJ determined that voluntary compliance was not possible after months of negotiations to reach a settlement and avoid litigation.

OREGON GOVERNOR'S EXECUTIVE ORDER (July 1,2013) – AN UNSUCCESSFUL REMEDY

1.) The Oregon Department of Human Services (ODHS) and the Oregon Department of Education (ODE) shall work together to further improve Oregon's systems of designing and delivering employment services to those with intellectual and developmental disabilities.

2.) Oregon will make significant reductions in state support for sheltered work over time.
3.) Oregon will make increased investments in employment services and supports for people with disabilities.
4.) Employment services will be provided immediately to working age people with I/DD who receive sheltered workshop services. Employment services shall be individualized and evidence-based or recognized as effective practices.
5.) Employment services will be provided immediately to transition age young adults (@ 16 – 23). Employment services shall be individualized and evidence-based or recognized as effective practices.
6.) Individualized employment Services shall be based on an individual's capabilities, choices, and strengths.
7.) ODDS and OVRS will provide Employment Services to at least 2000 individuals in the ODDS/OVRS Target Population, in accordance with a schedule (please refer to Appendix 1).
8.) ODDS shall adopt and implement policies and procedures for developing individualized career development plans. The policies will include a presumption that all individuals in the ODDS/OVRS are capable of working in an integrated employment setting. The primary purpose of all vocational assessments shall be to determine an individual's interests, strengths, and abilities, in order to identify a suitable match between the person and an integrated employment setting.
9.) By January 1, 2014, ODDS and OVRS will establish competencies for the provision of Employment Services, and will adopt and implement competency-based training standards for career development plans, job creation, job development, job coaching, and coordination of those services.
10.) By July 1,2016, ODDS and OVRS will purchase Employment Services for people with I/DD only from agencies or individual providers that are licensed, certified, credentialed or otherwise qualified as required by Oregon Administrative Rule. Such requirements for the provision of Employment Services will be competency-based and may include national credentialing programs as the APSE Certified Employment Support Professional exam or a substantial equivalent.
11.) By January 1, 2014, ODDS and OVRS will develop an outreach informational education campaign for all people receiving services from ODDS/OVRS that explains the benefits of employment, addresses family and perceived obstacle concerns to participating in employment services.
12.) Through a developed MOU agreement, ODE will partner with OVRS and ODDS to establish and implement a Statewide Transition Technical Assistance Network to assist high schools in providing Transition Services.

FUNDING and FINANCING PROJECT INITIATIVES

1.) By July 1, 2014, Oregon will no longer purchase or fund vocational assessments for individuals with I/DD that occur in sheltered workshop settings.
2.) By July 1, 2015, Oregon will no longer purchase or fund ***NEW*** sheltered workshop placements.
3.) State agencies will make good faith efforts, within available budgetary resources, to ensure that there are a sufficient number of qualified employment providers to deliver the services and supports necessary for individuals in the ODDS/OVRS system to receive competent employment services.
4.) By January 1, 2014, DHS will financially support new or existing technical assistance provider(s) or use other available training resources to provide leadership, training and technical assistance to counties, employment service providers, support service providers, and vocational rehabilitation staff.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

1.) By July 1, 2014, DHS will develop and implement a quality improvement initiative that is designed to promote Employment Services and to evaluate the quality of Employment Services provided to persons with I/DD.
2.) Starting January 1, 2014, an appointed State Employment Coordinator (as of 10/2013) and a newly formed Policy Review Committee (as of 07/2013) will monitor progress semi-annually through data

collection, data analysis, quality improvement activities and make annual recommendations to the Governor and legislature for performance improvements.

3.) Starting January 1, 2014, and semi-annually thereafter, ODDS and OVRS shall collect data and report to the Employment Coordinator and the Policy Review Committee data for working age individuals that will include:

- **a.** The number of individuals receiving Employment Services;
- **b.** The number of persons working in the following settings: individual integrated employment, self-employment, sheltered employment, and group;
- **c.** The number of individuals working in an integrated employment setting;
- **d.** The number of hours worked per week and hourly wages paid to those persons;
- **e.** The choices made by individuals between integrated work, sheltered work, and not working;
- **f.** Problems or barriers to placement and retaining employment in community-integrated settings;
- **g.** Service gaps;
- **f.** Complaints and grievances.

Appendix # 1: Services and Supports

a. By July 1, 2014, ODDS and/or OVRS will provide Employment Services to at least 50 individuals.

b. By July 1, 2015, ODDS and/or OVRS will provide Employment Services to at least an additional 100 individuals.

c. By July 1, 2016, ODDS and/or OVRS will provide Employment Services to at least an additional 200 individuals.

d. By July 1, 2017, ODDS and/or OVRS will provide Employment Services to at least an additional 275 individuals.

e. By July 1, 2018, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

f. By July 1, 2019, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

g. By July 1, 2020, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

h. By July 1, 2021, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

i. By July 1, 2022, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

Massachusetts

MASS. - Blueprint for Success: Employing Individuals with Intellectual Disabilities in Massachusetts

BACKGROUND

In response to recent United States Department of Justice (DOJ) litigation regarding Title II of the Americans with Disabilities Act and Olmstead v. L.C. , and CMS' "HCBS Final Rule" requirements regulating size and settings of non-residential service settings; a group of Massachusetts (MA) disability service providers, advocates, and the Department of Developmental Services (DDS) examined day and employment support service programs for adults with intellectual disabilities (ID). As a result of their analysis, the Massachusetts Association of Developmental Disabilities (ADDP), the Arc of Massachusetts, and the Massachusetts Department of Developmental Services (DDS) entered into a proactive plan to increase community-integrated competitive employment opportunities for people with intellectual disabilities (ID). The plan emphasizes the importance and benefits of having a job and contributing to community businesses through work.

ACTION STEPS

1.) Inform providers that purchasing sheltered workshop services will discontinue within five years.
2.) Require providers to submit business plans on how they are going to increase community-integrated, competitive employment and phase out sheltered workshop services.
3.) Require providers to make concerted efforts to assist people to enter into community-based, supported employment (individual or group), and re-structure their programs into employment services.
4.) Define and align all provider service practices with Employment First Policy.
5.) Develop, establish and implement a new standardized services rate structure that incentivizes integrated, community-based, supported employment (individual or group) services and outcomes (please refer to Appendix 2).
6.) Close new referrals to sheltered workshop programs as of January 1, 2014 as a first step to phase out by June 30, 2015.
7.) During fiscal year 2015, individuals currently in sheltered workshop programs will gradually transition into individual supported employment, group supported employment, and/or community-based day services (CBDS) programs (please refer to Appendix 1). Facility-based, day training and habilitation will only be a service option when it has been determined the most appropriate service option for the person.
8.) Increase the number of people who participate in community integrated individual and group supported employment that pays minimum wage or higher in fiscal years 2016, 2017 and 2018. Gradually phase out group employment settings that pay less than minimum wage.
9.) Expand the scope of CBDS programs to include service options with a career exploration/planning component to serve as a pathway to employment through use of a variety of different volunteer, internships (e.g., Project Search), situational assessments/discovery opportunities, skills training or other community-based experiences. Continue to transition individuals from CBDS into community-integrated work opportunities that pay minimum wage or higher. The CBDS model will also be used to provide complementary supports for individuals who work part-time and need and want to be engaged in structured, program services for the remainder of the work week.
10.) Develop and implement a common framework for a planning and assessment process that allows informed choice as an integral part of the development of a person-centered career plan.
11.) Recruit and fund state advocacy organizations to develop and conduct a comprehensive, statewide educational outreach campaign directed at people with disabilities and their families that includes informational resources, regional forums, family-to-family connection groups and peer support groups.
12.) Create via appointment an Employment First review council to facilitate implementation and monitor ongoing progress of the transition plan.

TRAINING AND SYSTEM DEVELOPMENT

1.) Engage in business consultation, strategic planning and technical assistance to providers on redesigning services and restructuring organizations to convert from congregate and segregated, sheltered workshops into individualized, community-integrated employment services and support provider, including Community-Based Day Services (CBDS).

2.) Develop comprehensive training for employment specialists/job developers with curriculum and field work experiences that are aligned with credentialing //certification entities for employment specialist professionals.

3.) Design educational material and resources for benefits analysis, planning and work incentives.

4.) Produce training on (a) career exploration and discovery approaches; (b) customized job development; (c) systematic instruction techniques, (d) working with specific populations; (e) technology on the job, and (f) other relevant topic areas to be identified.

5.) Create communities of practice that provide in-service learning courses.

6.) Conduct Peer-to-Peer learning sessions for providers to work together on common issues.

7.) Build and fund a coalition of regional employment collaboratives across the state to maximize resources, share best practices, share lessons learned, conduct macro-level job development and provide opportunities for partnership among state agencies, employment service provider organizations and employers. Central Massachusetts Employment Collaborative uncovered over 248 employment opportunities and 136 individuals with disabilities were hired at minimum wage or higher by businesses in the community.

8.) Draft a comprehensive MOU agreement that cooperatively collaborates and coordinates inter-agency responsibilities, resources, services and funding to achieve a unified effort toward getting youth and adults competitively employed in the community.

9.) UMass-Boston ICI will establish a consultant pool consisting of individuals and/or qualified organizations as subject matter experts and technical advisors.

FUNDING and FISCAL STRATEGY (please refer to Appendix #2)

1.)* A total investment of $26.7 million over four fiscal years, from 2015 through 2018 is projected.

2.) Cost analyses are based on the number of people who are receiving facility-based, sheltered workshop services on a full-time basis or part-time basis as of July 1, 2013. The total number of individuals participating in sheltered workshop services is 2,608: 1,251 attend sheltered workshops full-time (typically 30 hours/week) and 1,357 attend part-time (52%).

3.) An investment of new funding is needed to provide resources and opportunities for people to move from sheltered workshop services (rate = $8.42/hour) to individual (rate = $47.96/hour) or group (rate = $13.80/hour) supported employment, and/or CBDS programs (rate = average $12.92/hour). These services have higher rates due to service design and staffing ratio requirements. The incremental infusion of new funding provides a "bridge" to new service options for individuals currently receiving sheltered workshop services.

Important Note: The net cost to the state would only be approximately $13 million dollars due to Medicaid HCBS waiver reimbursement via federal financial participation at almost 50%. for these services.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

With UMass – Boston ICI, continue to develop and implement an employment outcome data collection system that:

1.) effectively records and reports relevant information and data on new job placements and movement within the service system in order to track and document progress; and

2.) informs the planning processes and transformation initiatives.

Appendix # 1: Services Descriptions

Center-Based Work Services (activity code 3169)
Center-based work services ("sheltered workshops") are essentially work preparatory services that are delivered in segregated settings and that provide supports leading to the acquisition, improvement, and retention of skills and abilities that prepare an individual for work and community participation. Services are not predominantly job-task oriented, but are intended to address underlying generalized habilitative goals, such as increasing a participants attention span and completing assigned tasks, goals that are associated with the successful performance of compensated work. It is intended that the service should be time-limited to assist individuals to move into supported employment options. This service must be provided in compliance with Department of Labor (DOL) requirements for compensation.

Individual Supported Employment (activity code 3168)
An individual receives assistance from a provider to obtain a job based on identified needs and interests. Individuals may receive supports at a job in the community or in a self-employed business. Regular or periodic assistance, training and support are provided for the purpose of developing, maintaining and/or improving job skills, and fostering career advancement opportunities. Natural supports are developed by the provider to help increase inclusion and independence of the individual within the community setting. Employees should have regular contact with co-workers, customers, supervisors and individuals without disabilities and have the same opportunities as their non-disabled co-workers. Individuals are generally paid by the employer, but in some circumstances may be paid by the provider agency.

Group Supported Employment (activity code 3181)
A small group of individuals, (typically 2 to 8), working in the community under the supervision of a provider agency. Emphasis is on work in an integrated environment, with the opportunity for individuals to have contact with co-workers, customers, supervisors, and others without disabilities. Group Supported Employment may include small groups in industry (enclave); provider businesses/small business model; mobile work crews which allow for integration, and temporary services which may assist in securing an individual position within a business. Most often, the individuals are considered employees of the provider agency and are paid and receive benefits from that agency.

Community-Based Day Supports (activity code 3163)
This program of supports is designed to enable an individual to enrich his or her life and enjoy a full range of community activities by providing opportunities for developing, enhancing, and maintaining competency in personal, social and community activities. Services include, but are not limited to, the following service options: career exploration, including assessing interests through volunteer experiences or situational assessments; community integration experiences to support fuller participation in community life; skill development and training; development of activities of daily living and independent living skills; socialization experiences and support to enhance interpersonal skills; and pursuit of personal interests and hobbies. This service is intended for individuals of working-age who may be on a "pathway" to employment; as a supplemental service for individuals who are employed part-time and need a structured and supervised program of services during the day when they are not working, which may include opportunities for socialization and peer support; and individuals who are of retirement-age and who need and want to participate in a structured and supervised program of services in a group setting.

Appendix # 2: Funding and Fiscal Strategy

FY 2014: This is an important planning year to conduct assessments and develop plans with individuals in sheltered workshop programs to determine which alternative service option(s) will best meet their needs.

FY 2015: The largest investment is needed this year to facilitate transition to individual or group supported employment, and/or to CBDS programs for **all** participants in center-based/sheltered workshops. It is expected a majority of individuals will initially move to CBDS programs, which will provide opportunities to explore work-related possibilities. This will enable DDS to reach the goal of phasing out sheltered workshop services and removing the concern of sub-minimum wage payments related to sheltered work programs by June 30, 2015. (Proposed investment: $11.1 million; Net state cost: 5.55 million).

FY 2016: It is expected that a larger number of individuals will move to individual or group supported employment options this year from CBDS programs. In addition, funding will provide participation in CBDS for individuals who work part-time. (Proposed investment: $6.3 million; Net state cost: $3.15 million).

FY 2017: There will be continued movement of individuals from CBDS programs to individual and/or group supported employment services to provide integrated employment opportunities for all individuals who had previously been participating in sheltered workshop programs. (Proposed investment: $8.3 million; Net state cost: $4.15 million).

FY 2018: The final year of investment is used to solidify gains made in integrated employment services for individuals in CBDS and also facilitate movement of individuals to group supported employment earning above minimum wage. (Proposed investment: $1 million; Net state cost: $500,000).

Results

- Ends the purchasing of sheltered workshop services and successfully transition individuals into other employment or service options by the end of fiscal year 2015.
- Eliminates sub-minimum wage payments used by sheltered workshops.
- This funding investment would support individuals to:
  - (a) obtain community-integrated, competitive jobs through individualized supported employment services, and
  - (b) facilitate movement of individuals in group supported employment to earning minimum wages or higher.
- Develops an employment services provider network and system of supports that are more responsive in meeting the needs of people with ID.
- Establishes a system of inclusive employment and day service options that support people with disabilities in competitive, community employment and life pursuits.

Appendix B: Service and settings definitions

Residential Setting/Service	Description
Adult foster care	Licensed, living arrangement that provides food, lodging, supervision, and household services. They may also provide personal care and medication assistance. Adult foster care providers may be licensed to serve up to four adults or five adults if all foster care residents are age 55 or older, have no serious or persistent mental illness, nor any developmental disability. There are two types of adult foster care: Family Adult Foster Care is an adult foster care home licensed by the Minnesota Department of Human Services. It is the home of the license holder and the license holder is the primary caregiver. Non-Family Adult Foster Care (Corporate Adult Foster Care) is an adult foster care home licensed by the Minnesota Department of Human Services that does not meet the definition of Family Adult Foster Care because the license holder does not live in the home and is not the primary caregiver. Instead, trained and hired staff generally provide services. The same foster care license requirements apply to both family and non-family homes. BI, CAC and CADI waiver recipients may use waiver services of adult foster care when the scope of services assessed and identified in the service plan exceeds the scope of services provided through the foster care payment rate paid from the person's assessed resources and the Group Residential Housing rate.
Assisted living residence	Assisted Living residences generally combine housing, support services, and some kind of health care. Individuals who choose assisted living can customize the services they receive to meet their individual needs. To be considered an assisted living residence, the facility must provide or make available, at a minimum, specified health-related and supportive services. Examples include: assistance with self-administration of medication or administration of medication, supervised by a registered nurse; two meals daily; daily check system; weekly housekeeping and laundry services; assistance with three or more activities of daily living (dressing, grooming, bathing, eating, transferring, continence care, and toileting); and assistance in arranging transportation and accessing community and social resources. Every assisted living facility must have a license from the Minnesota Department of Health in order to operate
Board and lodge	Board and Lodge vary greatly in size, some resemble small homes and others are more like apartment buildings. They are licensed by the Minnesota Department of Health (or local health department). Board and lodges provide sleeping accommodations and meals to five or more adults for a period of one week or more. They offer private or shared rooms with a private or attached bathroom. Substance abuse - Board and Lodge can provide housing for up to six months for clients who need stable supportive housing, and strives to provide its residents with additional support services, including Peer Support Services, yet many of these additional services are not currently reimbursable. Often, the client will reside in a "Sober House" while at the same time receive outpatient services from another provider. Homeless shelters are a subset of board and lodge facilities.
Board and lodge with special services	Many Board and Lodge facilities offer a variety of supportive services (housekeeping or laundry) or home care services (assistance with bathing or medication administration) to residents
Boarding care	Boarding Care homes are licensed by the Minnesota Department of Health and are homes for persons needing minimal nursing care. They provide personal or custodial care and related services for five or more older adults or people with disabilities. They have private or shared rooms with a private or attached bathroom. There are common areas for dining and for other activities.
Child foster care	Children under the age of 18 - BI, CAC and CADI waiver recipients may use the waiver service of child foster care when the scope of services assessed and identified in the service plan exceeds both the scope of services provided in the Out of Home Placement Plan and the payment rate that the lead agency is required to cover.
Children's residential care (Children's residential facilities – Rule 5)	Children's residential facilities standards (Minnesota Rules, Chapter 2960) govern the licensing of providers of residential care and treatment or detention or foster care services for children in out-of-home placement. These standards contain the licensing requirements for residential facilities and foster care and program certification requirements for program services offered in the licensed facilities. Statutory language defines "certification" as meaning the commissioner's written authorization for a license holder licensed by the Commissioner of Human Services or the Commissioner of Corrections to serve children in a residential program and provide specialized services based on certification standards in Minnesota Rules. The term "certification" and its

	derivatives have the same meaning and may be substituted for the term "licensure" and its derivatives.
Crisis respite (foster care)	Short-term care and intervention strategies to an individual for both medical and behavioral needs that support the caregiver and/or protect the person or others living with that person. Crisis respite services may be provided: • In-home or • Out-of-home in a specialized licensed foster care facility developed for the
Housing with services establishment	Generally apartment building settings with individual units. Family adult day services must meet standards in Minn. Stat. §245A.143 or Minn. R. 9555, parts 5105 to 6265. If you hold a license as an adult foster care provider and meet the family adult day services standards, DHS does not require you to obtain a separate family adult day services license.
Supervised living facilities	Group home setting serving five or more people with disabilities. SLF provides supervision, lodging, meals, counseling, developmental habilitation or rehabilitation services under a Minnesota Department of Health license to five or more adults who have a developmental disability, chemical dependency, mental illness, or a physical disability.
Supported living services	Developmental disability waiver services provided in a foster care setting are called Supported Living Services (SLS) under Residential Habilitation. Residential Habilitation: Services provided to a person who cannot live in his or her home without such services or who need outside support to remain in his or her home. Habilitation services are provided in the person's residence and in the community, and should be directed toward increasing and maintaining the person's physical, intellectual, emotional and social functioning.
Employment/Day Service/Setting	
Adult day services/Adult day care	Adult day services /Adult day care: Services provided to persons who are 18 years of age or older that are designed to meet the health and social needs of the person. The plan identifies the needs of the person and is directed toward the achievement of specific outcomes.
Family adult day services	A family adult day service program is a program that operates fewer than 24 hours per day and provides functionally impaired adults, none of which is under age 55, have serious or persistent mental illness or people with developmental disabilities or a related condition, with an individualized and coordinated set of services including health services, social services and nutritional services that are directed at maintaining or improving the participants' capabilities for self-care. A family adult day services license is only issued when the services are provided in the license holder's primary residence, and the license holder is the primary provider of care. The license holder may not serve more than eight adults at one time, including residents, if any, served under an adult foster care license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.
Structured day program	Service designed for persons who may benefit from continued rehabilitation and community integration directed at the development and maintenance of community living skills. (Only available through the Brain Injury waiver.)
Day training & habilitation	Licensed supports to provide persons with help to develop and maintain life skills, participate in community life and engage in proactive and satisfying activities of their own choosing.
Pre-vocational service	Services designed to prepare persons for paid or unpaid employment, as reflected in the plan of care.
Supported employment services	Services for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, needs intensive ongoing support to perform in a work setting. The person receiving services must be in a paid employment situation.

Minnesota Department of Education

A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools

Fiscal Year 2015

Report

To the

Legislature

As required by

Minnesota Statutes,

section 125A.0942

COMMISSIONER:

Brenda Cassellius, Ed. D.

February 1, 2015

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2015

Report to the Legislature

As required by Minnesota Statutes section 125A.0942

A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools

Cost of Report Preparation

The total cost for the Minnesota Department of Education (MDE) to prepare this report was approximately $20,000. Most of these costs involved staff time in compiling and analyzing data, staffing the stakeholder group, and preparing the written report. Incidental costs include paper, copying, and other office supplies.

Estimated costs are provided in accordance with Minnesota Statute, section 3.197, which requires that at the beginning of a report to the Legislature, the cost of preparing the report must be provided.

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INTRODUCTION

The Minnesota Legislature tasked MDE with developing a statewide plan "with specific and measurable implementation and outcome goals for reducing the use of restrictive procedures."[1] MDE has submitted reports to the Legislature in 2012, 2013, and 2014, providing summary data of prone restraint and restrictive procedures along with its progress and recommendations for reducing the use of restrictive procedures and eliminating the use of prone restraints.

We commend the reporting school districts for their commitment and candor in their submission of the required data to MDE. For the 2013-14 school year, MDE received responses from all public school districts and charter schools. For the 2012-13 school year, MDE received responses from all but one traditional school district and five charter schools. Data collected for the 2012 and 2013 legislative reports was submitted in varying forms by districts until statutory changes required that districts/charter schools use a form developed by MDE. Thus, data collected and reported after July 1, 2012, represents a consistent reporting format.

2012-2013 Stakeholder Work Group

MDE convened a restrictive procedures work group (2012 stakeholder group) during the 2012-13 school year, as charged by the Minnesota Legislature. The 2012 stakeholder group included representatives from the following legislatively mandated participants: school districts, school boards, special education directors, intermediate school districts, and advocacy organizations. The 2012 stakeholder group met on five occasions between September 2012 and January 2013 to review restrictive procedures data and discuss areas of agreement about how to reduce the use of restrictive procedures.

The statewide plan generated by the 2012 stakeholder group is set forth in the 2013 legislative report available on MDE's website.[2] The 2012 stakeholder group recommended 10 activities in the statewide plan and also recommended legislative changes to the restrictive procedure statutes. During the 2013 legislative session, most of the recommended changes, including extending the date for use of prone restraints to August 1, 2015, were passed by the Legislature. However, the Legislature did not authorize the requested appropriation funds targeted for use with students with disabilities experiencing the highest frequency of restrictive procedures, specifically prone restraints. "Prone restraint" means placing a child in a face down position.[3] As described more fully below, the 2014 Legislature authorized $250,000 in state funds targeted for use with those students.

Summary of Progress toward Implementing the 2012 Statewide Plan

During the 2013 legislative session, safe school levy funds were increased effective fiscal year 2015, and language was added to the levy fund statute to allow its use for co-locating and collaborating with mental health professionals who are not staff or contracted as staff. In

[1] Minn. Stat. § 125A.0942, subd. 3(b).

[2] See 2013 "The Use of Prone Restraint in Minnesota Schools," *available at* http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html

[3] Minn. Stat. § 125A.0941(e).

addition, the 2013 Omnibus Health and Human Services bill expanded the school-linked mental health grants program by $4.5 million for the 2014 and 2015 biennium.

During the 2013-14 school year, MDE provided training throughout the state on the changes to the restrictive procedures statutes and updated the sample forms on the MDE website. MDE also continued to work across the agency to develop a process for and to provide targeted technical assistance. In addition, MDE conducted a survey of school districts and met with the Department of Human Services (DHS) to assist in the development of an expert list. The list was posted on MDE's website in July 2014. Further, MDE continued to coordinate the school-wide positive behavior interventions and supports (PBIS) trainings across the state.

2013-2014 Stakeholder Work Group

MDE reconvened the restrictive procedure work group (2013 stakeholder group) during the 2013-14 school year, as charged by the Legislature. This group was tasked with developing a statewide plan with "specific and measurable implementation and outcome goals for reducing the use of restrictive procedures..."[4] The 2013 stakeholder group included representation from the following legislatively mandated participants: advocacy organizations, special education directors, teachers, intermediate school districts, school boards, day treatment providers, county social services, state human services department staff, mental health professionals, and autism experts.[5]

The 2013 stakeholder group met on four occasions between November 2013 and February 2014 to review the restrictive procedures data and discuss areas of agreement about how to reduce the use of restrictive procedures. The statewide plan that was generated by the 2013 stakeholder group contained eight goals and proposed amendments to Minnesota Statutes section 125A.0942.[6] As set forth in the 2013 statewide plan, the 2013 stakeholder group believed there was a need to continue to meet on a quarterly basis to review prone restraint data, review the annual data for restrictive procedures, review progress in implementing the goals, and discuss any needed changes.

Summary of Progress toward Implementing the 2013 Statewide Plan

During the 2014 legislative session, the Legislature passed the recommended changes, including the requested $250,000 in appropriation funds targeted for use with students with disabilities experiencing the highest frequency of restrictive procedures, specifically prone restraints.

During the summer of 2014, MDE began the process of developing a grant application targeted to seven districts who were using prone restraints and had students with disabilities experiencing the highest frequency of restrictive procedures; specifically prone restraint. Six districts submitted grant applications, and after a review and revision process, six grants totaling

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[4] Minn. Stat. § 125A.0942, subd. 3(b) (2013).

[5] *Id.*

[6] See Appendix A. of the 2014 legislative Report. available at http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html. (last visited Jan. 26, 2015).

$150,000 were approved. Each district is to complete their work under the grant by June 30, 2015. The six districts developed work plans to focus on one or more of the following areas to reduce the use of all restrictive procedures and eliminate the use of prone restraint:

- Consistent training to develop common language and standards for reporting restrictive procedures and clarify expectations;
- Keeping law enforcement calls for service stable as restrictive procedures are reduced and prone restraint is eliminated;
- Building staff capacity in the area of proactive behavior interventions to provide resources and targeted interventions to students with disabilities who have significant behavior challenges and mental health needs who are experiencing a high usage of restrictive procedures and a high usage of prone restraint;
- Increasing capacity related to data collection, understanding student behavior, using preventative and de-escalation strategies more consistently, and implementing interventions with fidelity, and
- Providing crisis services in the school setting to reduce the need for 911 calls and subsequent student hospitalization.

In addition, MDE developed a request for proposal (RFP) for three online training modules to address the three subsets of students with disabilities who experience the highest rate of prone restraint, as set forth in Goal No. 2(c) in the 2013 statewide plan. The RFP application deadline was January 15, 2015, and the MDE review should be completed by January 30, 2015. If MDE approves a RFP application, the three online training modules are to be completed by June 30, 2015.

In July 2014, MDE completed and posted the restrictive procedure expert list, after obtaining input from DHS and special education directors. This was a goal in the 2012 statewide plan and is also a goal in the Revised Olmstead Plan[7]. The list will continue to be edited as additional experts are identified and requests submitted to MDE for inclusion. In accordance with Goal No. 4 of the 2013 statewide plan, MDE collaborated with school districts, advocacy groups, and DHS and facilitated two panel discussions on the reduction of restrictive procedures to provide targeted assistance to districts continuing to use prone restraint. The first panel was held at MDE and the second panel discussion was held at DHS and district staff participated both in person and through a live video stream.

MDE has continued to coordinate the school-wide PBIS trainings across the state and is on track to add a minimum of 40 additional schools by June 30, 2014, and each subsequent year thereafter. At this time, 24 percent of all public schools in Minnesota have completed the positive behavior interventions and supports (PBIS) training. This is in accordance with Goal 6 of the 2013 Work Plan and a similar goal in the Revised Olmstead Plan.

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[7] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_documents. (last visited Jan. 26, 2015).

In addition, MDE updated and posted the "Use of Restrictive Procedures District Summary Form" in accordance with Goal 1(a) and the 2014 legislative amendment to Minnesota Statute section 125A.0942 subdivision 6. Additional Forms were updated and posted and MDE added links to DHS resources on its website. More detail is provided in Appendix A.

2014-2015 Stakeholder Work Group

MDE reconvened the restrictive procedure work group (2014 stakeholder group) during the 2014-15 school year as charged by the Legislature. This group continued to be tasked with developing a statewide plan with "specific and measurable implementation and outcome goals for reducing the use of restrictive procedures..."[8] The 2014 stakeholder group included representation from the following legislatively mandated participants: advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, state human services department staff, mental health professionals, and autism experts.[9] The 2014 stakeholder group met in September 2014 to review the data from the annual summary report for the 2013-14 school year and the prone restraint data for the quarter ending June 30, 2014. The 2014 stakeholder group continues to meet quarterly with meetings scheduled through July 2015 to review the prone restraint data. The statewide plan generated by the 2014 stakeholder group contains nine goals and proposed amendments to Minnesota Statutes, section 125A.0942. The current statewide plan reflects the consensus among the 2014 stakeholder group.

Summary of the Decreased Use of Restrictive Procedures in Minnesota Schools

In reviewing the data school districts submitted to MDE over the last three reporting periods, there has been a decrease in: the number of districts using restrictive procedures (including prone restraint), the number of students with disabilities experiencing the use of restrictive procedures, and the number of total restrictive procedure incidents.

A comparison of the last two reporting periods[10] demonstrates a reduction in the use of restrictive procedures during the 2013-14 school year, and a reduction in the use of prone restraint during the 2014 calendar year as follows:

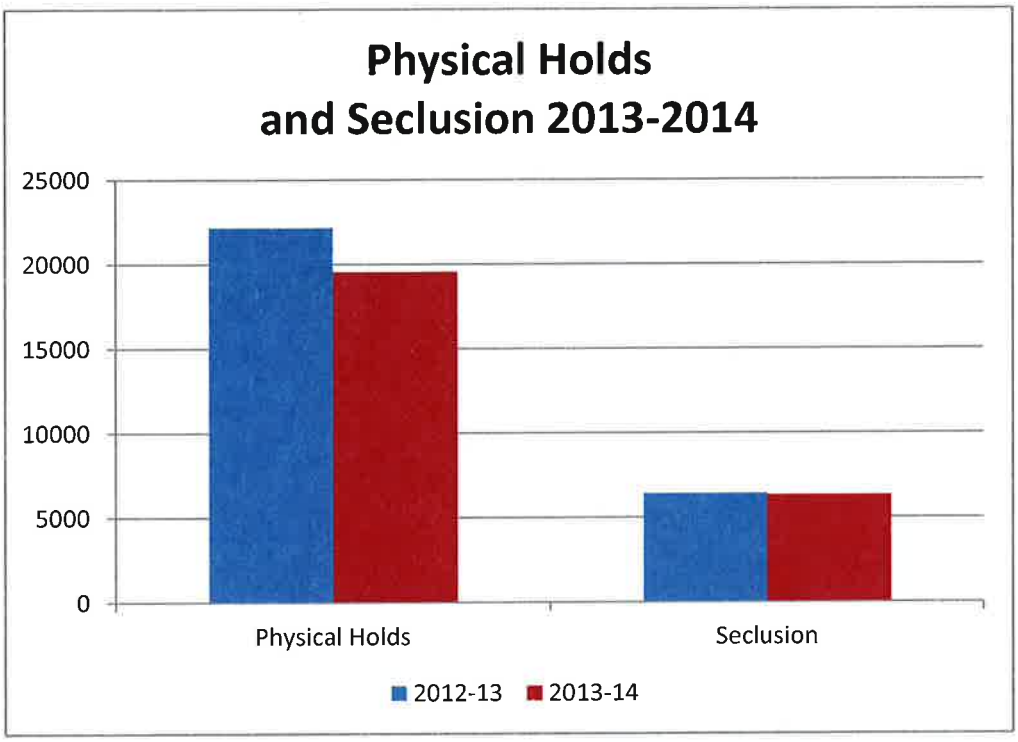
- 34 percent fewer incidents of prone restraint reported
- 12 percent fewer students with disabilities who experienced the use of prone restraint
- 19 percent fewer districts report the use of prone restraint
- 18 percent fewer Black students with disabilities experienced the use of prone restraint
- 9 percent fewer White students with disabilities experienced the use of prone restraint

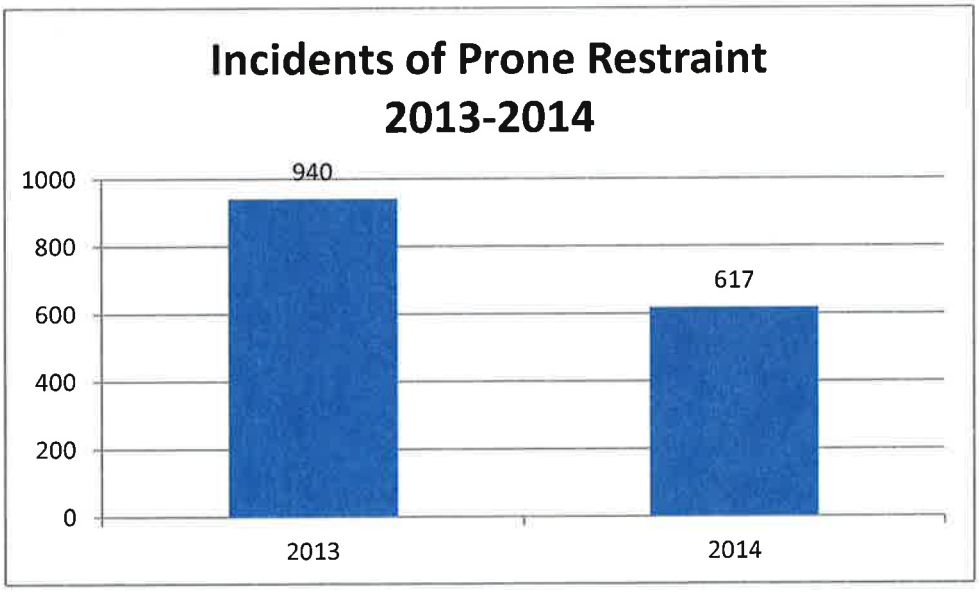
[8] Minn. Stat. § 125A.0942, subd. 3(b) (2014).

[9] *Id.*

[10] The reporting periods for restrictive procedures are 2012-13 and 2013-14. The reporting periods for prone restraint are the 2013 and 2014 calendar years.

- 16 percent fewer incidents of physical holding reported
- 2 percent fewer incidents of seclusion reported





HISTORY OF RESTRAINT IN MINNESOTA

There is an ongoing debate in Minnesota about the legality, morality, and efficacy of using seclusion[11] or restraint on individuals with disabilities. Some are concerned that these procedures are subject to misapplication and abuse, placing students at equal or greater risk than their problem behavior(s) pose to themselves or others.[12]

On February 1, 2012, MDE submitted a report to the Minnesota Legislature detailing the results of data on the use of prone restraint from August 1, 2011, through January 13, 2012.[13] MDE made important disclaimers about the quality of the data presented, which included the short reporting window, the lack of information about the use of other non/prone physical holding and seclusion, and inconsistency in reporting forms, with recommendations for improvements both in data reporting and in clarification regarding the use of restrictive procedures.

During the 2012 legislative session, Minnesota Statutes, sections 125A.0941 and 125A.0942, were amended to include a definition of prone restraint[14] and a revised definition of physical holding.[15] The statute limited the use of prone restraint to "children age five or older," but allowed its use until August 1, 2013,[16] and required districts to report the use of prone restraint on an MDE form.[17] Additionally, the Minnesota Legislature tasked MDE with developing a statewide plan "to reduce districts' use of restrictive procedures."[18] As noted above, MDE continued to collect data on prone restraint, gathered restrictive procedure summary data from districts for the 2011-12 school year, and assembled a group of stakeholders to assist MDE with developing a statewide plan.[19]

In February 2013, MDE submitted a report to the Minnesota Legislature that detailed the results of data collected on the use of prone restraint from January 14, 2012 through December 31, 2012. The report provided summary data on the use of all reported restrictive procedures in Minnesota during the 2011-12 school year and also provided MDE's progress and recommendations for reducing the use of restrictive procedures and eliminating the use of prone restraints.

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[11] Minnesota's restrictive procedures statute defines "seclusion" as "confining a child alone in a room from which egress is barred. Egress may be barred by an adult locking or closing the door in the room or preventing the child from leaving the room. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion." Minn. Stat. § 125A.0941(g) (2014).

[12] U.S. Senate, Health, Education, Labor, and Pensions Committee, *Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficulty to Remedy: A Review of Ten Cases* (Majority Staff Report, issued February 12, 2014), Majority Committee Staff Report. Retrieved from http://www.help.senate.gov/imo/media/doc/Seclusion%20and%20Restraints%20Final%20Report.pdf (last visited Jan. 26, 2015).

[13] For information related to the history of restraint in the educational setting prior to 2012, see 2012 and 2013 Legislative Reports, "The Use of Prone Restraint in Minnesota Schools," *available at* http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html.

[14] Minn. Stat. § 125A.0941(e) (2012).

[15] Minn. Stat. § 125A.0941(c) (2012).

[16] Minn. Stat. § 125A.0942, subd. 3(7) (2012).

[17] Minn. Stat. § 125A.0942, subd. 3(a)(7)(iv). (2012)

[18] Minn. Stat. § 125A.0942, subd. 3(b) (2012).

[19] *Id.*

During the 2013 legislative session, Minnesota Statutes, sections 125A.0941 and 125A.0942 were amended to provide more content specificity for the oversight committee for a district's restrictive procedure plan, clarified requirements for when an individual education plan (IEP) team meeting must be held following the use of a restrictive procedure, clarified that restrictive procedures can only be used in an emergency and not for disciplinary reasons, extended the time period for use of prone restraint until August 1, 2015, tasked MDE with developing a statewide plan to reduce the use of restrictive procedures, included paraprofessionals under the training section, added to the training requirements to ensure school staff are aware of school side positive behavior strategies used by the school and procedures related to timely reporting of the use of restrictive procedures, and required MDE to develop and maintain a list of experts to help IEP teams reduce the use of restrictive procedures.

In February 2014, MDE submitted a report to the Minnesota Legislature that detailed the results of data collected on the use of prone restraint from January 1, 2013 through December 31, 2013. The report provided summary data on the use of all reported restrictive procedures in Minnesota during the 2012-13 school year and also provided MDE's progress and recommendations for reducing the use of restrictive procedures and eliminating the use of prone restraints.

Regulation of Restraint in DHS Facilities

In 2011, DHS entered into a settlement agreement enforced by the federal court in Minnesota, regarding the inappropriate use of aversive and deprivation procedures, including the improper use of seclusion and restraint techniques. As part of the 2011 "METO Settlement,"[20] DHS is currently undertaking a rulemaking process to amend Minnesota Rules, Parts 9525.2700 to 9525.2810 (commonly referred to as "Rule 40"), to reflect best practices regarding the use of aversive and deprivation procedures in facilities that serve persons with developmental disabilities, including through the use of positive behavioral approaches and the elimination of particular restraint practices. On December 24, 2014, DHS published proposed rules.[21] A public hearing on the proposed rules is scheduled for February 23, 2015.

The Rule 40 Advisory Committee issued its final version of "Recommendations on Best Practices and Modernization of Rule 40" on July 2, 2013. To support the recommendations, DHS is holding Positive Supports Community of Practice meetings online on various training topics.[22]

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[20] METO Settlement, Case 0:09/cv/01775/DWF/FLN, Doc. 104/1, Attachment A, p. 5 (2011). Retrieved from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=137925. (last visited Jan. 26, 2015).

[21] Proposed Rules Governing Positive Support Strategies, Person-Centered Planning, Limits on Use of Restrictive Interventions and Emergency Use of Manual Restraint, and Repeal of Rules Governing Aversive and Deprivation Procedures in *Minnesota Rules*, 9525.2700 to 9525.2810; Revisor's ID No. R-04213.

[22] Minnesota Department of Human Services Positive Supports Community of Practice website, available at: http://mn.gov/dhs/partners-and-providers/continuing-care/provider-information/positive-supports/positive-support-cop.jsp (last visited Jan. 26, 2015).

As part of the 2011 Jensen stipulated class action settlement, the State of Minnesota agreed to develop an Olmstead Plan to move the state forward toward greater integration and inclusion for people with disabilities. The initial Olmstead Plan was submitted to Federal District Court (Court) on November 1, 2013. The State of Minnesota submitted Proposed Plan modifications to the Court, most recently on November 10, 2014 (Revised Olmstead Plan). On January 9, 2015, Justice Donovan Frank provisionally approved the State of Minnesota's Revised Olmstead Plan, subject to the Court's review of the State's modifications in accordance with the Order, which must be submitted by the State of Minnesota on March 20, 2015. As part of the Revised Olmstead Plan, MDE is responsible for two activities related to the elimination of the use of prone restraint in the public school setting by August 1, 2015, and reducing the use of restrictive procedures in the public school setting over the time period of June 30, 2015 to June 30, 2019.[23]

REGULATORY DEVELOPMENTS

Recent Minnesota Developments

During the 2014 legislative session, Minnesota Statutes, sections 125A.0941 through 125A.0942 were amended to:

- Provide more content specificity for a district restrictive procedure plan, by including a description of how the school will provide training on de-escalation techniques, consistent with Minnesota Statutes, section 122A.09, subdivision 4, paragraph (k);[24]
- Amend the date the legislative report is due and to make the workgroup ongoing; and
- Require districts to report the use of reasonable force, as defined in section 121A.582, which results in a physical hold as defined in section 125A.0941.25.

Federal Developments

The Keeping All Students Safe Act (H. 1893), legislation aimed at regulating restraint and seclusion on the federal level, was introduced in the United States House of Representatives by Representative George Miller on May 8, 2013, and the bill was referred to the Subcommittee on Early Childhood, Elementary, and Secondary Education.[26]

At a news conference on February 12, 2014, Senator Tom Harkin, Chairman of the Senate Health, Education, Labor, and Pensions (HELP) Committee, released the findings of an investigation into the use of seclusion and restraints. The majority staff report is titled, "Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficult to Remedy: A Review of Ten Cases." The report highlighted cases in which restraint was used as

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[23] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_home. (last visited Jan. 26, 2015).

[24] 2014 Minn. Laws ch. 1X, art. 17, sec. 1.

[25] *Id.*

[26] U.S. Library of Congress website http://beta.congress.gov/bill/113th-congress/house-bill/1893. (last visited Jan. 26, 2015).

a form of punishment or control.[27] At the event, Harkin announced the Keeping All Students Safe Act, a bill to ensure the effective implementation of positive behavioral interventions in the education setting. On February 24, 2014, the bill was introduced in the Senate, read twice, and referred to the Committee on HELP.

Currently, 40 states and the District of Columbia have legislation and/or education agency regulations or policies that prohibit the use of prone restraints or restraints that impede a child's ability to breathe within the school setting. Fifteen states specifically prohibit the use of "prone" restraint in educational settings by state statute, rule, or policy.[28]

Thirteen states specifically prohibit the use of prone restraint in educational settings by state statute, rule, or policy. In addition, 29 states have legislation and/or education agency regulations or policies that encompass all students, rather than only students with a disability. This is in accordance with Principle Four in the U.S. Department of Education, Office of Special Education and Rehabilitation Services (USDE OSERS) guidance document issued May 15, 2012, *Restraint and Seclusion: Resource Document*.[29]

Only four states (Vermont, Massachusetts, Rhode Island, and Minnesota) prohibit the use of restraints that impede a child's ability to breathe and specifically allow the use of prone restraint in limited circumstances. Appendix B contains a citation to and a description of the provisions in place for each state addressing restrictive procedures.

MINNESOTA'S PRONE RESTRAINT DATA

Important Disclaimers Regarding the Data

Reporting Window. School districts have been statutorily required to report to MDE regarding their use of prone restraint since August 1, 2011. As described in the 2012 report, the initial data only covered prone restraint reports received over a five-month period (August 1, 2011 through January 13, 2012). The 2013 report included data from prone restraint reports received January 13, 2012, through December 31, 2012. For the 2014 and 2015 reports, the included data on the use of prone restraint is over a 12 month calendar period (January 1 through December 31), with relevant comparisons to previous years' data. Beginning in September 2012, Districts have been required to use the MDE form for reporting prone restraint and the data has been more consistent since that occurred.

Not the Whole Picture. We acknowledged in prior reports that the use of prone restraint is best evaluated within the context of the statewide use of all other types of restrictive procedures by

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[27] U. S. Senate, Health, Education, Labor, and Pensions Committee, *Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficult to Remedy: A Review of Ten Cases*, Majority Committee Staff Report (Feb. 12, 2014), Retrieved at http://www.help.senate.gov/imo/media/doc/Seclusion%20and%20Restraints%20Final%20Report.pdf. (Last visited Jan. 26, 2015).

[28] Arkansas, District of Columbia, Georgia, Indiana, Iowa, Kansas, Kentucky, Michigan, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, West Virginia, Wyoming.

[29] U.S. Department of Education, Office of Special Education and Rehabilitation Services guidance document, *Restraint and Seclusion: Resource Document* (Issued May 15, 2012), Retrieved *at* https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf. (Last visited Jan. 26, 2015).

Minnesota school districts. Districts are required to maintain data on their use of restrictive procedures, including physical holding or seclusion,[30] and are required to report a summary of this data annually to MDE by June 30 of each year.[31] As summary data, the restrictive procedures data has some limitations not present with the prone restraint data. The summary data necessarily lacks information about the range of numbers of physical holds and uses of seclusion per individual student. The data also lacks information about the length of time students were physically held and secluded and the types of restraints being used.

Limitations in the Restrictive Procedures Data

We received close to or a 100 percent response rate from all public school districts, including charter schools, for the last two school years (2012-13 and 2013-14). It is important to note that the number of restrictive procedure incidents that districts reported in the annual summary may not be aligned with MDE's definition of an "incident" of restrictive procedure, as discussed below. Therefore, incident level comparisons between restrictive procedures incidents and prone restraint report incidents are not likely to be valid. However, as a result of the summary data, we are able to provide policy makers with data to substantiate the percentage of students in the state that have been reported as restricted compared to the data specific to prone restraint.

Outliers. For the 2014 calendar year, one student accounted for 11 percent, or 53 of the 489 reports of prone restraint. Cumulatively, five students account for 24 percent, or 116 of the 489 reports, and 10 students accounted for 35 percent, or 173 of the 489 reports. The remaining 148 students accounted for 65 percent of the reports. These figures are similar to outliers for data collected in prior years.[32]

Of those students who experienced the highest use of prone restraint during the 2014 calendar year, they were found eligible for special education services by meeting state criteria for Autism Spectrum Disorders (five), Emotional or Behavioral Disorders (two), Other Health Disabilities (two) and Developmental Cognitive Disability (one).

Including these unique situations in the overall data counts skews the appearance of the demographic data by incidents. However, this data is important for understanding the issues and potential solutions. The data illustrates that a relatively small number of students underlie the total number of reports and incidents. Though the specific students who make up this group change over time, intensive services targeted to these students are likely to have the greatest impact on diminishing the use of restrictive procedures.

Prone Restraint Data

Districts submitted written prone restraint reports to MDE through a secure website. Individual reports necessarily included personally identifying information related to specific students, and as such constitute non-releasable data under the Minnesota Government Data Practices Act.[33]

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[30] Minn. Stat. § 125A.0942, subd. 3(a).

[31] Minn. Stat. § 125A.0942, subd. 3(b).

[32] See prior Legislative Reports, *available at* http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html.

[33] Minn. Stat. § 13.02, subds. 5, 8a (2014).

MDE prepared and posted a summary of reported data by quarter on its Restrictive Procedures webpage.

Districts that Reported Use of Prone Restraint

District	2014 Reports	2013 Reports
Albert Lea (840)	1	0
Bemidji (31)	0	2
Benton-Stearns Ed. Dist. (6383)	57	72
Brainerd (181)	6	1
Buffalo-Hanover-Montrose (877)	0	2
Cambridge-Isanti (911)	1	0
Goodhue County Ed. Dist. (6051)	2	0
Hendricks (402)	0	2
Intermediate District 287	55	83
Intermediate District 917	137	218
Mankato (77)	23	36
Marshall (413)	0	12
Moorhead (152)	11	15
New London Spicer (345)	1	0
Northeast Metro 916	119	74
Pine City (578)	0	9
Southwest West Central (991)	74	85
Waterville-Elysian-Morristown (2143)	0	1
West Central Area (2342)	0	1
Willmar (347)	2	35
Total Prone Restraint Reports	**489**	**647**

Incidence of Prone Restraint by District

For the purposes of reporting, we consider prone restraint to begin when the child is placed in a prone position by one or more trained staff persons holding onto the child; it ends when the child is no longer being held. That cycle—a hold followed by the release of the hold—is one incident of prone restraint.

In more complex situations related to the same precipitating incident, this hold/release pattern was repeated a number of times before the child was returned to the classroom or other activity. Given that the statutory definition of a "physical hold" is based on the presence or absence of "body contact" or "physical contact," we determined that this situation involved several incidents

of prone restraint, all of which were included on one written report. This explains the difference between the number of "incidents" that occurred (617) and the number of "reports" MDE received (489).

MDE received reports of 617 prone restraint incidents that occurred during the 2014 calendar year, a substantial decrease from the 940 prone restraint incidents reported for calendar year 2013. During the 2014 calendar year:

- 13 districts reported the use of prone restraint, a decrease of 19 percent from 16 during calendar year 2013.[34]
- 158 students were restrained in a prone position by a staff member, a decrease of 12 percent from 180 students during calendar year 2013.

The majority of both prone restraint incidents and reports involved students at one of Minnesota's three intermediate school districts. This is not surprising given that the intermediate districts provide, among other important services, a program of integrated services for special education students.[35] As a rule, the intermediate districts provide services to students with disabilities who have not experienced success at their original district, and a significant percentage of these students exhibit atypical behavioral challenges in a school setting. Two of the three intermediate districts continued to show a decrease in both the number of reports and incidents of prone restraint from the previous legislative report. One intermediate district showed a year-over-year increase, though it was still down substantially from the 2012 report. At the stakeholder meetings, the intermediate districts shared the efforts made to implement data-driven positive behavior strategies and to review the restrictive procedures data on an ongoing basis, as well as staffing and environmental changes.

With the exception of the intermediate district described above and one independent school district, all other districts with reported use of prone restraint in calendar year 2013 showed a year-over-year decrease, some to zero for calendar 2014. In addition, four districts reported use of prone restraint in calendar year 2014, though no use was reported in the prior year. The use of prone restraint in greater Minnesota continues to be mostly reported by special education programs at cooperatives or education districts and districts that are regional centers. In greater Minnesota, these programs and districts function similarly to the intermediate school districts in the Twin Cities metropolitan area, in part, by serving students with the most challenging behaviors.

The following two charts represent the distribution of both prone restraint incidents and reports for the last two annual reporting periods. Statewide, the number of reports submitted, incidents reported, and students involved, and the number of districts using prone restraint during the 2014 calendar year have all decreased compared to the 2013 data, though, on a district level, two districts reported increases.

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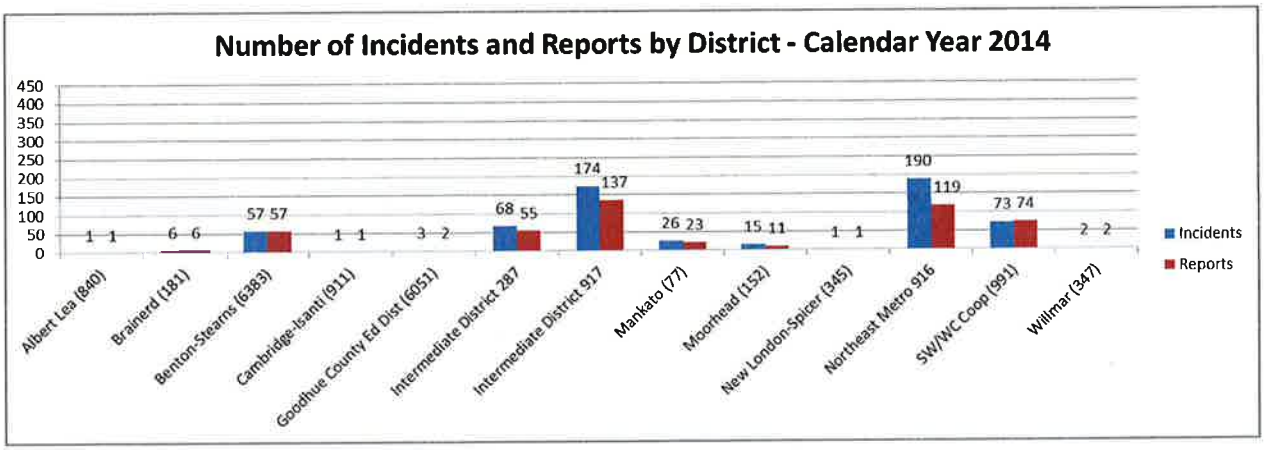
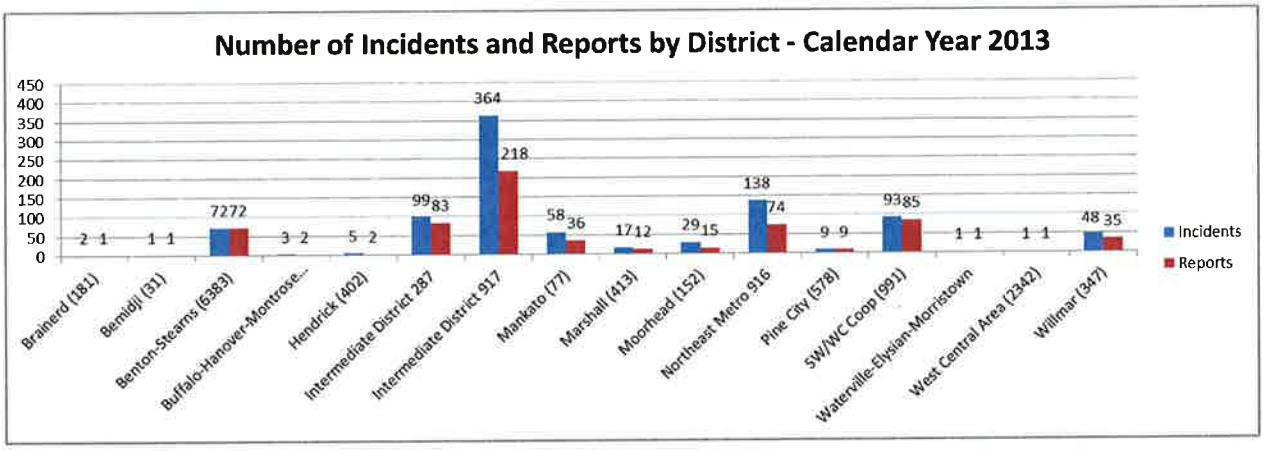
[34] *Id.*

[35] Minn. Stat. § 136D.01 (2014).



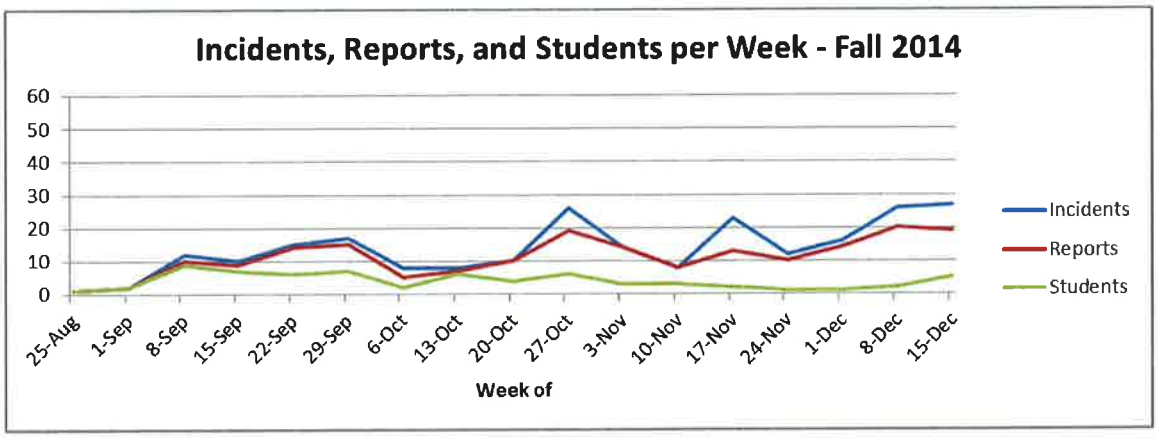


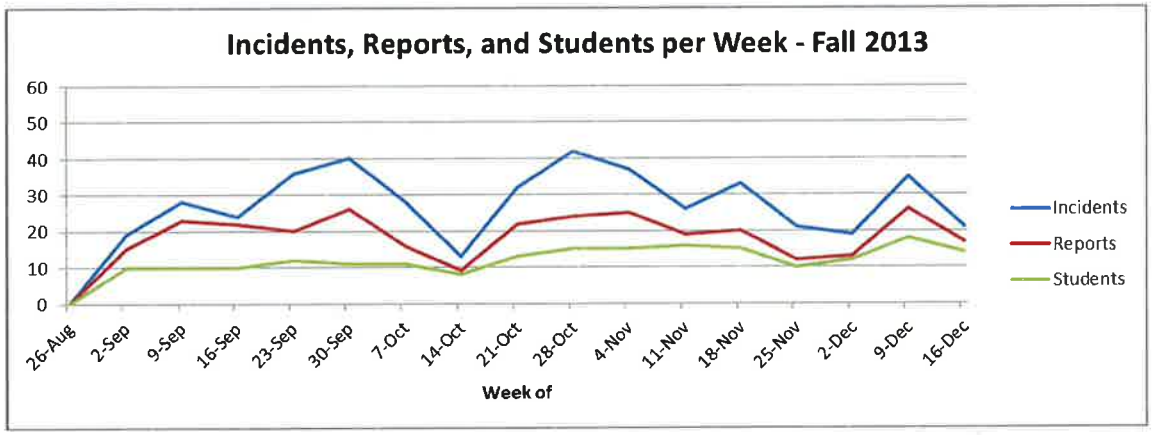
Number of Students in Prone Restraint

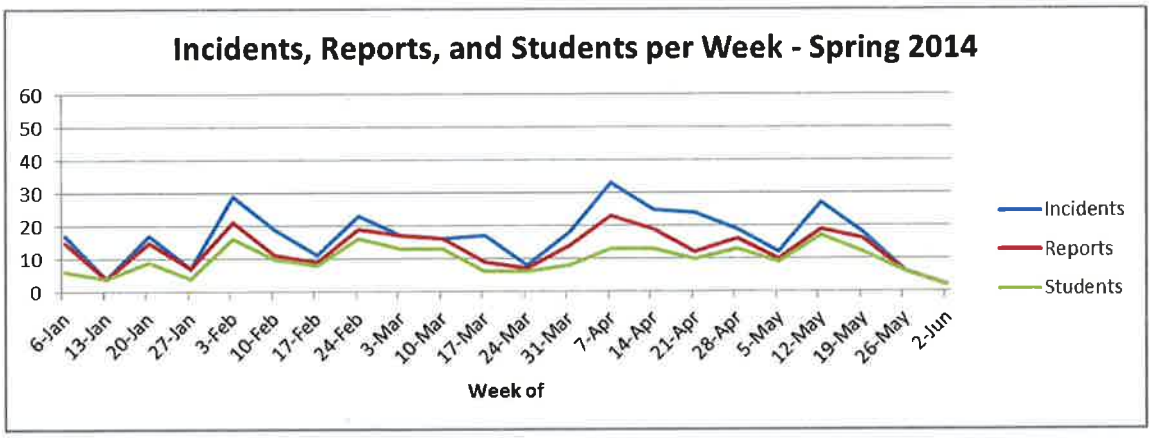
For the 2014 calendar year, districts reported that 158 students with disabilities were restrained using prone restraint one or more times. In comparing individual students who experienced prone restraint over multiple calendar years:

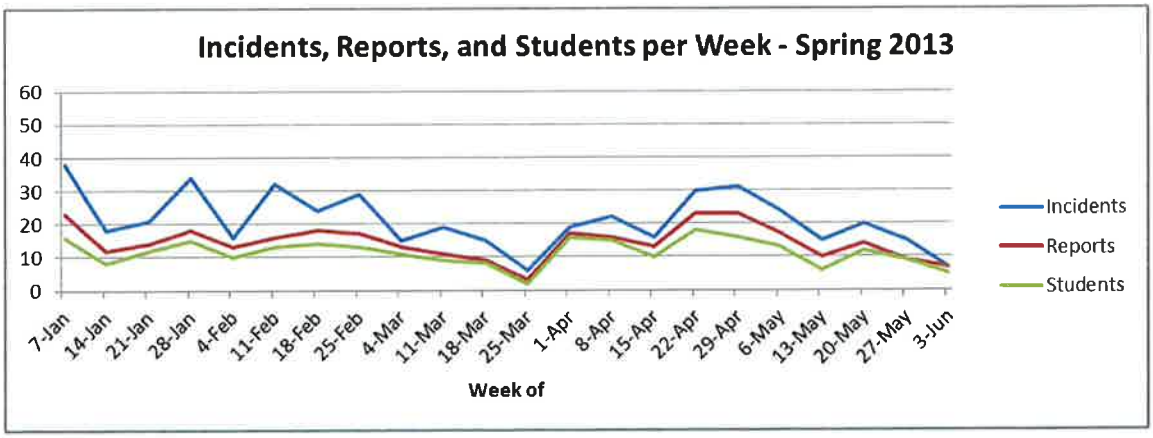
- 62 students experienced prone restraint during the 2013 and 2014 calendar reporting periods.
- 27 students experienced prone restraint during the 2012, 2013, and 2014 calendar reporting periods.
- 6 students experienced prone restraint at least once within all four reporting periods.

The following graphs show the number of incidents, reports, and students per week for comparisons of 2014 and 2013, fall and spring, respectively.


Incidents, Reports, and Students per Week - Fall 2014
60
50
40
30
20
10
0
25-Aug
1-Sep
8-Sep
15-Sep
22-Sep
29-Sep
6-Oct
13-Oct
20-Oct
27-Oct
3-Nov
10-Nov
17-Nov
24-Nov
1-Dec
8-Dec
15-Dec
Week of
Incidents
Reports
Students


Incidents, Reports, and Students per Week - Fall 2013
60
50
40
30
20
10
0
26-Aug
2-Sep
9-Sep
16-Sep
23-Sep
30-Sep
7-Oct
14-Oct
21-Oct
28-Oct
4-Nov
11-Nov
18-Nov
25-Nov
2-Dec
9-Dec
16-Dec
Week of
Incidents
Reports
Students


Incidents, Reports, and Students per Week - Spring 2014
60
50
40
30
20
10
0
6-Jan
13-Jan
20-Jan
27-Jan
3-Feb
10-Feb
17-Feb
24-Feb
3-Mar
10-Mar
17-Mar
24-Mar
31-Mar
7-Apr
14-Apr
21-Apr
28-Apr
5-May
12-May
19-May
26-May
2-Jun
Week of
Incidents
Reports
Students


Incidents, Reports, and Students per Week - Spring 2013
60
50
40
30
20
10
0
7-Jan
14-Jan
21-Jan
28-Jan
4-Feb
11-Feb
18-Feb
25-Feb
4-Mar
11-Mar
18-Mar
25-Mar
1-Apr
8-Apr
15-Apr
22-Apr
29-Apr
6-May
13-May
20-May
27-May
3-Jun
Week of
Incidents
Reports
Students

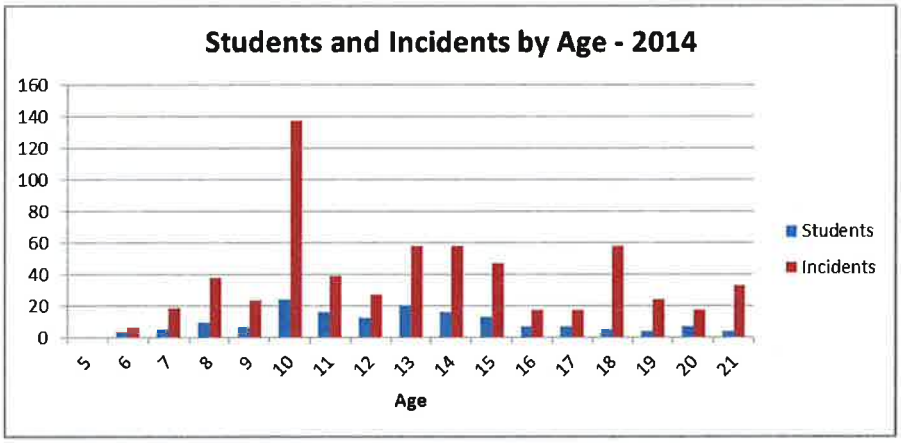
Length of Incident of Prone Restraint

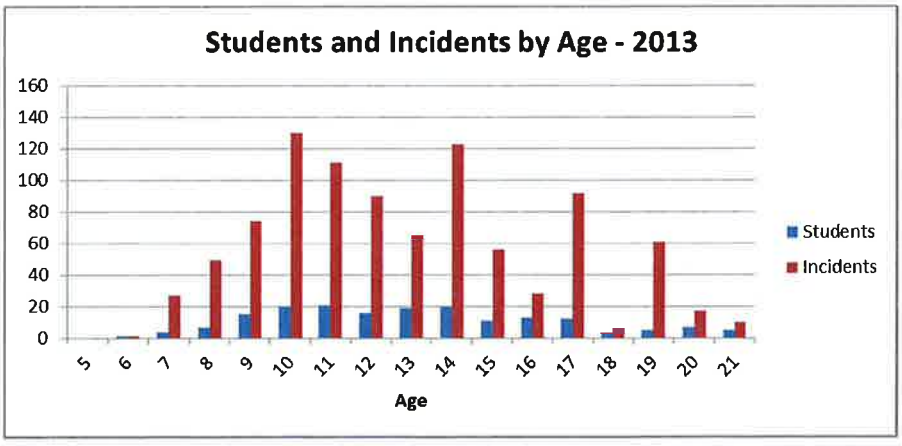
The 2014 data indicates the following:

- 50 percent of the 617 incidents of prone restraint lasted five minutes or less, compared to 56 percent during 2013.
- The number of restraints of five minutes or less also decreased from 525 in 2013 to 310 incidents in 2014.
- Nearly 90 percent of the reported incidents of prone restraint lasted 15 minutes or less.

Age of Students Placed in Prone Restraint

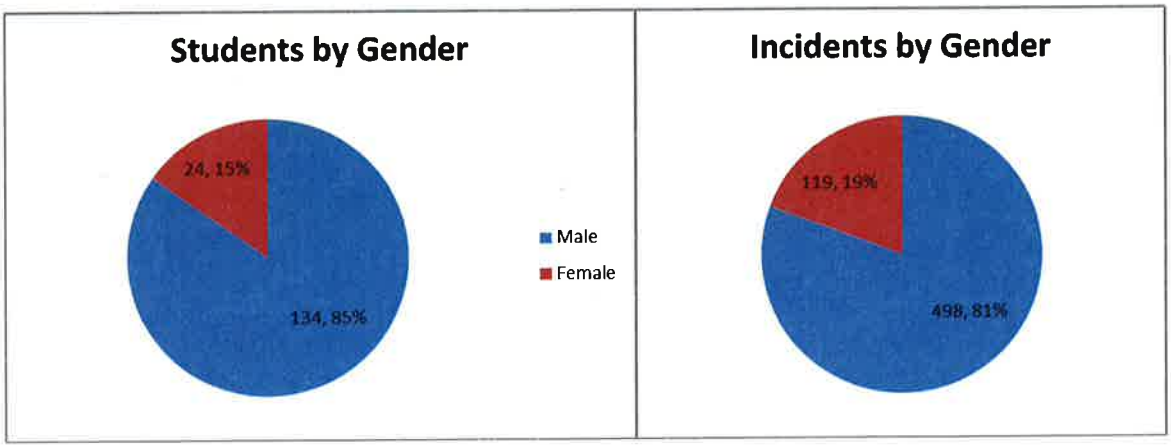
During the 2014 calendar year, prone restraint was used on children as young as 6 years old and as old as 21. This is consistent with prior years. Though the number of students and incidents are again down from the previous reporting periods, the relative peak usage of prone restraint by age, both by number of incidents and number of students, continues to be with middle school students. The peaks of incidents at ages 18 and 21 are due to the skewed effect of the outliers described earlier in this report, whereas the peak at age 10 is more the result of an aggregation: 137 incidents across 24 students.





Gender of Students Placed in Prone Restraint

The 2014 calendar year data shows that boys are more than six times more likely than girls to be restrained in a prone position, which is up from five times more likely in the previous reporting period, though consistent with the 2012 reporting period.

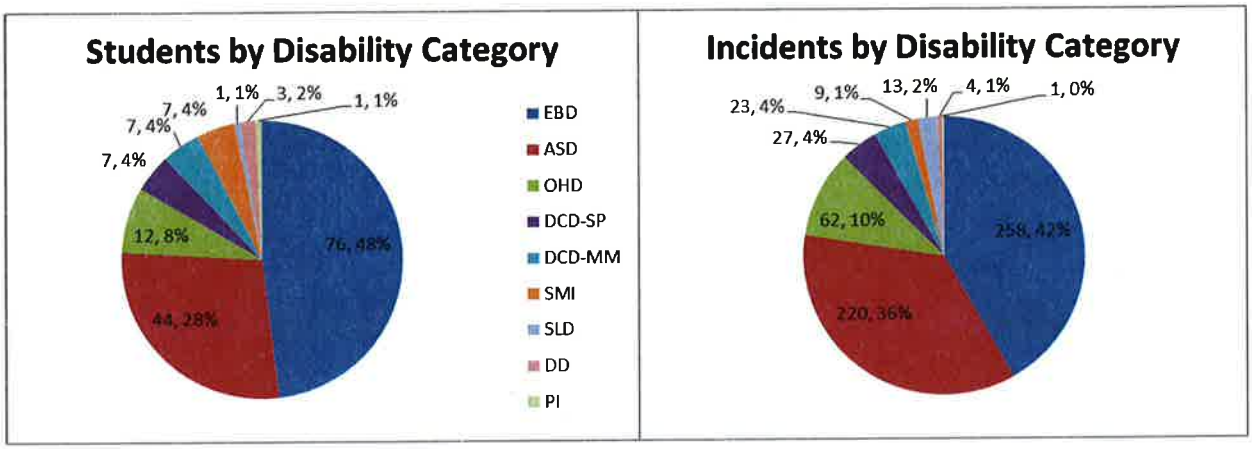


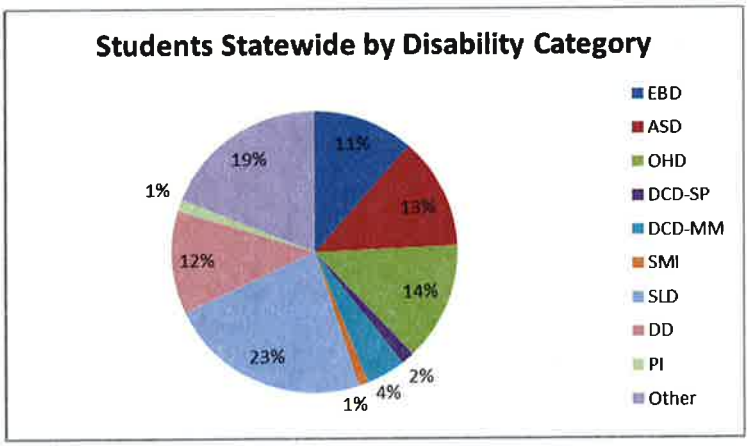
Students and Incidents by Disability Category

Overall, 68 percent of all incidents of prone restraint reported during the 2014 calendar year involved students who were eligible for special education under the following eligibility criteria: Autism Spectrum Disorders (ASD) or Emotional or Behavioral Disorders (EBD). Compared to the 2013 calendar year, this is a decrease from 84 percent of the incidents. Reduced relative usage with students under the ASD category accounts for the decrease.

The first chart below illustrates the number and percentage of students with disabilities subjected to prone restraint. The second chart illustrates the percentage of incidence represented by each specific category. For example, while ASD students represent 29 percent of all students who experienced the use of prone restraint, that same population represents 36 percent of all incidents reported for the same time period. For further comparison, the percentages of these students within the state's total special education population are illustrated in the third chart. For example, the same ASD students who represent 29 percent of all students who experienced the use of prone restraint and represent 36 percent of all incidents reported, are represented in 13 percent of the state's total special education population.[36]

[36] 2014 Child Count Totals by December 1, 2013 by Disability, Race/Ethnicity, and Age, retrieved from MDE Data Reports and Analytics, available at http://w20.education.state.mn.us/MDEAnalytics/Data.jsp.





Key

EBD = Emotional or Behavioral Disorders

ASD = Autism Spectrum Disorders

OHD = Other Health Disabilities

DCD-MM = Developmental Cognitive Disability-Mild to Moderate

DCD-SP = Developmental Cognitive Disability-Severe to Profound

SMI = Severely Multiply Impaired

SLD = Specific Learning Disability

DD = Developmental Delay

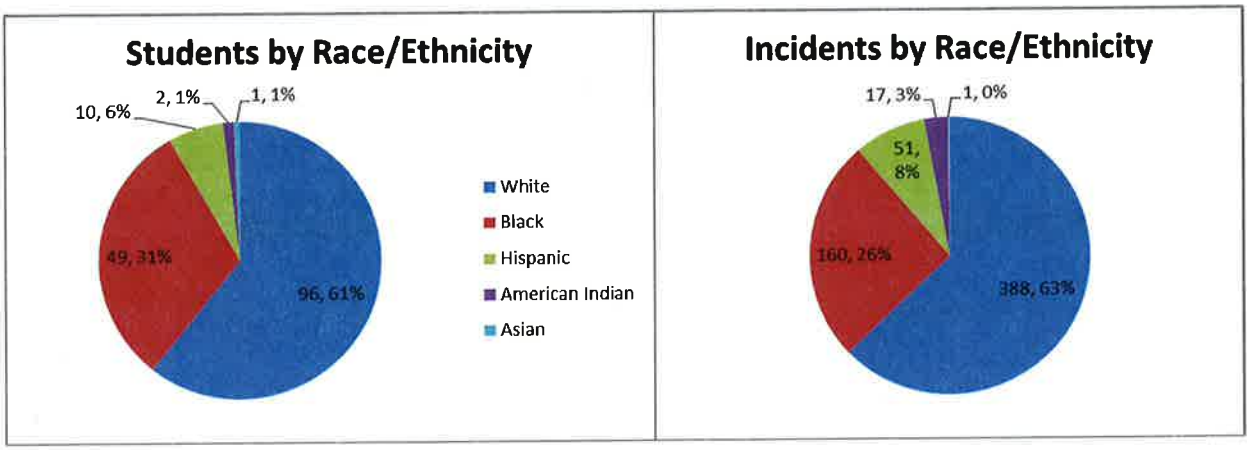
PI = Physically Impaired

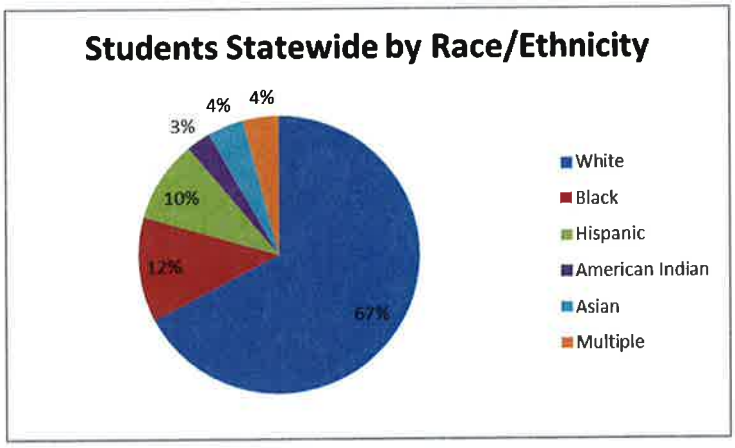
Students Involved In Prone Restraint by Race/Ethnicity

Compared to data from the 2013 calendar year, the proportion of Black students in prone restraint during the 2014 calendar year decreased from 32 percent to 31 percent. The proportion of incidents for Black students also decreased, from 32 percent to 26 percent. At the same time, the proportion of incidents for White students increased from 60 percent to 63 percent, for Hispanic students from seven percent to eight percent, and for American Indian students from less than one percent to three percent.

Much of the change in incidents by race/ethnicity can be attributed to the change in students who fall into the group of outliers described earlier in this report, more of whom were White students during 2014, compared to a larger proportion of Black students in 2013. In comparison

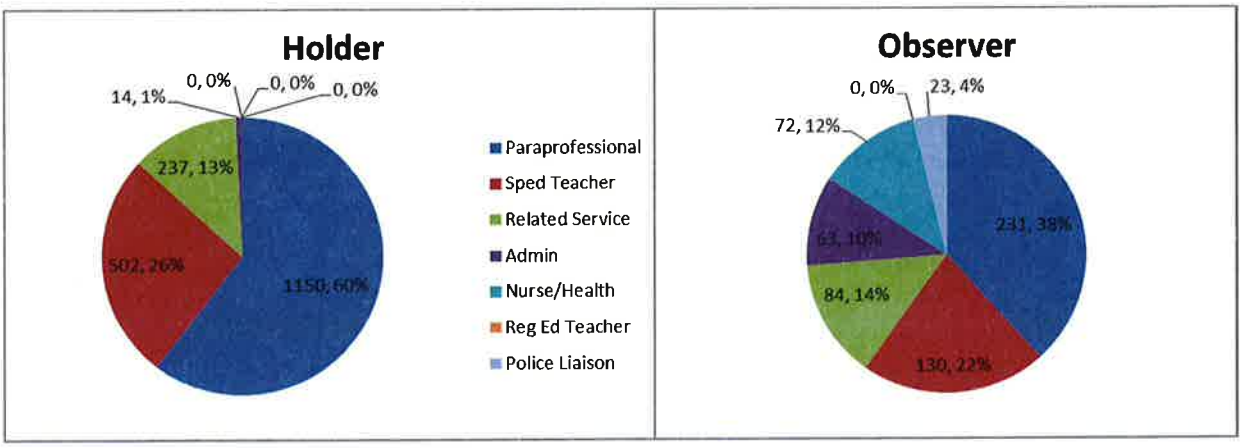
to the statewide population of students with disabilities, Black students continue to be overrepresented in prone restraint by number of students and incidents.





Staff Involved in the Use of Prone Restraint

Approximately 420 staff were involved in the use of prone restraint during the 2014 calendar year, either as a holder or an observer, down from approximately 520 in the previous calendar year. The median number of times a staff person was involved was two times (same as 2013), with a range of up to 48 times, which is down from 70 times in 2013. As in 2013, most reports included at least one paraprofessional as a holder (465 reports) and few reports included only paraprofessionals as holders (97). Across seven reports, 10 education staff were reported as holders and listed as not trained. The chart below shows the percentage of times various staff were holders or observers. For example, paraprofessionals were reported as holders 1,150 times across all reports during this reporting period.



Injuries Related to the Use of Prone Restraint

Across 489 prone restraint reports submitted for the 2014 calendar year, districts reported two student injuries and 24 staff injuries, down from seven and 36, respectively, as reported for 2013. Injury descriptions to staff included strained muscles, scratches, bruises, and bites, which included bleeding. The two reported student injuries were not clearly described; however, neither injury was indicated as necessitating a report to the ombudsman.

RESTRICTIVE PROCEDURES SUMMARY DATA

Following the 2013-14 school year, districts reported summary data to MDE on the use of restrictive procedures, which was due by June 30, 2014. On a form provided by MDE, districts reported:

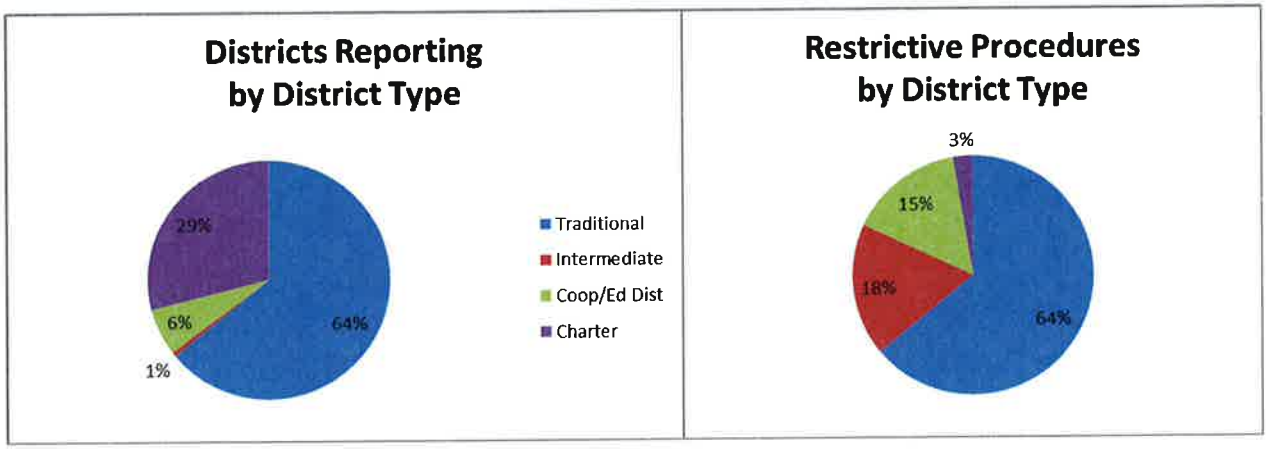
- the total number of students receiving special education services served by the district;
- the total number of incidents of restrictive procedures (includes physical holding, prone restraint, and seclusion);
- the total number of students receiving special education services upon whom a restrictive procedure was used;
- the total number of students receiving special education services upon whom restrictive procedures were used 10 or more school days during the school year;
- the total number of incidents of physical holding (including prone restraint);
- the total number of incidents of seclusion;
- the demographic information for the students (disability, age, race, and gender);
- the number of injuries to students and staff.

MDE received summary data from 522 districts (which includes independent and special school districts, charter schools, cooperatives, education districts, and intermediate school districts). This was a 100 percent response rate, which included district responses of no use of restrictive procedures.

Districts that Reported Use of Restrictive Procedures

Of the 522 districts that reported summary data to MDE, 249 of those districts (compared to 252 districts in 2013) reported use of restrictive procedures, whether physical holding, seclusion, or a combination of both. They include:

- 195 of 335 traditional districts
- 3 of 3 intermediate school districts
- 15 of 33 cooperatives and education districts
- 33 of 151 charter schools



While intermediate districts, cooperatives, and education districts comprise approximately seven percent of the total reporting districts, combined they reported 33 percent of the restrictive procedure use in the state. By contrast, charter schools represent approximately 29 percent of the reporting districts, but reported nearly no use of restrictive procedures. Traditional districts represent approximately 64 percent of the reporting districts and also reported 64 percent of restrictive procedure use. The proportion of restrictive procedures reported for the 2013-14 school year is higher as compared to the 2012-13 data for cooperatives, education districts, and charter schools, with intermediate and traditional districts down slightly.

Of the 249 districts that reported use of restrictive procedures:

- 172 (69 percent) reported use of only physical holding,
- 3 (1 percent) reported use of only seclusion, and
- 74 (30 percent) reported use of both physical holding and seclusion.

While this is consistent with previous reporting, it should be noted that the districts reporting usage changed. Of the 249 districts reporting use of restrictive procedures during the 2013-14 school year, 51 of the districts reported no usage of restrictive procedures the previous school year.

Statewide Data on the Use of All Restrictive Procedures

Across the state, during the 2013-14 school year, districts reported 13,214 physical holds and 6,323 uses of seclusion for a total of 19,537 restrictive procedures. This was a decrease of approximately 11 percent from the 2012-13 school year reporting.

When comparing the data, it should be noted that for the 2011-12 school year, only 474 districts submitted a summary restrictive procedure form, as compared to 513 districts and 522 districts respectively for the 2012-13 and 2013-14 school years.

School Year	Physical Holds	Uses of Seclusion	Restrictive Procedures
2013-14	13,214	6323	19,537
2012-13	15,738	6425	22,163
2011-12	16,604	5236	21,840

Of 138,883 special education students,[37] restrictive procedures were used with 2,740 students with disabilities, which is approximately two percent of the special education population. This percentage is the same as reported in the 2014 legislative report. Physical holding was used with 2,433 students, down from the data reported in the 2014 legislative report (2,604) and seclusion was used with 837 students, also down from the data reported in the 2014 legislative report (957).[38] Compared to the 2013-14 school year, the average number of physical holds per physically held student was 5.4, down from 6.0; the average number of uses of seclusion per secluded student was 7.6, up from 6.7; and the average number of restrictive procedures per restricted student was 7.2, down from 7.5.[39]

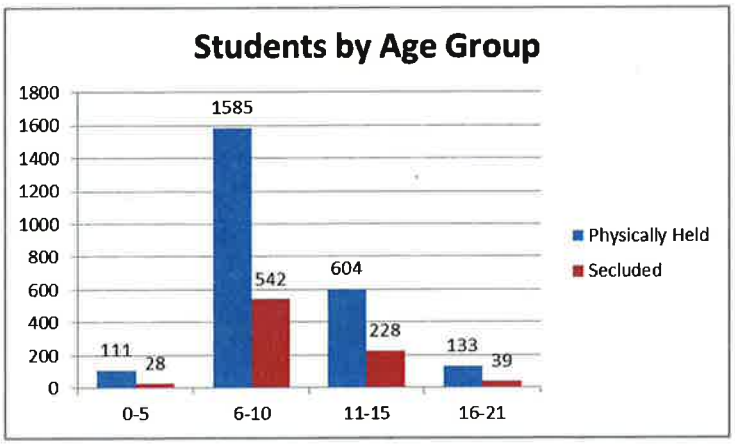
Age of Students in Restrictive Procedures

The majority of restrictive procedures reported for the 2013-14 school year were used with elementary through middle school students, with fewer uses with early childhood and high school students, consistent with the previous legislative reports.

[37] The number of special education students is based on an aggregation of districts' self-reported data in conjunction with the restrictive procedures reporting and may not match exactly with other aggregations by MDE of the number of special education students in the state.

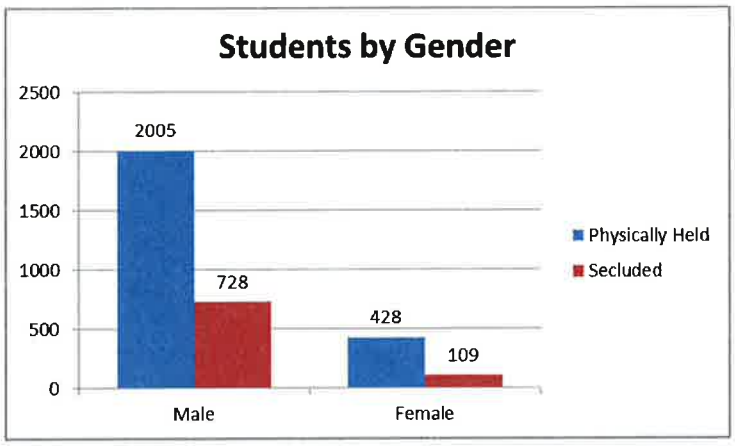
[38] The number of physically held students plus the number of secluded students is greater than the total number of students with whom restrictive procedures were used because a number of students where reported as both physically held and secluded.

[39] As with the previous footnote, the average number of restrictive procedures per restricted student may be higher than the averages for both physical holding and seclusion because of the number of students both physically held and secluded.



Gender of Students in Restrictive Procedures

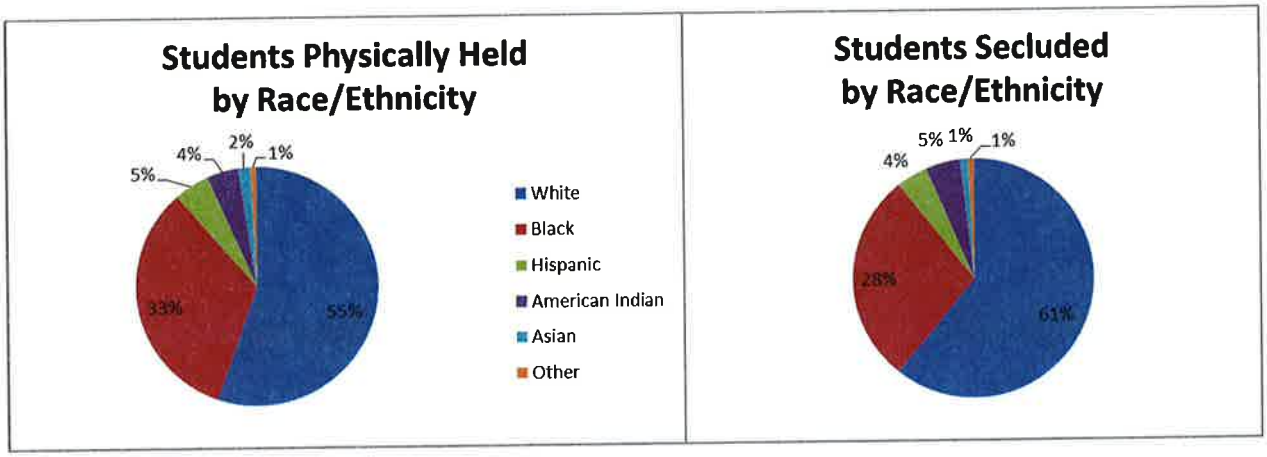
Based upon the data reported for the 2013-14 school year, boys are 4.7 times more likely to be physically held and 6.7 times more likely to be placed in seclusion than girls, consistent with previous legislative reports.

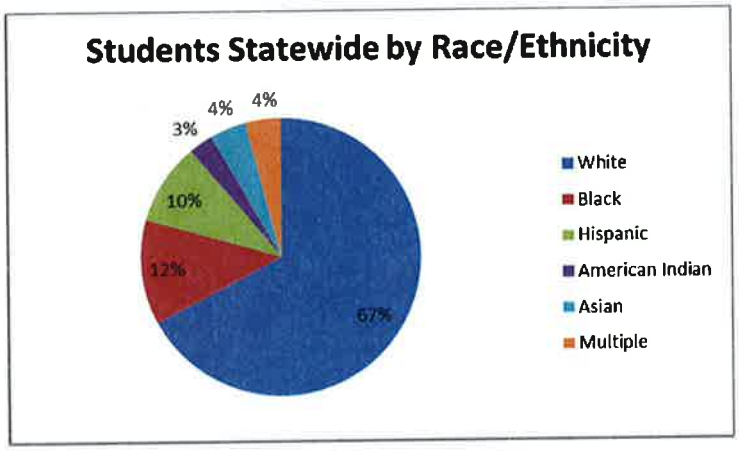


Race/Ethnicity of Students in Restrictive Procedures

Black students, who account for approximately 12 percent of the special education student population,[40] are overrepresented in both the physical holding and seclusion data, consistent with previous legislative reports. American Indian students, who account for approximately three percent of the special education population, are also overrepresented in the physical holding and seclusion data, though not to as great a degree.

[40] 2014 Child Count Totals by December 1, 2013 by Disability, Race/Ethnicity, and Age, retrieved from MDE Data Reports and Analytics, *available at* http://w20.education.state.mn.us/MDEAnalytics/Data.jsp.

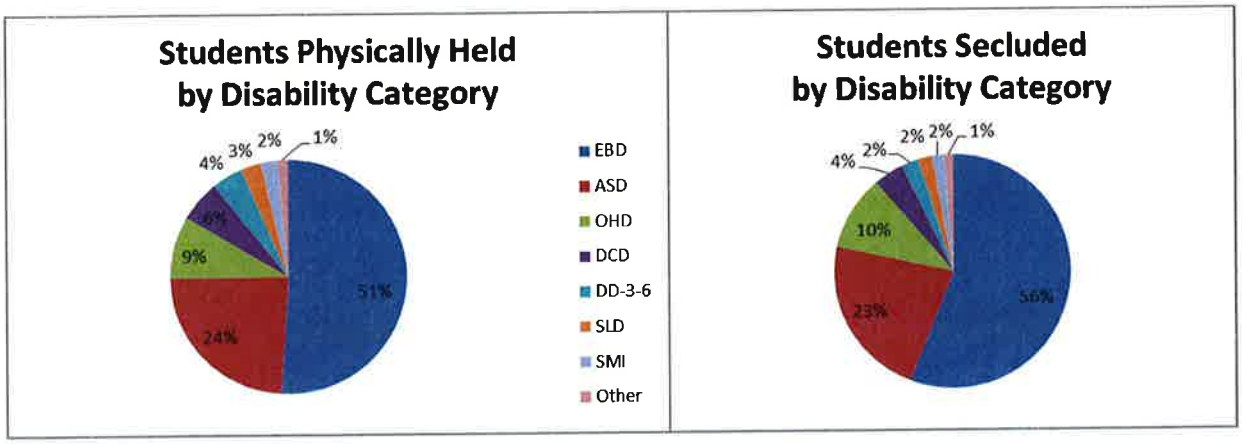




Disability Categories for Students in Restrictive Procedures

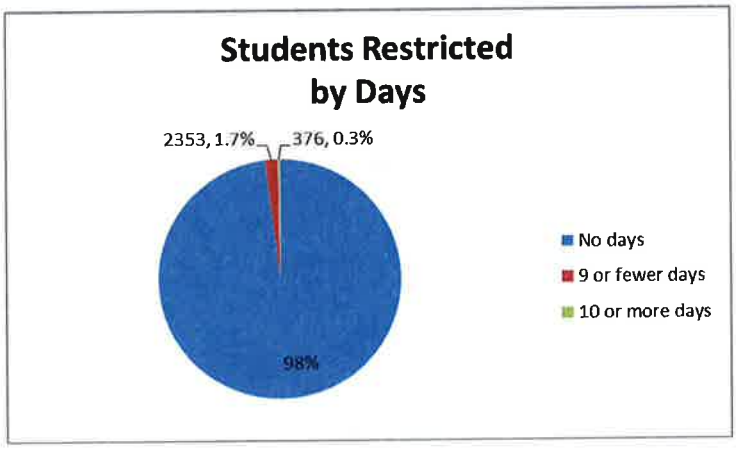
During the 2013-14 school year, students who received special education services by meeting eligibility criteria under the primary disability category of EBD or ASD accounted for three-fourths of the students who experienced the use of restrictive procedures, consistent with previous legislative reports. ASD students make up approximately 13 percent of the special education student population and EBD students make up approximately 11 percent.[41] The remaining one-fourth of restrictive procedures were used on students with Other Health Disabilities (OHD), Developmental Cognitive Disability (DCD), Developmental Delay, ages three through six (DD 3-6), Specific Learning Disability (SLD), and Severely Multiply Impaired (SMI). The categories of disabilities included in the "Other" category are, in order of prevalence: Deaf and Hard of Hearing (DHH), Speech or Language Impairments (SLI), Traumatic Brain Injury (TBI), and Physically Impaired (PI).

[41] 2014 Child Count Totals by December 1, 2013 by Disability, Race/Ethnicity, and Age, retrieved from MDE Data Reports and Analytics, *available at* http://w20.education.state.mn.us/MDEAnalytics/Data.jsp.



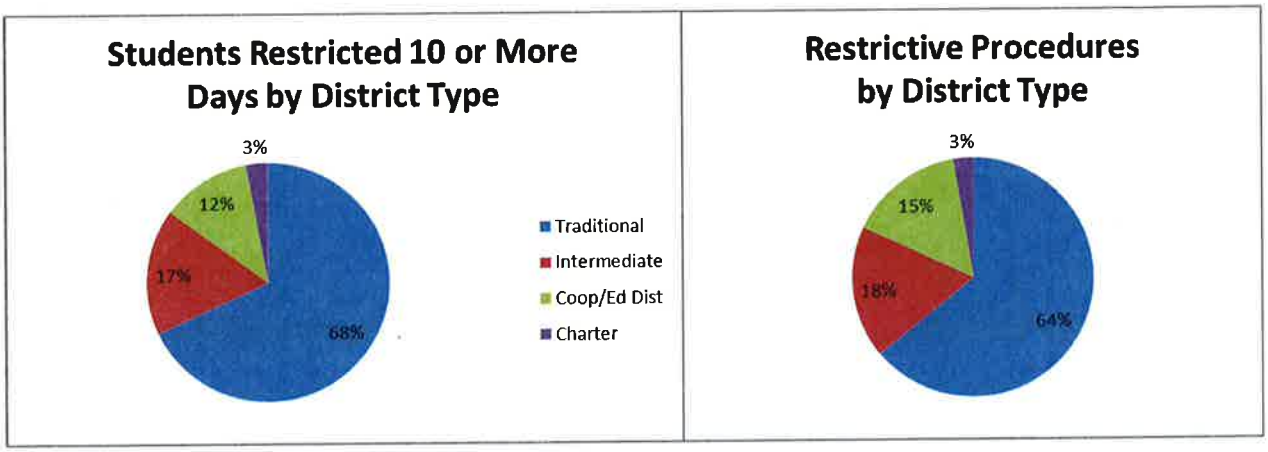
Students Restricted Ten or More Days

New in this legislative report is data on the number of students restricted 10 or more days. As has been noted in the prone restraint data since reporting began, a small number of students account for a large portion of the incidents of prone restraint. A threshold of 10 or more days was chosen for this restrictive procedures summary data point to be consistent with districts' obligation under statute to take additional action when restrictive procedures have been used 10 or more days within a school year.[42] Districts reported that a total of 376 special education students experienced the use of restrictive procedures over 10 or more days during the 2013-14 school year. These students account for approximately 0.3 percent of the special education student population.



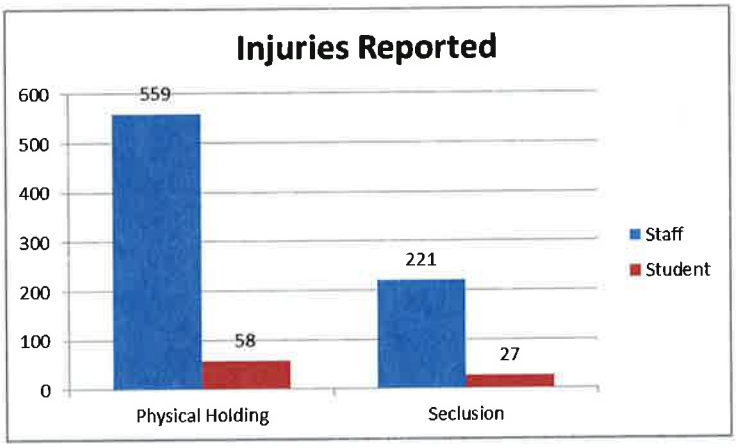
While the restrictive procedure summary data is more limited than individual incident prone restraint reports, the district level data for these outliers in the restrictive procedures population suggest the average number of restrictive procedures may be about 25 incidents of restrictive procedures per student, with 10 or more days of restriction. This would be consistent with the average for the outliers in the prone restraint data. Students who experienced the use of restrictive procedures over 10 or more days across all district types are in rough proportion to the number of incidents of restrictive procedures by district type.

[42] *See* Minn. Stat. § 125A.0942, subd. 2(d).



Injuries Related to the Use of Restrictive Procedures

Data about the number of injuries to both students and staff related to the use of restrictive procedures is reported as increased for all categories, with the exception of injuries related to physical holding for students. However, the data was new for the previous reporting period, so may reflect better reporting more than an actual increase in injuries. As stated in the previous legislative report, there is still some likelihood that injury data is underreported, inaccurately reported, and/or inconsistently reported. Several districts again called to inquire what constitutes an "injury" that should be reported, including questions about the severity and connection to the incident.



STATEWIDE PLAN

MDE is committed to ensuring that all students and all staff are safe in educational environments. We are also committed to working with the Minnesota Legislature and all interested stakeholders, including parents, educators, school administrators, and community leaders, to ensure schools have necessary and effective tools to support student safety while working together to eliminate the use of prone restraint and reduce the use of restrictive procedures. Please refer to Appendix A for the statewide plan, including recommendations and goals.

CONCLUSION

MDE respectfully submits this report to provide the Legislature with objective data to inform its continuing policy discussions regarding restrictive procedures and prone restraint. While the number of students affected by this discussion is small, about 0.1 percent of the special education student population in the case of prone restraint and about two percent for restrictive procedures, it is clear that these students have significant and complex needs.

We anticipate the data provided will result in informed decision-making, promoting safe educational environments. We appreciate the opportunity to inform the Legislature about this important issue and commend the Legislature for its continued commitment to this task.

Appendix A

2014 Statewide Plan to Reduce the Use of Restrictive Procedures and Eliminate Prone Restraint in Minnesota

I. Purpose

During the 2014 legislative session, the Minnesota Legislature tasked the Minnesota Department of Education (MDE) with developing a statewide plan with specific and measurable implementation and outcome goals for reducing the use of restrictive procedures.[43] To assist with developing a plan, MDE assembled a group of stakeholders. The stakeholder group included representation from advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, state human services department staff, mental health professionals, and autism experts.[44] Although invited, the stakeholder group did not have a representative from County Social Services. The group developed implementation and outcome goals that would move the state toward a reduction of restrictive procedures in the educational setting.

II. Stakeholder Work Group Charge

By February 1, 2015, and annually thereafter, stakeholders must recommend to the commissioner specific and measurable implementation and outcome goals for reducing the use of restrictive procedures and the commissioner must submit to the legislature a report on districts' progress in reducing the use of restrictive procedures that recommends how to further reduce these procedures and eliminate the use of prone restraints. The statewide plan includes the following components: measurable goals; the resources, training, technical assistance, mental health services, and collaborative efforts needed to significantly reduce districts' use of prone restraints; and recommendations to clarify and improve the law governing districts' use of restrictive procedures. The commissioner must consult with interested stakeholders when preparing the report, including representatives of advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, county social services, state human services department staff, mental health professionals, and autism experts. By June 30 each year, districts must report summary data on their use of restrictive procedures to the department, in a form and manner determined by the commissioner. The summary data must include information about the use of restrictive procedures, including use of reasonable force under section 121A.582.

Minnesota Department of Education

[43] Minn. Stat. § 125A.0942, Subd. 3(b) (2014).
[44] *Id.*

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III. Stakeholder Group Members

ARC Minnesota ..... Jacki McCormack
Autism Society of Minnesota ..... Jean Bender
Department of Human Services, Disability Services Division ..... Carol Anthony
Department of Human Services, Disability Services Division ..... Charles Young
Department of Human Services, Children's Mental Health Division ..... Karry Udvig
Department of Human Services, Children's Mental Health Division ..... Nelly Torori
Department of Human Services ..... Richard Amado
Education Minnesota ..... Katy Perry
Paraprofessional, Robbinsdale School District ..... Karen Krussow
Intermediate District 287 ..... Jennifer McIntyre
Intermediate District 917 ..... Melissa Schaller
Minnesota Administrators for Special Education ..... Jill Skarvold
Minnesota Disability Law Center ..... Dan Stewart
Minnesota School Board Association ..... Grace Keliher
National Alliance on Mental Illness ..... Sue Abderholden
Northeast Metro 916 ..... Connie Hayes
Northeast Metro 916 ..... Dan Naidicz
PACER Center ..... Jody Manning
PACER Center ..... Virginia Richardson

IV. Minnesota Department of Education Participants

Director, Compliance and Assistance ..... Marikay Canaga Litzau
Supervisor, Compliance and Assistance ..... Sara Winter
Assistant Commissioner ..... Daron Korte
Compliance Monitoring ..... Ross Oden
Compliance and Assistance ..... Pamela Hinze
Supervisor, Interagency Partnerships ..... Robyn Widley
Supervisor, Special Education ..... Eric Kloos
Special Education ..... Aaron Barnes

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V. Process

On September 26, 2014, MDE convened the 2014 Stakeholder Work Group (2014 Stakeholder Group) to review the annual restrictive procedures data for the 2013-14 school year. Additional meetings scheduled to review the quarterly prone restraint data occurred or will occur October 27, 2014, January 23, 2015, April 24, 2015, and July 24, 2015.

As set forth in the 2013 statewide plan, the stakeholders chose to meet quarterly and focus on reviewing the data, ongoing implementation efforts of the 2013 statewide plan, and to discuss successes and barriers in reducing restrictive procedures and the elimination of prone restraint.

Stakeholder Group Meetings

MDE staff convened members of the 2014 stakeholder group three times during the time period of September 26, 2014 and January 23, 2015. MDE staff facilitated an exchange of information and stakeholder input through review of:

- Aggregate data from districts' self-reported use of restrictive procedures for the 2013-14 school year;
- Quarterly aggregate data from districts' self-reported use of prone restraint;
- Existing statutory language;
- Strategies employed by intermediate districts to reduce restrictive procedures and eliminate prone restraint;
- Strategies employed by other districts to reduce restrictive procedures and eliminate prone restraint;
- Work accomplished from the 2013 statewide plan as set forth in Appendix A of the 2014 Legislative Report and input on ongoing implementation of that plan;
- The legislative appropriation and the process to utilize those funds to assist students experiencing the highest use of restrictive procedures, specifically prone restraint; and
- The education sections of the Olmstead Plan and status.

During the initial 2014 Stakeholder Group meeting, MDE informed the stakeholders that it had submitted a Form A proposing that the restrictive procedure statute be amended to specifically prohibit the use of prone restraint as of August 1, 2015, in accordance with the implementation requirements from the Revised Olmstead Plan, Education and Life Long Learning Action Item 1D (Proposed modifications July 10, 2014 and November 6, 2014). As set forth in action item 1D, stakeholders will discuss and recommend revisions to Minnesota Statutes section 125A.0942 subdivision 3(a)(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. Action item 1E requires MDE to report to the legislature on the districts' progress in reducing the use of restrictive procedures in Minnesota Schools and on stakeholder recommendations regarding Minnesota Statutes section 125A.0942 subdivision 3(a)(8). At the initial meeting, stakeholders did not raise any objection, and the meeting focused on a review of the annual restrictive procedures data and prone restraint data for the quarter ending June 30, 2014.

MDE staff and the stakeholders then reviewed the 2013 statewide plan goals and implementation efforts. MDE also provided an update on the $250,000 legislative appropriation.

APPENDIX A

MDE developed a grant process to target seven districts, including the three intermediate districts with students who experienced the highest usage of restrictive procedures and prone restraint. In addition, MDE was in the process of producing a request for proposal (RFP) for the development of three online training modules addressed in Goal 2(c) of the 2013 statewide plan. During a working lunch, there was a discussion to strategize ways MDE and the Minnesota Department of Human Services (DHS) could leverage services to support students who are experiencing high use of restrictive procedures, specifically prone restraint. MDE staff provided an update on the Olmstead Plan, and stakeholders were given the opportunity to share effective strategies as well as barriers in their efforts to reduce restrictive procedures and eliminate prone restraint.

During the second 2014 Stakeholder Group meeting, MDE sought input from stakeholders on venues for advertising the RFP. Prone restraint data from the quarter ending September 30, 2014 was reviewed. MDE staff provided a summary of the status of the implementation of the goals in the 2013 statewide plan. There was a brief discussion at the meeting about the October 15, 2014 Restrictive Procedures Reduction Discussion Panel (Panel) held to assist the education community in reducing the use of restrictive procedures and eliminating prone restraints in schools by sharing evidence-based best practices and effective strategies and resources. MDE staff, DHS staff, and 2014 Stakeholder Group members who participated on the Panel provided an overview of the training. The 2014 Stakeholder Group discussed what future panel discussions would look like. The 2014 Stakeholder Group also worked on developing questions to gather data about specific students to assist in identifying the students experiencing the highest usage of prone restraint. Ultimately, the 2014 Stakeholder Group chose not to proceed with the questionnaire. Time was again provided for stakeholders to seek ideas and feedback about challenging students.

The 2014 Stakeholder Group focused on the task of eliminating prone restraint and addressing successes and barriers toward reaching that ultimate goal. The stakeholders continued to share a desire to implement and revise as necessary, the 2013 statewide plan to reduce restrictive procedures, including eliminating prone restraint. Based upon a review of the prone restraint data, as well as the discussions held during the restrictive procedures 2014 Stakeholder Group meetings, the stakeholders all agreed on the need to focus resources on those students who experience a high use of restrictive procedures; specifically, prone restraint.

At the January 23, 2015 meeting, the 2014 Stakeholder Group reached consensus to: revise multiple goals, delete one goal from the 2013 Work Plan, add two additional goals, and work toward implementation of the nine goals that should be implemented by one or more state agencies, school districts, or community level entities. A brief discussion on the December 16, 2014 Restrictive Procedures Reduction Discussion Panel: Eliminating Prone Restraint in Schools was also held and included a discussion of future trainings.

In general, the process underscored the stakeholders' desire to reduce or eliminate restrictive procedures. There is shared belief that emergency situations in educational settings could be greatly reduced or eliminated with additional resources – especially mental health services and additional training on positive behavior supports and intervention. Further, that training and an exchange of successful strategies would assist districts in reducing the need for restrictive procedures. For purposes of this report, the goals in the 2013 statewide plan are listed in VI

below with a corresponding update on whether they have been completed or are in progress. The 2014 Stakeholder Group reviewed progress on the eight goals in the 2013 Work Plan and then made recommendations to revise those goals and to add additional goals. The goals in the 2014 statewide plan are listed in VII below.

During the 2014-15 meetings, the stakeholders continued to discuss the barriers to accessing appropriate day and residential treatment. Much discussion centered on the lack of day treatment facilities that worked with students with severe emotional outbursts. Those students are reportedly "kicked out" of day treatment facilities, and many are then enrolled in level three or level four programs. At one of the meetings, a stakeholder described a successful collaboration between the Minneapolis School District and a co-located day treatment center. While the stakeholders did not believe they could adequately address this goal within the next year, it was noted that some stakeholders are currently involved in other work to address these issues.

Finally, the stakeholder group discussed proposed statutory revisions needed to provide clarification or to support the implementation of some pieces of the proposed statewide plan. As set forth in Appendix A of the 2014 Legislative Report, the 2013 Stakeholder Group previously concluded that there was insufficient data to determine the extent to which reasonable force was being used that resulted in the use of a restrictive procedure on a student with a disability. In the fall of 2015, the 2014 Stakeholder Group will review the data collected related to the use of reasonable force on the 2014-15 annual summary report, and decide whether additional statutory changes would be needed to ensure that districts are not using reasonable force to avoid the reporting requirements in the restrictive procedure statute, or increasing removals of students from the school setting.

As indicated by the recommendations of the 2013 Stakeholder Group, the work on a statewide plan to greatly reduce or eliminate the use of restrictive procedures requires ongoing discussion and study to review what is successful, and continue to monitor the data and revise the goals, as appropriate. MDE will continue to collect and report the restrictive procedures data and convene the stakeholder meetings, once in the fall of 2015 and subsequent meetings as needed.

VI. 2013 Statewide Plan and Updates

Goal 1: On or before July 1, 2014, MDE will:

a. Based upon a review of the prone restraint reports received by MDE, MDE will develop a process to identify outliers in prone restraint reporting which will assist MDE in identifying schools and/or school districts that may need targeted technical assistance and thereafter contact and offer technical assistance to the identified schools and/or school districts. In determining whether an outlier exists, and in determining where data is an outlier, MDE will consider whether the prone restraint data is markedly different from other prone restraint data from a comparable school district. MDE has been receiving prone reports since the beginning of the 2011-12 school year.

1a Update: Since the first prone reporting began in August 2011, MDE developed a system to review prone reports within two business days. This review included contacting the district when

the report did not appear consistent or the staff was not trained. MDE staff in the Compliance and Assistance and Special Education divisions met when a high usage of prone restraint was reported on an individual student. During the summer of 2014, MDE staff met to discuss a more formal method to determine where data is an outlier. Beginning with the 2014-15 school year, MDE has identified outliers as any district currently intending to use and rely on the use of prone restraint. As set forth in more detail in goal four below, MDE provided targeted technical assistance by inviting the seven districts still using prone restraint to participate in a December 2014 restrictive procedures panel discussion. Based upon the quarterly report for prone restraint data ending December 31, 2014, five school districts used prone restraint one or more times. Only four districts reported the use of prone restraint during December 2014.

b. Develop a process for school districts to use for state targeted technical assistance related to reducing the use of restrictive procedures, including eliminating prone restraints.

1b Update: In addition to the restrictive procedures reduction discussion panel trainings, MDE provides the following training: Restrictive Procedures Overview for Individual Districts. This is an overview of Minnesota's restrictive procedures statutes pertaining to children with disabilities, including requirements that must be met before using restrictive procedures and the standards for use. This presentation is intended to assist individual districts that have questions about new statutory changes and requires the individual district requesting the training to actively participate in the presentation process along with, and with assistance from, MDE. MDE provided this training on January 26, 2015. MDE will also review training needs identified by districts in the annual summary forms to determine future trainings.

c. Develop and post on its website a Post-use Debriefing form. Developed and posted October 2014.

1c Update.: Completed. Delete 1c.

d. Update the MDE Sample Restrictive Procedures Plan and post it on its website in accordance with Minnesota Statutes section 125A.0942. Update: Original post: November 2011. Edited: April 2012. Edited: January 2014. Edited: September 2014.

1d Update: Completed. Ongoing goal.

e. Amend the MDE Restrictive Procedures Summary Form to allow school districts the option to identify one to two staff training needs, and to review the need to add or amend additional reporting requirements to address the unintended impacts of reducing restrictive procedures. MDE will update the form to clarify that districts must report all incidents involving students with a disability in which a staff member uses restrictive procedures, as defined in Minnesota Statutes, Section 125A.0941.

1e Update: MDE updated and posted the electronic *Use of Restrictive Procedures District Summary Data* form in April 2014. The amendments include a change to the definition of physical holding to include reasonable force covered by Minnesota Statutes, section 121A.6582, when the actions meet the definition of physical holding in Minnesota Statutes, section 125A.0941. Districts are required to report this data beginning with the

2014-15 school year and submit the report by June 30, 2015. In addition, the annual summary form was updated to include a training needs section and gives districts the opportunity to describe areas of training related to the reduction of restrictive procedures summary data reports for the 2013-14 school year, which contained training needs. Districts will again report training needs when they submit their annual reports on June 30, 2015. Completed. Delete 1e,

f. Make publically accessible, in an electronic format on MDE's website, information pertaining to how schools/school districts may access local mental health services for their students including Assertive Community Treatment (ACT) teams and mobile crisis response teams

1f Update: MDE posted the relevant links to the DHS website on June 30, 2014. Completed. Update link as needed

g. Make publically accessible, in an electronic format on MDE website, information and training pertaining to DHS's Positive Support Community of Practice bi-weekly live stream meetings.

1g Update: Posted link to Positive Supports Community of Practice February 2014. Completed. Update link as needed.

Goal 1 Action Items

- **MDE:** Responsible to implement Goal 1, a-g.
- **DHS:** Provide information to MDE related to Goal 1, f and g.
- **School Districts:** Request or utilize offered targeted technical assistance, identify, develop, and implement post-use debriefing and oversight committee procedures and forms based on model examples; collect and report in summary form the use of reasonable force when it results in the use of a physical hold or seclusion on a student with a disability; and to utilize the resources made available on the MDE website regarding accessing local mental health services and the DHS live stream meetings.

Goal 2: Beginning in March 2014, MDE will continue collaboration with DHS by:

a. Supporting implementation of evidence-based practices for positive behavior strategies through the channels already developed by DHS's Continuing Care Administration and Children's Mental Health Division, Positive Support Community of Practice;

2a Update: Goal 2(a) is incorporated in the Olmstead work related to children's mental health and continuing care. Currently, DHS is the lead to develop common definitions and MDE has provided input. An initial report has been completed by Rebecca Freeman, DHS consultant from the University of Minnesota, Institute on Community Integration.

b. Identifying systems for culturally responsive resource identification, consistent with the Positive Support Community of Practice, by collaborating with the Children's Mental Health and Disability Services Division of DHS, including at least the following:

i. Prevention;

ii. quality improvement;

iii. intensive intervention; and

iv. systems collaboration.

2b Update: MDE and DHS have collaborated in the following activities related to Goal 2(b), which are designed to increase awareness of cross agency and community resources and provide enhanced opportunities to work together to address children's and system needs to create the support needed to reduce the use of restrictive procedures:

- Olmstead activity related to mental health crisis,
- Suicide prevention planning workgroup with MDH and DHS,
- Workgroups regarding the development of new mental health benefits for children- e.g. psychosocial education, consultation, new option for psychiatric residential treatment facility (PRTF) setting, and school linked mental health project activities.

c. Researching three cross-expertise training models for statewide use:

i. a continuum of treatment and educational service options for students with a combination of severe mental illnesses and developmental disabilities, including Fetal Alcohol Spectrum Disorder;

ii. in collaboration with emotional and behavioral disorders (EBD) experts and mental health experts, develop an EBD training model that addresses strategies to reduce restrictive procedures used on students with severe aggressive/self-injurious behaviors; and

iii. in collaboration with autism spectrum disorder (ASD) experts, develop an ASD training model that addresses strategies to reduce restrictive procedures used on students with severe intellectual impairments and aggressive/self-injurious behaviors.

2c Update: MDE sent a RFP for development of the three training models in an electronic format. The RFP proposals submission deadline was January 15, 2015. They are in the process of being reviewed, and a final review will take place on January 30, 2015. The work is to be completed by June 30, 2015. If MDE approves an RFP vendor and resulting work product, MDE will then post the trainings for Districts and provide additional training as needed.

d. Identifying options for experts and expert review, funding, and other supports for students in need of long term, systemic, and intensive interventions;

2d Update: MDE and DHS have held statewide training on children's therapeutic services and supports (CTSS) funding that incorporated the (Positive Behavior Interventions and Support (PBIS) tier model, including Tier 3, as a service delivery model. MDE and DHS are working together on the School Mental Health Services Frameworks workgroup where MDE and DHS staff, together with county and school district staff, discuss, develop, and

disseminate integrated frameworks of mental health services delivery in schools (PBIS, CTSS, ACEs, etc.).

e. Supporting the coordinated implementation of the ASD Medical Assistance benefit authorized by the 2013 Legislature with regard to the respective roles of the education, human services, and healthcare systems in providing effective interventions and improving outcomes, including reduction in the use of restrictive procedures;

2e Update: Interagency meetings are held to coordinate services. This particular topic has not yet been addressed.

f. Supporting increased access to mental health treatment, including evidence-based practices, and awareness of mental health services in order to address the symptoms and behaviors of children and youth with mental illnesses, including those with intensive service needs, covered through the (Medical Assistance – individualized education plan (MA-IEP) program, School CTSS program, School-linked Mental Health Grant program, co-located Mental Health Services, and Mental Health in Schools Act.

2f Update: DHS and MDE staff meet on an ongoing basis to discuss different topics. MDE and DHS held a joint CTSS training in October 2014. At the December 5, 2014 Special Education Directors Forum held at MDE, MDE and DHS staff presented on MA-IEP issues, including behavior services and special education transportation. Current discussions between MDE and DHS include a discussion of the interplay between school linked mental health providers, community providers, and the provision of services under a student's IEP.

MDE and DHS staff, along with intermediate district staff, participate in an ongoing DHS work group on the issue of crisis services. The work group has discussed the need to develop a process that includes defining what crisis services are, how to access crisis services, and how to track school district use of crisis services. For purposes of the Olmstead Plan, this activity is focusing on DHS mobile crisis teams, which are funded through MA. Note: Some intermediate districts will continue to set up services with external crisis providers.

Goal 2 involves collaboration between MDE and DHS. Its purpose is to continue the current work and to share expertise for maximum use of resources as the agencies continue to work toward identifying evidence-based practices to address the needs of students with disabilities who are experiencing high rates of restrictive procedures. The 2013 Stakeholder Group provided MDE and DHS with the flexibility to determine the priority and scope of implementing goal number two, based upon resource issues and data demonstrating effectiveness.

Goal 2 Action Items

- **MDE and DHS:** Identify resources and experts external to districts, develop referral lists posted to MDE website, and ensure cultural responsiveness.
- **School Districts**: Provide input to MDE regarding resources and experts.
- **Advocacy Organizations:** Identify resources and experts external to districts and ensure parents are informed of the resource directory.

Goal 3: The Restrictive Procedures Workgroup will provide input to the Mental Health Workforce Summit in order to recommend training to reduce the use of restrictive procedures.

Goal 3 Action Items

- **MDE, DHS and Stakeholder Group:** Participate in listening sessions and planning for the Workforce Summit.

Goal 3 Update: MDE and DHS staff, as well as members of the stakeholder group, participated in listening sessions and planning for the 2014 Mental Health Summit. One stakeholder then attended "HealthForce Minnesota: Mental Health Summit" at Hennepin Technical College on May 28, 2014. No documentation that any training specific to the reduction of restrictive procedures was developed as part of the Summit. The Mental Health Workforce Summit is completed and a legislative report was developed in January 2015.

Goal 4: By August 1, 2014, MDE will collaborate with school districts, including, but not limited to, intermediate school districts, DHS, parent advocacy groups, and community partners to develop a restrictive procedures discussion panel on the legal and practical aspects of reducing the use of restrictive procedures and eliminating the use of the prone restraints to be available to the education community. Panel discussions will be scheduled beginning with the 2014-15 school year.

Goal 4 Update: On July 29, 2014, MDE held a collaboration meeting with stakeholders from DHS, districts, and parent advocacy groups. Subsequently, MDE scheduled and facilitated discussion panels on October 15, 2014 and December 16, 2014. The purpose of the October 15, 2014 discussion panel was to assist the education community in reducing the use of restrictive procedures and eliminating the use of prone restraints in schools by sharing evidence-based best practices and effective strategies and resources. After feedback and input from the 2014 Stakeholder Group, the December 16, 2014 discussion panel's purpose was to share evidence based best practices and effective strategies and resources to remove the barriers to eliminating the use of prone restraints in schools. That discussion panel targeted districts currently using prone restraint, and persons could attend in person or participate through a live stream. The barriers to eliminating prone restraint identified by the registrants were: 1) students with significant behaviors; 2) unintended negative consequences; 3) insufficient support for schools; 4) costs; and 5) lack of clarity about the laws.

Goal 4 Action Items

- **MDE:** Coordinate setting up the discussion panel.
- **DHS:** Participate in the discussion panel about evidence-based best practices.
- **School Districts:** Intermediate and other districts will participate to share effective strategies and resources. School Districts will make staff available to attend the panel discussions.

Goal 5: Consistent with Minnesota's 2013 Olmstead Plan, by June 30, 2015 and each subsequent year, a minimum of 40 additional schools will use the evidence-based practice of PBIS so that students are supported in the most integrated setting. Within this environment of school-wide positive behavior support, districts will train school staff and ensure that compatible school-wide and individual positive behavior approaches align.

Goal 5 Update: MDE is on target to meet this goal. Four hundred eighty-eight (24 percent) of all schools have gone through the PBIS training. Applications for the next PBIS cohort training closed on January 20, 2015. MDE and DHS continue to meet as part of the mental health advisory committee to address PBIS and school linked mental health grants and issues related to mental health. During the 2014-15 school year, the committee will study seven sites that have effective universal PBIS and effective school linked mental health services. The study will include looking at the alignment of school-wide and individual positive behavior approaches.

Goal 6: During the 2014 legislative session, the legislature will consider increasing the general education revenue to allocate state funding for supporting school districts to maintain focus and sustain fidelity of PBIS sites beyond the current two-year support for PBIS implementation. Districts will apply to MDE for state funding through an application process, which will include a requirement that school districts collect and report implementation data. The current cost is anticipated to be $240,000 and will increase as additional school sites complete two years of PBIS training.

Goal 6 Update: The state legislature did not increase revenue for this purpose. There may be proposed legislation during the 2015 legislative session to accelerate the number of schools completing PBIS training each year.

Goals 5 and 6 Action Items

- **MDE:** Provide ongoing technical assistance support and strive to adjust the fiscal burden partially away from special education.
- **School Districts:** Strive to create staff investment in the PBIS culture and make staff available for training.
- **University of Minnesota**: Provide training and technical assistance for Tier 3 level of PBIS.
- **Legislature:** Legislative action to establish a general fund stream to sustain PBIS training in school sites beyond the current two-year training, which is federally funded.

Goal 7: Annually, beginning February 1, 2015, MDE will submit a report to the Legislature summarizing the state's progress on reducing the use of restrictive procedures statewide with recommendations on how to further reduce their use.

As set forth in the prior statewide plan, the continued meetings of the 2013 stakeholder group will allow the group to continue policy work to ensure that positive school outcomes, positive school success for students with mental health and behavior health needs, including the receipt of necessary services and delivery, is reviewed and modified as necessary.

Goal 7 Update: MDE has submitted an annual legislative report related to the use of restrictive procedures in Minnesota public schools beginning on February 1, 2012. Based upon the recommendations in the 2013 statewide plan, the legislature authorized ongoing meetings of the restrictive procedures Stakeholder Group and annual legislative reports. MDE coordinated 2014 Stakeholder Group meetings, which were held in September, October, and January, to review summary restrictive procedures data and individual incidents of prone restraint. At each meeting, stakeholders were given the opportunity to provide input and share strategies and barriers in reducing the use of restrictive procedures and eliminating the use of prone restraint.

At the January 23, 2015 Stakeholder Group meeting, MDE staff reviewed the draft Appendix A for input, discussion, and final recommendations. The data contained in the 2015 Legislative Report has been shared at the restrictive procedures work group meetings. The legislative reports include a summary of progress in implementing the statewide plan, and contain additional recommendations to the Legislature to assist in the reduction of restrictive procedures and the elimination of prone restraint. The reports also include data to inform the Legislature and the public on the use of restrictive procedures in public schools, and to provide data comparisons between reporting periods. Appendix A of each report includes a statewide plan and recommendations for legislative changes to the restrictive procedure statues, and Appendix B provides a summary of other state statutes. This goal will be completed by February 1, 2015.

Goal 7 Action Items

- **MDE:** Submit a report annually and coordinate quarterly meetings of the stakeholder group.
- **School Districts**: Collection and reporting of summary restrictive procedures data and individual incidents of prone restraint.
- **Stakeholder Group**: Meet quarterly to review the data and progress toward goals and to review and revise goals as needed,

Goal 8: During the 2014 legislative session, the legislature will consider establishing a task force to make recommendations on how to integrate planning between the K-12 and post-secondary systems to assist students with disabilities with their transition from school to post-school activities. The task force members would include school district representatives, community based provider representatives, and county social service representatives.

While this goal is broader than the scope of the 2014 Stakeholder Group, the stakeholders wanted to emphasize the need for alignment of resources to allow for a positive transition from K-12 to post-school activities. For students with more significant needs, this planning is essential. The 2013 stakeholder group believes that implementation of these goals will result in the reduction of the use of restrictive procedures in the educational setting.

Goal 8 Update: The Legislature did not create a task force for this purpose.

VII. Goals Recommended by Stakeholder Group

The 2014 Stakeholder Group focused its work on reviewing data and implementation of the 2013 statewide plan. All recommendations by the 2014 Stakeholder Group are intended to reduce school districts' use of restrictive procedures and eliminate the use of prone restraint. As set forth in the 2013 statewide plan, the 2014 Stakeholder Group has provided MDE and DHS with flexibility in determining the priority and scope of implementing goal number two, based upon resource issues and data demonstrating effectiveness.

Goal 1: On or before August 1, 2015, MDE will:

Goal 1a: Based upon a review of the restrictive procedure data, MDE staff will contact the districts using prone restraint, and/or high usages of restrictive procedures, prior to August 1, 2015, to identify the areas of technical assistance needed and then facilitate the provision of onsite targeted technical assistance for individual students as needed. The 2014 Stakeholder workgroup supports legislative proposals during the 2015 Legislative Session for the creation of

PRTF in the Twin Cities, Youth Assertive Community Treatment (ACT) Teams, and reciprocity for teachers from other states as well as alternative licensure options.

Goal 1b: Develop a process for school districts to use targeted technical assistance related to reducing the use of restrictive procedures, and eliminating prone restraint by August 1, 2015. MDE will meet with the Restrictive Procedures stakeholders, including DHS, to discuss training and resources, and also partner with the National Alliance on Mental Illness (NAMI) and other appropriate advocacy agencies regarding parent resources. Targeted technical assistance may include teams from the intermediate districts or other level four programs to help provide expertise, including practical tools. The Stakeholder Group will explore the possibility of developing a video and contacting the regional centers to notify districts of this training opportunity.

Goal 1c: Update the MDE Sample Restrictive Procedures Plan and post it on its website in accordance with Minnesota Statutes section 125A.0942.

Goal 1d: Make publically accessible, in an electronic format on MDE's website, information pertaining to how schools/school districts may access local mental health services for their students including ACT teams and mobile crisis response teams

Goal 1e: Make publically accessible, in an electronic format on MDE's website, information pertaining to DHS's Positive Support Community of Practice bi-weekly live stream meetings.

Goal 1 Action Items

- **MDE:** Responsible to implement Goal 1, a-e.
- **DHS:** Collaborate with MDE for Goal 1b. Provide information to MDE related to Goal 1d and 1e.
- **School Districts:** Request or utilize offered targeted technical assistance, collect and report in summary form the use of reasonable force when it results in the use of a physical hold or seclusion on a student with a disability; and to utilize the resources made available on the MDE website regarding accessing local mental health services and the DHS live stream meetings.
- **All Stakeholders:** Support the Legislative Proposals outlined in Goal 1a.

Goal 2: Beginning in March 2014, MDE will continue collaboration with DHS by:

a. Supporting implementation of evidence-based practices for positive behavior strategies through the channels already developed by DHS's Continuing Care Administration and Children's Mental Health Division, Positive Support Community of Practice;

b. Identifying systems for culturally responsive resource identification, consistent with the Positive Support Community of Practice, by collaborating with the Children's Mental Health and Disability Services Division of DHS, including at least the following:

i. prevention;

ii. quality improvement;

iii. intensive intervention; and

iv. systems collaboration.

At future Stakeholder meetings, MDE will share resources from the PBIS Center that address cultural inequity.

c. Researching three cross-expertise training models for statewide use:

i. a continuum of treatment and educational service options for students with a combination of severe mental illnesses and developmental disabilities, including Fetal Alcohol Spectrum Disorder;

ii. in collaboration with emotional and behavioral disorders (EBD) experts and mental health experts, develop an EBD training model that addresses strategies to reduce restrictive procedures used on students with severe aggressive/self-injurious behaviors; and

iii. in collaboration with autism spectrum disorder (ASD) experts, develop an ASD training model that addresses strategies to reduce restrictive procedures used on students with severe intellectual impairments and aggressive/self-injurious behaviors.

If a Request for proposal (RFP) application is accepted and the training materials are developed in accordance with the RFP, the training will be disseminated on MDE's website and DVDs will be made available as an alternate format.

d. Identifying options for experts and expert review, funding, and other supports for students in need of long term, systemic, and intensive interventions;

e. Supporting the coordinated implementation of the ASD Medical Assistance benefit authorized by the 2013 Legislature with regard to the respective roles of the education, human services, and healthcare systems in providing effective interventions and improving outcomes, including reduction in the use of restrictive procedures;

f. Supporting increased access to mental health treatment, including evidence-based practices, and awareness of mental health services in order to address the symptoms and behaviors of children and youth with mental illnesses, including those with intensive service needs, covered through the MA-IEP program, School CTSS program, School-linked Mental Health Grant program, co-located Mental Health Services, and Mental Health in Schools Act.

Goal 2 involves collaboration between MDE and DHS. Its purpose is to continue the current work and to share expertise for maximum use of resources as the agencies continue to work toward identifying evidence-based practices to address the needs of students with disabilities who are experiencing high rates of restrictive procedures. The 2014 Stakeholder Group provided MDE and DHS with the flexibility to determine the priority and scope of implementing goal number two, based upon resource issues and data demonstrating effectiveness.

APPENDIX A

Goal 2 Action Items

- **MDE and DHS:** Identify resources and experts external to districts, develop, and update referral lists posted to MDE website, and ensure cultural responsiveness.
- **School Districts**: Provide input to MDE regarding resources and experts.
- **Advocacy Organizations:** Identify resources and experts external to districts and ensure parents are informed of the resource directory.

Goal 3: The Restrictive Procedure Workgroup will provide input to any follow-up meetings related to the Mental Health Workforce Summit in order to recommend training to reduce the use of restrictive procedures.

Goal 3 Action Items

- **MDE, DHS and Stakeholder Group:** Participate in any meetings and planning for a follow-up session to the Workforce Summit.

Goal 4: By August 1, 2015, MDE will collaborate with school districts, including, but not limited to, intermediate school districts, DHS, parent advocacy groups, and community partners to discuss different types of trainings related to the reduction of restrictive procedures to be available to the education community. Stakeholders who will participate in the discussions will include ARC, PACER, and Intermediates 287 and 917.

Goal 4 Action Items

- **MDE:** Coordinate setting up meetings to discuss trainings.
- **DHS:** Participate in the meetings and provide information about evidence based best practices.
- **School Districts:** Intermediate and other districts will participate to share effective strategies and resources. School Districts will make staff available to attend trainings.

Goal 5: Consistent with Minnesota's 2013 Olmstead Plan, by June 30, 2015 and each subsequent year, a minimum of 40 additional schools will use the evidence-based practice of PBIS so that students are supported in the most integrated setting. Within this environment of school-wide positive behavior support, districts will train school staff and ensure that compatible school-wide and individual positive behavior approaches align. During the fall of 2015, the stakeholders will review the data from the MDE and DHS case studies of seven sites with effective universal PBIS and effective school linked mental health services.

Goal 6: During the 2015 legislative session, the legislature will consider increasing the general education revenue to allocate state funding for supporting school districts to maintain focus and sustain fidelity of PBIS sites beyond the current two-year support for PBIS implementation. Districts will apply to MDE for state funding through an application process, which will include a requirement that school districts collect and report implementation data. The current cost is anticipated to be $240,000 and will increase as additional school sites complete two years of PBIS training. MDE will assign a priority for schools where students are experiencing high usages of restrictive procedures.

Goals 5 and 6 Action Items

- **MDE:** Provide ongoing technical assistance support and strive to adjust the fiscal burden partially away from special education.

- **School Districts:** Strive to create staff investment in the PBIS culture and make staff available for training.
- **University of Minnesota**: Provide training and technical assistance for Tier 3 level of PBIS.
- **Legislature:** Legislative action to establish a general fund stream to sustain PBIS training in school sites beyond the current two-year training, which is federally funded.

Goal 7: Annually, beginning February 1, 2015, MDE will submit a report to the Legislature summarizing the state's progress on reducing the use of restrictive procedures statewide with recommendations on how to further reduce their use. The 2015 Stakeholder Group will meet in the fall to review annual summary data from the 2014-15 school year, and will determine if additional meetings are necessary. The purpose of the meeting(s) is to allow the group to continue policy work to ensure that positive school outcomes, positive school success for students with mental health and behavior health needs, including the receipt of necessary services and delivery, is reviewed and modified as necessary.

Goal 7 Action Items

- **MDE:** Submit a report annually and coordinate meetings of the stakeholder group.
- **School Districts**: Collection and reporting of summary restrictive procedures data, and individual incidents of prone restraint until August 1, 2015.
- **Stakeholder Group**: Meet to review the data and progress toward goals and to review and revise goals as needed,

Goal 8: During the fall 2015 Stakeholder Group meeting, MDE staff and stakeholders will review the grantees' work plans and outcome results to determine if there are successful models that can be applied to other districts. During the 2015-16 school year, the stakeholders will discuss ways to share the results.

Goal 8 Action Items:

- **MDE**: Provide copies of the grantees' work plans and outcome results to the 2014 Stakeholder Group at the fall 2015 meeting.
- **Grantees**: Timely provide to MDE outcome results for their work plans and participate in discussions at the fall 2014 workgroup meeting.
- **Stakeholder Group**: Meet to review the grantees' work plans and outcome results and determine if there are successful models that can be applied to other districts. Discuss how to share the results.

Goal 9: During the fall 2015 Stakeholder Group meeting, MDE staff and stakeholders will review the student and staff injury data reported by districts in the annual restrictive procedure summary report for the 2013-14 and 2014-15 school years.

Goal 9 Action items:

- **MDE:** Provide a summary of the student and staff injury data reported by districts on the annual summary form for the 2013-14 and 2014-15 school years at the fall 2015 Stakeholder Group meeting.

- **Districts:** Provide staff and student injury data to MDE on the annual summary restrictive procedure summary form.
- **Stakeholder group:** Review the data at the fall 2015 Stakeholder Group meeting.

VIII. Recommendations

1. Support Stakeholder-Driven Changes to Statute.

The 2014 stakeholder group recommended that the Minnesota Legislature amend Minnesota Statutes, section 125A.0942 to make prone restraint a prohibited procedure, effective August 1, 2015. This recommendation aligns with the Minnesota Revised Olmstead Plan.

The 2014 stakeholder group also recommended that the Minnesota Legislature amend Minnesota Statutes, section 125A.0942 subdivision 3(b) to make the development of a statewide plan permissive. This allows the 2014 stakeholder group to work on the 2014 statewide plan and only make revisions to that plan as necessary.

The 2014 stakeholder group also recommended that the Legislature appropriate $250,000 to be available beginning with the 2015-16 school year, to ensure students can continue to be educated in the least restrictive environment with appropriate behavior interventions, supports, and expertise, and to avoid student placements into more restrictive environments to receive such services. The funds will be used to reimburse expert teams, as described in Goal 1b. The 2014 stakeholder group agreed that the funds are needed to provide training and services to district staff so that students can be educated in the least restrictive environment.

125A.0942 STANDARDS FOR RESTRICTIVE PROCEDURES.

Subdivision 1. **Restrictive procedures plan**. (a) Schools that intend to use restrictive procedures shall maintain and make publicly accessible in an electronic format on a school or district website or make a paper copy available upon request describing a restrictive procedures plan for children with disabilities that at least:

(1) lists the restrictive procedures the school intends to use;

(2) describes how the school will implement a range of positive behavior strategies and provide links to mental health services;

(3) describes how the school will provide training on de-escalation techniques, in accordance with 122A.09 Subd. 4.

(3) describes how the school will monitor and review the use of restrictive procedures, including:

(i) conducting post-use debriefings, consistent with subdivision 3, paragraph (a), clause (5); and

(ii) convening an oversight committee to undertake a quarterly review of the use of restrictive procedures based on patterns or problems indicated by similarities in the time of day, day of the week, duration of the use of a procedure, the individuals

involved, or other factors associated with the use of restrictive procedures; the number of times a restrictive procedure is used schoolwide and for individual children; the number and types of injuries, if any, resulting from the use of restrictive procedures; whether restrictive procedures are used in nonemergency situations; the need for additional staff training; and proposed actions to minimize the use of restrictive procedures; and

(4) includes a written description and documentation of the training staff completed under subdivision 5.

(b) Schools annually must publicly identify oversight committee members who must at least include:

(1) a mental health professional, school psychologist, or school social worker;

(2) an expert in positive behavior strategies;

(3) a special education administrator; and

(4) a general education administrator.

Subd. 2. **Restrictive procedures**. (a) Restrictive procedures may be used only by a licensed special education teacher, school social worker, school psychologist, behavior analyst certified by the National Behavior Analyst Certification Board, a person with a master's degree in behavior analysis, other licensed education professional, paraprofessional under section 120B.363, or mental health professional under section 245.4871, subdivision 27, who has completed the training program under subdivision 5.

(b) A school shall make reasonable efforts to notify the parent on the same day a restrictive procedure is used on the child, or if the school is unable to provide same-day notice, notice is sent within two days by written or electronic means or as otherwise indicated by the child's parent under paragraph (f).

(c) The district must hold a meeting of the individualized education program team, conduct or review a functional behavioral analysis, review data, consider developing additional or revised positive behavioral interventions and supports, consider actions to reduce the use of restrictive procedures, and modify the individualized education program or behavior intervention plan as appropriate. The district must hold the meeting: within ten calendar days after district staff use restrictive procedures on two separate school days within 30 calendar days or a pattern of use emerges and the child's individualized education program or behavior intervention plan does not provide for using restrictive procedures in an emergency; or at the request of a parent or the district after restrictive procedures are used. The district must review use of restrictive procedures at a child's annual individualized education program meeting when the child's individualized education program provides for using restrictive procedures in an emergency.

(d) If the [IEP] team under paragraph (c) determines that existing interventions and supports are ineffective in reducing the use of restrictive procedures or the district

uses restrictive procedures on a child on ten or more school days during the same school year, the team, as appropriate, either must consult with other professionals working with the child; consult with experts in behavior analysis, mental health, communication, or autism; consult with culturally competent professionals; review existing evaluations, resources, and successful strategies; or consider whether to reevaluate the child.

(e) At the [IEP] meeting under paragraph (c), the team must review any known medical or psychological limitations, including any medical information the parent provides voluntarily, that contraindicate the use of a restrictive procedure, consider whether to prohibit that restrictive procedure, and document any prohibition in [IEP] or [BIP].

(f) An [IEP] team may plan for using restrictive procedures and may include these procedures in a child's individualized education program or behavior intervention plan; however, the restrictive procedures may be used only in response to behavior that constitutes an emergency, consistent with this section. The [IEP] or [BIP] shall indicate how the parent wants to be notified when a restrictive procedure is used.

Subd. 3. **Physical holding or seclusion**. (a) Physical holding or seclusion may be used only in an emergency. A school that uses physical holding or seclusion shall meet the following requirements:

(1) physical holding or seclusion is the least intrusive intervention that effectively responds to the emergency;

(2) physical holding or seclusion is not used to discipline a noncompliant child;

(3) physical holding or seclusion ends when the threat of harm ends and the staff determines the child can safely return to the classroom or activity;

(4) staff directly observes the child while physical holding or seclusion is being used;

(5) each time physical holding or seclusion is used, the staff person who implements or oversees the physical holding or seclusion documents, as soon as possible after the incident concludes, the following information:

(i) a description of the incident that led to the physical holding or seclusion;

(ii) why a less restrictive measure failed or was determined by staff to be inappropriate or impractical;

(iii) the time the physical holding or seclusion began and the time the child was released; and

(iv) a brief record of the child's behavioral and physical status;

(6) the room used for seclusion must:

(i) be at least six feet by five feet;

(ii) be well lit, well ventilated, adequately heated, and clean;

(iii) have a window that allows staff to directly observe a child in seclusion;

(iv) have tamperproof fixtures, electrical switches located immediately outside the door, and secure ceilings;

(v) have doors that open out and are unlocked, locked with keyless locks that have immediate release mechanisms, or locked with locks that have immediate release mechanisms connected with a fire and emergency system; and

(vi) not contain objects that a child may use to injure the child or others;

(7) before using a room for seclusion, a school must:

(i) receive written notice from local authorities that the room and the locking mechanisms comply with applicable building, fire, and safety codes; and

(ii) register the room with the commissioner, who may view that room, and(b) By February 1, 2015, and annually thereafter, stakeholders may, as necessary, recommend to the commissioner specific and measurable implementation and outcome goals for reducing the use of restrictive procedures and the commissioner must submit to the legislature a report on districts' progress in reducing the use of restrictive procedures that recommends how to further reduce these procedures. The statewide plan includes the following components: measurable goals; the resources, training, technical assistance, mental health services, and collaborative efforts needed to significantly reduce districts' use of prone restraints; and recommendations to clarify and improve the law governing districts' use of restrictive procedures. The commissioner must consult with interested stakeholders when preparing the report, including representatives of advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, county social services, state human services department staff, mental health professionals, and autism experts. By June 30 each year, districts must report summary data on their use of restrictive procedures to the department, in a form and manner determined by the commissioner. The summary data must include information about the use of restrictive procedures, including use of reasonable force under section 121A.582.

~~(8) until August 1, 2015, a school district may use prone restraints with children age five or older if:~~

~~(i) the district has provided to the department a list of staff who have had specific training in the use of prone restraints;~~

~~(ii) the district provides information on the type of training that was provided and by whom;~~

~~(iii) only staff who received specific training use prone restraints; and~~

~~(iv) each incident of the use of prone restraints is reported to the department within five working days on a form provided by the department.~~

APPENDIX A

Subd. 4. **Prohibitions**. The following actions or procedures are prohibited:

(1) engaging in conduct prohibited under section 121A.58;

(2) requiring a child to assume and maintain a specified physical position, activity, or posture that induces physical pain;

(3) totally or partially restricting a child's senses as punishment;

(4) presenting an intense sound, light, or other sensory stimuli using smell, taste, substance, or spray as punishment;

(5) denying or restricting a child's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the child's functioning, except when temporarily removing the equipment or device is needed to prevent injury to the child or others or serious damage to the equipment or device, in which case the equipment or device shall be returned to the child as soon as possible;

(6) interacting with a child in a manner that constitutes sexual abuse, neglect, or physical abuse under section 626.556;

(7) withholding regularly scheduled meals or water;

(8) denying access to bathroom facilities;

(9) Effective August 1, 2015, prone restraint, and

(10) physical holding that restricts or impairs a child's ability to breathe, restricts or impairs a child's ability to communicate distress, places pressure or weight on a child's head, throat, neck, chest, lungs, sternum, diaphragm, back, or abdomen, or results in straddling a child's torso.

Subd. 5. **Training for staff.** (a) To meet the requirements of subdivision 1, staff who use restrictive procedures, including paraprofessionals, shall complete training in the following skills and knowledge areas:

(1) positive behavioral interventions;

(2) communicative intent of behaviors;

(3) relationship building;

(4) alternatives to restrictive procedures, including techniques to identify events and environmental factors that may escalate behavior;

(5) de-escalation methods;

(6) standards for using restrictive procedures only in an emergency;

(7) obtaining emergency medical assistance;

(8) the physiological and psychological impact of physical holding and seclusion;

(9) monitoring and responding to a child's physical signs of distress when physical holding is being used;

(10) recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding is used;

(11) district policies and procedures for timely reporting and documenting each incident involving use of a restricted procedure; and

(12) school-wide programs on positive behavior strategies.

(b) The commissioner, after consulting with the commissioner of human services, must develop and maintain a list of training programs that satisfy the requirements of paragraph (a). The commissioner also must develop and maintain a list of experts to help [IEP] teams reduce the use of restrictive procedures. The district shall maintain records of staff who have been trained and the organization or professional that conducted the training. The district may collaborate with children's community mental health providers to coordinate trainings.

Subd. 6.Behavior supports; reasonable force.

(a) School districts are encouraged to establish effective schoolwide systems of positive behavior interventions and supports.

(b) Nothing in this section or section 125A.0941 precludes the use of reasonable force under sections 121A.582; 609.06, subdivision 1; and 609.379. For the 2014-15 school year and later, districts must collect and submit to the commissioner summary data, consistent with subdivision 3, paragraph (b), on district use of reasonable force that is consistent with the definition of physical holding or seclusion for a child with a disability under this section.

2. Support Stakeholder Planned Action Items

MDE supports the consensus-based recommendations reached by the 2014 stakeholder group regarding actions that various stakeholders, agencies and the legislature can take to best ensure a reduction in the use of restrictive procedures in the Minnesota education system. As such, MDE recommends the above goals to reduce the use of restrictive procedures and eliminate prone restraints.

3. Strengthen Pre-Enrollment Screening

Pre-enrollment screening for change of placement should be conducted for students exhibiting challenging behaviors in order to pair consequences (both in emergency and in modification) with individual needs. This screening data should include a current (within the past 30 days) functional behavior assessment to ensure that receiving districts are able to design behavior response plans that are specific to the needs of the student.

Very often, intermediate school districts are the receiving districts in these situations. By relying on thorough pre-enrollment screening based on a detailed report of what prior interventions were used and their effect, intermediates and other receiving districts will be better equipped to address student needs. With this data, intermediate districts will have more effective tools for designing individualized and instructional behavior improvement plans that reflect interventions that are least restrictive for students.

APPENDIX B 2015

Legislative Language or **Policy Guidance** Currently in Effect in All States Relating Specifically to Prone Restraint or Restraint that Restricts or Impairs a Child's Ability to Breathe Within the School Setting

State	Citation	Language	
Alabama	Ala. Admin. Code r. 290-3-1-.02(1)(f)(1) (2014)	Prohibits: "(iv) Physical Restraint that restricts the flow of air to the student's lungs—Any method (face-down, face-up, or on your side) of physical restraint in which physical pressure is applied to the student's body that restricts the flow of air into the student's lungs. Use of this type of restraint is prohibited in Alabama public schools and educational programs."	Applies to all children
Alaska	HB 210 amends Alaska Stat. 14.33.120(c) (2014)	"A teacher, teacher's assistant, or other person responsible for students may not ...(3) physically retrain a student by placing the student on the student's back or stomach or in a manner that restricts the student's breathing."	Applies to children with disabilities
Arizona	The Use of Seclusion and Restraint: A Guidance Document on Best Practices Arizona Dept. Of Educ. (2014)	Prohibit some disciplinary procedures including a "physical restraint that places excess pressure on the chest or back or impedes the ability to breather or communicate is prohibited."	Applies to all children with disabilities
Arkansas	Arkansas Dept. of Educ. Advisory Guidelines for the Use of Student Restraints in Public School or Educational Settings, p. 13 (2014)	Prone restraint or other restraints that restrict breathing should never be used because they can cause serious injury or death."	Applies to all children

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State	Citation	Language	
California	Cal. Code Reg. tit. 5, § 3052(i)(4)(B)-(C) and (l)(1) and (5) (2013)	(i)(4) Emergency interventions may not include:...(B) employment of a device or material or objects which simultaneously immobilize all four extremities except that techniques such as prone containment may be used as an emergency intervention by staff trained in such procedures; and (C) an amount of force that exceeds that which is reasonable and necessary under the circumstances. (l) Prohibitions. (1) Any intervention that is designed to, or likely to, cause physical pain; (5) "Restrictive interventions which employ a device or material or objects that simultaneously immobilize all four extremities, including the procedure known as prone containment, except that prone containment or similar techniques may be used by trained personnel as a limited emergency intervention pursuant to subdivision (i)."	Applies to children with disabilities
Colorado	Colo. Code Reg. tit. 1, §§ 301-45, 2620-R-2.00 et seq. (2009)	2620-R-2.00(4) defines "positional asphyxia" to mean "an insufficient intake of oxygen as a result of body position that interferes with one's ability to breathe." 2620-R-2.02(1)(a) "the public education program shall ensure that: (i) no restraint is administered in such a way that the student is inhibited or impeded from breathing or communicating; (ii) no restraint is administered in such a way that places excess pressure on the student's chest, back, or causes positional asphyxia."	Applies to all children
Connecticut	Conn. Gen. Stat. §§ 46a-150(4) and 46a-151 Conn. Admin. Regs. §§ 10-76b-510-76b-11	46a-150(4) defines "life-threatening physical restraint" to mean "any physical restraint or hold of a person that restricts the flow of air into a person's lungs, whether by chest compression or any other means." 46a-151 prohibits the use of life-threatening physical restraint.	Applies to children with disabilities

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State	Citation	Language	
Delaware	Del. Code Chapt. 41, tit. 14 § 4112F (effective 7.1.14)	(b) Prohibitions and restriction on use. (2) Public school personnel may impose physical restraint only in conformity with all of the following standards: … (b) The physical restraint does not interfere with the student's ability to communicate in the student's primary language or mode of communication; (c) the physical restraint does not interfere with the student's ability to breathe or place weight or pressure on the student's head, throat, or neck; (d) the physical restraint does not recklessly exacerbate a medical or physical condition of the student …	Applies to all children
District of Columbia	57 D. C. Reg. 9457	2818.1 "Nonpublic special education school or program shall not use any form of prone restraint on a District of Columbia student. Use of such restraints as a policy or practice shall be grounds for denying or revoking a certificate of approval."	Applies to children with disabilities
Florida	Fla. Stat. § 1003.573	(4) Prohibited restraint. "School personnel may not use a mechanical restraint or a manual or physical restraint that restricts a student's breathing."	Applies to children with disabilities
Georgia	Ga. Comp. R. & r. 160-5-1-3.5	"(2)(b) The use of prone restraint is prohibited in Georgia public schools and educational programs."	Applies to all children
Hawaii	Haw. Rev. Stat. § 302A-1141[45]	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to children with disabilities
Idaho[46]		No laws or guidance on restraints.	

[45] Provides: No physical punishment of any kind may be inflicted upon any pupil, but reasonable force may be used by a teacher in order to restrain a pupil in attendance at school from hurting oneself or any other person or property, and reasonable force may be used … by a principal or the principal's agent only with another teacher present and out of the presence of any other student but only for the purpose outlined in § 703-309(2)(a)."

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State	Citation	Language	
Illinois	105 Ill. Comp. Stat. § 5/10-20.33 Ill. Admin. Code, tit. 23, § 1.285	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to all children
Indiana	Indiana SB 0345 (passed 5.13.13) Commission on Seclusion and Restraint in Schools, Model Seclusion and Restraint Plan[47] (8.1.13)	Requires a commission to adopt rules and model policy pertaining to seclusion and restraint. Model plan provides: IG. "Prone and supine forms of restraint are not authorized and shall be avoided." IH. "Seclusion and restraint shall never be used in a manner that restricts a child's breathing or harms the child."	Applies to all children
Iowa	Iowa Admin. Code r. 281-103.8	"(1) No employee shall use any prone restraints. For the purposes of this rule, "prone restraints" means those in which an individual is held face down on the floor. Employees who find themselves involved in the use of a prone restraint as the result of responding to an emergency must take immediate steps to end the prone restraint."	Applies to all children
Kansas	32 Kansas Register No. 14, 317 (April 4, 2013)	91-42-2(a)(1)(A) "Policies and procedures shall prohibit the following: (i) The use of prone, face-down, physical restraint; or face-up, physical restraint; physical restraint that obstructs the airway of a student; or any physical restraint that impacts a student's primary mode of communication."	Applies to all children

[46] Task force established in Aug. 2010 with proposed rules (IDAPA 08.02.03.160-161) however no action was taken.

[47] Schools are free to adopt a model plan as they see fit. However, any plan adopted by a school must contain, at a minimum, the elements listed in Indiana Code 20-20-40-13.

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State	Citation	Language	
Kentucky	704 Kentucky Admin. Regs. 7:160 (2013)	Section 3(2) "School personnel shall not impose the following on any student at any time: ... (d) Physical restraint that is life-threatening; (e) Prone or supine restraint; or (f) Physical restrict if they know that physical restraint is contraindicated based on the student's disability, health care needs, or medical or psychiatric condition."	Applies to all children
Louisiana	La. Rev. Stat. § 17:416.21(C)	(1)"Physical restraint shall be used only ... (c) In a manner that causes no physical injury to the student, results in the least possible discomfort, and does not interfere in any way with a student's breathing or ability to communicate with others;" . . . (3) "No student shall be physically restrained in a manner that places excessive pressure on the student's chest or back or that causes asphyxia; (4) A student shall be physically restrained only in a manner that is directly proportionate to the circumstances and to the student's size, age, and severity of behavior."	Applies to children with disabilities
Maine	LD 243[48] (passed 2013) 05-071 Department of Education, Chapter 33, Section 6	"2. Prohibited forms and uses of physical restraint ... C) No physical restraint may be used that restricts the free movement of the diaphragm or chest or that restricts the airway so as to interrupt normal breathing or speech (restraint-related positional asphyxia) of a student; D) No physical restraint may be used that relies on pain for control, including but not limited to joint hypertension, excessive force, unsupported take-down (e.g. tackle), the use of any physical structure (e.g. wall, railing or post), punching and hitting."	Applies to all children

[48] Revised existing statutory provisions pertaining to physical holding and seclusion.

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State	Citation	Language	
Maryland	Md. Regs. Code tit. 13A. § 13A.08.04.05(A)(1)(e)	Provides: "In applying restraint, school personnel may not: (i) Place a student in a face down position; (ii) Place a student in any position that will obstruct a student's airway or otherwise impair a student' s ability to breathe, obstruct a staff member's view of a student's face, restrict a student's face, restrict a student's ability to communicate distress, or place pressure on a student's head, neck, or torso; or (iii) straddle a student's torso."	Applies to all children
Massachusetts	Mass. Regs. Code, tit. 603, § 46.05(3) § 46.05(5)(a)	"Safest method. A person administering physical restraint shall use the safest method available and appropriate to the situation subject to the safety requirements set forth in 603 CMR 46.05(5). Floor or prone restraints shall be prohibited unless the staff member administering the restraint has received in-depth training according to the requirements of 603 CMR 46.03(3) and, in the judgment of the trained staff member, such method is required to provide safety for the student or others present." "Safety requirements. Additional requirements for the use of physical restraint: (a) No restraint shall be administered in such a way that the student is prevented from breathing or speaking. During the administration of a restraint, a staff member shall continuously monitor the physical status of the student, including skin color and respiration."	Applies to all children

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State	Citation	Language	
Michigan	Supporting Student Behavior: Standards for the Emergency Use of Seclusion and Restraint, p. 18 Dec. 2006 Michigan Department of Education	"E. Prohibited Practices. The following procedures are prohibited under all circumstances, including emergency situations: … any restraint that negatively impacts breathing; prone restraint: school personnel who find themselves involved in the use of a prone restraint as the result of responding to an emergency must take immediate steps to end the prone restraint." "Prone restraint is the restraint of a person face down." "restraints that negatively impact breathing include floor restraints, facedown position, or any position in which a person is bent over in such a way that it is difficult to breathe. This includes a seated or kneeling position in which a person being restrained is bent over at the waist. Sitting or lying across a person's back or stomach can interfere with breathing. When a person is lying facedown, even pressure to the arms and legs can interfere with a person's ability to move their chest or abdomen in order to breathe effectively."	Applies to all children

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State	Citation	Language	
Minnesota	Minn. Stat. §§ 125A.094 - .0942	Minn. Stat. § 125A.0942, Subd. 4(9) prohibits "physical holding that restricts or impairs a child's ability to breathe, restricts or impairs a child's ability to communicate distress, places pressure or weight on a child's head, throat, neck, chest, lungs, sternum, diaphragm, back, or abdomen, or results in straddling a child's torso." Minn. Stat. § 125A.0942, Subd. 3(a)(8) provides "until August 1, 2015, a school district may use prone restraints with children age five or older if: (i) the district has provided to the department a list of staff who have had specific training on the use of prone restraints; (ii) a district provides information on the type of training that was provided and by whom; (iii) only staff who received specific training use prone restraints; (iv) each incident of the use of prone restraints is reported to the department within five working days on a form provided by the department; and (v) the district, before using prone restraints, must review any known medical or psychological limitations that contraindicate the use of prone restraints."	Applies to children with disabilities
Mississippi		No laws or guidance on restraints.	

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State	Citation	Language	
Missouri	Mo. Rev. Stat. § 160.263 Missouri Dep't of Elementary and Secondary Educ., Model Policy on Seclusion and Restraint (July, 2010), p. 2	State statute requires all school districts to adopt a written policy addressing the use of restrictive behavioral interventions, including but not limited to definitions of restraint, seclusion, and time-out and descriptions of circumstances under which a restrictive behavioral intervention is allowed and prohibited. It also required the state education agency to develop a model policy. The model policy states that "[t]his policy is not an endorsement of the use of seclusion and restraint. A school district may adopt a policy prohibiting the use of seclusion, isolation or restraint." It further provides that "[p]hysical restraint shall: not place pressure or weight on the chest, lungs sternum, diaphragm, back, neck or throat of the student which restricts breathing."	Applies to all children
Montana	Montana Admin. R. 10.16.3346	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to children with disabilities

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State	Citation	Language	
Nebraska	Nebraska Adim. Code, tit. 92, R. 10, § 011.01(E) Nebraska Educ. Dept., Developing School Policies & Procedures for Physical Restraint and Seclusion in Nebraska Schools, (June, 2010), pp. 12, 27, 29, and 34	"Each school system has a seclusion and restraints policy approved by the school board or local governing body." At this time Nebraska does not have any statutes, regulations, or state policies regarding restraint or seclusion but schools are required to have school safety and security committees in charge of developing safety and security plans for each school in order to be accredited. Procedures related to these procedures "could be interpreted as coming under the scope of Nebraska's school safety policies," p. 12. Each school district may choose to format its policies according to its own practices, p. 27. Model policies include the following language: "The only physical restraints to be used are those taught by the approved Crisis Intervention Training Program," p. 29 and "Prone or supine forms of physical restraint are not authorized and should be avoided," p. 34.	Applies to all children
Nevada	Nev. Rev. Stat. §§ 388.521 – 388.5317[49] (1999)	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to children with disabilities

[49] Meaningful protections against seclusion and restraint but no specific prohibitions on prone restraint or restraints that restrict or impair a child's ability to breathe.

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State	Citation	Language	
New Hampshire	N.H. Rev. Stat. Ann. §§ 126-U:1 – 126-U:14	126-U: 4 "Prohibition of Dangerous Restraint Techniques. No school or facility shall use or threaten to use any of the following restraint and behavior control techniques: I) Any physical restraint or containment technique that: a) obstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing; b) places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child; c) obstructs the circulation of blood; d) involves pushing on or into the child's mouth, nose, eyes, or any part of the face or involves covering the face or body with anything, including soft objects such as pillows, blankets, or washcloths; or e) endangers a child's life or significantly exacerbates a child's medical condition."	Applies to all children

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State	Citation	Language	
New Jersey	New Jersey Dept. of Educ. Guidance Memo 2012-5 (9.18.12)	"The New Jersey Department of Education, Office of Special Education, endorses the use of [the United States Department of Education, Office of Special Education and Rehabilitative Services (USDE OSERS) May 15, 2012, Guidance Document] when developing Individual Education Programs (IEPs) which address the behavioral needs of students with disabilities."	Applies to all children
New Mexico[50]	State of New Mexico Public Educ. Dep't, Use of Physical Restraint as a Behavioral Intervention for Students with Disabilities, Memorandum (March 14, 2006)	Memorandum, pp. 3-4 "Offers the following guidance to IEP teams and building administrators: . . . No form of physical restraint may be used that restricts a student from speaking or breathing."	Applies to children with disabilities
New York	N.Y. Comp. R. and Regs., tit. 8, §§ 19.5(b) and 200.22[51] (2009)	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to all children
North Carolina	N.C. Gen. Stat. §§ 115C-391.1[52]	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to all children

[50] New Mexico does have a Children's Mental Health and Developmental Disabilities Act, which provides, under N.M. Stat. Ann. § 32A-6A-10(I), "In applying physical restraint, a mental health or developmental disabilities professional shall use only reasonable force as is necessary to protect the child or other person from imminent and serious physical harm." Additionally, in 2010, a legislative education study committee was proposed and a Restraint & Seclusion Work Group was created.

[51] New York has meaningful protections against the use of seclusion and restraint, however, such does not include any prohibition on prone restraint or restraints that restrict or impair a child's ability to breathe.

[52] North Carolina has meaningful protections against the use of seclusion and restraint, however, such does not include any prohibition on prone restraint or restraints that restrict or impair a child's ability to breathe.

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State	Citation	Language	
North Dakota		No laws or guidance on restraints.	
Ohio	Ohio Admin. Code § 3301-35-15 (Effective Aug. 1, 2013)	(C) "Prohibition on certain practices. The following practices are prohibited by school personnel under any circumstance: (1) prone restraint; (2) Any form of physical restraint that involves the intentional, knowing, or reckless use of any technique that: (a) involves the use of pinning down a student by placing knees to the torso, head, or neck of the student; (b) uses pressure point, pain compliance, or joint manipulation techniques; or (c) otherwise involves techniques that are used to unnecessarily cause pain." (D) "Physical restraint. (1) Prone restraint is prohibited … (2) Physical restraint may be used only if …(b) The physical restraint does not obstruct the student's ability to breathe; (c) The physical restraint does not interfere with the student's primary language or mode of communication…"	Applies to all children
Oklahoma	Oklahoma State Dep't of Educ., Guidelines for Minimizing the Use of Physical Restraint for Students with Disabilities in Oklahoma (May 2010)	"Prone restraints (restraints that position a student face down on his or her stomach or face up on the back) or any maneuver that places pressure or weight on the chest, sternum, lungs, diaphragm, neck, throat, or back must not be used. No restraint that prevents a student from speaking or breathing is allowed."	Applies to children with disabilities

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State	Citation	Language	
Oregon	OR Admin. R. 581-021-0550 to -0570 (2013)	OAR 581-021-0553: (1) "The use of a chemical restraint, mechanical restraint or prone restraint on a student in a public education program in this state is prohibited." "Prone restraint means a restraint in which a student is held face down on the floor." OAR 581-021-0550. "'Physical restraint' does not include prone restraint." OAR 581-021-0550.	Applies to all children
Pennsylvania	22 Pa. Code § 14.133(c)(3)	Provides "The use of prone restraints is prohibited in educational programs. Prone restraints are those in which a student or eligible young child is held face down on the floor."	Applies to children with disabilities

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State	Citation	Language	
Rhode Island	R.I. Bd. of Regents for Elementary and Secondary Education, Physical Restraint Regulations, 6.2(e) and 7.3(a) (September 1, 2002)	"6.2 Prohibitions: Physical restraint/crisis intervention are prohibited in the following circumstances:... (e) As in a restrictive intervention which employs a device or material or objects that simultaneously immobilize all four extremities, including the procedure known as prone containment, except that prone containment may be used by trained personnel as a limited emergency intervention when a documented part of a previously agreed upon written behavioral intervention plan." "7.3 Safety Requirements. Additional requirements for the use of physical restraint/crisis intervention are: (a) No restraint shall be administered in such a way that the student is prevented from breathing or speaking. During the administration of a restraint, a staff member shall continuously monitor the physical status of the student, including skin color and respiration. A restraint shall be released immediately upon a determination by the staff member administering the restraint that the student is no longer at risk of causing imminent physical harm to him or herself or others. (b) Restraint shall be administered in such a way so as to prevent or minimize physical harm. If, at any time during a physical restraint/crisis intervention, the student demonstrates significant physical distress, the student shall be released from the restraint immediately, and school staff shall take steps to seek medical assistance. (c) Program staff shall review and consider any known medical or psychological limitations and/or behavioral intervention plans regarding the use of physical restraint/crisis intervention on an individual student."	Applies to all children

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State	Citation	Language	
South Carolina	South Carolina Dep't of Educ., Guidelines on the Use of Seclusion and Restraint (2011), p. 8	"Prone restraints (with the student face down on his or her stomach) or supine restraints (with the student face up on the back) or any maneuver that places pressure or weight on the chest, lungs, sternum, diaphragm, back, neck or throat are prohibited."	Applies to children with disabilities
South Dakota		No laws or guidance on restraints.	
Tennessee	Tenn. Code Ann. § 49-10-1305(d)	"Any form of life threatening restraint, including restraint that restricts the flow of air into a person's lungs, whether by chest compression or any other means, to a student receiving special education services … is prohibited."	Applies to children with disabilities
Texas	19 Tex. Admin. Code § 89.1053(c)	"Use of restraint. A school employee, volunteer, or independent contractor may use restraint only in an emergency … with the following limitations. (1) Restraint shall be limited to the use of such reasonable force as is necessary to address the emergency… (3) Restraint shall be implemented in such a way as to protect the health and safety of the student and others. (4) Restraint shall not deprive the student of basic human necessities."	Applies to children with disabilities

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State	Citation	Language	
Utah	Utah Code §§ 53A-11-805 Utah State Office of Education, Least Restrictive Behavioral Interventions LRBI Guidelines, Positive Behavioral Supports and Selection of Least Restrictive Behavioral Interventions[53]	"Behavior reduction intervention which is in compliance with section 76-2-401 and with state and local rules adopted under section 53A-15-301 is excepted from this part."	Applies to children with disabilities
Vermont	Vt. Code R. §§ 4500 et seq.	4500.3(9) defines prone physical restraint "means holding a student face down on his or her stomach using physical force for the purpose of controlling the student's movement." 4502.1.1 provides "prone and supine physical restraints are more restrictive than other forms of physical restraint and may be used only when the student's size and severity of behavior require such a restraint because a less restrictive restraint has failed or would be ineffective to prevent harm to the student or others." 4501.1(c) prohibits school personnel and contract service providers from imposing on a student "any physical restraint, escort, or seclusion that restricts or limits breathing or communication, causes pain or is imposed without maintaining direct visual contact."	Applies to all children

[53] Utah has guidance found in this document. Nothing that discusses prone or restricts and impairs a child's ability to breathe.

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State	Citation	Language	
Virginia	Virginia Depart. of Educ., Guidelines for the Development of Policies and Procedures For Managing Student Behaviors in Emergency Situations in Virginia Public Schools (2009)	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to all children
Washington	Wash. Admin. Code § 392-172A-03125 (2013)	3(a) "Force and restraint in general. No force or restraint which is either unreasonable under the circumstances or deemed to be an unreasonable form of corporal punishment as a matter of state law may be used. See RCW 9A.16.100 which cites the following uses of force or restraint as uses which are presumed to be unreasonable and therefore unlawful … (iv) interfering with a student's breathing."	Applies to all children
West Virginia	W. Va. Code St. R. § 26-99	"A school employee and/or independent contractor may use restraint in an emergency as defined above with the following limitations: Restraint shall be limited to the use of such reasonable force as is necessary to address the emergency. Procedures and maneuvers that restrict breathing (e.g. prone restraint), place pressure or weight on the chest, lungs, sternum, diaphragm, back, neck or throat, or may cause physical harm are prohibited."	Applies to all children

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State	Citation	Language	
Wisconsin	2011 Act 125 Seclusion and Restraint (2012)	Section 2(3)(d) "None of the following maneuvers or techniques are used: 1) Those that do not give adequate attention and care to protecting the pupil's head. 2) Those that cause chest compression by placing pressure or weight on the pupil's chest, lungs, sternum, diaphragm, back, or abdomen. 3) Those that place pressure or weight on the pupil's neck or throat, on an artery, or on the back of the pupil's head or neck, or that otherwise obstruct the pupil's circulation or breathing. 4) Those that constitute corporal punishment."	Applies to all children
Wyoming	Wyo. Stat. § 21-2-202 Wyo. Educ. Rules 42-1 to 42-8 (Jan. 2012)	42-7(b)(i)(B): "Schools shall not utilize aversive interventions, mechanical restraints, or prone restraints at any time"	Applies to all children

Minnesota Department of Education

Note: this is NOT a comprehensive list; as programs are identified and information provided to the Minnesota Department of Education, it will be revised accordingly. "No Evidence" does not indicate the required element is not included in the program; it indicates no available documentation was provided and/or restrictive procedures are not part of the training program. The list will be revised at regular intervals as additional documentation becomes available. The purpose of the list is to assist users to identify existing programs that may inform the development of a more comprehensive Restrictive Procedures Plan outlined in Minnesota Statutes section 125A.0942, Subd. 1. No individual program can address implementation with fidelity, and the creation of a supporting infrastructure to ensure the plan is executed as intended. Contact has been initiated with the Minnesota Department of Human Services as per Minnesota Statutes section 125A.0942, Subd. 5. (b).

Crisis Prevention/Intervention Training Programs

Training Requirements — Training Programs

Training Requirements	*Crisis Consultant Group, LLC*	*Handle with Care*	*Managing Aggressive Behavior*	*Mandt System*
Positive behavioral interventions	No Evidence	No Evidence	No Evidence	Resources
Communicative intent of behaviors	No Evidence	Information	No Evidence	Information
Relationship building	Training	Information	Resources	Resources
Alternatives to restrictive procedures	Information	Training	Training	Training
De-escalation methods	Training	Training	Training	Training
Standards for using restrictive procedures	Training	Training	Resources	Resources
Obtaining emergency medical assistance	Information	No Evidence	No Evidence	Information
Physiological and psychological impact of physical holding and seclusion	Information	No Evidence	Resources	Resources
Monitoring and responding to a child's physical signs of distress	Training	Resources	No Evidence	Information
Recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding used	Training	Resources	No Evidence	Resources
District policies and procedures for timely reporting and documenting each incident involving use of a restrictive procedure	No Evidence	No Evidence	No Evidence	No Evidence
School-wide programs on positive behavior strategies	No Evidence	No Evidence	No Evidence	No Evidence

Minnesota Department of Education

Note: this is NOT a comprehensive list; as programs are identified and information provided to the Minnesota Department of Education, it will be revised accordingly. "No Evidence" does not indicate the required element is not included in the program; it indicates no available documentation was provided and/or restrictive procedures are not part of the training program. The list will be revised at regular intervals as additional documentation becomes available. The purpose of the list is to assist users to identify existing programs that may inform the development of a more comprehensive Restrictive Procedures Plan outlined in Minnesota Statutes section 125A.0942, Subd. 1. No individual program can address implementation with fidelity, and the creation of a supporting infrastructure to ensure the plan is executed as intended. Contact has been initiated with the Minnesota Department of Human Services as per Minnesota Statutes section 125A.0942, Subd. 5. (b).

Crisis Prevention/Intervention Training Programs

Training Requirements — Training Programs

Training Requirements	*NCI (CPI) Non-Violent Crisis Intervention*	*PCMA*	*Positive Behavior Facilitation*	*Right Response*
Positive behavioral interventions	Resources	Information	Information	Information
Communicative intent of behaviors	Information	Information	Information	Information
Relationship building	Information	Information	Resources	Information
Alternatives to restrictive procedures	Training	Training	Information	Training
De-escalation methods	Training	Training	Training	Training
Standards for using restrictive procedures	Resources	Resources	Information	Resources
Obtaining emergency medical assistance	Information	Information	No Evidence	No Evidence
Physiological and psychological impact of physical holding and seclusion	Resources	Resources	No Evidence	Resources
Monitoring and responding to a child's physical signs of distress	Information	Resources	No Evidence	No Evidence
Recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding used	Resources	Resources	No Evidence	No Evidence
District policies and procedures for timely reporting and documenting each incident involving use of a restrictive procedure	No Evidence	No Evidence	No Evidence	No Evidence
School-wide programs on positive behavior strategies	No Evidence	No Evidence	No Evidence	No Evidence

Minnesota Department of Education

Note: this is NOT a comprehensive list; as programs are identified and information provided to the Minnesota Department of Education, it will be revised accordingly. "No Evidence" does not indicate the required element is not included in the program; it indicates no available documentation was provided and/or restrictive procedures are not part of the training program. The list will be revised at regular intervals as additional documentation becomes available. The purpose of the list is to assist users to identify existing programs that may inform the development of a more comprehensive Restrictive Procedures Plan outlined in Minnesota Statutes section 125A.0942, Subd. 1. No individual program can address implementation with fidelity, and the creation of a supporting infrastructure to ensure the plan is executed as intended. Contact has been initiated with the Minnesota Department of Human Services as per Minnesota Statutes section 125A.0942, Subd. 5. (b).

Crisis Prevention/Intervention Training Programs

Training Requirements — Training Programs

Training Requirements	*Safe & Positive Approaches*	*Safe Crisis Management*	*Therapeutic Crisis Intervention*	*Therapeutic Options*
Positive behavioral interventions	Resources	Resources	No Evidence	Resources
Communicative intent of behaviors	No Evidence	Information	No Evidence	Information
Relationship building	No Evidence	Resources	Information	Resources
Alternatives to restrictive procedures	Training	Information	Training	Training
De-escalation methods	Training	Training	Training	Training
Standards for using restrictive procedures	Resources	Training	Resources	Training
Obtaining emergency medical assistance	No Evidence	No Evidence	No Evidence	No Evidence
Physiological and psychological impact of physical holding and seclusion	Resources	Resources	Resources	Resources
Monitoring and responding to a child's physical signs of distress	Information	Resources	No Evidence	No Evidence
Recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding used	Training	No Evidence	No Evidence	No Evidence
District policies and procedures for timely reporting and documenting each incident involving use of a restrictive procedure	No Evidence	No Evidence	No Evidence	No Evidence
School-wide programs on positive behavior strategies	No Evidence	No Evidence	No Evidence	No Evidence

Minnesota Department of Education

In accordance with Minnesota Statute 125A.0942, Subd. 5. (b)., the Minnesota Department of Education (MDE) has published the following list of experts on Reducing Restrictive Procedures. Experts were referred to MDE by schools and other experts in the field. MDE has not evaluated the experts included and the list does not necessarily constitute or imply endorsement, recommendation, or favoring by MDE. Each school seeking training and/or consultation is responsible for determining if the expert meets their needs and criteria. If you have feedback on the experts in this list or have names that you believe should be included, please email us at MDE.RRPExpert@state.mn.us. Thank you.

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Crisis Triage and Hand-off Process

Minnesota Department of Human Services
Community Supports Administration
February 2015

Minnesota Department of Human Services

For more information contact:

Minnesota Department of Human Services
Adult Mental Health Division
St. Paul, MN 55101
651-431-2225

This information is available in accessible formats to individuals with disabilities by calling 651-431-4262,
Or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

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Supports and Services section

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

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.

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 66.

Introduction

Crisis is defined as a condition of instability or danger that constitutes a turning point in a person's life. Crises occur where people live and work, in big cities and wide-open spaces, when people are alone or in community, during office hours and in the dead of night. The requirements for reliability across all support systems, ensuring that there is early crisis planning and immediate crisis response, as well as the gravity of the consequences if the response is not provided, demands extraordinary levels of systems coordination, integration, and synthesis.

The overarching goal of crisis services is to provide timely and appropriate support to people who are experiencing significant instability in their lives or are facing eminent danger. The term "crisis" covers a range of situations, such as those prompted by the loss of a caregiver or a significant change in a medical or health condition, that compromise the ability of a person or that person's support system to manage their symptoms or behaviors to such an extent that there is potential for serious harm to the person or others.

A response that is activated only when physical safety of the person or others is compromised is often "too little, too late" or "no help at all" in addressing the root of the crisis."[1] Effective crisis services, therefore, constitute an interconnected network of supports before, during, and after a crisis episode, during which appropriate responses must also meaningfully address the issues underlying the crisis.

Minnesota currently offers crisis services to people with disabilities through different service systems—community-based mental health services, home and community-based services, and state operated facilities. These three systems have different definitions of and responses to "crises." These differences are part of the underlying issues that lead to gaps in the crisis response system.

[1] *Practice Guidelines: Core Elements for Responding to Mental Health Crises.* HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.

Background Information

Current services

A number of existing efforts and planned initiatives are underway to serve people in crisis. There are themes around which these efforts and initiatives can be grouped, as follows:

Case Management: Related services include Community Support Services Crisis Teams; Metro Crisis Coordination Program in the seven county Twin Cities metro area; adult mental health crisis response teams, who routinely see clients in rural hospital emergency departments or jails; and an array of children's mental health services. Crisis response teams are expected to develop regional collaborations with law enforcement, probation officers, schools, case management, and emergency departments for referrals and to know when and how to access crisis services. Case managers are encouraged to develop crisis/relapse prevention plans as part of the individual's Community Support Plans. Crisis plans become part of a person-centered plan that seeks to proactively address both positive as well as challenging behaviors in the community. With the recipient's consent, these plans are shared with the mental health crisis response teams. Adult protective services is a 24/7 county-based common entry point for reporting suspected maltreatment of a vulnerable adult screening for immediate need for protective services or law enforcement, and referral to lead agency to investigate the alleged maltreatment. Additionally, there is a 2015 legislative proposal for enhanced crisis wrap-around services for persons with Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI), and Development Disability (DD) waiver services that had two or more behavioral-related hospitalizations in the previous calendar year.

Mobile Crisis Response Services: The mental health services system includes mobile crisis response teams in 79 counties and one tribe.

Training for Community Capacity: Mental health crisis teams provide community intervention with families and other affected persons; children's mental health services include families and guardians in service design and evaluation; Community Support Services provides training, mentoring, and coaching to clients and others, technical assistance to divert commitments and address crises; and the Minnesota Family Investment Program is developing short- and long-term crisis planning for families with children with mental illness.

Short-term Residential Crisis Stabilization and Respite Capacity: Crisis stabilization beds are available for short-term crisis services for adults; Minnesota Intensive Therapeutic Homes (MITH) Respite offers 30-day crisis return to forensic transitions to prevent revocation of provisional discharge; residential crisis stabilization facilities (licensed as either Intensive Residential Treatment Services or Adult Foster Care) provide structured living for adults who are fragile or are experiencing a crisis; the state-operated Life Bridge program provides housing and support during transitions; currently there are 16 crisis respite beds (≤90 day stay) available statewide for persons with developmental disabilities. There is also in-home crisis respite service available for persons who are on the Developmental Disabilities waiver.

Sustainable and Flexible Funding: A number of services are paid through federal waivers. In addition, services are funded through third-party payer billing, grant funding, county funding, state funding, medical assistance, and the Medicaid State Plan.

Technology-Assisted Consultations: Telepresence is implemented in 18 southwestern counties for Assertive Community Treatment teams, emergency rooms, and psychiatrists for consult; mental health crisis teams are beginning to use telepresence to assist mental health practitioners; Community Support Services Crisis consultation and telepresence is under expansion in the Southern Cities Clinic; and the Phase II Telepresence Option is being planned.

First Episode of Psychosis: A cross-divisional workgroup designed a proposal to strengthen the state's capacity to provide early identification and intensive intervention services for children and adults who have a first episode of psychosis.

Understandable and Accessible Information: The MNhelp.info Network provides objective information to individuals to help them make decisions about services; culturally-specific grants are available to help with outreach to diverse communities. There are recommendations in place for reforming case management to make services more accessible and less duplicative.

Help People Retain Housing: The Crisis Housing Fund provides temporary rental, mortgage, and utility assistance for persons with serious and persistent mental illness while they receive mental health treatment.

Provider Training: Positive support strategies and guidelines on emergency use of manual restraints, and a legislative proposal to provide training between Community Support Services teams, Metro Crisis Coordination Program, and Assertive Community Treatment teams to enhance competency of treating individuals with complex comorbid conditions.

Long-Term Monitoring: Community Support Services Extended Supports provides long-term monitoring for up to 75 individuals with clinical complexity and intellectual disabilities.

Post-Discharge Psychiatric Consultation: Consultation for individuals recently discharged from St. Peter Security Hospital, Anoka Metro Regional Center, and from community behavioral health hospitals where the discharge planning team determines that ongoing post discharge monitoring provided by psychiatrists and psychologists would be essential to successful community placement.

Crisis-related barriers to achieving integration

Although there are a number of crisis-related services, there are a number of barriers that currently exist in access, available services, and follow-up for people in crisis. The examples below help to illustrate the issues that are not yet adequately addressed.

Layering Effect: People with co-occurring conditions, such as those with both mental illness and developmental disabilities, may be treated and stabilized in crisis but end up back in the system because of the complexity of treating the co-occurring conditions. Or, in times of crisis they may not be able to

connect in a timely fashion with providers who have the necessary skills to support them, resulting in what may have been avoidable moves back to more restrictive settings. For example, at times the underlying mental health needs are not adequately addressed by providers of developmental disability services. Similarly, mental health providers may use talk-based therapies that are not well-targeted to the needs of people with developmental disabilities. If the mental health needs of people with developmental disabilities or brain injury are not met as they emerge, there can be further complications such as drug use, homelessness, and chronic physical disease. Another example is, when people are using services from different systems, there can be confusion about where to turn in a crisis. This can be particularly true for people who have recently transitioned from a more controlled setting to a more integrated setting.

Housing for Persons with Behavioral Issues: People with mental illnesses, dementia, developmental disabilities, or other disabilities who have experienced crisis may be admitted to psychiatric inpatient hospital units or other institutional settings without community options for re-establishing housing, or their options for future housing may be limited to sites far from their home communities when they can no longer stay in their former domiciles because of behavioral issues. There may be barriers to reestablishing housing, such as those found when subsidized housing sites screen out individuals with a history of violence or other behavioral issues.

Lack of Experienced, Trained Staff: Direct support workers may not have adequate training, experience, or assistance available to deal with crisis situations. When crisis situations arise, these staff may not be able to address the situation themselves, and also may not have access to someone in their organization with the appropriate skills. Providers may not be aware of the range of services that are available to help them with crisis incidents, and may not be knowledgeable about trauma-informed care, which can help providers identify the triggers of behavior that cause a life crisis.

Crises outside the Home: Crises may occur in the community, such as school, a day service program, or a vocation setting. Most interventions are focused on supporting the person in their home or residential setting.

Measurable Goals

Following are measurable goals that will result from Minnesota's efforts to improve the crisis system for people with disabilities. **These goals are dependent on funding requests currently under consideration in the 2015 legislative session.** *Note: Goal below builds to an increase of 500 people.*

In 2015

- Baseline of 7,045 people will receive crisis services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention.
- Expand DHS data reporting system to include elements for tracking this goal.
- Metro Crisis Coordination Program (MCCP) will begin providing specialty telephone consultation 24 hours a day to mobile mental health crisis teams who are serving people with traumatic brain injury or intellectual disability who are experiencing a mental health crisis.

In 2016

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,170 metro-wide - 125 people over the baseline of 7,045).
- Of the additional 125 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation. (*Note: this is our baseline year. The number will be adjusted as needed.)*
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 38 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2017

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,295 metro-wide - 250 people over the baseline of 7,045).
- Of the additional 250 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 63 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2018

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,420 metro-wide - 375 people over the baseline of 7,045).
- Of the additional 375 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 94 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2019

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,545 metro-wide - 500 people over the baseline of 7,045).
- Of the additional 500 people who will receive a crisis response service, half (250) people will receive immediate face-to-face services and half (250) people will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as safely possible give the traffic and weather.
- 125 people who receive face-to-face services will be able to remain in the community rather than be admitted to a hospital.

Process to Develop Strategic Approach

Community participation

Community members, particularly those who use public services, their families, advocates, service providers, and community partners, such as counties and tribes, all play a critical role in helping shape how public services are designed and delivered.

Within the last couple of years, as the Olmstead Plan was written and implementation began, there have been numerous ways in which the public engaged in processes that contributed to the development of the framework described in this report. The following list highlights some of this work.

- The Department of Human Services conducted numerous focus groups with people who use services, such as those organized through the National Alliance on Mental Illness Minnesota in planning the Minnesota Behavioral Health Homes.
- People who use mental health services and their families meet (typically) monthly to discuss adult mental health initiatives.
- The State Advisory Council on Mental Health consists of stakeholders representing all facets of the mental health system. The Local Advisory Workgroup, a subset of the Council, is made up of individuals with a lived experience of a mental illness, family members, and a county provider. The Subcommittee on Children's Mental Health provides recommendations to the Council. It is comprised of parents, people who presently or formerly used adolescent mental health services, and other stakeholders.
- Certified Peer Specialists quarterly networking
- Offenders with Mental Illness Workgroup
- Mental Health Improvement Workgroup
- ADAD Tribal and Citizen Advisory Council
- Community First Services and Supports and Money Follows the Person Implementation Council
- State Quality Council
- Traumatic Brain Injury Advisory Committee
- Autism Spectrum Disorder Advisory Council
- Home and Community Based Services Settings Rule forums
- Autism public meetings and other input opportunities
- Tribal listening session on people with brain injury and releases from correctional facilities
- Gaps analysis surveys and focus groups
- Olmstead Plan development process, including Olmstead Plan Committee, public meetings, and public comment period

State work groups

State-led work groups contributed to the development of the plan presented here and included people from a broad array of perspectives, including from the following:

- Adult mental health
- Children's mental health
- Disability services
- State-operated services
- County crisis services
- Youth services
- Minnesota Department of Health
- Minnesota Department of Education

In addition to participation in work groups, community subject matter experts contributed feedback and advice.

Strategic Approach to Crisis System

Minnesota is undertaking transformative systems change to achieve the goal of having people with disabilities living in the most integrated settings, being fully engaged in the community of their choice, and pursing their own life goals and interests. This transformation will take years to fully realize, and our wide-reaching, cross-sector approach needs to be strategic to be feasible and successful. The crisis triage and hand-off concept, which is the focus of this report, fits within a broader strategic approach to crisis response and intervention. And, in turn, the crisis strategic approach interlocks with other key strategic focuses, such as building a person-centered culture, effective transitions, increased access to housing, and competitive employment. The barriers identified in the earlier section are addressed in various ways across these strategic focuses as well as in the crisis area.

The three-pronged approach to improving crisis response and intervention services includes: 1) improving crisis triage and hand-off; 2) use of positive supports and person-centered planning; and 3) mental health system reform.

Crisis triage and hand-off

The intent of the statewide crisis triage and hand-off system is to efficiently get people to the best service for them in times of crisis, and to ensure that the hand-off between providers is effective. To do this, the state must develop a statewide, integrated, crisis information, intake, referral, and assessment network model. The intent is to have a centralized point of entry, that people in crisis contact in a crisis, regardless of their diagnosis or what type of services they provide (e.g., community-based mental health services, state-operated services, waiver services).

This is envisioned as a single statewide phone number. The people staffing the phone/portal will provide an immediate response to requests for crisis services statewide with appropriate triage and coordination among crisis services. They will be skilled in crisis assessment and determine both the urgency of the need intervention, and the most appropriate provider for that intervention. They will be well-versed in the services that are available across the state and who they serve.

The access, intake, and processes for service delivery determination and authorization will be seamless to the person. Having a single point of entry, staffed by skilled providers, will decrease confusion, duplication of effort and gaps, resulting in callers getting to the right service in a timely manner. This is crucial as timely, appropriate intervention is the best way to stabilize crisis situations.

In addition to getting the person to necessary services, the intent of the centralized triage system is to ensure that crisis services are delivered in the least restrictive setting possible.

Another key feature of the centralized system is that the triage providers will follow-up with the callers to see it the person actually connected with and received the appropriate service in a timely manner. If there are problems identified, the triage system can work to resolve them, if that is possible, or, at a minimum, record the system failure.

One of the benefits of a centralized system will be the opportunity to track meaningful data that will be used to help us measure the success of the system, identify gaps, and continuously improve the state triage system.

For example, the system will be designed to track data, such as:

- Response times
- Crisis resolutions
    - Resolutions that result in the person remaining in their home, returning home from a medical facility, i.e. ER/urgent care, etc.
- Outcome comparisons by access route, geographic location, population, etc.
- Crisis interventions initiated in psychiatric hospitals, other hospitals and other facilities despite the individual not meeting requirements for those levels of care

While the current system is fragmented, it does have strengths upon which the model can be built. The state will strategically develop this network in phases, using the opportunities and strengths that are available.

Developments in technology in recent years are a great boon to this kind of effort.[2] Some parts of the crisis response system are already beginning to make use of tele-presence technology.[3] Another existing strength is that Minnesota already has pieces of a 'centralized' system for crisis response. Specifically, within the Twin Cities metropolitan area, mental health services are already using a central point of access and triage protocols.

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[2] For example, Minnesota operates technologically integrated systems (i.e., MNhelp.info Network and its Senior Linkage Line, Disability Linkage Line, and Veterans Linkage Line) that support people, help them navigate complex service systems, connect policy and service professionals in 'real time', follow-up with them, and track/measure the effectiveness in achieving meaningful outcomes for people.

[3] Community Support Services (CSS) Crisis Teams, Southern Cities Clinic use telepresence and 18 counties in southwestern Minnesota also telepresence for consultation between Assertive Community Treatment (ACT) teams, emergency rooms, and psychiatrists.

The first phase of developing a statewide triage system is currently underway and expected to last through June 2015. This work centers on defining the roles and responsibilities within the state-operated services and county and provider system of waiver services. These two systems are administered by the Department of Human Services Direct Care and Treatment Administration and the Disability Services Division of the Community Supports Administration, respectively. They support many people with co-occurring conditions, people who are moving from segregated settings to more integrated settings and people who are at high risk of experiencing crises and returning to segregated settings.

Building upon the first phase, also in 2015, the second phase will involve building the statewide triage and hand-off system. This work will center on adding mental health services that are administered through the Adult and Children's Mental Health Divisions of the Community Supports Administration into the project. This phase will include planning and initial implementation. Implementation will begin with realigning currently available resources and continue as resources and opportunities become available.

Also in 2015, there is proposed legislation to build a single statewide number for all mental health crisis services. If this is enacted, it will provide a significant platform upon which to build the single triage system for all disability-related crises (i.e., mental health and/or behavior-related crises).

Positive supports and person-centered planning

Promoting statewide use of positive supports is one of the three-prongs of Minnesota's crisis strategy. The term *positive supports* refer to practices that are person-centered, encourage self-determined behavior, build on social and emotional skills, and take a person's physical, social and mental health into consideration. Positive supports include strategies that teach people productive ways to deal with stress. These supports are essential to eliminate the use of prohibited procedures, avoid emergency use of manual restraints, and prevent physical harm to the individual and others.

The use of positive supports has been proven to be effective in preventing problem behavior and helping a person gain new skills or alternative behaviors to participate effectively in community life. Problem behavior can trigger a crisis situation; the use of positive supports, therefore, is a strategy for avoiding crises.

Person-centered planning is the foundation for positive support practices. Pro-active person-centered planning and assessment anticipates, prevents, and/or responds in a timely way to potential or actual crisis situations, in a way that promotes maintaining individuals in the community, particularly for people with co-occurring conditions.

In October 2014, the Minnesota Departments of Human Services and Education produced a report entitled *Minnesota's Statewide Plan: Building Effective Systems for Implementing Positive Practices and Supports.* The report provides a framework for organizing policies, technical assistance, and resources to ensure people receiving services, are treated with respect, and receive the support they need to live independent, self-determined, and meaningful lives in their home communities. The plan described in

the report will be successful by a) designing and implementing technical assistance that involves teaching organizations to embed the values and vision outlined in the Minnesota Olmstead plan into the everyday actions taken by individuals providing services, and b) working collaboratively with stakeholders who represent people receiving services across the lifespan, family members, caregivers, advocates, practitioners, and community members. The report represents a first step in the state-wide planning process. The plan itself will continue to be refined and updated as it is implemented.

The plan identifies six implementation goals: 1) establishing a technical assistance infrastructure across agencies, 2) designing and implementing strategies for data-based decision making and evaluation, 3) creating a marketing plan for increasing awareness of positive supports across the state, 4) expanding pre-service and aligning in-service training systems state-wide, 5) developing and maintaining an inventory of policies related to restrictive practices and positive supports, and 6) expanding interagency crisis prevention planning. A graphic illustration of the logic model for the plan appears in Appendix A.

Mental health system reform

Minnesota's mental health infrastructure is insufficient with many gaps, poor measurement, and insufficient service availability. Gaps in the system can mean that opportunities for early intervention are missed and crisis situations arise. Gaps in the system can mean that when there is a crisis situation the intervention takes place in a more restrictive setting than is necessary. Sometimes people in crisis go into a segregated setting and, once there, encounter barriers to moving back into integrated settings.

Minnesota has a package of mental health reforms before the Legislature in 2015 that address several of the gaps listed on page 3 in this report. More information about these reforms is in Appendix B.

Prevention and early intervention

- Offer training and consultation for staff at 250 child care centers. Provide assessments and treatment for 1,250-2,500 children with mental health concerns.
- Pilot a new model to help schools support students with mental health and substance use disorders in order to reduce arrests, expulsions and suspensions, while increasing referrals for treatment and services.
- Strengthen the state's capacity to serve youth (16-26) with early signs of psychosis and bridge gaps between children's and adult mental health services.
- Increase availability of mental health crisis services, moving toward a goal of 24 hours statewide coverage for both children and adults.
- Establish one statewide number for all mental health crisis services.
- Improve consistency and quality of crisis services.
- Expand children's mental health respite care grants to serve 500-1,000 additional children and their families.
- Provide training on Adverse Childhood Experiences to 5,000 community partners, parents, and providers. Support local efforts to provide earlier intervention.

Reform and enhance Minnesota's mental health treatment system

- Analyze the state's payment structure for mental health services and develop reforms to stabilize the state's financially fragile mental health system.
- Provide grant funding to stabilize intensive mental health services infrastructure (IRTS/RCS/ACT).
- Provide an immediate rate increase for mobile crisis services to retain current services and promote expansion.
- Enhance the state's community mental health centers, which are the foundation of the public mental health safety net.
- Apply for Federal demonstration project to implement improvements and receive 90 percent federal financial match.
- Implement Behavioral Health Homes to provide integrated psychical and mental health care.

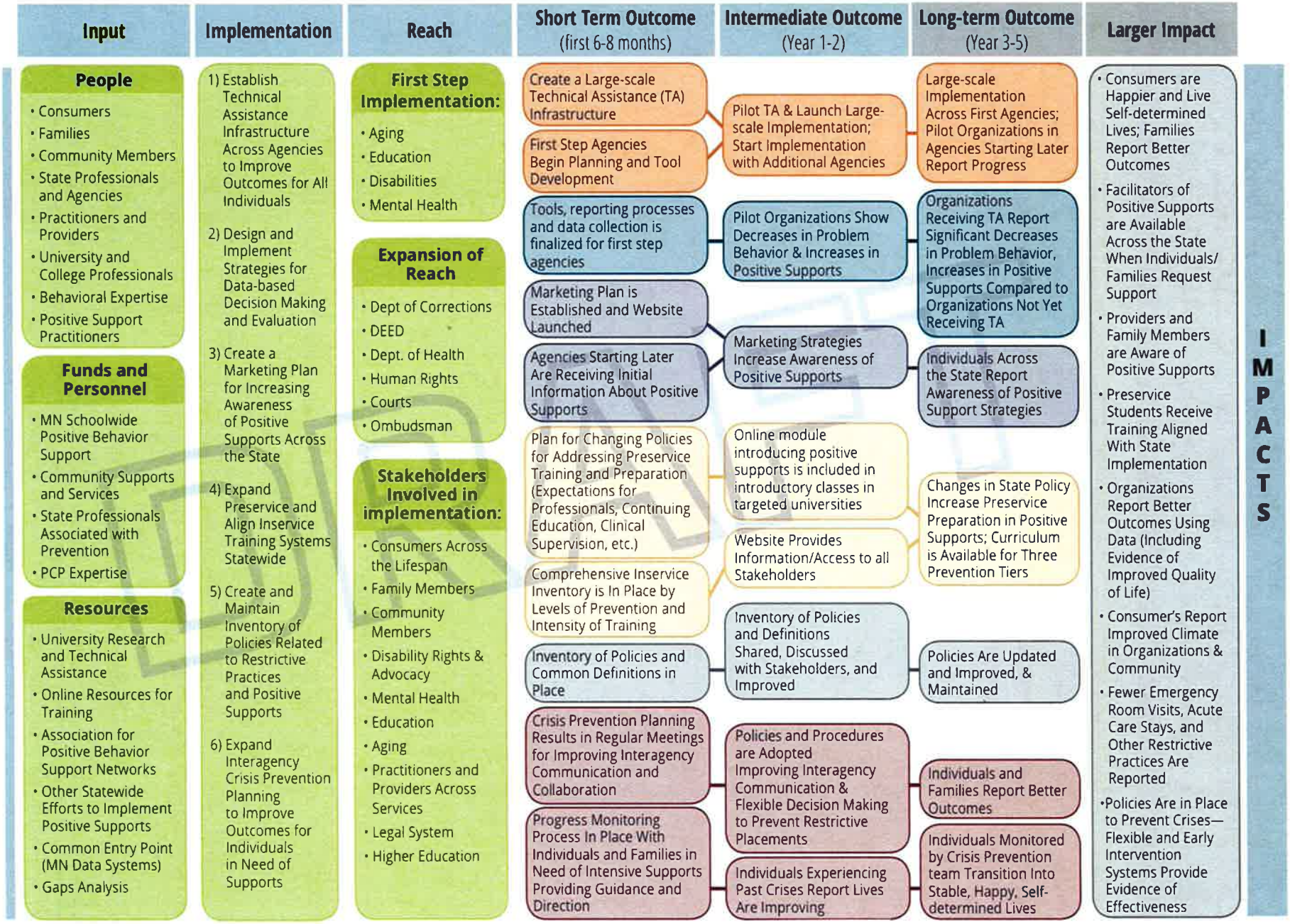
Expand capacity to care for children and adults with complex needs

- Establish Psychiatric Residential Treatment Facilities (PRTF) to support children with very serious mental illnesses who are going unserved.
- Establish extended-stay hospital psychiatric beds, on a contract basis, for youth in need of intensive services on a longer term basis, including those currently served at the Child and Adolescent Behavioral Health Services (CABHS) program.
- Create three new Intensive Residential Treatment Service (IRTS) programs for people transitioning from Anoka-Metro Regional Treatment Center.
- Sustain improvements at MSH including more clinical services, strengthened treatment teams, and increased programming opportunities for patients.
- Create a public psychiatry track in the University of Minnesota's residency program.

Promote and support recovery

- Expand housing with supports grants to serve 1,260 adults with serious mental illness in permanent supportive housing.
- Enhance the quality of current Assertive Community Treatment services.
- Expand high quality Assertive Community Treatment services across Minnesota.
- Develop a Forensic Assertive Community Treatment Team to serve people involved with the criminal justice system.
- Allow greater flexibility to use current funding to help more people exit institutional settings and return to the community.

Appendix A: Positive Supports Implementation Plan Logic Model



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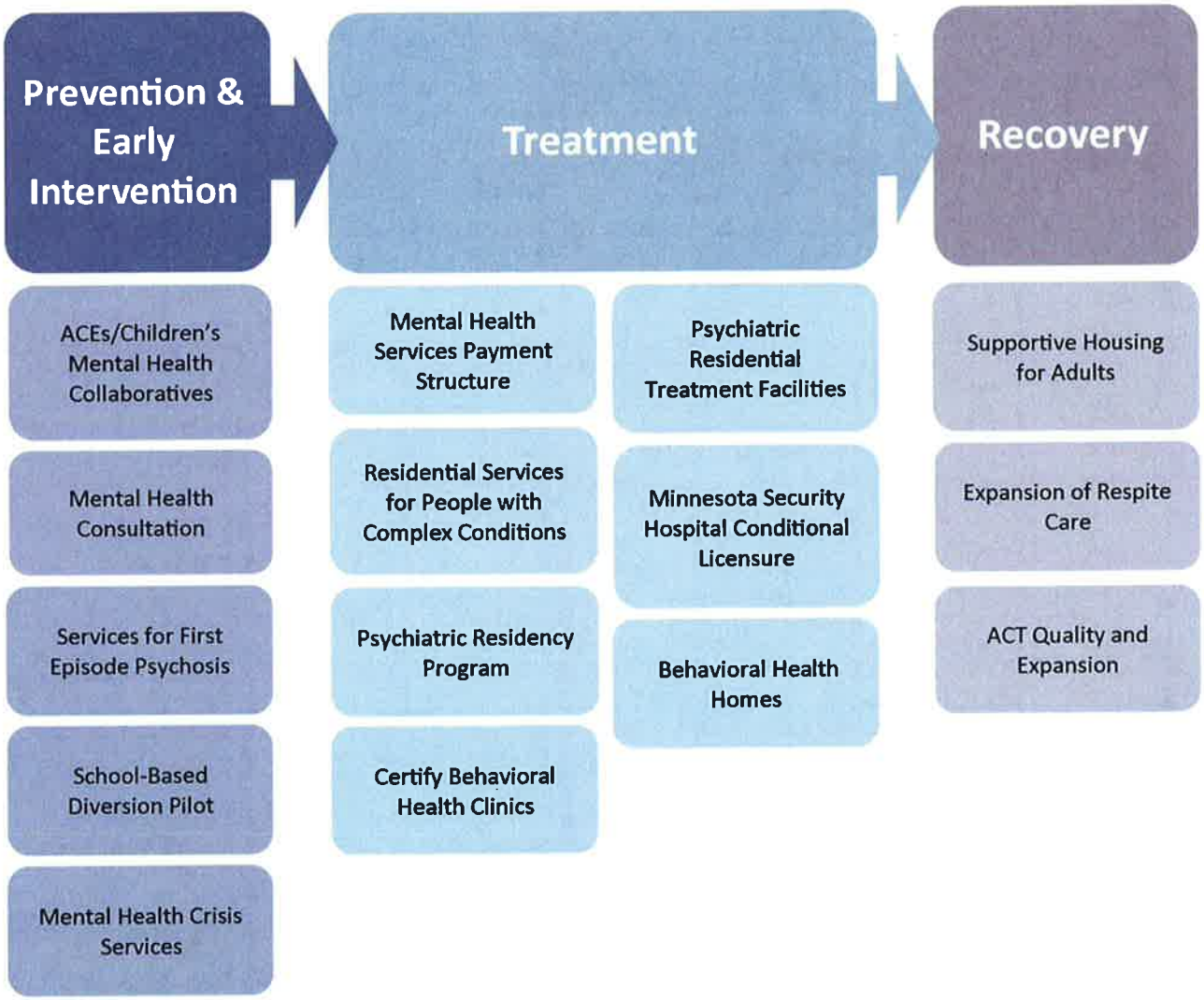
Appendix B: Mental Health System Reform Proposals

2015 Mental Health Reform

The Problem	The Solution	The Impact
Minnesota's mental health infrastructure is insufficient with too many gaps, poor measurement, and insufficient service availability.	A continuum of care that includes: • Mental health promotion and mental illness prevention • Clinical service stability and quality • Community supports	More than 230,000 adults and 75,000 children with mental illness and their families will have the services available they need.

Building a continuum of mental health care for all Minnesotans



Current opportunities

Problem:

Minnesota's Mental Health System is Fragile:

- Residential services are in demand but capacity is shrinking. The Woodlands Center Intensive Mental Health Service (IRTS) closed earlier this year and others are in financially precarious positions.
- Community mental health services are vulnerable. Riverwood Community Mental Health Center, which served some 3,000 clients, closed suddenly in 2014.

Problem:

Existing Community Capacity Does Not Meet Needs:

- Minnesota lacks community-based services for adults, especially those with the greatest needs. Anoka Metro Regional Treatment Center has a waiting list of over 75.
- Intensive children's services are not available in Minnesota. There are between 300-400 children each year with aggressive or self-injurious behaviors whose needs cannot be met.
- Prevention resources are limited. Focus has been on treatment and interventions, leaving prevention and early interventions behind.
- Minnesota has a severe mental health workforce shortage. Most of Minnesota is designated as a Mental Health Professional Shortage Area.
- Employment supports need to be expanded. People with serious mental illnesses in Minnesota have an 80 percent unemployment rate.

Problem:

Housing services are insufficient for those with multiple service needs

- Over 50 percent of children and adults in Minnesota who are homeless live with a mental illness.
- Residential reimbursement rates are inadequate. The average monthly room and board costs for Intensive Residential Treatment Services (IRTS) and residential crisis providers are $1,210 per client. The current monthly group residential housing rate is $876 per client.
- Capital improvements are not covered in current rate structure.
- Lack of treatment services for the most acute children and adults. The system does not have adequate resources for the most aggressive clients.
- Some children's services are not available in Minnesota. We have between 300-400 children each year who would be best served in Psychiatric Residential Treatment Facilities
- There is a workforce shortage. Most of Minnesota is designated as a Mental Health Professional Shortage Area.

2015 Reform Initiatives

Build a More Solid Foundation of Prevention and Early Intervention

Mental Health Consultation for Early Childhood Providers

- Offer training and consultation for staff at 250 child care centers. Provide assessments and treatment for 1,250-2,500 children with mental health concerns.

School-Based Diversion Pilot for Students w/Co-Occurring Disorders

- Pilot a new model to help schools support students with mental health and substance use disorders in order to reduce arrests, expulsions and suspensions, while increasing referrals for treatment and services.

Services and Supports for First Episode Psychosis

- Strengthen the state's capacity to serve youth (16-26) with early signs of psychosis and bridge gaps between children's and adult mental health services.

Mental Health Crisis Services

- Increase availability of mental health crisis services, moving toward a goal of 24 hours statewide coverage for both children and adults.
- Establish one statewide number for all crisis services.
- Improve consistency and quality of crisis services

Expansion of Respite Care

- Expand children's mental health respite care grants to serve 500-1,000 additional children and their families.

ACEs/Children's Mental Health & Family Services Collaboratives

- Provide training on Adverse Childhood Experiences to 5,000 community partners, parents, and providers. Support local efforts to provide earlier intervention.

Reform and Enhance Minnesota's Mental Health Treatment System

Stabilize and Reform Mental Health Services Payment Structure

- Analyze the state's payment structure for mental health services and develop reforms to stabilize the state's financially fragile mental health system.
- Provide grant funding to stabilize intensive mental health services infrastructure (IRTS/RCS/ACT).
- Provide an immediate rate increase for mobile crisis services to retain current services and promote expansion.

Certify Behavioral Health Clinics

- Enhance the state's community mental health centers, which are the foundation of the public mental health safety net.
- Apply for Federal demonstration project to implement improvements and receive 90 percent federal financial match.

Behavioral Health Homes

- Implement Behavioral Health Homes to provide integrated psychical and mental health care.

Expand Capacity to Care for Children and Adults with Complex Needs

Establish Psychiatric Residential Treatment Facilities

- Establish Psychiatric Residential Treatment Facilities (PRTF) to support children with very serious mental illnesses who are going unserved.
- Establish extended-stay hospital psychiatric beds, on a contract basis, for youth in need of intensive services on a longer term basis, including those currently served at the Child and Adolescent Behavioral Health Services (CABHS) program.

Residential Services for People with Complex Conditions

- Create three new Intensive Residential Treatment Service (IRTS) programs for people transitioning from Anoka-Metro Regional Treatment Center.

Minnesota Security Hospital (MSH) Conditional Licensure

- Sustain improvements at MSH including more clinical services, strengthened treatment teams, and increased programming opportunities for patients.

Psychiatric Residency Program

- Create a public psychiatry track in the University of Minnesota's residency program.

Promote and Support Recovery

Supportive Housing for Adults with Serious Mental Illness

- Expand housing with supports grants to serve 1,260 adults with serious mental illness in permanent supportive housing.

Assertive Community Treatment (ACT) Quality and Expansion

- Enhance the quality of current ACT services.
- Expand high quality ACT services across Minnesota.
- Develop a Forensic ACT Team to serve people involved with the criminal justice system.

Increase Flexibility for Transitions to Community Initiative

- Allow greater flexibility to use current funding to help more people exit institutional settings and return to the community.

Delivery System for Oral Health

Health Care Administration

February 2015

For more information contact:

Minnesota Department of Human Services
Health Care Administration
P.O. Box 64984
St. Paul, MN 55164-0984
(651) 431-2202

Legislative Report

Minnesota Department of **Human Services**

This information is available in accessible formats to individuals with disabilities by calling Health Care Administration, 651-431-2202

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I. Executive summary

Under the Laws of Minnesota 2014, Chapter 312, article 24, section 47, the Department was required to consult with stakeholders and provide recommendations to the legislature on a new delivery system for oral health and dental services. This report lays out the recommendations resulting from the most recent stakeholder engagement and also previous studies and reports that have examined dental services in the Medical Assistance (MA) and Minnesota Care programs, collectively referred to as the Minnesota Health Care Programs (MHCP).

The three fundamental areas that must be addressed are the base rate payments, administrative burden, and critical access dental payments. Addressing these three areas provides the environment necessary to increase access to dental services, helps ensure the services they provide are of good quality and are fairly compensated.

II. Legislation

Laws of Minnesota 2014, Chapter 312, article 24, section 47:

(a) The commissioner of human services, in consultation with the commissioner of health, shall convene a work group to develop a new delivery and reimbursement system for oral health and dental services that are provided to enrollees of the state public health care programs. The new system must ensure cost-effective delivery and an increase in access to services.

(b) The commissioner shall consult with dental providers enrolled in the state public health programs, including providers who serve substantial numbers of low-income and uninsured patients and are currently receiving critical access dental payments; private practicing dentists; nonprofit community clinics; managed care and county-based purchasing plans; and health plan companies that provide either directly or through contracts with providers dental services to enrollees of state public health care programs.

(c) The commissioner shall submit a report containing the proposed delivery and reimbursement system, including draft legislation to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance by January 15, 2015.

III. Introduction

Minnesota's Medical Assistance program continues to rank extremely low compared to other states on important measures of access to dental services. For example, for several years Minnesota has ranked amongst the lowest group of states in percentage of children receiving a preventive dental service in a year. Over the past few years, several reports, including one specific to MHCP dental rates published by the Office of the Legislative Auditor (OLA) and another more comprehensive study presented to the legislature by the Department last year, have identified a variety of contributing factors that have both hindered access to and have limited the quality of dental services provided to MHCP enrollees. The major contributing factors identified in those previous studies have been confirmed again during recent discussions with stakeholders. The three factors most consistently identified are:

1. The base rates for dental services are too low. The rates are, in large part calculated from a set of base charges that are now more than 20 years old.
2. The administration of the dental program for MHCP is distributed among too many entities, which requires dental providers, most of which are small businesses, to navigate anywhere from three to nine different sets of administrative requirements.
3. The Critical Access Dental (CAD) program is a payment program that has not resulted in increased access. Instead, it creates a disincentive for private practice dentists to participate as public program providers. Furthermore, the CAD program makes payments based on volume without regard for quality or outcomes.

The Department, as part of the previous study provided to the legislature in 2014, interviewed over 75 stakeholders. The 2014 study conducted by the Department is included for your reference. In developing this report, the Department hosted a meeting with all interested stakeholders and the Department of Health to review and discuss the findings and recommendations laid out in the 2014 study. Several stakeholders also met individually with the Department to discuss issues further.

The Department was required to convene a workgroup for this report; however, a stakeholder workgroup was formed by Senator Rosen which took on the work of discussing these issues. As a result, a separate workgroup formed by the Department was not necessary. Through the course of Senator Rosen's workgroup meetings, a fourth item was discussed in addition to the three items noted above. The workgroup discussed whether a value-based payment system could be created to replace the current payment method that pays dental providers by individual service. Similar concepts had been brought up by one or two stakeholders during the Department's 2014 study, but were not identified by a majority of the dental industry as a major barrier to improving access and quality of care across MHCP. Although Senator Rosen's workgroup is continuing to meet, the three main drivers, low base rates, administrative burden, and CAD, remain the primary focus of the workgroup.

Considering all past reports and workgroup input, the Department puts forward the following recommendations which address the three main barriers to dental provider participation that have been consistently identified by stakeholders. Where consensus is lacking amongst the stakeholders for all or a portion of the Department's recommendation, that lack of consensus is noted. The recommendations for each of the three issues are outlined in detail below.

IV. Base Rate Change

The base rate for dental services should be increased. Raising the base rate is consistent with the recommendations in the OLA report and the 2014 DHS study. There is consensus on increasing the base rates; however, there is not full consensus regarding the amount of the increase. Dental providers have suggested an increase that would double the current base rates. The Department favors a more moderate increase of 15% above the current base rate. The 15% increase should be sufficient particularly if coupled with administrative simplification, since reducing the administrative burden will save money for providers, effectively translating into an additional rate increase. In addition, the base rate year should be updated to 2013, which means that rates would be updated to reflect the percentage of 2013 charges necessary to achieve the desired amount of the base rate increase. Updating the base rate year will better align payments with more current provider costs and will make the rate methodology more transparent and easier to understand for both new and existing dental providers.

V. Administrative Simplification

The administrative burden on dental providers needs to be reduced. Reducing the administrative burden resulting from multiple health plans and dental administrators has been noted by several providers to be of equal or even greater importance to those dental providers than the rates, particularly for smaller rural practices. Unlike medical providers, most of whom are affiliated with larger health systems; most dental practices do not have the administrative infrastructure and economies of scale to support multiple administrative rules, requirements, and systems. As a result, the current distributed model for administration translates to significant administrative costs for dental providers. Medicaid staff in other states have indicated that without making it easy for dental providers to do business with the Medicaid program, dental providers will not enroll as participating providers and will continue to refuse to treat Medicaid patients.

There is consensus on the need to ease the administrative burden for dental providers; however, there remains a good deal of debate amongst the stakeholders as to how to best alleviate the administrative burden. The Department, the majority of private practice dental providers and some non-profit providers favor a single administrator model. Under such a model, a single entity is contracted to administer the dental benefit for the entire MHCP population, including fee-for-service and managed care enrollees. The single administrator recruits and enrolls dental providers, pays claims, authorizes services, coordinates with health care services, tracks utilization of dental services, and monitors quality and outcomes. For dental providers, the result is one set of rules which apply to all MHCP enrollees and one method to receive the information necessary to do business, such as patient eligibility, coverage of services, and utilization limitations. As a result of a single point of contact for administrative activity, dental providers could expect to see a reduction in the administrative activities and costs related to MHCP enrollee care. The benefit to enrollees is having one contact for assistance to arrange for dental care and experiencing seamless dental benefits that follow them. Medicaid programs in several states have demonstrated that the single administrator model coupled with fair rates paid to providers is a successful strategy in improving access and health outcomes.

Not all stakeholders prefer the single administrator model. The managed care organizations and their contracted dental administrators along with some of the non-profit providers and many of the safety net dental providers favor an alternative strategy. The proposed alternative strategy consists of ongoing collaboration to reach mutual agreement on how to address the issues that have been raised by providers frustrated by the administrative burden. The Department is willing to work with stakeholders on exploring the viability of a uniform collaborative approach. However, in the absence of specific regulatory requirements the monitoring and enforcement around compliance will be extremely challenging and may not adequately address the concerns of providers.

The Department's conclusions from the 2014 study indicate that based on the success achieved in other states, a single administrator model is the option best positioned to accomplish the goal of administrative simplification. Given the lack of consensus among stakeholders on this particular issue, further discussion and ongoing review of any concrete solutions may be warranted.

VI. Critical Access Dental Program (CAD)

The CAD program needs to be restructured to better align the proportion of the total amount of payment that represents an add-on payment. The current 35% add-on payment is arguably an indicator that the base rate payment is too low. Moreover, if the base rate increases without any corresponding adjustments to the CAD payments, the dollar value of the gap between payment to private, non-CAD dental clinics and CAD clinics grows larger. The significant disparity in payment between CAD and non-CAD providers providing the same services has been identified as an issue that discourages private dentist participation. A realignment of CAD payments should be done in a manner that holds harmless the current CAD providers, but allows the payment gap between CAD and non-CAD to decrease.

In order to hold CAD providers harmless, providers that are both CAD designated and designated community clinics (CC) must be handled differently than CAD designated providers that are not community clinics. Under the current structure, a CAD provider that is also a community dental clinic receives the base rate plus 20% of the base rate as an add-on for being a community clinic and then 35% is added on to that total for CAD payment. The effect is a greater than 35% increase because the CAD add-on payment is also being applied to the CC add-on.

The following describes how the base rate increase and the CAD add-on would be adjusted together for each type of clinic:

- **For non-community clinic CAD providers**, the base rate increase can be made with a proportionate reduction in CAD payments. Therefore, with the 15% increase in base rate the department supports, the CAD rate for non-community clinic CAD providers would be adjusted to 20%. The result is no reduction in overall payment to those non-community clinic CAD providers.
- **For community clinic CAD providers,** the payment structure should ensure that CAD payments take into consideration the effect of the CC add-on and ensure that the combination of the CC and CAD payments no longer cumulatively inflate the total payment. To accomplish this goal, the base rate of 15% should be combined with the 17.4% CAD rate to account for the cumulative effect that results from the 20 % community clinic add on. This would ensure no reduction in overall payments to these providers.

Delivery System for Oral Health

Current State

Dental Provider	Current CC add-on	Current CAD add-on	Total Value of add-on payments
Community Clinic CAD	20%	35%	62%
Non-Community Clinic CAD	0%	35%	35%

Proposed Future State

Dental Provider	Base Rate Increase	CC add-on	Proposed CAD add-on	Total value vs. current payment structure
Community Clinic CAD	15%	20%	17.4%	No change
Non-Community Clinic CAD	15%	0%	20%	No change
Non-CAD dental clinic	15%	0%	0%	15% increase

The OLA report was critical of the multiple payments made to dental providers under the current payment structure, and dental providers have stated that it is difficult for them to track these multiple payments and reconcile them to determine whether they were appropriately paid for a specific patient visit. Furthermore, the CAD payments for services provided to managed care enrollees are calculated quarterly and are paid by DHS through the MCOs. As a result, the CAD add-on payments are delayed by at least 2-3 months from when the service was delivered. Eliminating the CAD add-on payments is probably not feasible in the near term unless and until sufficient dental providers are participating and access is improved. Nonetheless, re-setting the proportionality is at least a step in the right direction toward reducing dental providers' reliance on the separate add-on payments.

The current CAD program has also been criticized as a payment for volume of services provided rather than payment for quality and outcomes. Another frequent criticism is that the criteria for designation are primarily based on non-profit status, affiliation with educational institutions, or ownership by a government entity. Recent provisions now allow private dental clinics to receive CAD payments, but many additional enrollment requirements apply: the private clinics must be located in a dental Health Provider Shortage Area (HPSA); at least 50% of their patients must be public program or uninsured; and they must not place a cap on the volume of MHCP patients they will see. In contrast, many of the non-profit CAD clinics are able to cap their MHCP patient volume to 10% of their total patient population. The CAD program criteria should be modified so that all or a significant portion of the payments are based on outcome measures that promote quality, efficiency, and improved oral health status for patients. Additionally, requirements should be similar for non-profit and private dental providers so that high performing providers are incented to participate in MHCP, regardless of their business model.

VII. Conclusion

Improvement in dental outcomes for MHCP enrollees cannot be accomplished without significant and fundamental changes to the current dental program. Although the stakeholder workgroup has more recently discussed possible large scale payment reforms, the dental provider community generally favors and has built their business models to accommodate payments made based on the services rendered to each patient. The Department welcomes the opportunity to continue discussions about longer-term reforms and how to move the dental community toward more innovative payment models. However, new large-scale innovations and reforms require ample time to adequately develop, test, and expand. In the interim, Minnesota should not wait for those larger plans to evolve - the need is immediate and steps must be taken now. The number of enrollees who want to access dental services is far greater than the currently enrolled providers can serve, particularly in rural Minnesota where dental providers are already scarce. In order to increase access, more private dentists must be willing to provide services to MHCP enrollees. The three fundamental areas that must be addressed immediately are the base rate payments, administrative burden, and critical access dental payments. Addressing these three areas provides the environment necessary for the number of enrolled dental providers to grow, and helps ensure the services they provide are of good quality and are fairly compensated.

Greater Minnesota Transit Investment Plan

January 2011

www.dot.state.mn.us/transit/reports/investmentplan

Your Destination...Our Priority

Greater Minnesota Transit Investment Plan 2010-2030

February 2011

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Upper Minnesota Valley Regional Development Commission
East Central Regional Development Commission
Southwest Regional Development Commission
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Mn/DOT District 6

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Minnesota Department of Transportation
Transportation Building
395 John Ireland Boulevard
Saint Paul, MN 55155

February 2011

Dear Citizens of Minnesota,

I am pleased to share with you the Greater Minnesota Transit Investment Plan. This plan is the result of extensive collaboration between the Minnesota Department of Transportation and citizens, stakeholders, and partners throughout Minnesota. I want to thank everyone who took the time to participate in our outreach meetings and provide comments and suggestions throughout the planning process.

The Greater Minnesota Transit Investment Plan provides the link between the goals and strategies established in the Greater Minnesota Transit Plan, published in 2009, and funding allocations to each public transit system in Greater Minnesota. The plan analyzes projected demand for transit services in Greater Minnesota and the cost of meeting that demand from 2010 until 2030. In addition, the plan outlines Mn/DOT's investment priorities for expanding or reducing transit service according to future state and federal funding levels. Although specific investment priorities will continue to evolve over time, promoting mass transit as a means to improve mobility and accessibility for all Minnesotans will remain essential to Mn/DOT's core strategies.

The Greater Minnesota Transit Investment Plan demonstrates that demand for public transit services in Minnesota is growing. State, federal, and local support will be needed to provide additional transit services to meet this demand. Regardless of future funding levels, Mn/DOT will continue to work toward its mission to provide the highest quality, dependable multimodal transportation system to Minnesotans. The full copy of the Greater Minnesota Transit Investment Plan and additional information are also available on Mn/DOT's website: http://www.dot.state.mn.us/transit/reports/investmentplan/.

Sincerely,

Thomas K. Sorel

Commissioner

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Executive Summary

Minnesota's public transit systems provide transportation alternatives to driving alone and enable all citizens to participate in the state's communities and economy. The Minnesota Department of Transportation (Mn/DOT)'s strategic vision is to be a global leader in transportation. Mn/DOT is committed to upholding public needs and collaboration with internal and external partners to create a safe, efficient, and sustainable transportation system for the future. To that end, Mn/DOT's strategic directions include improving mobility and accessibility for all Minnesotans through the promotion of public transportation. The Greater Minnesota Transit Investment Plan projects future need for transit services in Greater Minnesota and estimates the cost of providing additional services to reduce unmet need.

In 2009, Mn/DOT completed the Greater Minnesota Transit Plan, a policy plan that defined the vision, policies, and strategies for transit in Greater Minnesota. The Greater Minnesota Transit Investment Plan identifies specific priorities for future transit investment. These investment priorities connect the goals of the policy plan to Mn/DOT's annual funding allocation to individual transit systems. The Greater Minnesota Transit Investment Plan will help decision-makers prepare for growing transit demand in Minnesota and increase public understanding of Mn/DOT's priorities for future transit investment.

Minnesota Statutes, Section 174.24

Legislative direction for the Greater Minnesota Transit Investment Plan requires Mn/DOT to:

- Conduct an analysis of total transit needs in Greater Minnesota
- Calculate the level of service required to meet total transit service needs in Greater Minnesota
- Prepare an analysis of costs and revenues
- Develop a plan to reduce total [unmet] transit service needs

In addition, the Legislature directed Mn/DOT to specifically identify the passenger levels, levels of service, and costs necessary to address the following targets:

- Meet 80 percent of total transit service needs in Greater Minnesota by 2015
- Meet 90 percent of total transit service needs in Greater Minnesota by 2025
- Identify costs of meeting 100 percent of total transit service needs every five years from 2010 to 2030

Goal

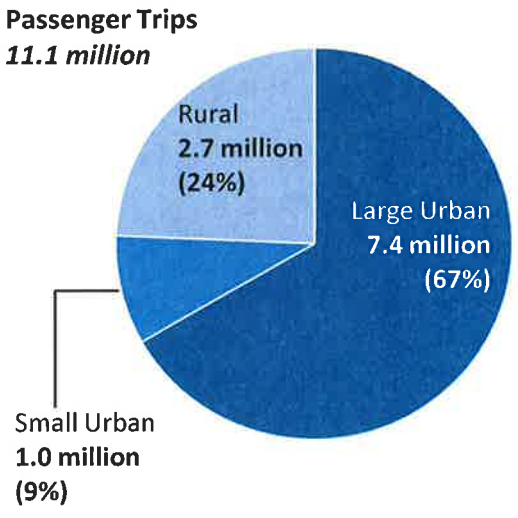
The goal of the Greater Minnesota Transit Investment Plan is to reduce unmet transit service needs by:

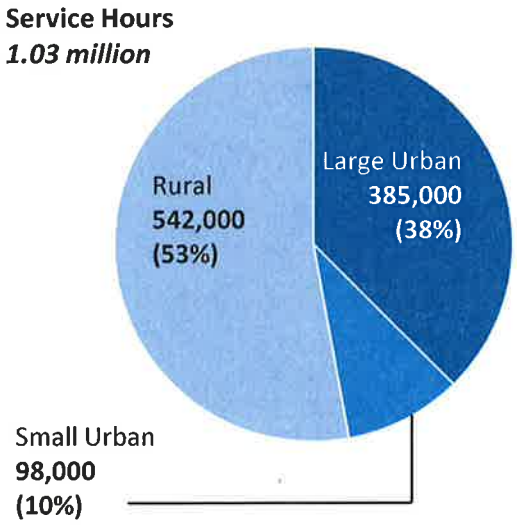
- Understanding the needs of current transit customers and developing a profile of current riders using **market research**
- Determining total and unmet transit needs at the county level using **technical analysis**
- Building support for transit investment priorities through extensive **public outreach** throughout the planning process

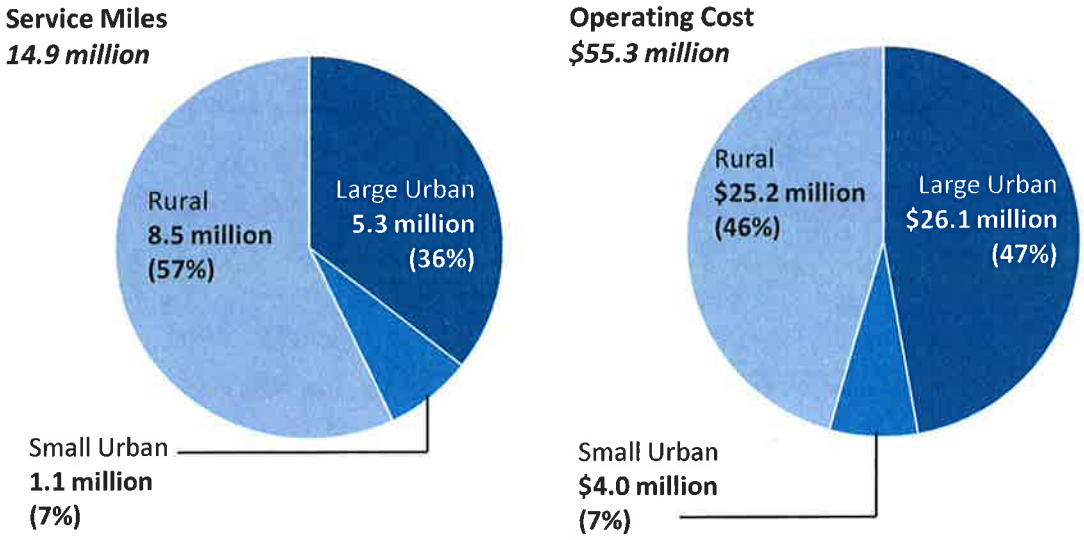
Current Level of Service

Public transportation needs in Minnesota are growing along with Minnesota's overall population and the population of transit-dependent riders. Minnesota's public transportation systems are growing in response to these needs. In 1990, 40 of Greater Minnesota's 80 counties had some form of public transportation system; in 2009, the number of counties with public transportation systems was 76.

Greater Minnesota transit systems served 11.1 million passenger trips statewide in 2009. A total of 1.03 million service hours were operated, and transit vehicles traveled 14.9 million miles to serve passenger needs. Local, state, and federal sources combined to fund transit programs at a level of $55.3 million. These statistics are detailed by transit system peer group below.







Summary of Needs

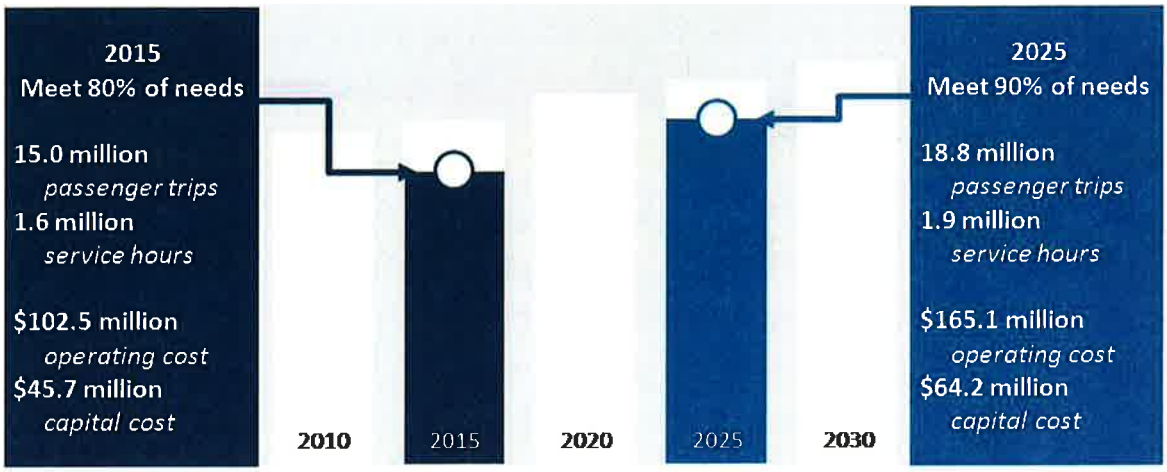
In order to satisfy the legislative mandate for determining transit needs and costs, Mn/DOT developed models for calculating passenger demand, service levels needed to meet demand, and operating and capital costs of providing service. Using market research as a baseline, the models yield a reasonable 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.

To meet 100 percent of Greater Minnesota's projected transit needs, services would need to be provided at the following levels:

	2010	2015	2020	2025	2030
Total Passenger Demand (millions of trips)	18.1	18.8	20.2	20.9	22.0
Service Hours to Meet Demand (millions)	1.8	2.0	2.1	2.1	2.2
Annual Operating Cost (millions)	$103.7	$128.1	$153.8	$183.4	$216.9
Capital Cost - Vehicle Replacement (millions, five-year totals)	--	$50.2	$57.9	$66.7	$76.6
Capital Cost - Additional Vehicles (millions)	$33.5	$6.9	$4.3	$4.6	$4.4

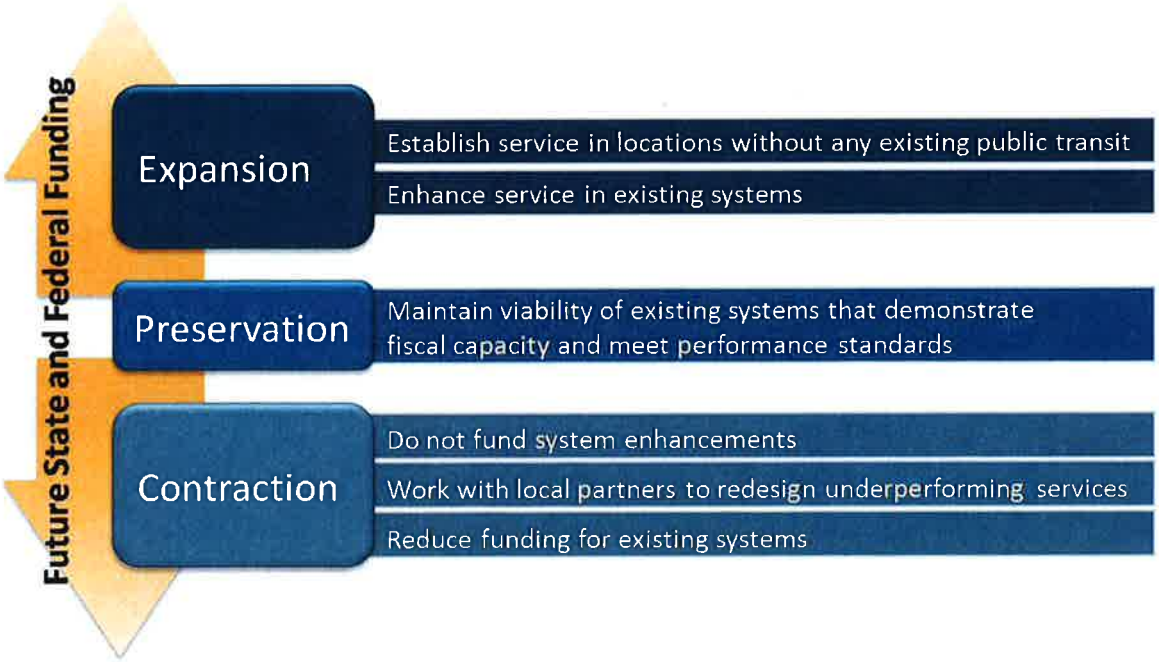
The 2010 additional vehicle capital cost value represents the fleet required to fully close the gap between current levels of service and new service required to meet 100 percent of estimated needs. Values in subsequent years represent the fleet required to meet new levels of service to serve expanding transit need.

Meeting the specific legislative targets for 2015 and 2025 would require the following levels of service:



Summary of Transit Investment Priorities

In an effort to prioritize how Mn/DOT would reduce unmet transit need, the Greater Minnesota Transit Investment Plan sets priorities to guide future investments in public transit. The outcome is a delineation of transit investment priorities that correspond to changing funding scenarios. Mn/DOT's approach to increased or decreased funding scenarios is illustrated below. Mn/DOT's first priority for Greater Minnesota transit is to preserve existing systems by funding each system at a level sufficient to continue the current level of service in the future.



In scenarios of increased future funding, Mn/DOT's highest priority for Greater Minnesota service expansion is to establish service in locations without any existing public transit. Assuming all eligible locations are served by public transit, Mn/DOT's priorities for service expansion, listed in order of importance, include:

- Expand service hours in the morning and night to provide more trips.
- Expand multi-county services to link more communities.
- Provide service on more days of the week.
- Expand service frequencies and coverage.
- Expand service to provide consistent levels of service statewide.

In scenarios of reduced future funding for transit, Mn/DOT will evaluate system applications according to the following principles, listed in consecutive order:

- Funding for system enhancement will not be considered.
- Mn/DOT will work with systems to redesign underperforming service segments.
- Mn/DOT will reduce state and federal funding to those systems with underperforming service segments.
- If decreases in state and federal funding for transit necessitate additional reductions, Mn/DOT will reduce funding allocations to systems that meet or exceed performance standards.

Identified Program Management Tools

Mn/DOT will work with systems to ensure systems incorporate the following program management tools, listed in no particular order, to help implement the investment priorities:

- Explore ways to increase the use of technology to gain efficiencies in transit delivery.
- Refine services using service-level performance measures to increase efficiency of transit delivery.
- Coordinate with other transit providers, including tribes (e.g. White Earth Public Transit), volunteer drivers, Section 5310 programs for the elderly and persons with disabilities, and taxi providers, to increase service delivery options.
- Increase marketing to reach more customers and make citizens more aware of the services that exist in their community.
- Provide transit service without charge for disabled veterans (applies only to fixed-route systems).

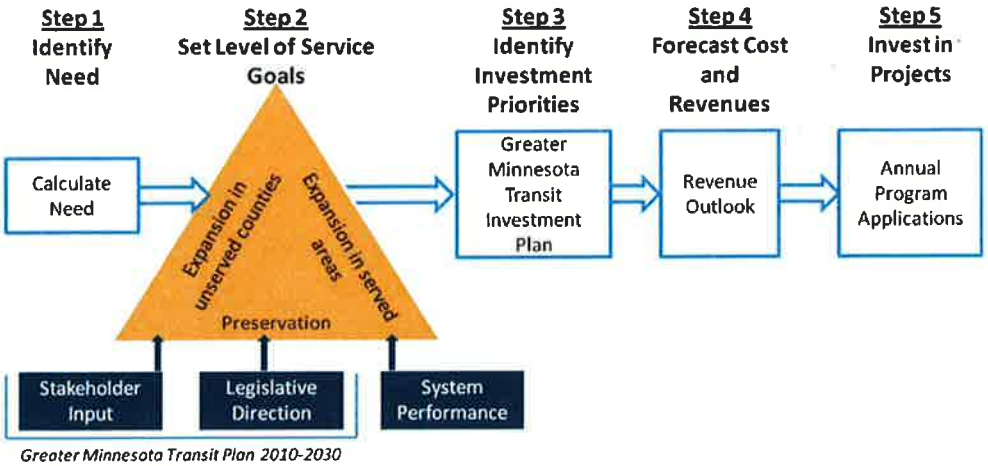
Chapter 1:
Plan Purpose and Development

Minnesota's public transit systems provide transportation alternatives to driving alone and enable all citizens to participate in the state's communities and economy. The Minnesota Department of Transportation (Mn/DOT)'s strategic vision is to be a global leader in transportation. Mn/DOT is committed to upholding public needs and collaboration with internal and external partners to create a safe, efficient, and sustainable transportation system for the future. To that end, Mn/DOT's strategic directions include improving mobility and accessibility for all Minnesotans through the promotion of public transportation. The Greater Minnesota Transit Investment Plan projects future need for transit services in Greater Minnesota and estimates the cost of providing additional services to reduce unmet need.

The Greater Minnesota Transit Investment Plan and its predecessor, the Greater Minnesota Transit Plan 2010-2030, are part of Mn/DOT's Family of Plans, which includes the Statewide Transportation Policy Plan and mode-specific plans for highways, freight and passenger rail, bicycles and pedestrians, aviation, and transit. Together, the Family of Plans establishes Mn/DOT policy, objectives, strategies, performance targets, and investment priorities for Minnesota's transportation system.

In 2009, Mn/DOT completed the Greater Minnesota Transit Plan, a policy plan that defined the vision, policies, and strategies for transit in Greater Minnesota. The Greater Minnesota Transit Investment Plan identifies specific priorities for future transit investment. These investment priorities connect the goals of the policy plan to Mn/DOT's annual funding allocation to individual transit systems. The Greater Minnesota Transit Investment Plan will help decision-makers prepare for growing transit demand in Minnesota and increase public understanding of Mn/DOT's priorities for future transit investment. Figure 1.1 depicts the main elements of the Greater Minnesota Transit Investment Plan and how it will be integrated with Mn/DOT's programming process.

Figure 1.1 Greater Minnesota Transit Planning and Programming Process



Minnesota Statutes, Section 174.24

Specific directions for the Greater Minnesota Transit Investment Plan are defined in Minnesota Statutes, Section 174.24 Subdivision 1a (emphasis added):

> The commissioner [of transportation] shall develop a greater Minnesota transit investment plan that contains a goal of meeting at least 80 percent of total transit service needs in greater Minnesota by July 1, 2015, and meeting at least 90 percent of total transit service needs in greater Minnesota by July 1, 2025.
>
> The plan must include, but is not limited to, the following:
>
> 1. an **analysis of ridership and total transit service needs** throughout greater Minnesota;
> 2. a calculation of the level and type of **service required to meet total transit service needs**, for the transit system classifications as provided under subdivision 3b, paragraph (c), of urbanized area, small urban area, rural area, and elderly and disabled service;
> 3. an **analysis of costs and revenue options**;
> 4. a **plan to reduce total [unmet] transit service needs** as specified in this subdivision; and
> 5. identification of the **operating and capital costs** necessary to meet 100 percent of the greater Minnesota transit targeted and projected bus service hours, as identified in the greater Minnesota transit plan, for 2010, 2015, 2020, 2025, and 2030.
>
> The plan must specifically address special transportation service ridership and needs. The plan must also provide that recipients of operating assistance under this section provide fixed-route public transit service without charge for disabled veterans in accordance with subdivision 7.

Goal

The goal of the Greater Minnesota Transit Investment Plan is to reduce unmet transit service needs by employing the following strategies:

- Understanding the needs of current transit customers and developing a profile of current riders using **market research**
- Determining total and unmet transit needs at the county level using mathematical modeling and **technical analysis**
- Building support for transit investment priorities by incorporating extensive **public outreach** throughout the planning process

Each of the above strategies was addressed in the planning process. These components are outlined in the following sections.

Market Research

Mn/DOT used a range of market research techniques to qualitatively and quantitatively understand how transit is perceived in Greater Minnesota. Market research tasks included the following:

- **Demographic profiles.** Mn/DOT undertook a mapping process to graphically represent the connectivity between transit services, key destinations, and transit-dependent populations. The goals of the exercise were to identify and interpret significant demographic patterns, determine whether certain populations who may depend on transit are currently served, and identify gaps in service.

- **Focus groups.** Mn/DOT conducted a series of 12 focus groups to consult with non-users of public transit and gather perceptions of transit services and transit need among this group. Focus group participants included seniors, minorities, persons of low income, and persons with disabilities.

- **Onboard surveys.** Mn/DOT administered an onboard survey to riders on every Greater Minnesota public transit system to gather data about current transit riders and better understand transit needs throughout Greater Minnesota. The survey yielded a total of 10,998 valid responses from riders of 59 systems.

Technical Analysis

Technical analysis in the Greater Minnesota Transit Investment Plan focused on satisfying the legislative mandate for calculating the level of total transit needs and the costs of meeting these needs. To arrive at these answers, Mn/DOT developed two mathematical models, one to project passenger demand (number of transit trips) and the other to project service hours needed to serve the future levels of demand. Results of the service hour model were used to calculate the future costs of providing transit.

Public Outreach

The public involvement process was a key component in the development of investment priorities. Mn/DOT employed several public involvement strategies to ensure all interested stakeholders had opportunity to comment. Additionally, the planning process focused more intensive involvement strategies on stakeholders known to have a high interest in transit investments. The state's Regional Development Commissions (RDCs) or equivalent organizations assisted in the implementation of the public involvement strategies and were instrumental in gathering comments from their communities. Regional boundaries and their county compositions are shown for reference in Figure 1.2.

Figure 1.2 Greater Minnesota Economic Development Regions

Region 1	Kittson, Marshall, Norman, Pennington, Polk, Red Lake, Roseau
Region 2	Beltrami, Clearwater, Hubbard, Lake of the Woods, Mahnomen
Region 3	Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis
Region 4	Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse, Wilkin
Region 5	Cass, Crow Wing, Morrison, Todd, Wadena
Region 6E	Kandiyohi, McLeod, Meeker, Renville
Region 6W	Big Stone, Chippewa, Lac qui Parle, Swift, Yellow Medicine
Region 7E	Chisago, Isanti, Kanabec, Mille Lacs, Pine
Region 7W	Benton, Sherburne, Stearns, Wright
Region 8	Cottonwood, Jackson, Lincoln, Lyon, Murray, Nobles, Pipestone, Redwood, Rock
Region 9	Blue Earth, Brown, Faribault, Le Sueur, Martin, Nicollet, Sibley, Waseca, Watonwan
Region 10	Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona

Mn/DOT conducted public outreach activities in close coordination with market research tasks. The primary public involvement strategies included structured interviews, outreach meetings and presentations, web page publications, and a public hearing.

Throughout the development of the plan, Mn/DOT presented market research, technical analysis, and public involvement findings to stakeholders. Before finalizing the plan, Mn/DOT engaged stakeholders in discussions regarding draft investment priorities. A summary document of comments received during this process is available on the project website[1].

Investment Priorities

One of the chief outcomes of this plan is a defined set of transit investment priorities, which are informed by the outcomes of the market research and technical analysis components of the plan. Stakeholder involvement played a key role in shaping the development of priorities throughout the planning process.

Investment priorities were developed to address how Mn/DOT would respond to various future funding scenarios for Greater Minnesota transit. Based on these outcomes, Mn/DOT has developed a plan for preserving existing services at current funding levels and priorities for service expansion and contraction in the event of increased or decreased funding.

[1] http://www.dot.state.mn.us/transit/reports/investmentplan/

Project Management and Decision-Making Process

The project management and decision-making structure for the Greater Minnesota Transit Investment Plan incorporated a Mn/DOT Project Management Team (PMT), a Plan Advisory Committee (PAC), and a Technical Advisory Committee (TAC). The PAC and TAC provided policy and technical guidance to the PMT during the development of the plan. Public outreach and opinion-gathering informed the decision-making of these groups. The commissioner of transportation is charged with submitting the Greater Minnesota Transit Investment Plan to the Minnesota Legislature.

Project Management Team (PMT)

The PMT included key Mn/DOT planning and technical staff and was responsible for managing the development of the plan and ensuring that external and internal communications provided ongoing opportunities to influence the decision-making process.

Technical Advisory Committee (TAC)

The TAC provided overall technical advisory services that guided the work of the PMT. Responsibilities included providing data, offering feedback on the plan methodology, facilitating stakeholder communications, evaluating market research, and recommending investment priorities for consideration by the PAC. The TAC was chaired by Jack Larson of Arrowhead Transit and included the members listed in Table 1.1.

Table 1.1 Technical Advisory Committee Membership

Area	Representative	
District 1	Don Mohawk, District Project Manager Jack Larson (Chair), Arrowhead Transit	
District 2	Kent Ehrenstrom, District Project Manager Greg Negard, Paul Bunyan Transit	
District 3	Sue Siemers, District Project Manager Dave Tripp, St. Cloud Metro Bus	
District 4	Keven Anderson, District Project Manager Harold Jennissen, Rainbow Rider Transit	
District 6	Jean Meyer, District Project Manager Tony Knauer, Rochester Public Transit	
District 7	Jan Klassen, District Project Manager Terrie Gulden, Rock County Heartland Express	
District 8	Bev Herfindahl, District Project Manager Marc Hall (Vice Chair), Pipestone County Transit	
Mn/DOT Office of Transit	Sarah Lenz (representative) John Groothuis (alternate) Noel Shughart (staff support) Judy Ellison (staff support)	Fay Cleaveland (staff support) Becky Alper (staff support) Mike Schadauer (staff support)

Plan Advisory Committee (PAC)

The PAC was responsible for providing strategic policy guidance at key project milestones, culminating in the development of the investment priorities. The PAC considered market research findings, stakeholder comments, and technical analysis when offering policy guidance. The PAC was comprised of key stakeholders and partners, including representatives from other state agencies, local planning agencies, and public transit providers. Members of the PAC are listed in Table 1.2.

Table 1.2 Plan Advisory Committee Membership

Organization/Agency	Representative
Association of Minnesota Counties	Ryan O'Connor
University of Minnesota Center for Transportation Studies	Gina Baas
Department of Employment and Economic Development	Paul Bridges
Department of Human Services	Bob Ries
Greater Minnesota Metropolitan Planning Organization Representative	Mikel Kunza
League of Minnesota Cities	Anne Finn
Metropolitan Council	Amy Vennewitz
Minnesota Board on Aging	Jackie Peichel
Minnesota Public Transit Association	Tony Kellen
Minnesota State Council on Disabilities	Joan Wilshire
Mn/DOT District Planner Representative	Lisa Bigham/Steve Voss (alternate)
Mn/DOT District Transit Project Manager Representative	Kent Ehrenstrom/Sue Siemers (alternate)
Mn/DOT Modal Planning and Program Management Division	Ray Rought
Mn/DOT Office of Capital Programs and Performance Measures	Peggy Reichert
Mn/DOT Office of Statewide Multimodal Planning	Mark Nelson
Mn/DOT Office of Transit	Mike Schadauer (Chair)
Office of Governor Tim Pawlenty	Rima Kawas (ex-officio)
Regional Development Commission Representative	Ronda Allis
TAC Representative	Marc Hall
Transit System Representative	Linda Elfstrand

Current Level of Service

Public transportation needs in Minnesota are growing along with Minnesota's overall population and its population of transit-dependent riders. Minnesota's public transportation systems are growing in response to these needs. In 1990, 40 counties had some form of public transportation system; in 2009, the number of counties with public transportation systems was 76. Only four counties in Greater Minnesota currently lack some form of public transportation service, as shown in Figure 1.4 on the next page.

To meet transportation needs, Greater Minnesota transit systems served 11.1 million passenger trips statewide in 2009. A total of 1.03 million service hours were operated, and transit vehicles traveled 14.9 million miles to serve passenger needs. Local, state, and federal sources combined to fund transit programs at a level of $55.3 million. Figure 1.3 details these statistics by transit system peer group.

Figure 1.3 Statewide Operating Statistics by Peer Group (2009)

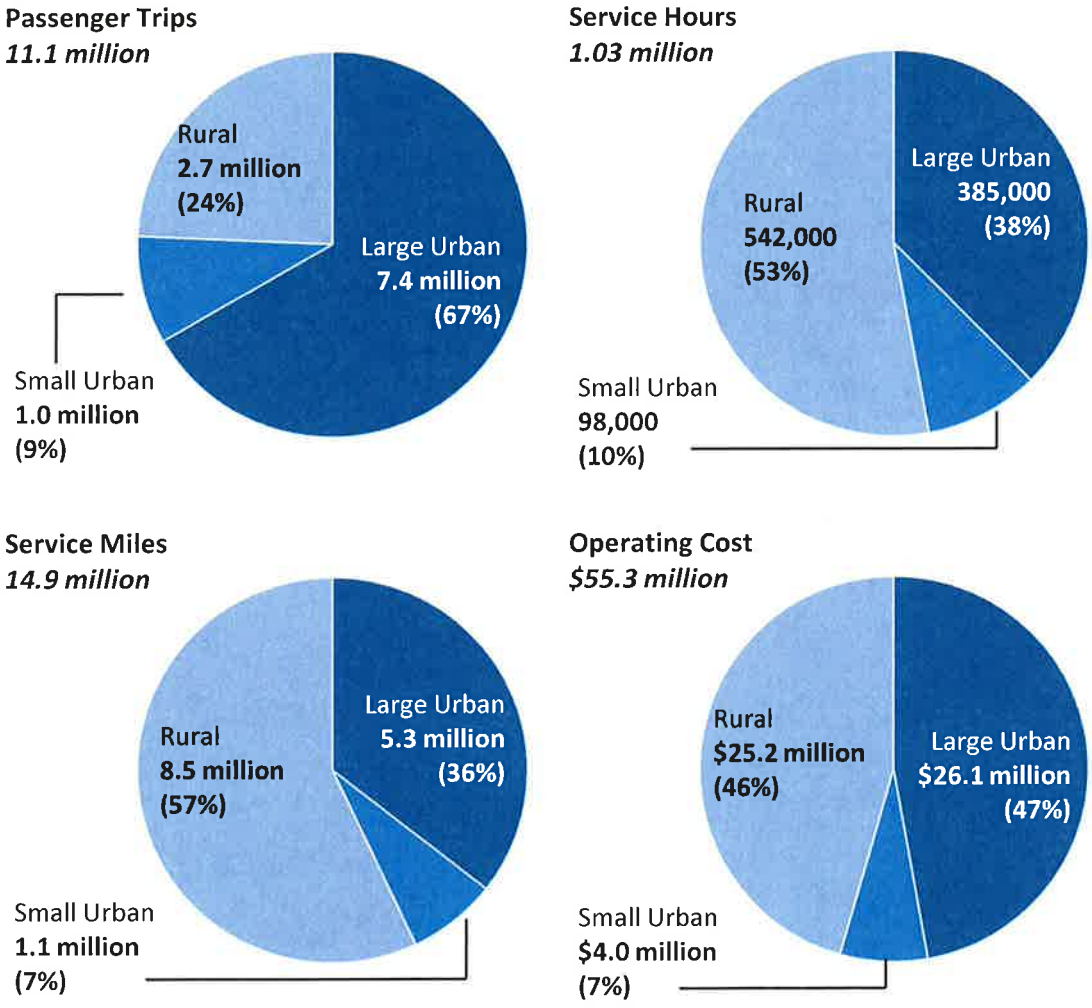
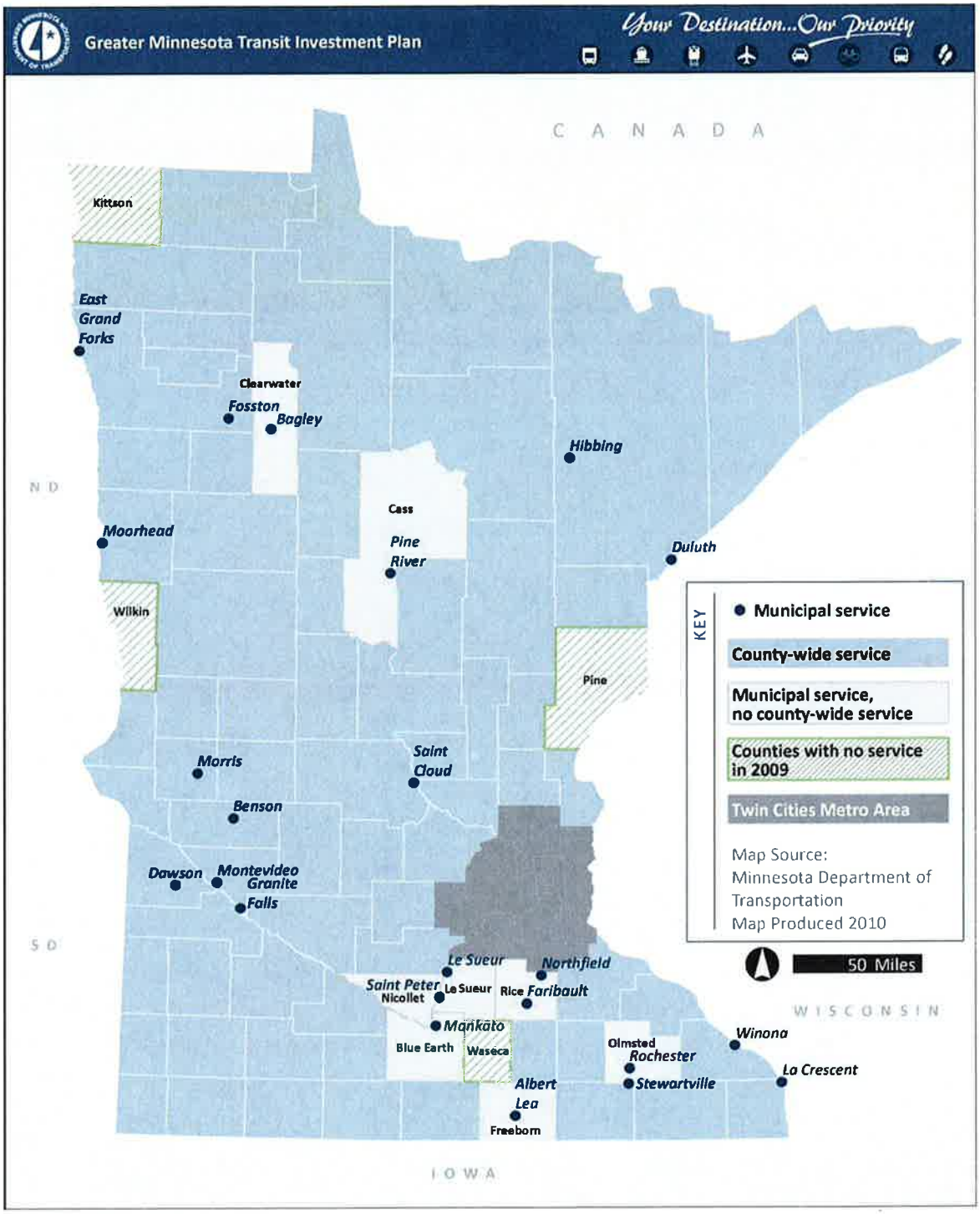


Figure 1.4 Greater Minnesota Transit Service Coverage (2009)



Source: Mn/DOT Office of Transit

Peer Groups

Within the plan's technical analysis, systems are treated differently by peer group to account for the substantial differences in operating environments and characteristics between the various transit services throughout Greater Minnesota. For the purposes of this plan, Greater Minnesota transit systems are initially classified into three peer groups: large urban, small urban, and rural. These peer group divisions supplant the classifications used in previous Greater Minnesota transit planning efforts. The peer groups were developed based on system size, service area, and type of service provided. Systems classified in each peer group are listed in Table 1.3.

Table 1.3 Transit System Peer Groups (2010)

Peer Group	Transit Systems	
Large Urban (7 systems)	Duluth Transit Authority	Moorhead Metropolitan Area Transit
	East Grand Forks Transit	Rochester Public Transit
	La Crescent Apple Express	St. Cloud Metro Bus
	Mankato Public Transit	
Small Urban (12 systems)	Albert Lea Transit	Montevideo Heartland Express
	Benson Heartland Express	Morris Transit
	Faribault Flyer	Northfield Transit
	Granite Falls Heartland Express	St. Peter Transit
	Hibbing Area Transit	Stewartville Heartland Express
	Le Sueur Heartland Express	Winona Transit Service
Rural (40 systems)	Arrowhead Transit	Pine River Ride With Us Bus
	Austin/Mower County Area Transit (AMCAT)	Pipestone County Transit
	Becker County Transit	Prairie Five RIDES
	Brainerd/Crow Wing Public Transit	Prairieland Transit
	Brown County Heartland Express	Rainbow Rider Transit
	Chisago-Isanti County Heartland Express	Red Lake Transit
	Cottonwood County Transit	Renville County Heartland Express
	Dawson Heartland Express	RiverRider Public Transit System
	FAR North Public Transit	Rock County Heartland Express
	Faribault County Prairie Express	SEMCAC Transportation
	Fosston Transit	Steele County Area Transit (SCAT)
	Grant County Alpha Transit	Three Rivers Hiawathaland Transit
	Hubbard County Heartland Express	Timber Trails Public Transit
	Kandiyohi Area Transit (KAT)	Trailblazer Transit
	Lincoln County Heartland Express	Transit Alternatives
	Mahnomen County Heartland Express	Tri-CAP Transit Connection
	Martin County Express	Tri-Valley Heartland Express Bus
	Meeker County Public Transit	Wadena County Friendly Rider Transit
	Murray County Heartland Express	Watonwan Take Me There
	Paul Bunyan Transit	Western Community Transit

System performance varies greatly by peer group, as illustrated in Table 1.4. Comparing the performance of the peer groups illustrates some key challenges in providing service to the wide cross-section of transit markets in Greater Minnesota. Small urban and rural systems require less operating assistance to provide an hour of service than large urban systems. However, due to higher productivity, a large urban passenger trip can be provided for roughly half the cost of a small urban passenger trip, and about a third of the cost of a rural passenger trip. Rural systems, which serve two thirds of the total Greater Minnesota population, often travel long distances to provide a passenger trip, resulting in

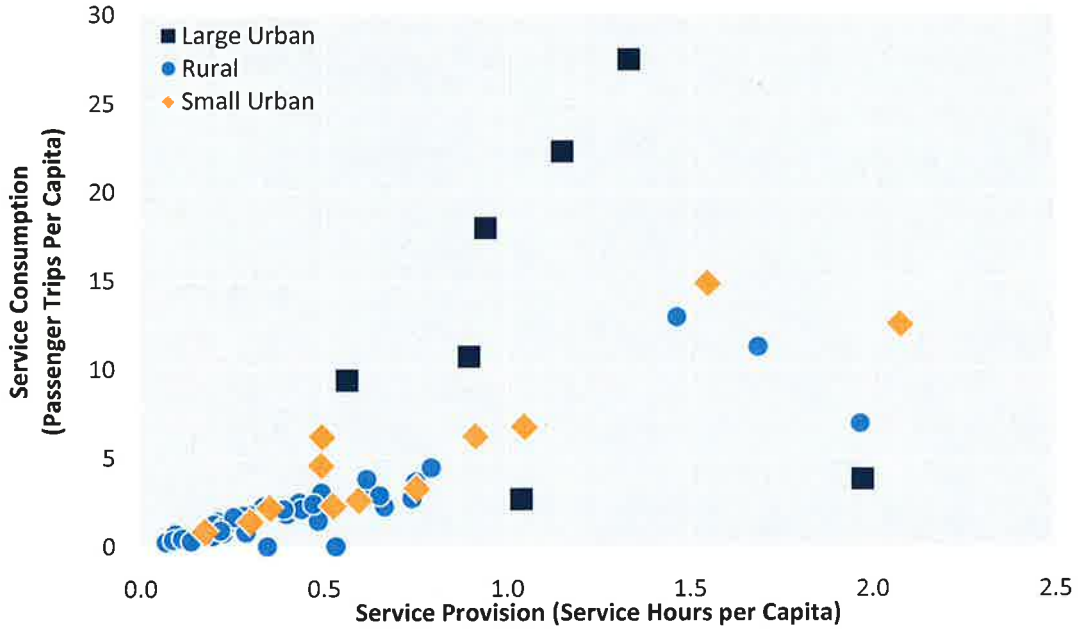
higher per-passenger costs and lower productivity, as measured by passengers per service hour.

Table 1.4 Transit System Peer Group Performance Comparison (2009)

	Large Urban (Typical Range)	Small Urban (Average)	Rural (Average)
Cost per passenger	$2.50–$3.25	$5.50	$9.00
Cost per service hour	$50–$75	$40	$45
Passengers per service hour	20–24	7	5
Passenger trips per capita	20–25	5	2.5
Service hours per capita	1.0–1.2	0.8	0.4

Performance also varies widely within peer groups. Figure 1.5 shows per capita provision and consumption of service by peer group as an example of variation within peer groups. These per capita measures may be used as a key indicator of service equity throughout the state. Most rural systems (shown with circles) annually provide less than an hour of service per capita and serve fewer than five passenger trips per capita; however, some outlier systems provide more service and serve as many as 13 annual passenger trips per capita. Small urban systems (shown with diamonds) are similar to rural systems in their distribution. The seven large urban systems (shown with squares) are distributed throughout the plot, providing anywhere from 0.6 to 2 annual hours of service per capita and serving as few as 2.7 and as many as 27.5 annual trips per capita.

Figure 1.5 Performance Variation among Peer Groups (2009)



Source: Mn/DOT Office of Transit

The wide variation in performance among public transit system peer groups validates Mn/DOT's decision to carry forward the concept of peer groups into the analysis of statewide needs.

Statewide Demographic Overview

Transit service needs will increase in the future as the population of transit-dependent Minnesotans grows. Table 1.5 and Table 1.6 detail projected changes in population by region. From 2000 to 2030, the population of Greater Minnesota is expected to increase by 32 percent—adding nearly three quarters of a million people, with the largest population gains in the Minnesota Development Regions[2] immediately north and northwest of the Twin Cities. In 2000, approximately 14 percent of Greater Minnesota residents were age 65 or older; by 2030, seniors will account for 23 percent of the population. In 2000, persons in poverty made up 8 to 16 percent of the regions' total populations. It is anticipated that this population will grow at about the same rate as the general population. Persons with disabilities comprise 15 to 20 percent of the total population in most Greater Minnesota regions; this group is also expected to grow at a pace similar to that of the general population.

Table 1.5 Change in Total Population and 65+ Population, 2000-2030

	Total Population			Population 65 and Over		
Region	2000	2030	Change 2000-2030	2000	2030	Change 2000-2030
1	88,472	94,030	6%	15,062	23,520	56%
2	76,161	96,920	27%	11,042	22,980	108%
3	322,073	346,880	8%	53,637	92,120	72%
4	210,059	255,180	21%	36,061	66,720	85%
5	152,100	197,380	30%	25,929	54,360	110%
6E	115,899	133,530	15%	18,094	32,720	81%
6W	50,011	44,500	-11%	10,368	13,370	29%
7E	136,244	256,140	88%	17,142	52,250	205%
7W	321,795	629,200	96%	30,925	103,560	235%
8	121,717	116,900	-4%	23,191	30,200	30%
9	222,790	250,360	12%	33,737	56,760	68%
10	460,102	589,370	28%	63,833	131,740	106%
Total	**2,277,423**	**3,010,390**	**32%**	**339,021**	**680,300**	**101%**

Source: Minnesota State Demographer

Table 1.6 Change in Persons in Poverty and Persons with Disabilities, 2000-2030

	Population in Poverty			Population with Disabilities		
Region	2000	2030	Change 2000-2030	2000	2030	Change 2000-2030
1	8,742	9,263	6%	13,874	14,774	6%
2	12,459	16,246	30%	14,373	18,192	27%
3	37,623	40,355	7%	59,046	63,317	7%
4	23,129	28,214	22%	33,718	41,138	22%
5	17,542	22,592	29%	28,744	37,116	29%
6E	9,757	11,094	14%	17,693	20,256	14%
6W	4,296	3,819	-11%	6,744	6,020	-11%
7E	12,357	22,289	80%	24,011	44,035	83%
7W	25,288	46,437	84%	43,996	86,263	96%
8	11,501	11,069	-4%	17,199	16,496	-4%
9	21,455	24,185	13%	30,798	34,552	12%
10	37,828	47,134	25%	64,615	82,171	27%
Total	**221,977**	**282,696**	**27%**	**354,811**	**464,330**	**31%**

Source: U.S. Census 2000, Minnesota State Demographer

[2] See Figure 1.2 on page 1-4 for reference.

Demographic Profile Findings

The demographic profile and transit service mapping exercise conducted during this planning process represented Mn/DOT's first-ever attempt at mapping all Greater Minnesota public transit services. The resulting visual representations helped stakeholders understand the great diversity of transit service needs, existing levels of service, and operating environments that exist in Greater Minnesota. The maps depicted transit services along with six demographic base layers, population density, persons in poverty, minority populations, populations with limited English proficiency, persons 65 or older, and zero-vehicle households. Mn/DOT used the maps for stakeholder discussions and displayed them at public open houses.

Two of the regional maps are presented on the following pages to show the diversity of conditions and services across the state. A map for each Minnesota Development Region can be found on the project website[3].

Region 9, located in south central Minnesota, is an area representative of these vast differences. A demographic profile map showing the region's population density, key destinations, and transit services is reproduced in Figure 1.6 on the following page. The region's largest city, Mankato, has a relatively dense core area and is served by a large urban fixed-route transit system. Many of the smaller communities in the region, including St. Peter, Le Sueur, Blue Earth, and Fairmont, serve their populations with municipal dial-a-ride service. Brown, Watonwan, and Martin counties are all served by rural countywide demand-response service. A network of rural route service connects smaller communities to key destinations in Fairmont, Blue Earth, New Ulm, and other towns. Region 9 also includes Waseca County, one of the four Greater Minnesota counties currently unserved by any kind of public transit service.

Region 3 is located in northeast Minnesota, and exhibits a very different variety of transit services. The region includes the Duluth Transit Authority, which carries more than a quarter of all Greater Minnesota transit passenger trips. In addition, each of Region 3's seven expansive counties is served by some type of transit service operated by Arrowhead Transit. The region's extensive network of rural community-to-community routes connects people from across the Arrowhead to key destinations in the Duluth area, as well as the Iron Range towns of Grand Rapids, Hibbing, and Virginia. Figure 1.7 contains a demographic profile map showing Region 3.

[3] http://www.dot.state.mn.us/transit/reports/investmentplan/

Figure 1.6 Demographic Map – Region 9 Population Density

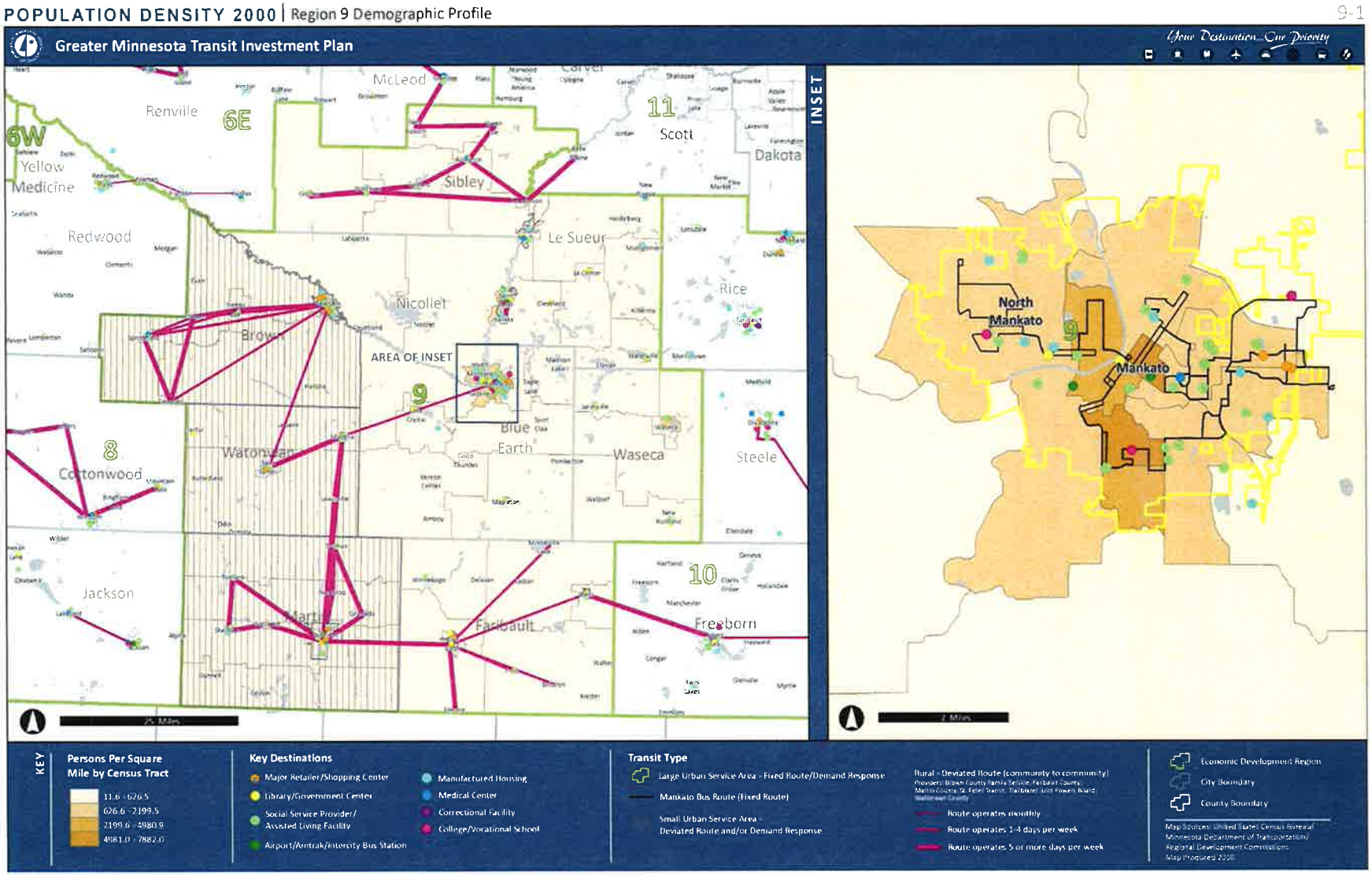


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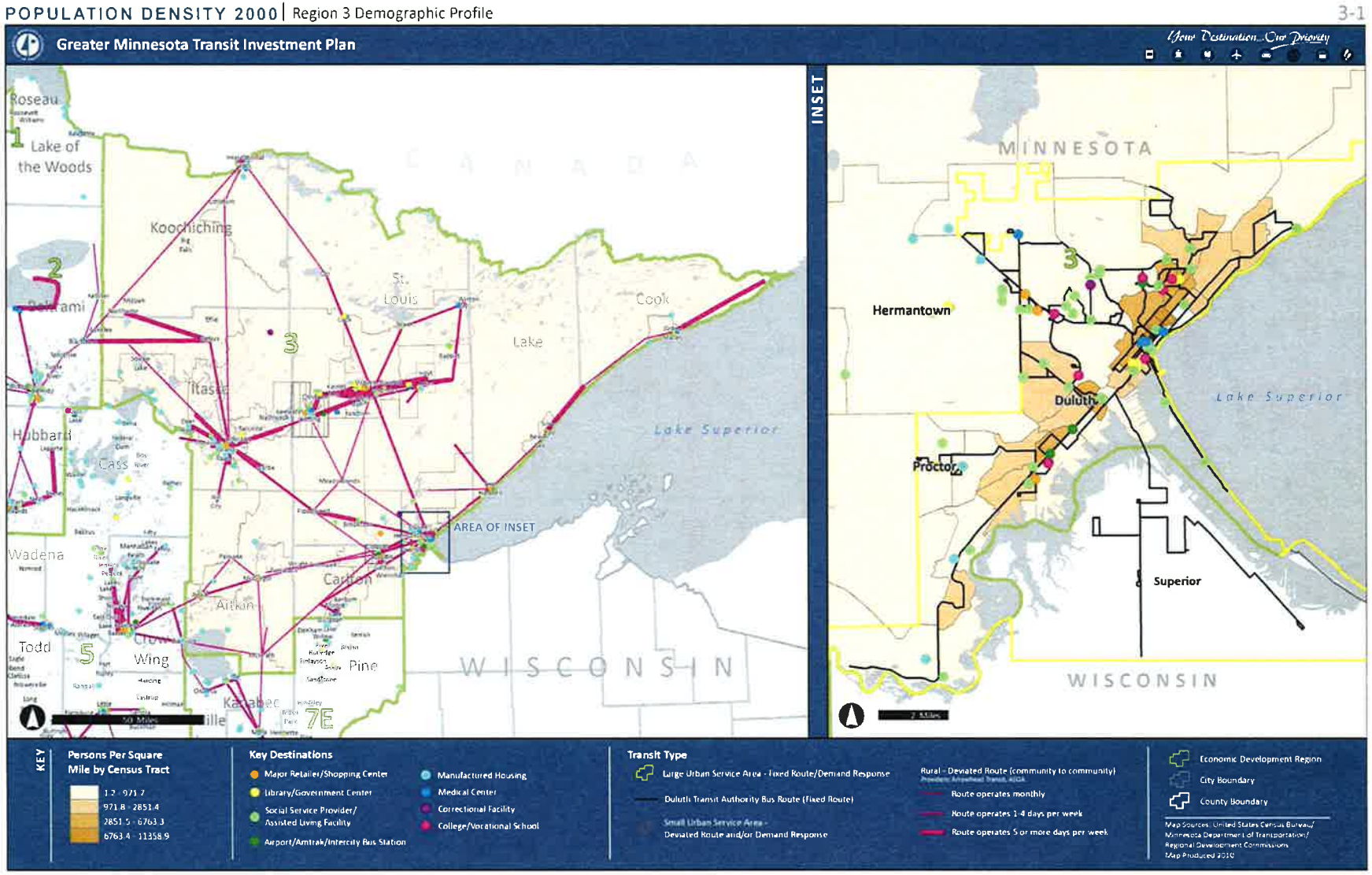
Figure 1.7 Demographic Map – Region 3 Population Density



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Transit Funding Sources

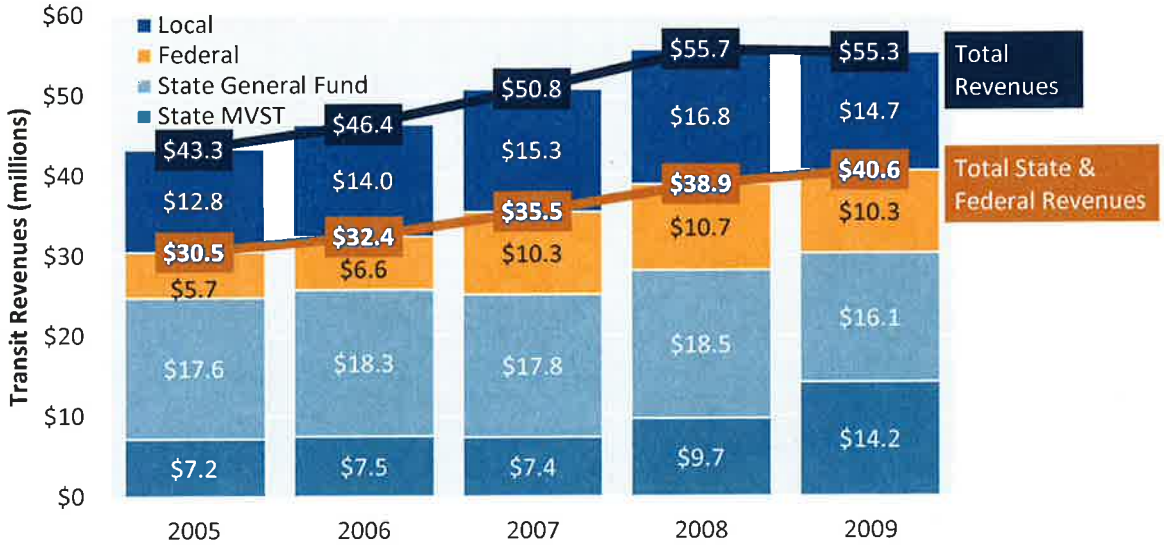
The Mn/DOT Office of Transit is responsible for the administration of state and federal transit assistance funds for Greater Minnesota. Public transportation programs in Minnesota are funded through a federal-state-local partnership. When state and federal funds are adequate, local sources pay a maximum share of the total operating costs, either 15 or 20 percent, depending on the type of service operated. During some recent years the available state and federal funds have not been sufficient to fully fund service at the legislative targets of 80 and 85 percent. Local systems have the option to fund additional transit service beyond their 15 to 20 percent requirement when that is the case.

Public transit operations in Minnesota are supported at the state and federal level from a variety of sources. A major source of state funding is the Motor Vehicle Sales Tax (MVST), which collects revenues from automotive sales and directs up to 40 percent of these funds towards transit assistance. Currently, Greater Minnesota transit's share of MVST revenue is set at 3.75 percent. This share will increase to 4 percent in State Fiscal Year 2012. Other funding for public transit systems in Greater Minnesota has historically come from appropriations from the state's General Fund. Funding from the Federal Transit Administration through operating and capital programs forms the remainder of Greater Minnesota's public transit budget.

Funding sources for Greater Minnesota transit operations for 2005 through 2009 are shown in Figure 1.8. In 2009, the distribution of operating funding was as follows:

- General Fund – 29%
- MVST – 26%
- Federal funds – 19%
- Local funds – 26%

Figure 1.8 Greater Minnesota Transit Operating Funding Sources, 2005-2009



Source: Mn/DOT Office of Transit

Chapter 2: Market Research

At the outset of the planning process, Mn/DOT and its RDC partners undertook two extensive market research tasks to better understand the needs of current and potential Greater Minnesota transit customers. Market research consisted of a statewide survey of current transit users and a set of focus groups held to consult with people who do not currently use transit. The goal of conducting these tasks was to obtain a reliable and valid base of information to feed into development of investment priorities. The results of the onboard survey and focus groups provided a foundation from which Mn/DOT could conduct technical analysis and draft its investment priorities.

Onboard Surveys

Mn/DOT developed an onboard rider survey to be administered on each public transit system in Greater Minnesota, with the goal of using transit riders' input to better understand statewide transit needs. The onboard survey was conducted in March, April, and May 2010, during which a total of 10,998 riders of 59 public transit systems responded to the survey. The key findings are documented in this plan, and a complete report of survey findings is available on the Greater Minnesota Transit Investment Plan website[4].

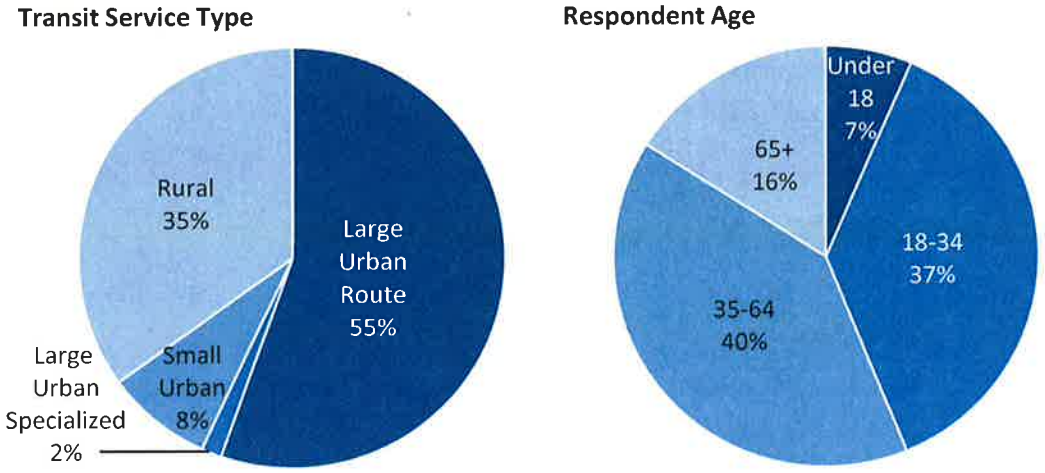
Respondent Profile

The survey asked a number of questions about demographics and personal attributes to learn more about who uses transit in Greater Minnesota. The two most important differentiators of survey respondents' transit behaviors and opinions are the type of transit system used and the age of the respondent. Figure 2.1 illustrates the distribution of respondents by these two characteristics. Over half of respondents are users of large urban services (including fixed-route and elderly and disabled services), while about 35 percent use rural services and the remaining 8 percent use small urban systems. Seventy-seven percent of respondents are between the ages of 18 and 64, while 16 percent are older than 64 and 7 percent are younger than 18.

Sixty percent of respondents are female and 40 percent are male. Survey respondents skew strongly toward lower income households, with 63 percent of respondents reporting household income of less than $20,000. An estimated five of six respondents are below the Greater Minnesota average household income of about $45,000.

[4] http://www.dot.state.mn.us/transit/reports/investmentplan/

Figure 2.1 Survey Respondents by Transit Service Type and Age



Because Mn/DOT has recently begun to monitor trends related to populations with limited English proficiency, the survey asked respondents about their language. English is the first language for 93 percent of respondents. Among those for whom English is not the first language, 96 percent said they understand English very well or well. Transit riders are more ethnically diverse than the population as a whole. Seventy-nine percent of respondents are white; in comparison, approximately 95 percent of the general population of Greater Minnesota is white.

Respondents were also asked about other characteristics associated with transit use. Fifty one percent of respondents do not have a driver's license. Twenty percent have an impairment or disability that requires assistance in riding transit. Four percent of respondents are disabled veterans who are entitled to free rides on fixed-route systems. Nearly 14 percent of respondents from large urban elderly and disabled services are disabled veterans, while the percent of respondents who are disabled veterans from the other transit system types range from 3.4 percent on large urban route service to 4.4 percent on rural services.

Transit Behaviors

During their sampled trips, one third of respondents were riding to work and one in five to school, for a total of 53 percent for these two most common destinations. Seventeen percent were traveling to shopping, 13 percent to a medical appointment, and 8 percent to a social engagement. The remaining nine percent of respondents were traveling to a variety of destinations that were not statistically significant.

A total of 53 percent were riding transit either because they do not have a car or because they do not drive. Another 4 percent do not like to drive. Fourteen percent were riding transit because it saves money, 8 percent because it saves time, and 6 percent because it is better for the environment. The remaining 15 percent of respondents rode transit for a variety of reasons that were not statistically significant.

More than half of respondents ride transit at least five days a week, and 86 percent ride at least twice a week. One in four has been riding transit for less than one year. This

indicates that many users are brand new to transit, requiring systems to continually update marketing information.

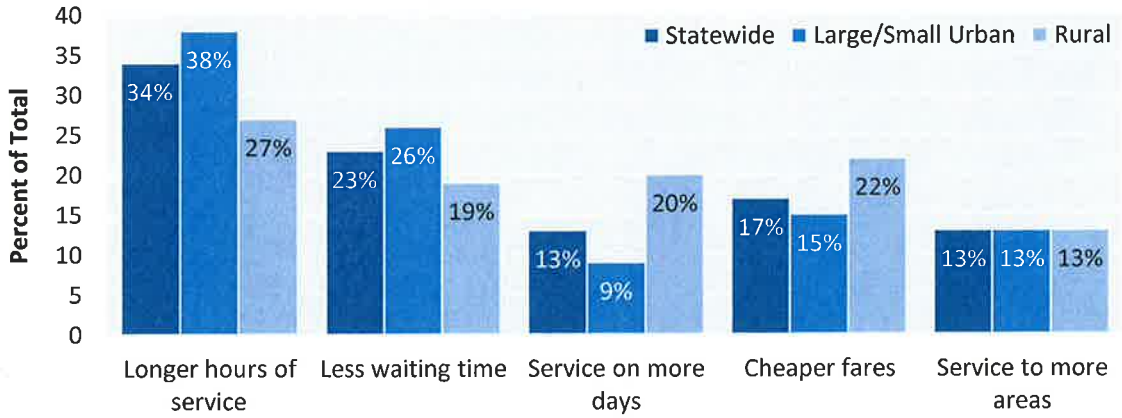
Attitudes and Opinions

The survey asked respondents how satisfied they were with the availability of transit within their community. Sixty-nine percent are very satisfied with their transit service, 27 percent are somewhat satisfied, and 4 percent are not very satisfied or not satisfied at all. Riders age 65 and over are most likely to be very satisfied with their transit service (85 percent). African-Americans are least likely to be very satisfied (56 percent). Still, more than half of every age and ethnic group reported themselves as "very satisfied" with their transit service. The level of satisfaction with transit service seems to be related to whether one has a car and/or a driver's license. If one has no other mobility option, then the level of satisfaction is generally higher. Those who drive a car are more likely to compare their transit service to the mobility they experience with their car, and find transit to be wanting. These people are more likely to ride transit because it saves time or money.

One of the onboard survey's key goals was to gauge the level of needs being met by current transit services. Respondents were asked "What percent of your transportation needs are served by the bus?" The average Greater Minnesota transit user reported 67.7 percent of needs being met. This finding is used later in the plan's technical analysis to help determine the level of unmet needs across the state. The level of needs being served varied little across the transit system peer groups, suggesting that there are sizable unmet needs for transit throughout the state.

Respondents were also asked what potential changes to transit service would be most valuable to them. Figure 2.2 illustrates the results. A total of 70 percent of respondents preferred improvements related to the time service is available, through longer hours of service, less waiting time between buses, and service on more days of the week.

Figure 2.2 Survey Respondents' Preferred Improvements to Transit Services



Only riders of large urban elderly and disabled services did not list longer hours of service as one of their top two changes. Riders of large urban elderly and disabled

services and respondents with household incomes greater than $50,000 rated less waiting time as their first choice for improvement.

Differentials by Transit System Type

Respondent characteristics from each transit system peer group vary from the statewide aggregate. The peer groups include **large urban** (both fixed-route and elderly and disabled services), **small urban** route deviation and on-demand services, and **rural** route deviation and on-demand services.

- **Large urban fixed-route** service users are younger, ride more frequently, are more likely to ride to work or school, and do so on a more discretionary basis, as they are more likely to have a car and a driver's license. They are more likely to prefer receiving transit information via email or a website.

- **Large urban elderly and disabled service** riders are much older, ride less frequently, are more likely to ride to medical appointments, and are less likely to have a car and a driver's license. They are three times more likely than the statewide aggregate to report having limited physical mobility and/or need assistance in riding transit. They report the highest percentage of transportation needs being met by their transit service (73.2 percent versus 67.7 percent statewide). Their preferred transit enhancement is less waiting time, and they prefer to receive transit information via direct mail.

- **Small urban** riders are older, ride less frequently, are more likely to ride to shopping, and are less likely to have a car and a driver's license. They resemble the statewide aggregate on most other dimensions.

- **Rural** service users are older and more likely to ride to work, but they ride less frequently. They are also more likely to ride to medical appointments and shopping. They are less likely to have a car and a driver's license. They are more likely to prefer receiving transit information via direct mail.

Differentials by Age

After transit system type, age is the greatest differentiator of characteristics and opinions among Greater Minnesota transit customers.

- **Riders under 18** are most likely ride to school and do so more than twice a week. They are more likely to want cheaper fares, but household income is highest for riders under 18 than for any age group.

- **Riders age 18-34** mostly ride to work or school, and 92 percent ride more than twice a week.

- **Riders age 35-64** mostly ride to work, and 90 percent ride more than twice a week. Almost half have ridden public transit for more than five years.

- **Riders age 65 and over** ride less frequently and are more likely to ride to shopping (33 percent) and medical appointments (29.5 percent). More than 40 percent have ridden transit for five years or more. Transit ridership becomes less gender-diverse with age; riders age 65 or over are 76 percent female. Riders over 65 are also less racially diverse than the statewide aggregate.

Focus Groups

Focus groups were held in March and April 2010 to consult with non-users of public transit and gather perceptions of transit services and transit need among this group. Each RDC was responsible for conducting one focus group in its region, for a total of 12 sessions statewide. RDCs used their existing networks to identify and invite 10 to12 participants. RDCs screened invitees to ensure they were not regular transit riders and were not employed by a stakeholder agency, e.g. transit provider, RDC, local politician, etc. Focus group membership included representation from seniors, persons with low incomes, minorities, and persons with disabilities.

Focus group discussions focused on four themes: current traveling experiences, transit perceptions, marketing, and future alternatives. Comments were generally consistent throughout the state with few differences between regions. Discussions of each theme are summarized in the following sections.

Current Traveling Experiences

- **Use of personal vehicles.** The majority of participants used their own vehicles for their daily trips. Many had never used or thought about taking public transit.
- **Types of trips.** Types of trips varied by demographic group. Those with children noted an increased number of trips per day due to children's activities. Retired participants noted inconsistent schedules and multiple trips per day for recreation and volunteer purposes.
- **Knowledge of transit service.** Knowledge of existing services varied by area. In some areas, like Bemidji, there was widespread knowledge of transit services and how they worked. In other areas, there was little to no knowledge.

Transit Perceptions

- **Convenience.** The majority of participants do not use transit because it is inconvenient (e.g. does not go where they need to go, long travel times, long wait times).
- **Independence.** Many participants noted they like their independence and transit is an impediment.
- **Who transit service is for.** There were many comments that participants did not know services were available to the general public and thought transit service was only for the elderly and disabled. Others felt that only those that need it should use it.

- **Weather.** Participants often used weather as a reason for not using transit, not wanting to wait outside in the cold or the difficulty of maneuvering sidewalks with large snow banks.
- **Personal safety.** Some participants noted personal safety as a reason for not using transit. Others noted child safety as a reason for not using public transit, for example lack of seat belts.
- **Waste of money/use of service.** Some participants had seen partially full or nearly empty buses and viewed this service as a waste of money.
- **Cost of fares.** This was not considered as a barrier to using transit. Most that had knowledge of fares thought they were reasonable.

Marketing

- **Increased promotions.** The majority of participants felt that additional promotions were needed on the services available.
- **Incentives to ride.** Many participants noted that incentives to ride would increase transit usage. Examples included free service days, discounted passes, or free passes for students. While many suggested incentives, not all indicated that such incentives would increase their likelihood to use transit.
- **Where users get information.** Many participants indicated they would use the phone book to get information on local transit services. Other options included the internet, brochures, and flyers in the community.
- **Where systems offer information.** Most participants felt that information should be placed on bulletin boards throughout the community, in locations such as grocery stores, churches and senior centers.

Future Alternatives

- **Increased use "in the future."** Many participants noted they could see an increased use of transit "in the future." Some noted just a general increase in use, and some noted they would use it themselves. Reasons for increased use included aging, high fuel prices, increased vehicle ownership costs, and lack of parking.
- **Efficiency of service.** Many participants noted a need for increased efficiency of service. This included shorter trips, fewer stops, shorter wait times, express bus lanes, and coordinated services with community organizations and businesses.
- **Expansion of service.** Many participants noted a need for increased services, such as weekend and evening hours, increased service area, and fixed-route service versus dial-a-ride.

Chapter 3: Technical Analysis

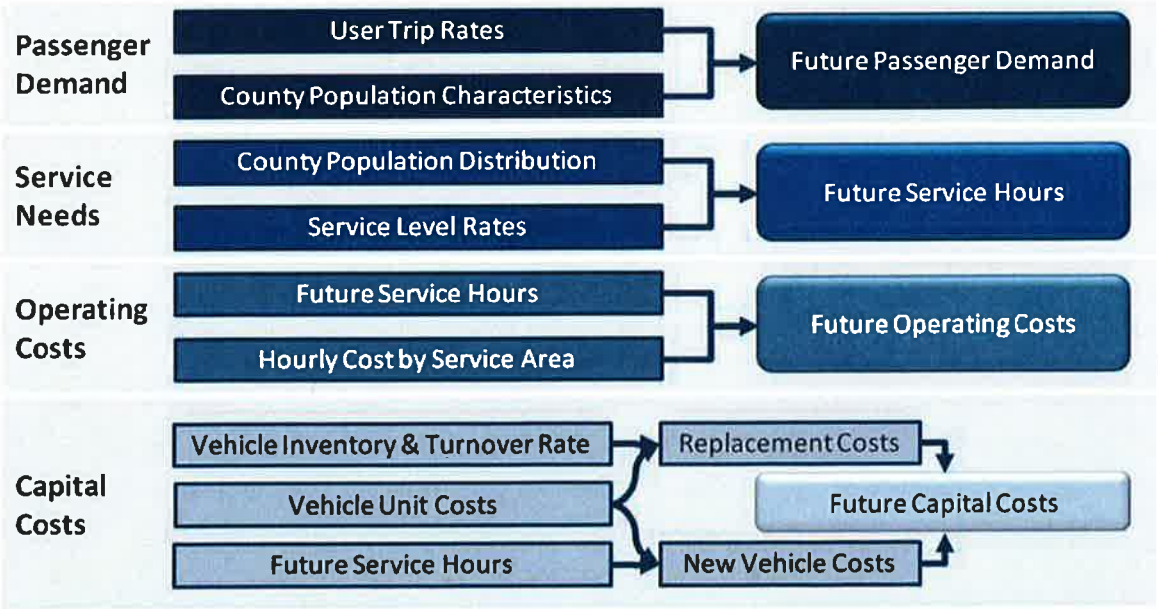
Technical analysis within the Greater Minnesota transit plan addresses five components that affect future transit service provision:

- **Passenger demand** estimates project how many transit trips Greater Minnesota residents will need to make in the future
- **Service level** estimates determine how many hours of service transit providers will need to operate to meet demand levels
- **Operating cost** estimates gauge how much the additional service will cost to provide
- **Capital cost** calculations address costs of replacing existing transit vehicles and purchasing new vehicles to provide additional service
- **Future revenues** provide a framework to understand funding for transit services

Market research and public outreach findings are incorporated in the technical analysis methodologies. The analysis results are used to better understand the size of the investment gap between current transit services and projected needs, and to guide potential investment strategies for future services.

In order to better understand total transit service needs in Greater Minnesota, Mn/DOT developed models to estimate future transit needs in terms of both passenger demand and service hours. Unit costs and inflation factors are applied to these future transit need projections in order to estimate the operating and capital funds needed to fully meet future transit needs in Greater Minnesota. Figure 3.1 illustrates the model methodology.

Figure 3.1 Technical Analysis Methodology



Passenger Demand Estimation

Demand estimation techniques often form the basis for establishing transit needs. Several models have been developed in other states to estimate transit demand; however, no one method fits all geographies. After reviewing existing models for estimating transit needs, Mn/DOT determined that an alternative approach was needed for the Greater Minnesota Transit Investment Plan. The Minnesota Hybrid Demand Model was developed for this plan using portions of models used in other states to better reflect the diversity of transit services and service areas found across Greater Minnesota. The Minnesota Hybrid Demand Model estimates demand using two basic components:

- All Greater Minnesota counties have a base level of public transit demand that can be adequately represented by applying specific trip rate factors to transit-dependent populations of seniors, persons with disabilities, and low-income persons.
- In counties with a large urban center (population above 50,000), an additional component of transit demand is incorporated to account for expanded markets of commuters, students, and general travelers. Other select counties with special service conditions also exhibit a high level of need that exceeds the base level represented by the first model component. Current services in these locations serve unique user groups, such as college/university students or other unique travel markets.

Each component of the model was calibrated using transit trip rates factored to represent the 100th percentile of per capita passenger trip rates found across all Greater Minnesota transit systems in 2009. In addition, trip rates were factored to represent the levels of need currently being met in large urban areas and select counties with special service conditions, according to 2008 utilization data from Mn/DOT and the results of the onboard user survey. Future year total county projections shown in Table 3.1 on the following page were combined with elderly population projections to form the basis for future year demand estimates. This information is provided by the Minnesota State Demographer[5]. Additional information on persons with disabilities, low-income populations, and zero-car households is based on the 2000 U.S. Census.

The model is detailed in Figure 3.2.

Figure 3.2 Minnesota Hybrid Model for Passenger Demand Estimation

Annual Demand by County =		4.2	X	Population 65 years or older
	+	15.0	X	Population with disabilities under 65 years
	+	7.0	X	Low-income, non-disabled population under 65 years
	+	3 x 365 x P	X	Zero-vehicle households in counties with major urban centers and special service conditions counties

(Fixed-route Factor "P" varies by urban center or county to calibrate to current demand, and ranges from 20 to 50%)

[5] Detailed projections can be viewed in a technical memorandum on the project website at http://www.dot.state.mn.us/transit/reports/investmentplan/

Table 3.1 Future Year Population Projections by County

County	2000	2010	2020	2030	County	2000	2010	2020	2030
Aitkin	15,301	17,050	18,700	19,370	Martin*	21,802	20,470	19,970	19,620
Becker	30,000	34,300	38,210	39,860	McLeod	34,898	38,930	42,230	44,660
Beltrami	39,650	46,590	52,380	56,430	Meeker	22,644	24,470	26,250	27,200
Benton	34,226	43,730	51,490	56,970	Mille Lacs	22,330	29,620	35,970	40,630
Big Stone	5,820	5,290	5,160	5,110	Morrison	31,712	34,480	37,470	39,450
Blue Earth	55,941	60,830	64,730	68,060	Mower	38,603	39,290	40,330	40,990
Brown	26,911	26,600	26,990	27,280	Murray	9,165	8,610	8,460	8,340
Carlton	31,671	36,950	41,950	45,300	Nicollet	29,771	32,390	34,980	36,490
Cass	27,150	31,040	34,500	36,250	Nobles	20,832	20,500	20,630	20,590
Chippewa	13,088	12,790	13,040	13,130	Norman	7,442	6,900	6,990	7,040
Chisago	41,101	59,160	75,600	89,320	Olmsted	124,277	148,130	168,400	183,290
Clay	51,229	57,080	63,020	66,910	Otter Tail	57,159	59,040	61,930	63,700
Clearwater	8,423	8,790	9,270	9,470	Pennington	13,584	14,050	14,760	15,210
Cook	5,168	5,570	6,050	6,320	Pine	26,530	30,660	34,320	36,450
Cottonwood	12,167	11,700	11,690	11,740	Pipestone*	9,895	9,220	9,270	9,250
Crow Wing	55,099	65,220	73,960	79,750	Polk	31,369	31,850	33,370	34,280
Dodge	17,731	21,660	25,110	27,740	Pope	11,236	11,560	12,270	12,670
Douglas	32,821	37,890	42,750	45,920	Red Lake	4,299	4,350	4,520	4,600
Faribault	16,181	15,250	15,190	15,050	Redwood	16,815	15,660	15,430	15,280
Fillmore	21,122	21,960	23,000	23,640	Renville	17,154	16,860	17,300	17,590
Freeborn	32,584	31,950	32,050	32,020	Rice	56,665	66,420	75,500	82,230
Goodhue	44,127	48,030	52,170	55,200	Rock*	9,721	9,590	9,890	10,010
Grant	6,289	6,080	6,280	6,390	Roseau	16,338	17,080	18,330	19,170
Houston	19,718	20,350	21,270	22,080	Sherburne	64,417	101,560	134,390	161,990
Hubbard	18,376	19,560	20,840	21,430	Sibley	15,356	15,370	15,700	15,840
Isanti	31,287	45,080	57,710	68,770	St. Louis	200,528	198,010	200,490	202,040
Itasca	43,992	45,610	47,630	48,470	Stearns	133,166	154,220	173,520	188,760
Jackson	11,268	11,220	11,390	11,490	Steele	33,680	38,450	42,900	46,030
Kanabec	14,996	17,560	19,710	20,970	Stevens*	10,053	9,650	9,960	10,210
Kandiyohi	41,203	42,000	43,320	44,080	Swift*	11,956	10,810	10,300	9,960
Kittson	5,285	4,420	4,000	3,720	Todd	24,426	25,200	26,230	26,630
Koochiching	14,355	13,690	13,400	13,150	Traverse	4,134	3,530	3,170	2,970
Lac qui Parle	8,067	7,150	6,830	6,640	Wabasha	21,610	22,940	24,380	25,170
Lake	11,058	11,480	11,990	12,230	Wadena	13,713	14,110	14,830	15,300
Lake of the Woods	4,522	4,410	4,500	4,530	Waseca	19,526	19,700	20,400	20,760
Le Sueur	25,426	29,910	34,090	37,090	Watonwan	11,876	10,900	10,500	10,170
Lincoln	6,429	5,930	5,970	5,950	Wilkin	7,138	6,610	6,620	6,550
Lyon	25,425	24,220	24,210	24,250	Winona*	49,985	49,430	50,200	50,980
Mahnomen	5,190	5,120	5,100	5,060	Wright	89,986	136,110	181,240	221,480
Marshall	10,155	9,860	9,990	10,010	Yellow Medicine	11,080	10,100	9,970	9,660

*Denotes special conditions counties

Source: Minnesota State Demographer

Figure 3.3 provides an illustrative example of the demand model application for County A, a hypothetical county with population characteristics as shown in Table 3.2.

Table 3.2 Hypothetical County A Population Characteristics

	Year 2000	Year 2030
Total population	55,000	65,000
Population age 65 or older	6,500	10,500
Low-income population	12.7%	12.7%
Population with disabilities	14.6%	14.6%
Zero-vehicle households	2.7%	2.7%

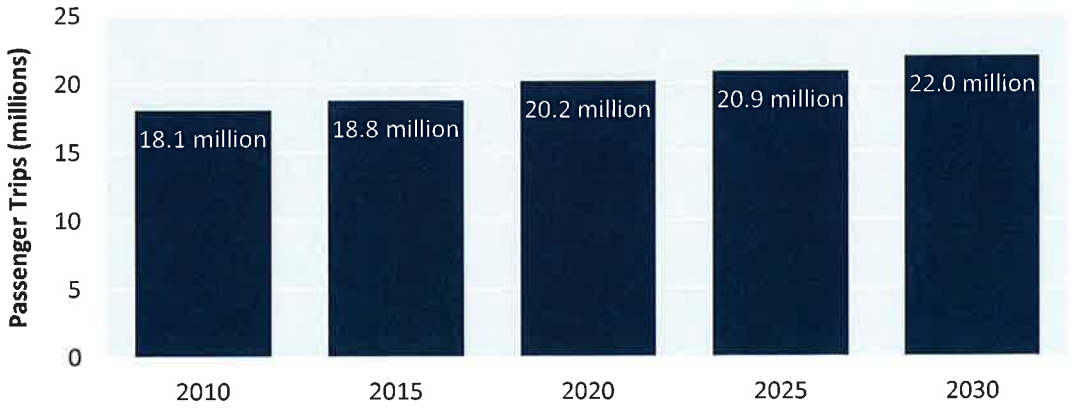
Figure 3.3 Hypothetical County A Year 2030 Estimated Passenger Demand

	4.2	X	***6,500***	persons age 65 or older (year 2030)
+	15.0	X	***9,455***	persons with disabilities under 65 years (year 2030)
+	7.0	X	***8,273***	low-income, non-disabled persons under 65 years (year 2030)
+	3 x 365 x ***20%***	X	***1,733***	zero-vehicle households (year 2030)
=			**606,563**	**annual one-way transit trips in 2030**

(Fixed-route Factor $P_{County\ A}$ = 20%)

Transit need estimates were developed for each of Greater Minnesota's 80 counties with the method illustrated above and aggregated to produce a statewide total. The result is an estimate of total transit service needs in Greater Minnesota, measured in annual one-way passenger trips potentially using public transit. The calculations account for the needs of all Greater Minnesota residents, including persons with disabilities. Statewide passenger demand estimates are shown in Figure 3.4.

Figure 3.4 Statewide Total Annual Estimated Passenger Demand



In 2009, the level of passenger demand met was 11.1 million annual trips, representing 61 percent of 2010 projected demand.

Service Level Estimation

Service hours are used to establish transit service level needs. In order to produce future transit service hour estimates for Greater Minnesota, Mn/DOT developed the Minnesota Service Hours Model. The primary inputs for the model are current service levels, current county population estimates, and future county population projections. To develop the service hour projections, annual per capita service hour target rates for the county population within each transit peer group, shown in Table 3.3, were applied to the future population of each county. The medium-sized urban area peer group was added for this analysis to account for significant differences in current amounts of per capita service provided.

Table 3.3 Service Hours per Capita Target Rates by Peer Group

Peer Group	Target Rate
Large urban (Duluth, Rochester, St. Cloud)	1.50-1.75
Medium urban (Moorhead, Mankato, La Crescent, East Grand Forks)	1.00
Small urban	0.75
Rural – High service level	0.75
Rural – Low service level	0.50

Target rates of service hours per capita were selected as the best way to project standardized service levels across the state. The rates are based on current statewide peer group averages and the percent of needs currently being met according to the onboard survey results. For each county, transit peer group target rates were applied to the population segments they serve. County populations were allocated into the following segments:

- Urban (for counties that contain the cities of Duluth, Rochester, St. Cloud, Moorhead, Mankato, La Crescent, and East Grand Forks)
- Cities over 10,000 (not including cities in the urban category)
- Rural (includes cities under 10,000)

For initial model setup, 2008 county-level service hours targets were applied to the total county population to derive a county-specific service hours per capita target rate. To develop future service hours projections, the county-specific service hours per capita target rate was applied to future population estimates provided by the State Demographer. The complete service hours model is illustrated in Figure 3.5.

Figure 3.5 Minnesota Service Hours Model

Current (2008) Service Hours by County		Large Urban Segment	X Large Urban Target Rate
	+	Medium Urban Segment	X Medium Urban Target Rate
	+	Small Urban Segment	X Small Urban Target Rate
	+	Rural (High Service Level) Segment	X Rural Target Rate
	+	Rural (Low Service Level) Segment	X Rural Target Rate
	= +	Special Consideration Segment	X Special Consideration Target Rate
Service Hours Per Capita Target Rate	=	*Current Service Hours by County* / Current County Population	
County Future Service Hours	=	Future Population Projections	X *Service Hours Per Capita Target Rate*

Figure 3.6 provides an illustrative example of the service hours model application for County B, a hypothetical county with population characteristics as shown in Table 3.4.

Table 3.4 Hypothetical County B Population Distribution

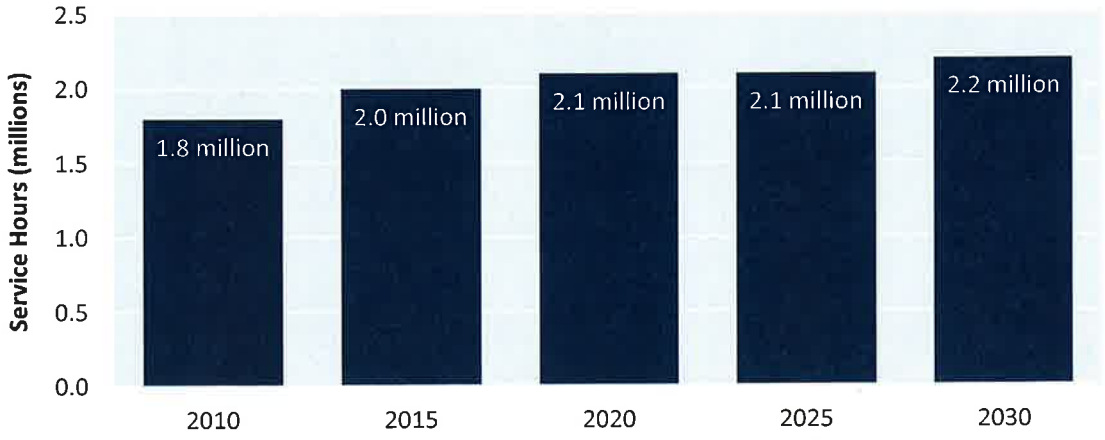
	Year 2010	Year 2030
Total population	60,000	75,000
Large urban population	30,000	--
Small urban population	20,000	--
Rural population	10,000	--

Figure 3.6 Hypothetical County B Year 2030 Estimated Service Hour Needs

Current Annual Service Hours Target	=	***30,000*** large urban population	X	***1.50***	=	45,000	
		+ ***20,000*** small urban population	X	***0.75***	=	15,000	
		+ ***10,000*** rural population	X	***0.50***	=	5,000	
						= 65,000 *current annual service hours*	
Service Hours Per Capita Target Rate	=	***65,000*** current annual service hours / **60,000** total current population				= *1.08 service hours per capita*	
2030 Service Hours	=	*75,000* total persons (2030)	X	*1.08* service hours per capita		= *81,200 service hours*	

Service level estimates calculated for each county and aggregated at the statewide level. Statewide service level estimates are shown in Figure 3.7.

Figure 3.7 Annual Service Hours Needed to Fully Meet Passenger Demand



The level of service provided in 2009 was 1.03 million statewide service hours, representing 57 percent of 2010 projected service hour needs.

Current Service Gap

According to Mn/DOT, the total number of passenger trips served in 2009 was 11,056,833 and the actual number of service hours operated was 1,025,425. Based on the demand estimates conducted as part of this analysis, 2009 services met approximately 61 percent of passenger demand and 57 percent of projected service hour needs statewide. This differs slightly from the results of the onboard survey, which indicate about 68 percent of transit needs being met in areas where public transit services are currently available. The slight difference in needs met is attributable to the cities and counties that do not currently have any public transit service in operation. Table 3.5 includes a comparison of the actual versus projected 2010 need (passenger demand and service hours).

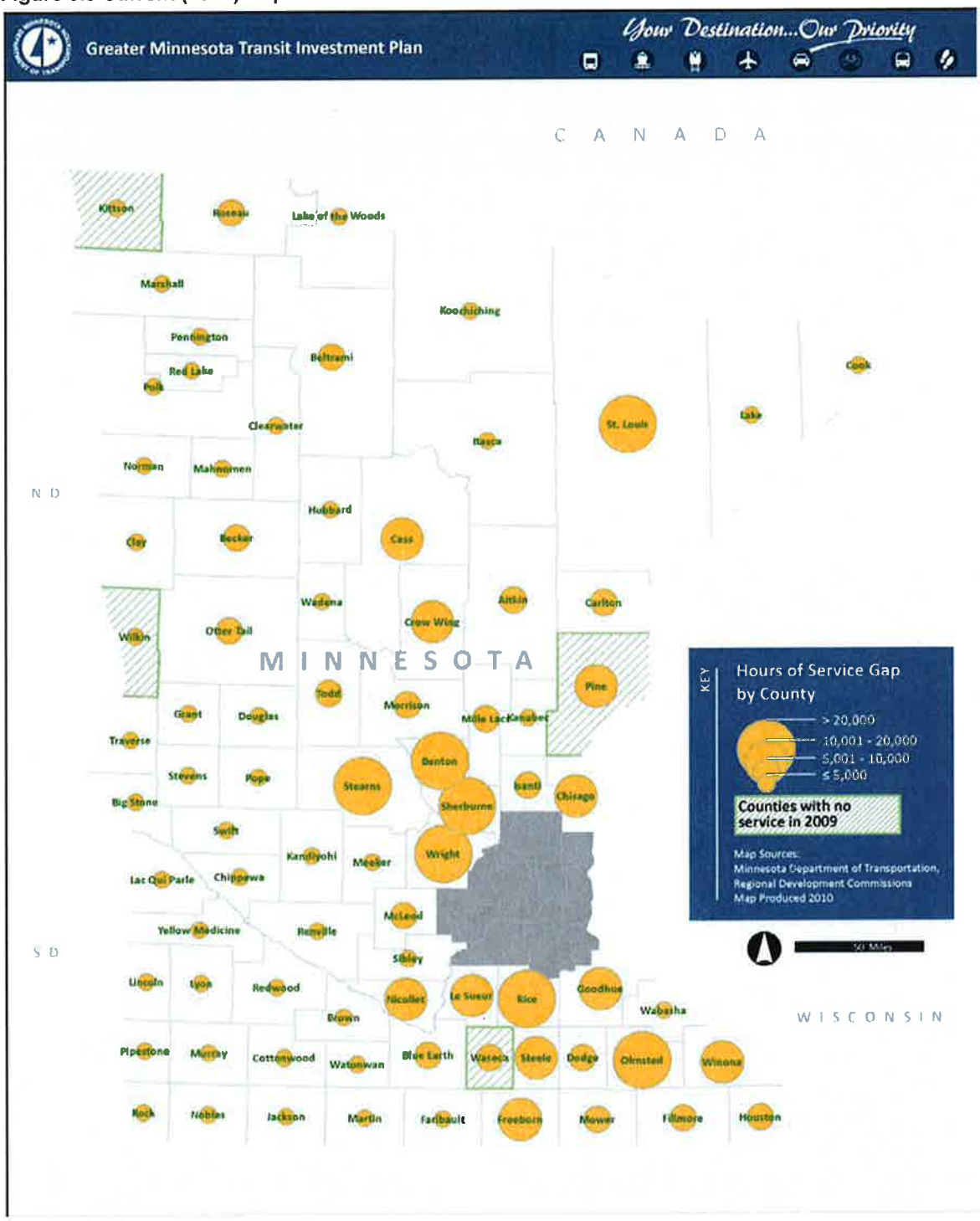
Table 3.5 2010 Statewide Service Gap

	Actual (2009)	Projected (2010)	Gap	Percent of Total Projected Need Served
Passenger demand	11,056,833	18,132,000	7,075,167	61%
Service hours	1,025,425	1,836,000	810,575	57%

Figure 3.8 on the following page shows the service hour gap by county. The information depicted in the figure is also included in tabular form in a technical memorandum available on the project website[6].

[6] http://www.dot.state.mn.us/transit/reports/investmentplan/

Figure 3.8 Current (2010) Gap in Service Hours



Operating Costs

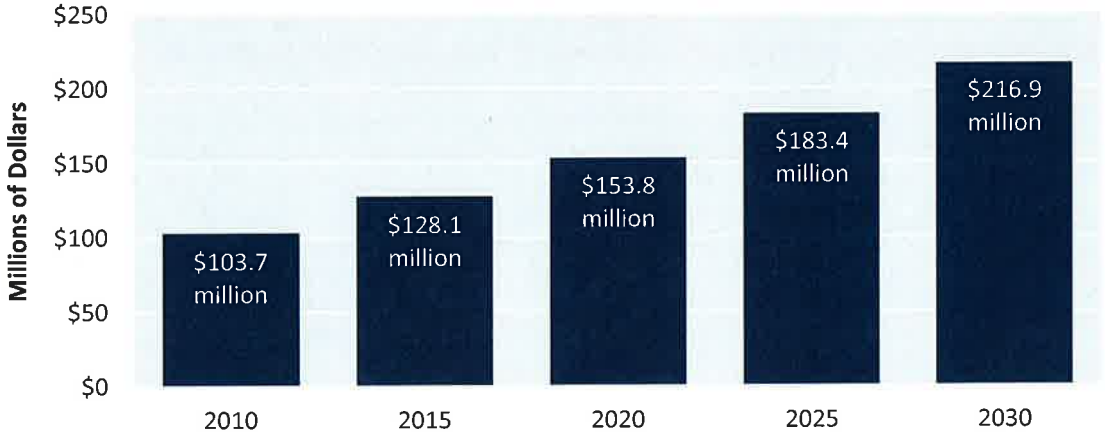
In order to guide potential investment strategies for future services and to better understand the size of the investment gap between current transit services and projected needs, Mn/DOT developed a model to estimate the cost to meet future transit needs in Greater Minnesota. The primary inputs for the cost model are the future service need estimates (service hours) developed as part of this analysis and current operating expenses per service hour. To develop the cost estimates, an average expense per hour rate for transit system peer groups was applied to the future service hours for each county and adjusted for inflation, assuming costs will increase at 2.85 percent per year. The hourly rates for each peer group are presented in Table 3.6.

Table 3.6 Operating Cost Hourly Rates by Peer Group

Peer Group	Average Cost per Hour (2009 dollars)
Large urban	$70.10
Medium urban	$65.70
Small urban/rural	$45.20

Projected total annual operating costs are shown for future years through 2030 in Figure 3.9.

Figure 3.9 Annual Operating Cost of Fully Meeting Future Service Needs

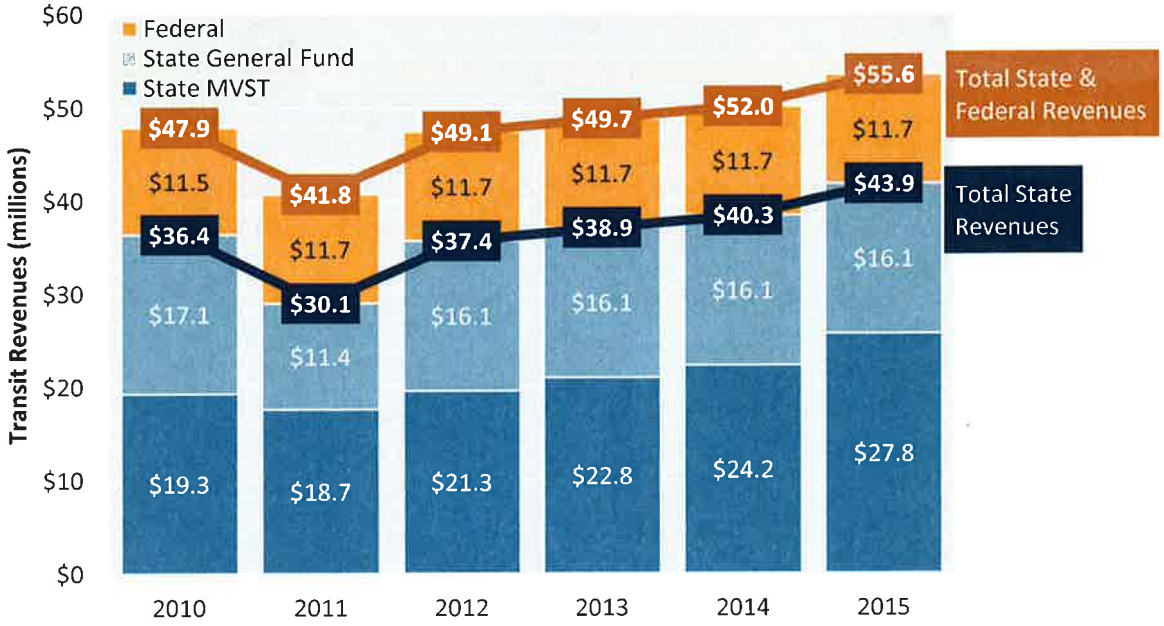


The total operating cost for services in 2009 was $55.3 million.

Operating Revenues

Projected state and federal Greater Minnesota public transit operating revenues through 2015 are illustrated in Figure 3.10.

Figure 3.10 Projected State/Federal Greater Minnesota Transit Operating Revenues, 2010-2015



Sources: Mn/DOT Office of Transit, MMB November 2010 MVST Forecast

It is projected that total transit operating revenues from state and federal sources will decline in 2011, and then grow to $55.6 million in 2015.

Capital Costs

Capital cost estimates include vehicle replacement costs for existing services and costs of purchasing new vehicles required to serve future needs.

Vehicle Replacement

Fleet replacement costs are a product of vehicle cost and service life, both of which vary considerably according to vehicle type. To maintain a safe and viable transit system, it is assumed that a certain percentage of each system's fleet must be replaced annually. Vehicle fleet replacement costs are calculated by applying vehicle turnover rates to vehicle unit costs and current fleet size. Inflation-adjusted fleet replacement costs required to maintain existing systems annually through 2015 and in five-year increments through 2030 are presented in Table 3.7 and Table 3.8. System needs are grouped into large/medium urban and small urban/rural classifications to reflect current fleet composition.

Table 3.7 2011-2015 Annual Fleet Replacement Cost (in millions)

Year	Large/Medium Urban	Small Urban/Rural	Annual Total
2011	$4.3	$5.2	$9.5
2012	$4.4	$5.3	$9.7
2013	$4.5	$5.5	$10.0
2014	$4.7	$5.7	$10.4
2015	$4.8	$5.8	$10.6

Table 3.8 2011-2030 Vehicle Replacement Costs in Five-Year Increments (in millions)

Years	Large/Medium Urban	Small Urban/Rural	Five-Year Total
2011-2015	$22.7	$27.5	$50.2
2016-2020	$26.2	$31.7	$57.9
2021-2025	$30.2	$36.5	$66.7
2025-2030	$34.6	$42.0	$76.6

New Vehicle Requirement

New transit vehicles are needed to meet current and projected future service needs in both unserved and underserved areas. New vehicle needs are projected using a model based on the results of the Minnesota Service Hours Model (see Figure 3.5). The primary inputs for the capital cost model are the estimated service hours to meet the needs targets, current service hours, transit vehicle unit costs, and the average annual service hours per transit vehicle. Figure 3.11 summarizes the capital cost model for new vehicles.

Figure 3.11 Capital Cost Model for New Vehicle Requirement

Target Year Capital Cost = Vehicle Unit Costs (Table 3.9) X *Target Year Vehicle Fleet Gap by Population Segment*

Target Year Vehicle Fleet Gap by Population Segment = $\dfrac{\text{Target Year Service Hours Gap} \times \textit{Representative Population Segment Distribution}}{\text{2,500 (average annual service hours per vehicle)}}$

The average annual service hours per transit vehicle (2,500 hours) was applied to the service hours gap for the population represented by each transit system peer group in each county to derive the additional vehicle fleet needed to meet unmet service needs. A vehicle unit cost was then applied to develop the estimated capital cost of meeting each target. The Greater Minnesota transit fleet consists of vehicles from three different classes, ranging from low-capacity cutaway buses to heavy duty, high-capacity fixed-route buses. Table 3.9 lists the estimated 2010 vehicle unit costs by class and the population segment typically served by each.

Table 3.9 Vehicle Unit Cost by Class

Vehicle Class	Population Segment Served	Estimated Vehicle Cost (2010)
600/700 (high-capacity)	Urban	$305,000
500 (mid-capacity)	Small urban (cities over 10,000)	$114,000
300/400 (low-capacity)	Rural	$66,000

Unit costs are increased by 2.85 percent annually for future year estimates to account for inflation. The total vehicles and related capital cost required to meet 100 percent of needs are summarized in Table 3.10. These costs are incurred in addition to the ongoing fleet replacement costs.

Table 3.10 Capital Cost of Additional Vehicles Required to Meet 100 Percent of Future Needs

	2010	2015	2020	2025	2030
Total new vehicles required	297	53	36	32	26
Class 600/700	49	9	6	6	5
Class 500	48	9	6	5	4
Class 400	200	35	24	21	17
Total cost (adjusted for inflation)	$33.6 million	$6.9 million	$4.3 million	$4.6 million	$4.4 million

The 2010 additional vehicle capital cost value represents the fleet required to fully close the service gap from current levels of service. Values in subsequent years represent the fleet required to meet new levels of service to serve expanding transit need.

Sources of Capital Funding

Capital funding sources for Greater Minnesota transit vehicles include Federal 5307 Formula Funds, Federal 5309 Discretionary Funds (Competitive Funds), and Federal Highway Administration Flex Funds. Of these, Federal Highway Administration Flex Funds are the primary funding source for maintaining the Greater Minnesota transit capital program. The current capital funding level from these funding sources allows Greater Minnesota transit systems to meet the majority of their existing capital needs.

Chapter 4: Public Involvement

Mn/DOT was committed to integrating public involvement into decision-making throughout the Greater Minnesota Transit Investment Plan process. Pairing public involvement techniques with the results of market research and technical analysis helped Mn/DOT gain an understanding of existing transit service needs and informed the development of the plan.

The goals of the public outreach program included the following:

- **Creating early and continuous opportunities for involvement.** Mn/DOT conducted two rounds of outreach meetings at key points in the plan.
- **Providing timely information about the plan development.** Mn/DOT regularly briefed stakeholders on plan progress and maintained current information for public consumption on the project website. RDCs conducted over 50 stakeholder presentations throughout the state, engaging the public in dialogue about investment priorities.
- **Reaching a diverse set of stakeholders.** Together with its RDC partners, Mn/DOT included a wide array of stakeholder voices in the planning process. Mn/DOT targeted transit-dependent populations, including persons with disabilities, seniors, minorities, and persons with low incomes for participation in market research and public outreach presentations.
- **Seeking review and comment at key decision-making points.** Before finalizing the plan, Mn/DOT held public open houses and engaged stakeholders in extensive discussions regarding draft investment priorities.
- **Integrating public comment and market research into the decision-making process.** Feedback from the project stakeholder committees directly affected the planning process. In addition, Mn/DOT used the findings of structured interviews as an input to technical analysis.

The specific involvement strategies employed during the plan included structured stakeholder interviews, outreach meetings and presentations, public open houses, web page publications, and a public hearing.

Structured Interviews

The purpose of the structured interviews was to engage stakeholders in an in-depth discussion regarding investment priorities in cases of increased and decreased funding scenarios.

A total of 24 structured interviews were conducted with key stakeholders from across the state to test validity of Greater Minnesota transit investment priorities. Questions focused on investment priorities for rural versus urban areas, availability of services, cost-effectiveness, service investment priorities, expansion of fixed-route service versus dial-a-ride, marketing, and pricing of transit services.

Participants represented the following groups:

- Veterans services
- Chambers of commerce
- Key destinations
- Social services
- Senior services
- Health care organizations
- Minority organizations
- Citizens

Participants represented organizations/citizens from across Greater Minnesota. The following geographic areas were represented:

- Statewide
- Southwestern Minnesota
- West Central Minnesota
- Southeastern Minnesota
- Northwestern Minnesota
- St. Cloud area
- Duluth area
- Wadena area
- Brainerd Lakes area
- Mankato area
- Fargo/Moorhead area
- Bemidji area
- Aitkin County
- Blue Earth County
- Carlton County
- Chisago County
- Isanti County
- Kanabec County
- LeSueur County
- Mille Lacs County
- Pine County
- Renville County
- Waseca County

The following key themes emerged from the structured interviews:

- **Rural vs. urban.** The majority felt that expanding service in rural Minnesota is an important investment priority, as the need for access to services is significant. Others felt that investments should be made in growing urban areas where systems provide the most rides.

- **Availability of service.** The majority felt that transit should be available to every Minnesotan, although concerns about the feasibility and cost of doing so were noted by some.

- **Cost-effectiveness.** Many respondents felt that cost-effectiveness was a good measure for determining investment priorities, while others felt that it should not be the only criterion evaluated.

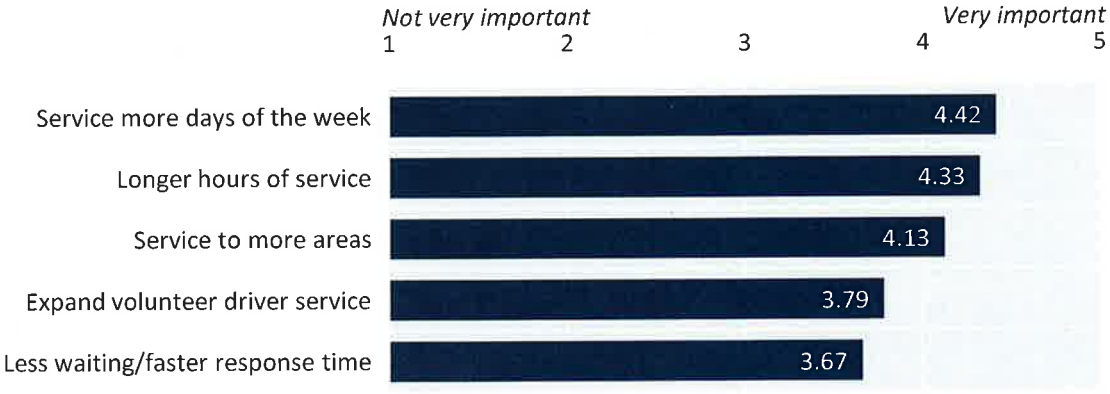
- **Fixed-route vs. dial-a-ride/on-demand.** Dial-a-ride or on-demand service was more preferred than fixed-route service.

- **Marketing.** A need for increased marketing was noted by most respondents. Several respondents noted that collaboration with community organizations and alternative marketing tactics were needed.

- **Fare price.** The majority of respondents did not feel that fare price was a barrier to transit use. Other barriers, such as availability, awareness, and connectivity, were noted.

- **Investment priorities.** Service expansions in terms of days of the week, service hours, and areas served were most important to interview participants. Participants were asked to state the importance of five expansion options on a scale of 1 to 5, with 1 being the least important and 5 being the most important. Results are shown in Figure 4.1.

Figure 4.1 Importance of Potential Transit Improvements (Interview Participants)



Outreach Meetings and Presentations

RDCs or equivalent organizations each held outreach meetings and gave presentations to interested organizations in their communities. Over 50 stakeholder presentations were given throughout Greater Minnesota. The presentations provided an opportunity to share information on key elements of the plan as well as provided an opportunity for in-depth dialogue. Participants were not only encouraged to comment orally, but also to provide written comment on comment cards. Throughout the development of the plan, approximately 300 comment cards were collected. Some highlights from the comments received are:

- Providing service in more areas is the most important priority for expansion.

- Providing longer hours of service and service more days of the week are also high priorities.

- Transit services need to be marketed to potential customers so that people know what services are available in their communities.

- Rural areas need transit services and must not be penalized for low passenger volumes.

Public Open Houses

Each RDC held an open house to present technical analysis findings to the public and review draft investment priorities. Open houses were widely publicized and held in transit accessible locations. Attendees provided generally positive feedback on the investment priorities.

Web Page

Mn/DOT dedicated a page on its website to provide current information on the Greater Minnesota Transit Investment Plan. Mn/DOT used the web page as a repository for results of market research, technical analysis, and public outreach processes. Notices for stakeholder participation opportunities were also posted on the web page.

Public Hearing

Mn/DOT held a public hearing on the draft Greater Minnesota Transit Investment Plan on January 19, 2011. The hearing was held via video conference at all Mn/DOT district offices and via web-based Adobe Connect software to encourage participation from all geographic areas. Key themes from the comments included:

- The need for increased transit funding to ensure transit needs are met statewide.
- The importance of transit services in helping seniors live at home, especially in rural areas.
- The need for increased coordination among transportation services.

Chapter 5: Summary of Needs

The market research, technical analysis, and public outreach undertaken during the course of this planning process underscore the fact that there is not one simple way to calculate statewide transit needs. Due to the diversity of areas served by public transit and the mix of users in Greater Minnesota, transit means different things to different stakeholders and perceptions and expectations of transit service will continue to vary in the future. Using market research as a baseline, the mathematical models developed in this plan have yielded a reasonable foundation for quantifying Greater Minnesota's transit needs and costs in future years, which can be used to shape priorities and direct resources toward filling the current gaps in transit service.

Response to Legislative Targets

The Minnesota State Legislature required this plan to identify the capital and operating costs necessary to meet 100 percent of total transit service needs for 2010, 2015, 2020, 2025, and 2030. These needs and costs are shown in Table 5.1.

Table 5.1 Summary of Future Needs and Costs (100-percent level), 2010-2030

	2010	2015	2020	2025	2030
Total Passenger Demand (millions of trips)	18.1	18.8	20.2	20.9	22.0
Service Hours to Meet Demand (millions)	1.8	2.0	2.1	2.1	2.2
Annual Operating Cost (millions)	$103.7	$128.1	$153.8	$183.4	$216.9
Capital Cost - Vehicle Replacement (five-year totals)	--	$50.2	$57.9	$66.7	$76.6
Capital Cost - New Vehicles (millions)	$33.5	$6.9	$4.3	$4.6	$4.4

Vehicle replacement costs through 2010 are accounted for under current funding programs. The 2010 new vehicle capital cost value represents the fleet required to fully close the gap between current levels of service and new service required to meet 100 percent of estimated needs. Values in subsequent years represent the fleet required to meet new levels of need to serve the expanding population.

2015 and 2025 Targets

The Minnesota State Legislature set a goal of meeting 80 percent of Greater Minnesota transit needs by 2015. Current transit services meet approximately 61 percent of passenger needs. To reach the 2015 goal, Greater Minnesota transit systems will need to serve significantly more passenger trips, which will require more service hours. Greater Minnesota transit systems are on track to provide approximately 1.03 million service hours in 2010. By 2015, 1.6 million service hours will be needed to meet the targeted 80 percent of passenger trips; in other words, transit systems will need to collectively operate 570,000 more service hours annually by 2015 in order to meet the 80-percent target.

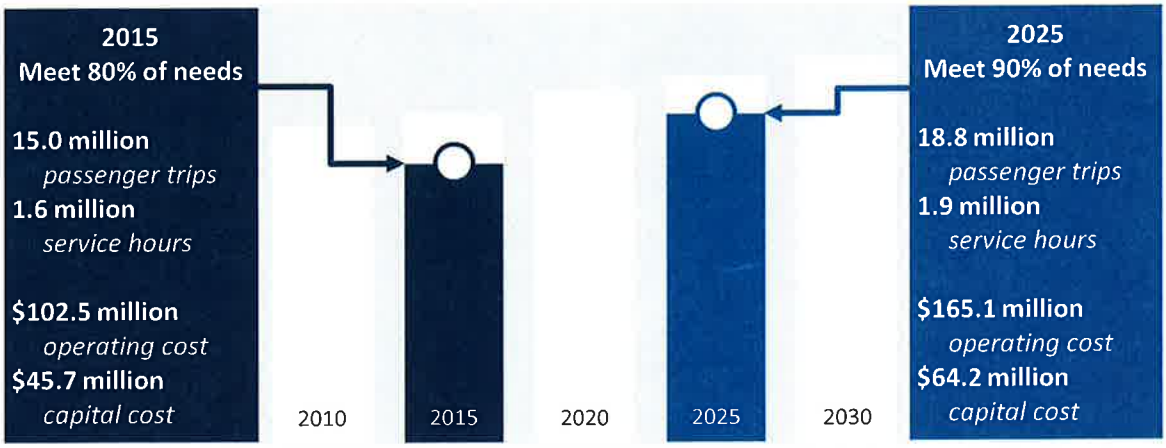
- **$102.5 million** in annual operating revenues from state, federal, and local sources will be required to meet the 80-percent target in 2015.
- **$45.7 million** will be needed to meet the capital needs associated with the 2015 target.

In addition, the Legislature directed Mn/DOT to specifically identify the passenger levels, levels of service, and costs necessary to meet 90 percent of total transit service needs by 2025. To reach the 2025 target of serving 18.8 million annual passenger trips, Greater Minnesota transit systems will need to provide 1.9 million annual service hours.

- **$165.1 million** in annual operating revenues will be required to meet the 90-percent target in 2025.
- **$64.2 million** in capital investment will be required to meet the 2025 target.

The costs of meeting the specific 80-percent and 90-percent legislative targets are illustrated in Figure 5.1.

Figure 5.1 Summary of Future Needs to Meet Legislative Targets



*2015 capital cost includes vehicle replacements from 2010 to 2015 and new vehicle purchases needed to fill service gap between current levels and 2015 target
*2025 capital cost includes vehicle replacements from 2015-2025 and new vehicle purchases needed to fill service gap between 2015 target and 2025 target

State/Federal Funding Gap

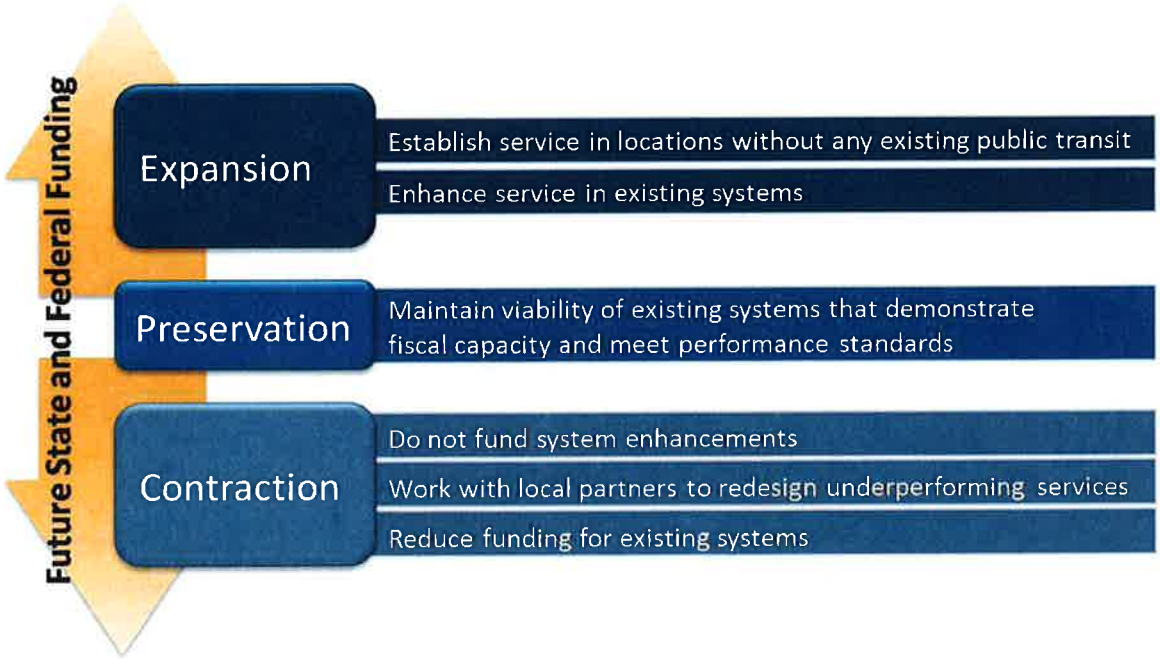
The cost implications of meeting the service needs are substantial. In calculating the funding gap between projected funding and funds needed to meet the 2015 target, it is assumed that the combined state and federal share of total statewide operating funds is 82.7 percent and the local share covers the remaining 17.3 percent. State and federal revenues are expected to remain relatively flat over the near term. By 2015, these combined sources are anticipated to grow to $55.6 million over 2010 levels of $47.9 million. The small increase in operating revenue will not even cover the expected cost increases from inflation, leaving a $29.2 million state/federal funding gap to meet the 2015 target.

Chapter 6:
Transit Investment Priorities

In addition to calculating future service needs, the Greater Minnesota Transit Investment Plan sets priorities to guide future transit investments so that unmet service needs can be reduced. As Mn/DOT undertook development of the plan, it sought to better understand the needs of current and potential transit customers, estimate the gap between current service levels and reasonable needs levels, and incorporate the thoughts and directions from stakeholders who routinely deal with transit providers and customers. In addition, Mn/DOT carefully considered the needs of program administration so that any forthcoming changes would not impede progress already being made toward meeting transit needs across the state. The outcome is a delineation of transit investment priorities that correspond to changing funding scenarios.

Figure 6.1 illustrates Mn/DOT's recommended approach to increased or decreased funding scenarios. Mn/DOT plans to re-evaluate investment priorities every four years and make adjustments as needed.

Figure 6.1 Transit Funding Scenarios and Service Implications



Preservation

Mn/DOT's first priority for Greater Minnesota transit is to preserve existing systems by funding each system at a level sufficient to continue the current level of service in the future. To qualify for preservation, a system must demonstrate local fiscal capacity and meet performance standards as measured through an annual system review process.

Mn/DOT will implement an annual review of transit systems to determine eligibility for state support of system preservation. Mn/DOT will use a three-step review process to establish system eligibility:

1. **Conduct system-level performance reviews based on peer groups.** Three peer groups will be established for large urban systems, small urban systems, and rural systems. Reviews will use the following measures:

   - Cost per passenger
   - Cost per service hour
   - Passengers per service hour
   - System revenue to total operating cost ratio

   Systems that fall more than 20 percent short of the average performance for any one measure for the peer group within which they reside will be subjected to follow-up operational analysis. New services will be expected to meet performance measures within three years of start-up.

2. **Check compliance with state and federal reporting requirements.** Systems must comply with the following requirements to be eligible for the maximum level of preservation funding:

   - Monthly reporting to Mn/DOT
   - Incident reporting
   - Drug and alcohol reporting
   - Federal Financial Accountability and Transparency Act (FFATA) reporting
   - Disadvantaged Business Enterprise (DBE) reporting
   - Applicable federal reporting
   - Satisfactory outcome to annual site visit

3. **Conduct follow-up operational analysis.** If a system fails on either of the first two steps, Mn/DOT will require a follow-up analysis at the system and service segment level as needed to identify causes of poor performance. Mn/DOT will work with systems to improve performance.

Expansion

Service expansion priorities address how additional funds would be spent after all current systems are maintained at their current levels, should increased funding become available for Greater Minnesota transit.

Mn/DOT's highest priority for Greater Minnesota service expansion is to establish service in locations without any existing public transit. This priority is directly shaped by legislative mandate[7]. To be eligible for service, locations would have to demonstrate local fiscal capacity and ability to meet performance measures within three years of development.

After service is established in unserved areas, Mn/DOT's top priorities for enhancing service in existing systems, listed in order of importance, are to:

- **Expand service hours in the morning and night to provide more trips.** Expanding service hours was the most important service expansion identified by current passengers during the onboard survey.
- **Expand multi-county services to link more communities.** Stakeholders expressed a need for more services connecting residents and destinations across county boundaries.
- **Provide service on more days of the week.** Some communities only have service two days a week; others communities have weekday service but would like to add service on one or both weekend days.
- **Expand service frequencies and coverage.** For example, expanding frequencies in an urban system could mean running buses every half hour instead of every hour. In a rural system, it could mean the ability to schedule dial-a-ride one day in advance instead of two. An example of adding coverage in an existing area is adding a new bus route or adding a new community within a county-wide system.
- **Expand service to provide consistent levels of service statewide.** Consistent statewide levels of service mean that peer group communities can provide similar amounts of service hours with their state and federal funding dollars.

[7]Minnesota Statutes, Section 174.01, Subdivision 2, Part 6

Contraction

The following priorities address how Mn/DOT will evaluate funding applications and allocate available funds in the event that future funding for transit is reduced. Four guidelines define Mn/DOT's response to a reduced-funding scenario. Guidelines are listed in consecutive order.

- In an environment of contracted funds, funding for system enhancement will not be considered. In other words, if there is not enough money to adequately preserve all existing systems statewide, no one system will receive any additional money for enhancement.
- Mn/DOT will work with systems to redesign underperforming service segments. Mn/DOT and the transit provider will evaluate performance measures set for peer groups in more detail to see how systems can operate more efficiently.
- Mn/DOT will reduce state and federal funding to those systems with service segments that underperform on the performance measures.
- If decreases in state and federal funding for transit necessitate additional reductions, Mn/DOT will reduce funding allocations to systems that meet or exceed performance standards.

Identified Program Management Tools

Mn/DOT believes every Greater Minnesota public transit system should integrate program management tools into its operations. Mn/DOT expects that these will be utilized by public transit systems regardless of future funding levels.

Mn/DOT will work with systems to ensure the following tools, listed in no particular order, are used to help implement the investment priorities:

- Explore ways to increase the use of technology to gain efficiencies in transit delivery.
- Refine services using service-level performance measures to increase efficiency of transit delivery.
- Coordinate with other transit providers, including tribes (e.g. White Earth Public Transit), volunteer drivers, Section 5310 programs for the elderly and persons with disabilities, and taxi providers, to increase service delivery options.
- Increase marketing to reach more customers and make citizens more aware of the services that exist in their community.
- Provide transit service without charge for disabled veterans (applies only to fixed-route systems).

Appendix A: Supporting Documentation

All documents listed below are available on the project website at http://www.dot.state.mn.us/transit/reports/investmentplan/. Accessible formats are available on the web or by request from Mn/DOT.

- Public Involvement Strategy
- Structured Interview Summary Report
- Focus Group Summary Report
- Onboard Survey Form
- Onboard Survey Summary Report
- Demographic Profile Sample Maps
- Transit Needs Calculation Technical Memorandum
- Technical Analysis Documentation Memorandum

Appendix B: Glossary

This glossary defines terms that appear in the Greater Minnesota Transit Investment Plan. Many of these terms have multiple definitions; therefore, terms are defined as they are used in the context of this plan.

ADA paratransit: Demand-response transit service mandated by the Americans with Disabilities Act (ADA). Provided within ¾ mile of fixed routes to certified users who are unable to use fixed routes due to a disability or health condition.

Capital cost: The cost of equipment and facilities required to support transportation systems: vehicles, radios, shelters, etc.

Coordination: A cooperative arrangement among transportation providers and/or purchasers, which is aimed at realizing increased benefits through the shared management and/or operation of one or more transportation related functions.

Cost-effectiveness: The ratio of the cost of a transit system to the level of service provided. Various measures may be used to determine cost-effectiveness, e.g. cost per passenger trip.

Dedicated funding source: A funding source that by law is available for use only to support a specific purpose, and cannot be diverted to other uses; e.g., the federal gasoline tax can only be used for highway investments and, since 1983, for transit capital projects.

Demand estimation of need: The use of projection models to estimate future year transit needs in terms of both passenger demand and service hours

Demand-response/dial-a-ride service: A transportation service characterized by flexible routing and scheduling of relatively small vehicles to provide door-to-door or point-to-point transportation at the user's demand.

Elderly and disabled transportation: Transportation service to persons that are physically disabled and/or elderly and live in areas with a population over 50,000.

System revenue to total operating cost ratio: Total local revenue, including fares, advertising, service contracts, and taxes, divided by total operating cost.

Federal Transit Administration (FTA): A part of the United States Department of Transportation that administers the federal program of financial assistance to public transit.

Fixed-route transit: Transportation service operated over a set route or network of routes on a regular time schedule; also called regular route.

Local fiscal capacity: A transit subrecipient's ability to:

- Provide, at a minimum, the local share required for capital improvement/replacement and existing operations and expanded services.
- Manage operational and capital transit programs to meet ongoing operational cash flow needs and to meet planned and incidental capital replacement needs.
- Establish and maintain transit accounts within the existing accounting system to manage transit farebox, cash, and contract revenue, and to segregate transit revenue and costs from other agency's program revenue and costs.
- Provide all Mn/DOT fiscal and operational reporting in a timely manner.
- Provide program and project management oversight to assure the fiscal integrity of state and federal funding.

Marketing: A comprehensive process to induce greater use of transportation services by determining the needs or demand of the community and potential customers, developing and implementing service on the basis of these needs, pricing the services, promoting the services, and evaluating the services as implemented in relation to customer needs and marketing goals.

Motor Vehicle Sales Tax (MVST): A source of revenue for Minnesota public transit. See Minnesota Statute 279B.09. Thirty-six percent of money collected on the purchase price of motor vehicles registered in Minnesota is deposited in the metropolitan area transit account under section 16A.88. Four percent must be deposited in the Greater Minnesota transit account under section 16A.88. The Greater Minnesota transit account supports the Public Transit Participation Program in Minnesota Statutes, Section 174.24.

Operating cost: The recurring costs of providing transit service; e.g. wages, salaries, fuel, oil, taxes, maintenance, depreciation, insurance, marketing, etc.

Passenger trip: A one-way trip made by one person from origin to destination. One round trip equals two passenger trips.

Peer group: A group of transit systems which individually share many commonalities, and for which averages are collectively determined on key statistics regarding the operating environment and level of service.

Public transportation: Transportation service that is available to any person upon payment of the fare either directly, subsidized by public policy, or through some contractual arrangement, and which cannot be reserved for the private or exclusive use of one individual or group. "Public" in this sense refers to the access to the service, not to the ownership of the system that provides the service.

Service hours: The total number of hours when the vehicle is in revenue service (i.e., the time when a vehicle is available to the general public and there is an expectation of carrying passengers). Excludes deadhead hours, but includes recovery/layover time.

Rural area: A geographic area with a population center of less than 2,500.

Service gap: The difference between the actual level of passenger trips and service hours provided and the projected level of need estimated as part of this plan.

Service span: The duration of time that service is made available or operated during the course of the service day e.g., 6:00 a.m. to 10:00 p.m.

Stakeholder: An individual or organization that has an interest in the decisions which affect transit safety and operations. Stakeholders include the public, industry, interest groups, and state and local officials.

Small urban: A geographic area with a central city that has a population of between 2,500 and 50,000.

Total operating cost: The total of all operating costs incurred during the transit system calendar year, excluding expenses associated with capital grants.

Total passengers: The total of all revenue passengers, plus transfer passengers on second and successive rides, and free ride passengers.

Transit-dependent passenger: A person who does not have immediate access to a private vehicle, or because of age or health reasons cannot drive and must rely on others for transportation.

Urbanized area: A geographic area with a central city that has a population of over 50,000.

Vehicle service life: The standard life cycle for different vehicle classifications. The minimum life cycle is determined by the FTA.

Olmstead Plan:

Health Care and Community Supports Administrations Overview of Behavioral Health Homes

January 2015

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Introduction

On January 28, 2013, Governor Mark Dayton issued an executive order establishing an Olmstead Sub-Cabinet to develop and implement a comprehensive Minnesota Olmstead Plan. The main purpose of the Olmstead Plan is to move the state forward, towards greater integration and inclusion for people with disabilities.

In accordance with objective 1C under the Healthcare and Healthy Living section of the Olmstead Plan the Health Care and Community Supports administrations are charged with:

Developing 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 people with serious mental illness who are Medicaid consumers 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.

By December 31, 2014, DHS was to 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.

The following report provides a summary of the work accomplished in meeting these objectives.

Background

The 2010 Patient Protection and Affordable Care Act (ACA) established the "State Option to Provide Coordinated Care through a Health Home for Individuals with Chronic Conditions", which provides funding for a two-year enhanced (90-percent) federal match for health home services for eligible Medicaid enrollees. This enhanced federal funding gives states critical resources to build provider capacity and provide an additional window of time needed to realize a return on their investment.

The federal health home model expands upon the concept of the more commonly used term, medical homes (in Minnesota referred to as Health Care Homes) by serving the whole person across the primary care, long-term services and supports, and mental health and substance use disorder treatment components of the health care delivery system. Health homes coordinate a variety of services including primary care and specialty care, and ensure referrals to community supports and services are effectively managed. The key feature of health homes, comprehensive care management, supports the person in managing chronic conditions and achieving their self-management goals by facilitating the provision of clinical services that contribute to improved health outcomes.

The Community Supports and Health Care Administrations of DHS are working together to design a behavioral health home (BHH) model which will operate under a "whole person" philosophy and assure access to and coordinated delivery of primary care and behavioral health services for adults and children with serious mental illness (SMI).

The administrations are working together because of the known barriers to health care access, early mortality and high co-occurrence of chronic health conditions for individuals with SMI. These conditions are generally associated with modifiable risk factors more prevalent in the adult SMI population including smoking, chemical dependency, and poor nutrition. Children who are exposed to psychological trauma are proven to have a significant risk of poorer physical health as adults and also much more likely to have serious emotional disturbance.

People with SMI often lack access to adequate health care and those with access are less likely to receive care for comorbid chronic conditions that meets clinical practice guidelines. Quality care for people with SMI requires coordination between health care and behavioral health systems and integrated treatment for co-occurring mental health and substance abuse disorders.

DHS is developing a framework that will require a standard of integrated care which encompasses mental, behavioral, physical health conditions and considers the influence of multiple conditions, social factors, social function, and consumer preferences to personalize assessment, treatments, and goals of care.

DHS believes that more integrated care, regardless of setting, contributes to improved health and decreases the risk of adverse outcomes.

Consumer and Stakeholder Engagement to Inform Design

Consumer Engagement

In planning for behavioral health homes, DHS has contracted with the National Alliance on Mental Illness (NAMI) Minnesota to engage people living with mental illness across the State in an opportunity to shape policy. Through their participation in focus groups, Medicaid participants from a very wide range of communities are providing feedback on topics that will inform the development of Minnesota's behavioral health home model. The focus group questions concentrate on topics such as: accessing physical and mental health care, transition of care experiences, methods of obtaining health information, opinions surrounding the facets of integrated care, the ways in which individual, cultural, spiritual, and gender values should be incorporated into the care process.

A preliminary report was completed in December of 2014; see Appendix A, which provides an overview of focus groups completed to date. Focus groups began in September 2014 and at this time, 22 focus groups have been conducted, reaching 182 individuals with mental illness, family members, and transition aged youth. A total of 28 focus groups were scheduled, six groups were rescheduled; five for non-attendance and one due to inclement weather. In total, eight additional focus groups are scheduled to be conducted and two non-English focus group transcripts are pending translation. The

final report, due March 2015, will include a detailed analysis of the data and recommendations for its integration within BHH policy.

Stakeholder Engagement

Stakeholder engagement activities include short and longer-term advisory workgroups, a Request for Information, and a learning community.

An initial short-term advisory workgroup for preliminary input on behavioral health home planning was held in the winter of 2013. This group was one of five workgroups providing input to DHS as part of what was called the Adult Mental Health Reform initiatives informing the Reform 2020 report.

A long-term BHH Advisory Group was developed and began meeting in August of 2013 and has met 11 times. The group is scheduled to meet at least every two months and represents over 26 different stakeholder groups.

A Request for Information (RFI) was issued in April 2013 seeking public input and comments regarding improved integration and coordination of behavioral health and primary care services for Medical Assistance (MA) consumers. Findings were used to inform the design of the framework.

DHS has also established a Behavioral Health Home First Implementers learning community of providers that are interested in becoming certified behavioral health homes. This group will share best practices about how to best meet person's individual needs including person-centered planning and supporting integrated service delivery. Behavioral Health Home First Implementers will also receive support from DHS in preparation for certification. Thirty-five agencies across the state indicated interest in participating in this group. An initial needs assessment was conducted and will inform the development of curriculum focused on health home certification and on topics related to integration of mental and physical health. The group will use different modalities for sharing information, including regional meetings, webinars around specific health home topics, and group-based technical assistance. The group will begin meeting in February of 2015 and will for 18 months. An analysis will be completed to determine if the modality is effective in increasing the capacity to provide integrated care; if it is funding will be sought to continue learning community activities.

Proposal Design

Goals and Guiding Principles

DHS is developing a framework for health homes to serve the needs of complex populations covered by Medical Assistance. DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality. See Appendix B for the design and implementation timeline.

The goals of the health home framework are to:

1. Improve health outcomes (preventative, routine, treatment of health conditions) of individuals enrolled.
2. Improve experience of care for the individual.
3. Improve the quality of life and wellness of the individual.
4. Reduce health care costs.

The guiding principles of behavioral health homes are:

1. BHH services are distinguished by the presence of a multi-disciplinary team that shares information and collaborates to deliver a holistic, coordinated plan of care.
2. BHH services are an opportunity to better meet the needs of individuals experiencing serious mental illness and their families by addressing the individual's physical, mental, and behavioral health, including wellness goals.
3. BHH services will take a person-centered approach and will engage and respect the individual and family in their health care and recovery/resiliency.
4. BHH services are to respect, assess and use the cultural values, strengths, languages, and practices of the individual and family in supporting the individual's health goals.

Eligibility

Behavioral health home services will be made available to adults with serious mental illness (SMI) or a serious and persistent mental illness (SPMI), and children and youth experiencing a severe emotional disturbance (SED) as defined in MN Statute 245.462 subdivision 20(a) or 245.4871 subdivision 15 (2) and has a current diagnostic assessment as defined in MN Rule 9505.0372 subpart 1 items B or C, as performed or reviewed by a mental health professional employed or contracted by the behavioral health homes.

Potentially eligible individuals will be identified through the Medicaid claims system. DHS will provide certified behavioral health homes with a list of individuals that they already serve that are eligible for BHH services. Certified behavioral health homes will also recruit and identify potentially eligible individuals.

Participation in behavioral health homes is voluntary and eligible individuals will receive state-developed materials to inform them of the choice to participate in a BHH.

After eligibility for BHH services has been determined and information about the services has been provided to the eligible individual, the individual will be given the option to opt in to receiving BHH services. The opt-in process will include an informed consent form created by the State that will include the individual rights and responsibilities as a consumer of these services.

Behavioral health home services may not duplicate services or payments under targeted case management, assertive community treatment (ACT) or home and community-based waivers (HCBW)

where there is case management services provided. Individuals will need information on the various case management options to determine where their needs are best met.

Services

In a behavioral health home, consumers identified with serious mental illness will have their comprehensive physical and behavioral health needs addressed in a coordinated manner. This includes care planning to address chronic conditions (e.g. addressing steps to meet the consumers health goals), ongoing coordination of care between behavioral and physical health (e.g. comprehensive review of all prescribed medications), and also coordination with medical and behavioral specialists not at the BHH site (e.g. appropriate use and timing of elective surgery). Where appropriate non clinical service coordination will be added so that individuals in this model will have health care coordinated with social supports. Appropriate family and consumer support includes education to improve self-management.

"Health Home Services" as articulated by the Affordable Care Act, Section 2703 and in Minnesota State law (256B.0757) requires:

1. Comprehensive care management, using team-based strategies
2. Care coordination and health promotion
3. Comprehensive transitional care between health care and community settings
4. Individual and family support, including authorized representatives
5. Referral to community and social support services, and
6. The use of health information technology to link services, as feasible and appropriate

Several of these services, including health and wellness, direct education and support to family members, and intentional support with transitions, are not traditionally covered under Medicaid and offer an opportunity to provide more person-centered care.

Initial engagement

Behavioral health homes will be responsible to conduct specific activities as part of the initial engagement with clients:

Recruitment

- Take referrals.
- Recruit potential clients.
- Initiate contact with potential clients.
- Schedule intake appointments.
- Engage in community outreach.

Intake

- Check Medicaid eligibility for potential clients.
- Provide clients with BHH program materials, including the rights and responsibilities document, and inform clients about the choice to participate.
- Gather client consent.

- Determine if a diagnostic assessment has occurred within the last 12 months and obtain results. If the diagnostic assessment has not occurred within the last 12 months, assist the client in scheduling an appointment with the licensed mental health professional to complete the updated assessment.
- Set up an appointment with the client for an initial assessment.

A Behavioral health home will be responsible for conducting minimum activities under each of the six federally required services.

Comprehensive Care Management

Comprehensive care management is a collaborative process designed to manage medical, social, and mental health conditions more effectively based on population health data and tailored to the individual patient.

Behavioral health homes will be responsible to conduct the following activities as part of the comprehensive care management services:

(Activities applicable to all patients collectively)

- Design and implement new activities and workflows that increase patient engagement and optimize clinical efficiency.
- Design and implement communication and care coordination tools, to ensure that care is consistent among a client's many providers, as well as between the provider and the BHH.
- Deploy electronic and non-electronic tools to effectively make use of best practices and evidence to guide care efficiently and correctly.

Population Health Management

- Use a searchable electronic health record and patient registry to collect individual and practice-level data that allows providers to identify, track, and segment the population, improve outcomes over time, manage BHH services, provide appropriate follow-up, and identify any gaps in care.
- Select common clinical conditions and target cohorts on which to focus and define the patient population.
- Use the patient registry information to report outcomes to DHS as needed.
- Monitor and analyze data to manage the patient panel
- The integration specialist must review the patient registry regularly to track individuals' medications, lab results, and symptom management and use this data to adjust treatment as needed.
- The registry must contain:

  (1) For each participant, the name, age, gender, contact information, and identification number assigned by the health care provider, if any

  (2) Sufficient data elements to issue a report that shows any gaps in care for groups of participants with a chronic or complex condition; and

  3) Additional fields to be determined by DHS.

(Activities specific to an individual patient within targeted populations)

- Meet with each client and evaluate their initial and ongoing needs. Elements to evaluate include the patient's clinical condition, feasibility of completing various interventions, and the patient's values, preferences and readiness to engage in self-management and treatment.
- Utilize care strategies including health information technology and other tools to communicate and coordinate with the patient and with other caregivers to ensure that the care plan is being executed safely and efficiently.
- Measure services and interventions offered; the reason for implementation or non-implementation, and outcomes of each intervention.

Care Coordination

Care coordination is the compilation, implementation, and monitoring of the individualized, holistic health action plan with the client's family or identified supports through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Overarching activities of care coordination include the provision of case management services necessary to ensure individuals and their identified supports have access to medical, behavioral health, pharmacology and recovery support services (e.g. housing, access to benefits, vocational, social, and educational, etc.).

Specific care coordination activities are conducted with individuals and their identified supports, medical, behavioral health and community providers, and across and between care settings.

Behavioral health homes will be responsible to conduct the following activities as part of the care coordination services:

Initial assessment

- Assess the client's immediate safety and transportation needs and identify any barriers to participating in BHH services.
- Develop and implement an immediate needs plan for the client.

Comprehensive wellness assessment

- Conduct a comprehensive wellness assessment. The assessment process must begin within 30 days of intake and be completed within 60 days.
- Include a face-to-face meeting between the client and the systems navigator. The integration specialist must also meet with the client to complete components of the wellness assessment. In a mental health setting, the integration specialist must be an RN and focus on the individual's health care needs. In a primary care setting, the integration specialist must be a mental health professional and focus on the individual's mental health needs.
- Talk with internal and external professionals to gather information for the health action plan and make initial connections to begin establishing relationships required for ongoing care coordination.
- The assessment must include the skills, strengths, current resources, and current needs in the following areas:
    - Review of the diagnostic assessment;
    - Mental health and chemical/substance use and abuse knowledge of symptoms and illness management and treatment resources, and the individual's view of recovery;

    - Screenings for substance abuse using CAGE-AID or GAIN-SS tools, alcohol, and tobacco. A substance abuse screen is not required if a substance abuse disorder is already known and documented.
  - Health as it relates to chronic conditions, health wellness and literacy, lifestyle, self-management, and nutrition, access to health care, including information about the client's primary care doctor, primary care clinic, and dentist;
  - Culture and spiritual beliefs and practices;
  - Employment and education;
  - Social functioning, including the use of leisure time;
  - Interpersonal functioning including relationship with family and social support network;
  - Self-care and independent living capacity;
  - Income, financial assistance and legal;
  - Risks and vulnerabilities;
  - Housing;
  - Transportation;
  - Program utilization; (e.g. food support, Minnesota Family Improvement Program, Minnesota Supplemental Aid, Child Care Assistance Program)
  - Access to food;
  - Access to child care;
  - Social services and community supports
  - Self-navigation and self-advocacy skills; and
  - Other domains as appropriate.
- Obtain appropriate releases of information as needed to gather information needed for the comprehensive wellness assessment. DHS will create a release of information template for BHHs to utilize if they do not have such a form already developed. All releases of information must follow Minnesota state privacy laws.
- Conduct a portion of the assessment in the client's home/living situation. The client has the right to refuse services in their home.

Health action plan development

- Draft an initial health action plan based on the comprehensive assessment within 60 days of intake.
- Talk with the client to ensure that the health action plan is based on their identified needs and goals.
- Demonstrate the client-centered nature of the plan by including the client's goal statement in first person language and the client signature. Provide a copy of the plan to the client.
- Update the comprehensive assessment and health action plan at least every 6 months thereafter.

Ongoing care coordination

- Maintain regular and ongoing contact with the client and/or their identified supports to prevent unnecessary inpatient readmissions, emergency department visits and/or other adverse outcomes such as homelessness, loss of established care/service providers, and loss of employment/schooling.
- Monitor client progress on goals in the health action plan and the need for plan alterations.

- Monitor the use of routine and preventative primary care, dental care, and well-child physician visits.
- Conduct appropriate referrals.
- Assist the client in setting up needed appointments, preparing for appointments, and accompanying the client to appointments as appropriate.
- Assist the client in follow-up care and follow-through on recommendations from the appointment(s).
- Initiate and maintain coordination with client's providers and formal and informal supports to ensure that the client has the resources necessary to follow the health action plan.
- Identify and share individual level information in a timely manner with professionals and providers that are involved in the individual's care.
- Demonstrate engagement of area hospitals, primary care practices and behavioral health providers to collaborate for care coordination.
- Maintain current releases of information as needed for communication with providers that are involved in the client's care.
- Ensure linkages to medication monitoring if it is an identified need.
- Coordinate communication and collaboration within the BHH team on behalf of the client.
- Foster communication with and between the individual, their providers and their identified supports.

Health and Wellness Promotion Services

Health and wellness promotion services encourage and support healthy living and motivate individuals and/or their identified supports to adopt healthy behaviors and promote better management of their health and wellness. Health and wellness promotion services place a strong emphasis on skills development through health education and wellness interventions so individuals and/or their identified supports can monitor and manage their chronic health conditions to improve health outcomes.

Behavioral health homes will be responsible to conduct the following activities as part of the health and wellness promotion services:

- Provide clients with information to increase their understanding of the illnesses/health conditions identified in the comprehensive wellness assessment, and educate clients on how those conditions relate to and impact various facets of their life.
- Work with clients to increase their knowledge of illness-specific management as well as overall daily health maintenance.
- Support clients in activities aimed at increasing their self-management and reaching their health goals.
- Support clients in recovery and resiliency.
- Help clients and/or clients' identified supports to make healthy lifestyle choices within their budget.
- Provide onsite coaching, classes, and information on topics including: wellness and health-promoting lifestyle interventions, substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy support, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and promoting independence and skill development related to self-administration of medications.

Comprehensive Transitional Care

Comprehensive transitional care activities are specialized care coordination services that focus on the movement of individuals between or within different levels of care or settings or while shifting from the use of reactive care and treatment to proactive care via health promotion and health management. Transition services are designed to streamline plans of care and crisis management plans, reduce barriers to timely access, reduce inappropriate hospital, residential treatment, and nursing home admissions, interrupt patterns of frequent emergency department use, and prevent gaps in services which could result in (re)admission to a higher level of care or longer lengths of stay at an unnecessary level of care.

Behavioral health homes will be responsible to conduct the following activities as part of the comprehensive transitional care services:

- Ensure adequate and continuous client services and supports following and in between services and settings such as, hospitalization, homelessness, shelters, domestic violence shelters, residential treatment, prison, juvenile justice, children and family services, treatment foster care, foster care, special education and other settings and services with which the client may be involved.
- Participate in discharge planning in collaboration with the individual and the appropriate facility staff to assist in the development and implementation of the transition of the client to the least restrictive setting possible.
- Advocate with the client to ensure that clients/families are included in transition planning.
- Work with other agencies to ensure that information is shared between agencies regarding a transition.
- Establish a protocol for contacting clients and/or their identified supports and services following discharge from hospitals, residential treatment, and other settings, to assure clients are reconnected to ongoing services and community and social supports.

Referral to Community and Social Support Services

Referral to community and social support services occurs in collaboration with the client and/or their identified supports. The BHH provider identifies and provides referrals to a variety of services and assists clients in setting up appointments, preparing for appointments, and accompanying the client to appointments as appropriate.

Behavioral health homes will be responsible to conduct the following activities as part of the referral to community and social supports services:

- Connect clients to community resources as identified in their comprehensive wellness assessment, including but not limited to, medical and behavioral health care, entitlements and benefits, respite, housing, transportation, legal services, educational and employment services, financial services, wellness and health promotion services, specialized support groups, substance use prevention and treatment, social integration and skill building, and other services as identified by the individual and/or their identified supports.
- Check in with the client and their family after a referral is made in order to confirm if they need further assistance in scheduling or preparing for appointments, or assistance in following up after connecting with community resources.

- Maintain adequate knowledge of agencies and resources in order to connect individuals and/or their caregivers to a wide array of support services to help them overcome access or service barriers, increase self-efficacy skills and improve overall health.

Individual and Family Support Services

Individual and family support services are activities, materials, or services aimed to help clients reduce barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-efficacy skills, and improve health outcomes.

Behavioral health homes will be responsible to conduct the following activities as part of the individual and family support services:

- Assist clients and families with accessing self-help resources, peer support services, support groups, wellness centers, and other care programs focused on the need of the individuals and their families and/or identified supports.
- Assist clients with obtaining and adhering to prescribed medication and treatments.
- Offer family support and education activities.
- Support clients and/or clients' identified supports in improving their social networks.
- Teach individuals and families how to navigate systems of care in order to identify and utilize resources to attain their highest level of health and functioning within their families and community.

NOTE: Utilization of health information technology is federally required to link services, as possible and appropriate. BHH provider standards may evolve as experience is gained and as permitted by Minnesota law.

Provider Requirements

Federal requirements

Behavioral health home providers must have the capacity to perform the health home functions specified below by Centers for Medicare and Medicaid Services (CMS):

1) Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
2) Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4) Coordinate and provide access to mental health and substance abuse services;
5) Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6) Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7) Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;

8) Coordinate and provide access to long-term care supports and services;
9) Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10) Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
11) Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

State requirements

DHS will certify behavioral health homes and providers must be enrolled as a Medicaid provider. Behavioral health homes must serve as the central point of contact for consumers and ensure person-centered development of a health action plan and implementation of services which improve experience of care, health outcomes and reduce avoidable health care costs.

At a minimum, BHH providers will be expected to:

- Be enrolled as a Medicaid provider and comply with the Medicaid program requirements.
- Successfully complete the State certification process and maintain certification by meeting standards as developed by the State.
- Demonstrate processes that allow them to understand and serve the BHH population.
- Maintain the required BHH team structure as described above and provide the federally required services of comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, referral to community and social support services, and use of health information technology to link services.
- Conduct comprehensive screenings and assessments that address behavioral, medical, and social service and community support needs.
- Create and maintain an individualized health action plan for each consumer that encompasses behavioral and physical health and social services and community supports.
- Use health information technology to link services, identify and manage care gaps; and facilitate communication among health home team members and other providers.
- Use an electronic health record and patient registry to collect individual and practice-level data that allows them to identify, track, and segment the population and improve outcomes over time.
- Establish processes in order to identify and share individual level information in a timely manner with professionals and providers that involved in the individual's care.
- Demonstrate engagement of area hospitals, primary care practices and behavioral health providers to collaborate with the Health Home on care coordination.
- Track individuals' medications, lab results, and symptom management and use this data to adjust treatment as needed.
- Demonstrate commitment by leadership to pursue integration and support practice transformation.
- Establish a continuous quality improvement plan, and collect and report data that will inform state and federal evaluations.

BHH teams will be integrated with both primary care and behavioral health providers:

- In a behavioral health setting, the required integrated team must include a nurse care manager.
- In a primary care setting, the team must include a licensed mental health professional.

Behavioral health home providers must also:

- Directly provide, or subcontract for the provision of, all required health home services.
- Maintain documentation of all team member qualifications in their personnel files.
- Participate in federal and state-required evaluation activities including documentation of behavioral health home services.
- Maintain compliance with all of the terms and conditions of a certified behavioral health home provider or will be discontinued as a provider of services.
- Provide a 60 day notice if they plan to determinate the delivery of behavioral health home services. Providers must inform consumers that they will no longer provide services and support the individual in finding a new behavioral health home provider.

Team Members

BHH services will be administered through a team based approach. The members listed below are the minimum requirements for a behavioral health home team, with the exception of an optional external professional. In order to qualify as one of these team members, a person must meet at least one of the qualifications listed below their title. One person can fill more than one membership roll.

Team Member: Consumer

Roles and Responsibilities

The decision to participate in BHH services rests with the consumer. The BHH model is designed to promote consumer's trust in their care team and to ensure holistic treatment of consumer's medical and behavioral health. Consumers play a vital part in the development and management of their health under the BHH model, therefore consumers are responsible for voicing their needs, concerns, questions, barriers, strengths, skills, desires and goals to their Behavioral Health Home team with the support and assistance of the Qualified Health Home Specialist and the Care Coordinator as needed. Consumers are responsible for communicating regularly with the Behavioral Health Home team, including reaching out to appropriate team members as needed and returning phone calls, emails, and all other appropriate forms communication. They are responsible for engaging in the planning and implementation processes of their treatments and therapies.

Team Member: Team Leader

Required Qualification

- Clinic manager
- Other executives

Roles and Responsibilities

The team leader provides the BHH with executive leadership as a champion for integration. They determine the size and overall composition of the BHH team. They are responsible for ensuring that needed memorandums of understanding are in place and that the BHH has access to resources and

tools including but not limited to overhead, health information technology, protected time on a calendar, support staff, medical records, and screening tools. They serve as the outward facing liaison to the wider community and provide administrative outreach to diverse communities. The team leader determines quality improvement and communication protocols for the BHH and is responsible for overseeing the certification and recertification process, and ensuring that the BHH meets all required reporting and evaluation responsibilities.

Team Member: Integration Specialist (Care Management)

Required Qualification

- Registered Nurse when BHH services are offered in a mental health setting.
- Mental health professional as defined in M.S. 245.4871 Subd. 27, 1-6 or M.S. 245.462 Subd. 18 1-6 when BHH services are offered in a primary care setting.

Roles and Responsibilities

The integration specialist position illustrates the importance that the BHH program places on integration of primary care and mental health. The integration specialist is the reciprocal professional whose required qualifications are contingent on the setting of the BHH. If the BHH is located in a mental health setting, the integration specialist must be a Registered Nurse whereas if the BHH is located in a primary care setting, the integration specialist must be a mental health professional.

With the guidance of their supervisor and in collaboration with the BHH team, the integration specialist is the primary team member responsible for providing the comprehensive care management within the BHH. The integration specialist will utilize the patient registry to manage medical, social, and mental health conditions based on population health data and tailored to the individual patient. The integration specialist is responsible for activities that are applicable to all patients collectively and to individual patients within the targeted populations.

The integration specialist is responsible for individual and family support services in relation to the management of population health. The integration specialist may also contribute to the provision of the other health home services and is also available to run wellness groups for clients as appropriate. In some settings, the integration specialist may serve as the supervisor of systems navigator or the same individual may serve both positions in settings where client populations are small.

Team Member: Behavioral Health Home Systems Navigator (Care Coordination)

Required Qualification

Case manager as defined in M.S. 245.4871 Subd.4, M.S 245.462 Subd. 4 or
Mental health practitioner as defined in M.S. 245.4871 Subd. 26. or M.S 245.462 Subd. 17

Roles and Responsibilities

With the guidance of their supervisor and in collaboration with the BHH team, the BHH systems navigator is the primary entity responsible for providing the care coordination within the BHH. The BHH systems navigator may contribute to the provision of health and wellness promotion services. In settings with a large client population, there may be multiple BHH systems navigator within one BHH.

Conversely, in settings with small client populations, there may be one individual that fulfills the roles of both integration specialist and systems navigator. They are also available to conduct wellness groups as appropriate contingent on their individual training.

Team Member: Qualified Health Home Specialist

Required Qualification

- Community health worker as defined in M.S. 256B.0625 Subd. 49
- Peer support specialist as defined in M.S. 256B.0615
- Family peer support specialist (upcoming definition and certification at DHS),
- Case management associate as defined in M.S. 245.462 Subd.4 (g) or M.S. 245.4871 Subd. 4 (j),
- Mental health rehabilitation worker as defined in M.S. 256B.0623 Subd. 5 (4)

Roles and Responsibilities

The qualified health home specialist serves as a coach whose primary focus is to support and assist clients in reaching their goals. They interact with the clients on the phone or in person on a regular basis to build trusting relationships and assist the client with identifying barriers to accessing care. They can meet with a client before appointments, help clients organize health concerns and prioritize issues to discuss with health providers. They can also meet with clients after office visits to review provider instructions and check for client understanding and access to resources to follow provider instructions. They provide ongoing motivation, encouragement, and positive feedback when the client makes constructive changes or progress.

With the guidance of their supervisor and in collaboration with the BHH team, the qualified health home specialist is the primary entity responsible for the health and wellness promotion services and assists the BHH systems navigator in coordinating care, serving as the secondary entity responsible for care coordination services.

The qualified health home specialist is responsible for providing individual and family support services on a regular basis for overall client needs. The qualified health home specialist may contribute to the provision of the comprehensive transitional care and referral to community and social support services. Qualified health home specialists are also available to conduct wellness groups as appropriate contingent on their individual training. There may be multiple qualified health home specialists dependent on the size of the BHH.

Team Member: Consulting Physicians

Required Qualification

- Primary care physician
- Psychiatrist
- Psychologist
- Specialized MD/ therapist

Roles and Responsibilities
The consulting physician is not a required team member but rather an option contingent on the needs of the client. The consulting physician is responsible for ongoing case consultation and recommendations for the health action plan and may contribute to the provision of BHH services through case consultation.

Team Member: External Professionals

Required Qualification
Professionals from organizations that provide:

- Housing
- Food
- Special education
- Criminal/justice system
- Chemical dependency
- Respite care
- Social support services
- Employment services

Roles and Responsibilities
The external professional is not a required team member but rather an option contingent on the needs of the client. As needed and appropriate, external professionals will provide recommendations for the health action plan and ongoing consultation, and may contribute to the provision of BHH services through case consultation.

Health Home Monitoring, Quality Improvement and Performance Measures

There are specific state monitoring, quality improvement reporting, and evaluation requirements expected under the federal health home provision. In addition, DHS has identified further performance measures to demonstrate outcomes for those served by BHH and to monitor service providers.

Monitoring
DHS will ensure there is a defined methodology, including data sources and measurement specifications, for:

- Tracking avoidable hospital readmissions
- Calculating cost savings that result from improved chronic disease management, and
- Tracking the use of health information technology in providing health home services to improve coordination and management of care and consumer adherence to recommendation made by their provider.

Quality Improvement
As part of the continuous quality improvement process, DHS is required to report on a set of CMS quality measures including:

- reduction in hospital admissions,
- emergency room visits, and
- skilled nursing facility admissions.

Evaluation

DHS must provide assurance that it will report to CMS information submitted by behavioral health home providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act as described by CMS. DHS must also assure the completion of a state evaluation that assesses the impact of behavioral health home services on consumer and family experience; health care utilization, and costs.

Additional State Performance Measures

DHS must create a set of performance measures specific to the targeted populations of adults and children with serious mental illness. These measures will include:

- Follow-up after hospitalization for mental illness,
- Use of Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Services Intensity Instrument (ECSII),
- Consumer experience of care,
- Use of routine and preventative primary care,
- Use of dental care,
- Well-child physician visits,
- Screening for alcohol and other drug use, and
- Depression remission using PHQ-9 for adults.

State Plan Amendment

The Medicaid Health Home State Plan Option, authorized under the Affordable Care Act (Section 2703), allows states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions, of which serious mental illness is an identified chronic condition. States are required to submit a State Plan Amendment (SPA) and enter into negations the Centers for Medicare and Medicaid Services (CMS). Services may not begin until federal approval is obtained.

The BHH SPA is in draft form and will be posted for public comment in February 2015. DHS is scheduled to submit the SPA in 2nd quarter of 2015. As noted previously, DHS must also obtain a legislative appropriation to implement the proposal as currently developed. If the legislative proposal does not move forward this legislative session the model, services, and payment must fit under the existing Health Care Program.

Fiscal Analysis

A 2013 program utilization and claims analysis identified that approximately 109,644 people in Minnesota Health Care Programs (MHCP) met criteria of SMI, SPMI, and SED. As noted previously, BHH services are voluntary and an individual cannot receive duplicative case management/care coordination services such as target case management (TCM), home and community base waivered case management (HCBS), or Assertive Community Treatment (ACT). This same analysis determined that

23,334 people received TCM, 16,388 received HCBW services, and 1,931 received services through ACT. This leaves a total of 73,212 individuals who are potential consumers of BHH services.

Our goals within the Olmstead Plan include:

- By January 1, 2017, 15% (10,981) of eligible individuals will choose to access care through this model;
- By January 1, 2018, 20% (14,642) of eligible individuals will choose to access care through this model;
- By January 1, 2019, 25% (18,303) of eligible individuals will choose to access care through this model.

Our original timeline had Minnesota implementing BHH services on July 1, 2015; however, the Governor's budget proposal pushes back the start time of BHH services by six months to January 1, 2016. The fiscal estimate, with an effective date of January 1, 2016, has a net cost to the General Fund of $6.9 million in the FY2016-17 biennium and $23.8 million in the FY2018-19 biennium once the federal match is no longer 90%.

MHCP claims data indicate that persons meeting the criteria to be served in a behavioral health home are very expensive relative to other consumers. Even after removing costs for behavioral health and chemical dependency services, long term care services, and access services, those meeting the criteria for behavioral health homes have an additional $4,100 in annual professional, inpatient hospital, and pharmacy claims when compared with other consumers. The services offered under this proposal are expected to reduce this difference in cost.

A legislative appropriation is necessary to provide the administrative dollars necessary to develop the operation framework including MMIS system changes, certification portal, contractual reporting mechanism's necessary to allow designated providers to report on all mandated quality measures and state required outcome measures.

Conclusion

The implementation of behavioral health homes is a first step in the development of a framework to provide services in a person-centered system of care. This framework will facilitates access to and coordination of the full array of primary, acute, and behavioral health care and findings from implementation will be used determine populations to serve under subsequent models.

For More Information

For additional information, please contact Jennifer Blanchard at Jennifer.Blanchard@state.mn.us

Appendix A

Minnesota Behavioral Health Home Planning and Community Engagement

Preliminary Report- Final Report Available March 2015

By the Department of Human Services in partnership with National Alliance on Mental Illness (NAMI) Minnesota

12/15/2014

Background:

The Community Supports and Health Care Administrations of Minnesota's Department of Human Services (DHS) are working together to design a Behavioral Health Home (BHH) model which will operate under a "whole person" philosophy and assure access to and coordinated delivery of primary care and behavioral health services for adults and children with serious mental illness.

DHS is developing a framework that will require a standard of integrated care which encompasses mental, behavioral, physical health conditions and considers the influence of multiple conditions, social factors, social function, and consumer preferences to personalize assessment, treatments, and goals of care. DHS believes that more integrated care, regardless of setting, contributes to improved health and decreases the risk of adverse outcomes, including hospital admissions. DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality. DHS may build on this framework to serve other complex populations in the future.

Methods:

In planning the Minnesota Behavioral Health Homes (BHH), the Department of Human Services has contracted with the National Alliance on Mental Illness (NAMI) Minnesota to engage people living with mental illness across the State in an opportunity to shape policy. Through their participation in focus groups, Medicaid participants from a very wide range of communities are providing feedback on topics that will inform the development of Minnesota's Behavioral Health Home model. The focus group questions concentrate on topics such as: accessing physical and mental health care, transition of care experiences, methods of obtaining health information, opinions surrounding the facets of integrated care, the ways in which individual, cultural, spiritual, and gender values should be incorporated into the care process.

This report provides an overview of focus groups completed to date. Focus groups began in September 2014 and at this time, 22 focus groups have been conducted, reaching 182 individuals with mental illness, family members, and transition aged youth. Please see table 1 for details. A total of 28 focus groups were scheduled, six groups were rescheduled; five for non-attendance and one due to inclement weather. In total, eight additional focus groups are scheduled to be conducted and two non-English focus group transcripts are pending translation. The final report will include a detailed analysis of the data and recommendations for its integration within BHH policy.

Results:

Initial analysis of focus group data reveals the following themes:

Relationship: Trust and relationships with providers were the most salient themes that have emerged across all focus groups thus far. Having a good relationship with providers was identified as affecting the following: fostering trust, receiving appropriate care, increased follow-through with care plans, increased medication adherence, and increased hope for recovery.

Trust: Most focus group participants mentioned trust as an important component in determining issues such as: when and how care was accessed, level of disclosure to providers, perceived level of personal wellness one has the ability to achieve, the quality of provider recommendations, and the likelihood of their adherence to their provider's recommendations. In each of the focus groups, participants discussed factors that either cultivated or impeded trust between them and their health providers. The following factors were consistently identified as contributors to building trust: providers asking questions about the whole person instead of just focusing on the illness, providers sharing information about themselves, providers actively listening, providers taking time to give and discuss information (rather than simply providing pamphlets), and found to be most important, was the perception that the providers cared. In contrast, the following factors were identified as impeding trust: provider rushing appointments, not being listened to (identified as a sign that providers didn't care), providers recommending medications without enough perceived participant input or information, and providers recommending medications without the discussion of other treatments.

Barriers to Wellness and Care: The following elements were discussed as the barriers that impede a participant's ability to receive effective medical care and manage their needs: wait times, cost, previous negative experiences, emergency room use when not connected to a primary care provider and being barred from making appointments or using the ER when money is owed. Many participants reported negative experiences with care where they felt stereotyped, disrespected, or where medical issues were dismissed by providers as a symptom of their mental illness.

Barriers that impeded participant's ability to receive effective mental health care included: unavailability of appointments when needed, lack of providers, lack of systems to respond to an emerging crisis, inadequate transition services and planning, HIPAA regulations that prevent families/support network from being involved in care or being given information, and lack of a care system for mental illnesses that are not yet crisis's but are unmanageable by the consumer or family members.

Overall, similarities in positive and negative experiences were loosely based on location, cultural group, and age. In two focus groups a particular service provider was spontaneously identified as a place where parallel positive experiences seemed to occur regularly. This hospital/clinic described by participants was structured and functioned in a manner similar to the projected Behavioral Health Home model and resulted in reported high levels of care, trust, wellness, adherence, and satisfaction.

Education: Most participants reported getting the majority of their information about health conditions or wellness on the internet, or by talking to a trusted friend, family member, or someone with the same experience. Many participants expressed a preference for getting health or mental health information from their providers but they had not had positive experiences in attempting to obtain it from them. Participants had experienced that providers did not have the time to give information to them or their family members in way where the implications of the information was discussed, but rather opted to give written information to be read at home.

Self-Advocacy: Adults and youth with mental illness along with their family members, all discussed the need for self-advocacy as a means for getting their needed care, needed support services, and

preferences considered in treatment planning. These participants discussed the distress they experienced by not knowing how to navigate the system, what questions to ask, or who to turn to for help. Individuals with mental illness voiced an inability to self-advocate at times. Additionally, they indicated that it was difficult to know that self- advocacy was needed when they were in crisis, when they were experiencing certain mental illness symptoms, or when they were experiencing chronic disease flare-ups. For many of them, the need to engage in self-advocacy occurred in response to situations where it was felt that providers were not listening, were not including information felt to be important, or were not making recommendations that aligned with their or their family's desires. Family members discussed experiencing a continuing need to advocate for the consumer while highlighting the stress they experience in researching their loved one's illness and exploring the possible systems and services that could be utilized for assistance.

Discussion and Recommendations:

These focus group findings exemplify a broad range of experiences, preferences, values and views that highlight the difficulty of addressing complex and diverse health needs in a model of services and systems meant to be universally responsive to diverse target populations. However, a number of practical recommendations identified in the spectrum of groups emerged. Practices such as increased appointment time for a new patient's first few appointments would allow the provider and patient to get to know each other better, thereby initiating a strong basis for trust within their future relationship. Simple behaviors such as new providers saying to patients, "I am going to be your doctor," and employing a practice of asking "get to know you" questions in addition to the "what is the problem" questions are believed to provide a fruitful set of initial discussions. Integrating the final focus groups and analyzing the data from the complete set will be fruitful terrain for additional recommendations grounded in consumer experience.

Conclusion:

The range of experiences elucidated in the completed and forthcoming focus groups will be further elaborated on in the final report due in March 2015. Additional information will include detailed demographics of the participants, more health discussion themes, specific examples of participant experiences, a full analysis of the data, and focused recommendations to implement within the BHH program. This data has the potential to be extremely valuable not only for this program, but for anyone providing health services for this population.

Table 1:

Adult Participants			
Subgroup	**Date**	**Location**	**# Attending**
Spanish Speaking	11/18/2014	Centro Cultural Center	22
Russian	12/9/2014	Jewish Family Center	8
Veterans	11/18/2014	St. Cloud Library	6
Criminal Justice	10/14/2014	Phillis Wheatley Community Center	4
Criminal Justice	10/15/2014	Phillis Wheatley Community Center	4
African American	10/24/2014	Ujamaa	8
Homeless	10/19/2014	St. Stephens	22
Bemidji (Northwest region)	10/6/2014	Hope House	8
Brainard (Central region)	10/14/2014	1st Lutheran	16
Worthington (Southwest)	10/28/2014	Southwest Mental Health	7
Winona (Southeast)	11/3/2014	Connection Support Group	35
Hoffman (Western)	12/10/2014	Hoffman Community Center	10
Hmong Elders	12/16/2014	Park Ave Elder Center	11
Transition-Age Youth			
Subgroup	**Date**	**Location**	**# Attending**
Homeless/American Indian	10/20/2014	Aun Dah Yun	5
Homeless	10/24/2014	The link	2
Spanish Speaking	10/26/2014	Aqui Para Ti	2
Brainerd (Central Region)	10/14/2014	Northern Pines Youth Act	8
Duluth (Northeast)	11/6/2014	Amberwing	4
Family Members			
Subgroup	**Date**	**Location**	**# Attending**
Parents with Mental Illnesses	10/27/2014	Phillis Wheatley	3
Bemidji (Northwest region)	10/6//2014	Hope House	5
Worthington (Southwest)	10/28/2014	SW Mental Health	7
Duluth (Northeast)	11/6/2014	Amberwing	2

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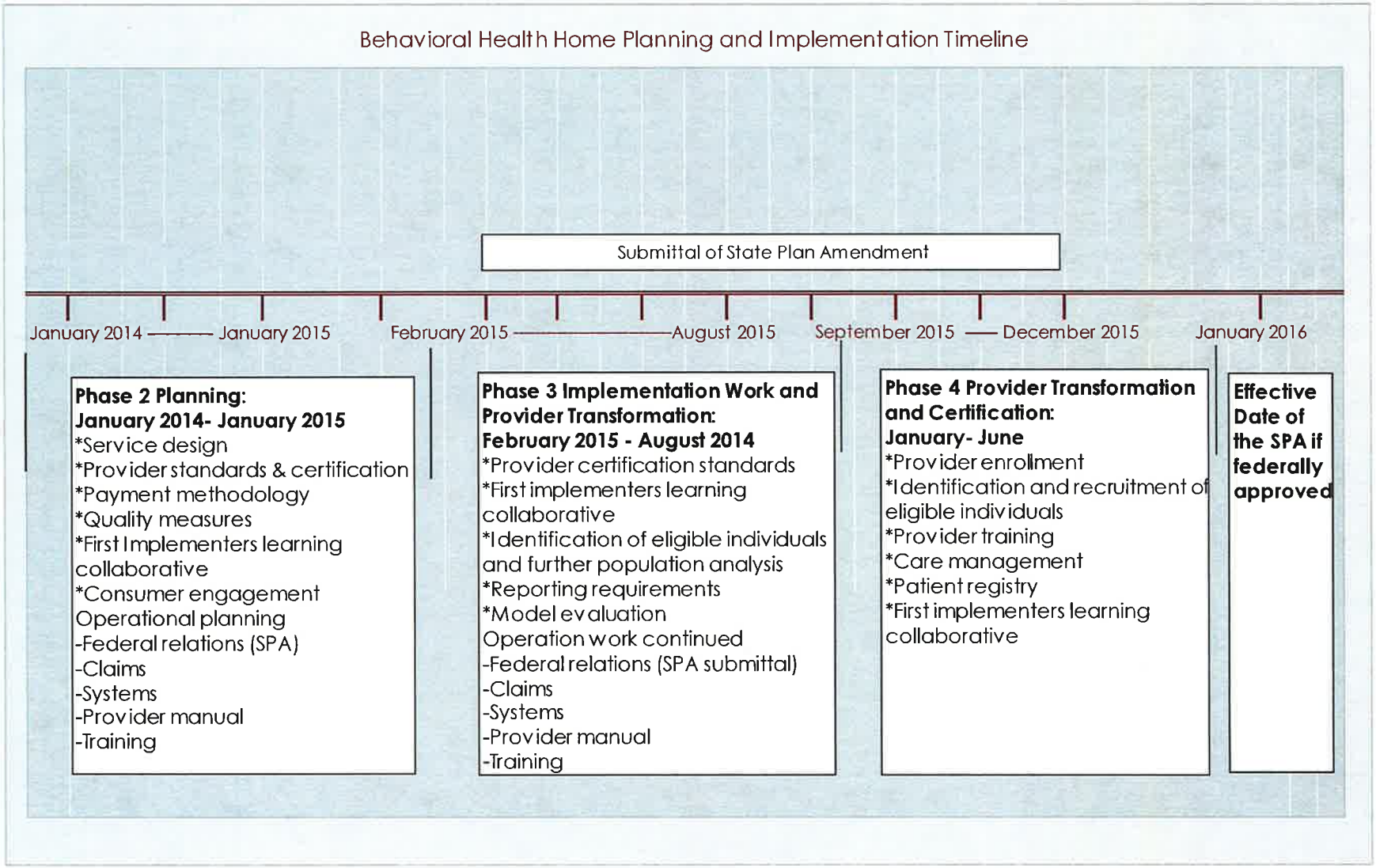
Appendix B



Home and Community-Based Supports and Services Waiver Waiting List Report

March 3, 2015

I. Executive Summary

A. Legal Requirements

Olmstead Plan. The Olmstead Plan requires the Department of Human Services to report to the subcabinet recommendations for improving the home and community-based services waiting list, including prioritizing based on urgency and need, and describing how these practices will result in the waiting list moving at a reasonable pace.(SS 4B, p. 68).

Olmstead v. L.C. The phrase "reasonable pace" comes from the U.S. Supreme Court's decision in *Olmstead v. L.C.,* where the Court said that a state could meet its responsibility for providing home and community-based services "if, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated..."[1] The Court also said the state must have "leeway" to "maintain a range of facilities and to administer services with an even hand." *Id.*

Jensen v. DHS. On January 9, 2015, the Court in *Jensen v. DHS* found Minnesota's waiting list goals inadequate (specifically, the goal of prioritizing the waiting list and the goal of providing home and community-based services to 80 residents of intermediate care facilities for developmentally disabled persons). The Court stated, "This proposal does not adequately address the current baseline of 3,502 individuals who have requested a 'Developmental Disabilities (DD) waiver' and 1,450 individuals who have requested a 'Community Alternatives for Disabled Individuals (CADI) waiver.' If the State wishes to address existing services and support needs, the State must provide a deadline for completion of the waiting list." *Jensen, et.al. v. DHS, et.al.,* (Minn. Dist.) 09-cv-01775 DWF-FLN, Doc. 378, p. 10.

B. Wait List Recommendations

DHS has four recommendations to ensure that individuals will receive the services they need in the community at a reasonable pace that allows the state "to maintain a range of facilities and to administer its services with an even hand."[2]

Recommendation 1: Enhanced Assessment.

By December 1, 2015, DHS will require lead agencies to enhance their assessment of individual need through a person-centered planning process that includes planning for when the individual may need waiver services.

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[1] 119 S.Ct. 2176, 2189; 527 U.S 581, 605-6 (1999).
[2] 119 S.Ct. at 2189; 527 U.S. at 605.

Recommendation 2: Wait list categorization.

DHS will divide the waiting list into four categories:

A. Institutional Exit: This category includes any person in an intermediate care facility for persons with developmental disabilities (ICF/DD) or nursing facility who does not oppose leaving the facility. For this category, service planning will begin within 45 days after a needs assessment or other indication shows the person is not opposed to leaving the facility.

Waivered services will begin as soon as practicable, but no later than 180 days after the indication that the person is not opposed to leaving the facility.

Once waiver services are authorized, the person will be removed from the wait list.

B. Immediate Need: This category includes any person in the community who meets at least one of the criteria listed in Minn. Stat. §256B.092, subd. 12(b) and Minn. Stat. §256B, subd. 11a(b) (has an unstable living situation due to age, incapacity, or sudden loss of caregivers; is moving from an institution due to bed closure; experiences a sudden closure of their current living arrangement; requires protection from confirmed abuse, neglect, or exploitation; experiences a sudden change in need that can no longer be met through state plan services or other funding resources alone; or meets other priorities established by the department).

Waivered services will begin as soon as practicable, but no later than 90 days after the person meets criteria in Minn. Stat. §256B.092, subd. 12(b) or Minn. Stat. §256B, subd. 11a(b).

Once waiver services are authorized, the person will be removed from the waiting list.

C. Defined Need: This category includes any person who is assessed as needing waiver services within a year from the date of assessment.

Waivered services will begin as soon as practicable, but no later than 365 days after the date of the assessment.

Once waiver services are authorized, the person will be removed from the wait list.

D. Future Need: This category includes any person who is assessed as needing waiver services more than a year after the assessment date.

The person is not placed on the wait list, but will be tracked on a "future interest" list.

The person will be assessed annually, and will be placed on the wait list upon meeting the definition of "defined need or "immediate need."

Recommendation 3: Data capture and reporting.

The enhanced assessment will capture information we do not have now that will show how long it takes for authorization of a waiver in each category.

By December 1, 2015, DHS will require lead agencies to begin tracking the information captured by the enhanced assessment process. By June 1, 2016 DHS will report the first six months' of data to the Subcabinet. After we have a year of data, beginning December 31, 2016, DHS will report the information twice a year to the subcabinet.

DHS will require lead agencies to track:

- why individuals are on wait lists for services;
- how many individuals are in each urgency category;
- the time it takes for individuals to move off the wait list in each category;
- gaps in services and resources; and,
- any other important information about the pace at which people move off the wait list revealed by the enhanced assessment.

Recommendation 4: Oversight

Through training, technical assistance, outreach, and monitoring, DHS will work with lead agencies to implement the new waiting list process.

II. Discussion

A. What "waiver' means.

Minnesota provides home and community-based services funded by Medical Assistance to people who require the level of care that would otherwise be provided in institutional settings. Because the federal government waives some of the institutional requirements of Medical Assistance funding, these home and community-based services are called "waivers." Minnesota has five home and community-based service waivers that provide community alternatives to nursing homes, intermediate care facilities for persons with developmental disabilities, and hospital settings. Of these five waivers, two currently have waiting lists: 1) the Developmental Disabilities (DD) Waiver; and 2) the Community Alternatives for Disabled Individuals (CADI) Waiver.

B. What causes a waiver waiting list?

Waiver services are not an entitlement, which means that states can set limits on the growth of these programs. In Minnesota, waiting lists occur because the budgets for the waivers are limited, both by: 1) the amount the federal government approves in the state

waiver plans; and, 2) the amount the legislature appropriates for the state share of the service costs. A wait list is created when people who cannot access the waiver.

C. How many people are on the waiting list?

As of January 3, 2015, there were 1,412 people on the waiting list for the CADI Waiver and 3,462 people on the waiting list for the DD waiver.

The CADI waiver waiting list, however, is likely to disappear in July 2015. This is because, under current law, as of July 1, 2015, there will be no growth limits for the CADI waiver, effectively eliminating this waiting list. In addition, the DD Waiver allows for greater growth than in the past.[3].

D. How long do people wait for waiver services?

1. Institutional settings:

CADI Waiver: Data for the last four years shows that individuals who resided in a nursing facility within 90 days of their most recent assessment started CADI waiver services between 224 and 322 days from the time of their initial assessment for services. See Appendix B, Table 4.

DD Waiver: Data for the last four years shows that individuals living in intermediate care facilities for persons with developmental disabilities (ICF/DD) who did not oppose moving to the community and requested to move within a year had a median wait time between 9 days and 84 days. See Appendix B, Table 3.

2. Non-institutional settings:

CADI Waiver: Data for the last four years shows that individuals who did not reside in a nursing facility within 90 days of the most recent assessment started services between a median of 59 days and 134 days from the initial assessment for services. See Appendix B, Table 6.

DD Waiver: Data for the last four years shows that individuals who were not living in an ICF/DD when starting DD Waiver services had a median wait time between 19 and 315 days after they were classified as having a need for services within one year. See Appendix B, Table 5.

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[3] Appendix A shows the average monthly enrollment limits for the CADI and DD waivers for the past five years.

E. Waiting list totals do not tell the whole story.

While we know how many people are on the waiting list and the median number of days some categories of individuals waited to receive services, these facts do not tell the whole story. Other important information includes:

1. Most people receive other MA-funded services and supports while on the waiver waiting list.

Being on a waiting list does not mean the person is not receiving any supports or services. People typically are eligible for one or more state plan services that are entitlements, such as home care services. Federal and state law requires that people access state plan services first and use waiver services only if the state plan services are insufficient to meet their needs. Minnesota has a robust set of state plan services. Almost all individuals on the DD Waiting list receive some type of service, assessment, or case management. (See Appendix B, Table 7 showing types of state services).

Transition-age youth who have left school and are on a waiver waiting list may be able to access state or county funded services, in addition to Medical Assistance state plan services. As of January 3, 2015, 23.5% of individuals on the DD Waiver waiting list access county funded services, often day training and habilitation, 7.8% access the Family Support Grant and 5.0% access non-ICF/DD or nursing facility respite care. (Appendix B, Table 10).

2. Statute sets priorities for receipt of waiver services.

Where state-funded services are insufficient to meet needs, Minnesota law establishes priorities for waiver services, giving top priority to individuals who:

> (1) No longer require the intensity of services provided where they are currently living; or
> (2) Make a request to move from an institutional setting.[4]

Minn. Stat. §256B.092, subd. 12 (2014)(DD waiver).

The next priority is for individuals who:

> (1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;
> (2) are moving from an institution due to bed closures;
> (3) experience a sudden closure of their current living arrangement;

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[4] The language—"make a request to move" is different from the standard in the *Olmstead* decision, which requires states to provide community-based care when appropriate and "the affected persons do not oppose" it. 119 S.Ct. at 2190 527 U.S. at 607.

(4) require protection from confirmed abuse, neglect, or exploitation;
(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or
(6) meet other priorities established by the department.

Id.

3. Waiting list totals don't reveal whether people receive services when they need them.

The total number of people on the waiting lists only tells us the number of people eligible for but not yet receiving waiver-funded services. The wait list totals do not reveal:

- why an individual is waiting for services (e.g., whether it is availability of the waiver or another reason--such as development of the person-centered plan, recruitment of a provider, or completion of modification to housing);
- the urgency of an individual's need for waivered services, and, if urgent, how many days have passed since the need became urgent;
- whether an individual does not desire waivered services to begin at the time placed on the waiting list, but rather, at some future point, and when (e.g., a family with a child living at home planning for adulthood; a person meeting current needs with state plan services who anticipates a future need for waivered services); and
- the extent to which an individual receives other supports and services.

The waiting list does not differentiate between people who have immediate needs and those who desire to reserve a spot for future access to services when the need arises. The data captured by the enhanced assessment process will help answer these questions.

F. Capacity

DHS has forecasted significant growth in the disability waivers during the next biennium (starting July 1, 2015). Enrollment limits on the CADI waiver will expire on that date and the DD waiver will have additional growth. DHS forecasts that nearly $300 million additional dollars will be spent on disability waivers in the next biennium. This will allow more individuals to access waiver services.[5]

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[5] Appendix A shows the average monthly enrollment limits for the CADI and DD waivers for the past five years.

G. How we will ensure our wait lists move at a reasonable pace.

1. We will enhance our assessment of individual need.

In order to better serve the needs of individuals on the waiting list, we will implement a new, comprehensive needs assessment.

The needs assessment will use person-centered planning to help people make decisions about their goals and to identify which services can meet them. The enhanced needs assessment will connect people to the right services and supports when they are needed, which may include a waiver at the time of assessment or at some time in the future. Lead agencies will conduct the assessments and develop community support plans.

Enhanced assessment will answer why a person is on a waiver waiting list and whether there is an immediate need for waivered services.

Lead agencies will begin using enhanced assessment by December 1, 2015.

2. We will divide the waiting list into four urgency categories.[6]

Urgency Category	Definition	Commencement of Services
1. Institutional Exit	Any person in an ICF/DD or nursing facility who does not oppose leaving the facility.	Service planning begins within 45 days after a needs assessment or other indication shows the person is not opposed to leaving the facility. Waivered services begin as soon as practicable, but no later than 180 days after the indication that the person is not opposed to leaving the facility. Once allocated the waiver, the person will be removed from the waiting list.

[6] Stakeholders recommended this categorization during a series of three sessions held to gather suggestions for improving processes related to waiver waiting lists. Appendix C contains a list of workgroup members.

2. Immediate Need	A person who meets at least one of the criteria listed in Minn. Stat. §256B.092, subd. 12(b) or Minn. Stat. §256B.49, subd. 11a(b).	Waivered services will begin as soon as practicable, but no later than 90 days after the person meets criteria in Minn. Stat. §256B.092, subd. 12(b) or Minn. Stat. §256B.49, subd. 11a(b). Once allocated waiver services, the person will be removed from the waiting list.
3. Defined Need	A person who is assessed as needing waiver services within a year from the date of assessment.	Waivered services will begin as soon as practicable, but no later than 365 days after the date of the assessment. Once allocated waiver services, the person will be removed from the wait list.
4. Future Need	A person who is assessed as needing waiver services more than a year after the assessment date.	The person is not placed on the waiting list, but will be tracked on a "future interest" list. The person will be assessed annually, and will be placed on the waiting list upon meeting the definition of "defined need Or "immediate need."

3. We will report what the enhanced assessment teaches us to the subcabinet.

The enhanced assessment will answer the questions we do not currently know. By December 31, 2016, we will have enough experience with the enhanced assessment to begin reporting twice each year to the subcabinet what we learn about:

- why individuals are on waiting lists for services;
- how many individuals are in each urgency category;
- the time it takes for individuals to move off the wait list in each category;
- gaps in services and resources; and,
- any other important information about the pace at which people move off the waiting list revealed by the enhanced assessment.

4. We will report available waiting list data to the subcabinet during the transition.

DHS will continue to provide bimonthly status reports to the subcabinet until data from the enhanced assessment is available. DHS will enhance these reports by including information similar to the data contained in this report.

5. We will provide waiting list data to lead agencies during the transition.

By July 1, 2015, DHS will provide waiting list information to lead agencies on a quarterly basis. Information will include a list of people on the lead agency's waiting list and the length of time that has passed since their initial assessment. Statewide summary data of this information will be provided to the subcabinet as described in number 4.

6. We will work to implement the new waiting list process.

Assuring effective implementation of these changes will require technical assistance, outreach and compliance monitoring and reporting. DHS will engage in the following quality implementation activities.

a. We will provide technical assistance to lead agencies.

To ensure individuals are placed in the appropriate waiting list categories and data is collected consistently, DHS will provide statewide technical assistance to lead agencies.

If lead agencies do not comply with timelines, DHS will undertake steps to learn why, and provide appropriate technical assistance. Additionally, DHS will consider reallocating resources if a county is unable to serve individuals with urgent needs within their county waiver budget.

b. We will reach out to individuals and families.

DHS will engage with its partners, including organizations such as Arc Minnesota and local Arc chapters, through July – December, 2015, to educate individuals and families about changes to waiver waiting lists.

c. We will monitor lead agencies' compliance with timelines.

In January 2016, DHS will begin monitoring lead agency compliance on a monthly basis. DHS already reviews county waiting lists and provides technical assistance

during its county waiver review. We will add a monthly compliance report which will include:

- Any assessed individuals who were not assigned an urgency category;
- An overall compliance score based upon assignation of urgency categories; and
- A list of individuals whose service start date is within 30 days of the report.

III. Recommendations Summary

DHS recommends that DHS commence the following actions by the following dates:

A. **July 1, 2015**:

1. For each lead agency, DHS will report on the number of individuals on disability waiver waiting lists and how long individuals have been on the lists.
    a) DHS will report each lead agencies' data to each lead agency, and will report aggregate state-wide data to the subcabinet.
    b) DHS will provide these reports on a quarterly basis until June 1, 2016, at which time DHS will begin reporting on the data specified in Recommendation 3 to the extent it is available.
2. DHS will engage with partners to educate individuals and families about changes to waiver waiting lists.

B. **October 31, 2015:**

1. Provide lead agencies with a mechanism to track the data specified in Recommendation 3 for all disability waivers;
2. Provide training and technical assistance, as needed, to lead agencies on enhanced assessment, classifying waiting list categories, and using the tracking mechanism.

C. **December 1, 2015:**

1. Require lead agencies to use the enhanced assessment;
2. Require lead agencies to track data according to the mechanism DHS provides;
3. Require lead agencies to authorize waiver services to individuals within the time periods specified herein;
4. Begin to track lead agencies' compliance and take steps to assist lead agencies with achieving compliance;
5. Collect the data specified in Recommendation 3.

D. **June 1, 2016:** Report to the Subcabinet on the data collected since December 1, 2015.

E. **January 15, 2016:** Report the waiting list data specified in Recommendation 3 to the subcabinet twice each year.

Appendix A: Historic Waiver Enrollment Limits

CADI Waiver Average Monthly Enrollment Limits (2010 – 2015)

Fiscal Year	Average Monthly Enrollment Limit
2010	95 people
2011	60 people
2012	60 people
2013	60 people
2014	85 people
2015[7]	Unlimited

DD Waiver Average Monthly Enrollment Limits (2010 – 2015)

Calendar Year	Average Monthly Enrollment Limit
2010	15 people
2011	6 people
2012	6 people
2013	6 people
2014	15 people
2015[8]	25 people

[7] As of July 1, 2015
[8] As of July 1, 2015

Appendix B: Data Analysis Results

Table 1 displays the total number of individuals who started DD Waiver services by calendar year.[9]

Table 1

Calendar Year	Number of Individuals
2011	657
2012	573
2013	631
2014	509
TOTAL	**2,370**

Table 2 displays the total number of individuals who started CADI Waiver services by calendar year.[10]

Table 2

Calendar Year	Number of Individuals
2011	2,958
2012	2,114
2013	2,823
2014	2,432
TOTAL	**10,327**

Table 3 reports the median number of days that passed between the date an individual indicated they needed waiver services within a year and the start of waiver services. This data is for individuals who resided in an ICF/DD within 90 days of their most recent assessment.

Table 3

Calendar Year	Median Number of Days from Waiver Need Index of "1" to Service Agreement Start
2011	84 days
2012	11 days
2013	19 days
2014	9 days

[9] Waiver start numbers include all people, not just those starting from a waiting list.
[10] Waiver start numbers include all people, not just those starting from a waiting list.

Table 4 displays the median number of days from the initial assessment to the start of CADI Waiver services for individuals who resided in a nursing facility within 90 days of the most recent assessment.

Table 4

Calendar Year	Median Number of Days from Initial Assessment to Service Agreement Start
2011	224 days
2012	265 days
2013	275 days
2014	322 days

Table 5 reports the median number of days that passed between the date an individual indicated they needed waiver services within a year and the start of waiver services. This data is for individuals who did not reside in an ICF/DD within 90 days of their most recent assessment.

Table 5

Calendar Year	Median Number of Days from Waiver Need Index of "1" to Service Agreement Start
2011	315 days
2012	15 days
2013	23 days
2014	19 days

Table 6 displays the median number of days from the initial assessment to the start of CADI Waiver services for individuals who did not reside in a nursing facility within 90 days of the most recent assessment.

Table 6

Calendar Year	Median Number of Years from Initial Assessment to Service Agreement Start
2011	59 days
2012	62 days
2013	130 days
2014	134 days

Table 7 displays non-waiver services individuals received the year before starting CADI or DD waiver services. These individuals did not reside in a nursing facility or ICF/DD at the time of the last assessment. This data displays totals between calendar year 2011 and 2014.

Table 7

Service	Number of Individuals Using this Service	Percentage of Individuals Using this Service
Mental Health Services	4,421	34.8%
Transportation Services: • Access Services • Transportation	3,839	30.2%
Home Care Services: • Consumer Directed Home Care • Home Health Services • Personal Care • Private Duty Nursing	3,415	26.9%
Assessments: • DD Screenings • Long-Term Care Consultation Pre-Admission Screening • Pre-Admission Screening and Resident Review	2,780	21.9%
Case Management Services: • Child Welfare Targeted Case Management • HIV Case Management • Home Care Targeted Case Management • Relocation Services Coordination • Vulnerable Adult Targeted Case Management	1,974	15.6%
School-Based Services: • IEP Nursing	1,120	8.8%
Nursing Facility Services	865	6.8%
Child & Teen Check-up Services: • Child and Teen Check-Up Outreach • Child and Teen Check-Up Services	324	2.6%
Chemical Dependency Services	286	2.3%
Administrative Services: • Buy-In • Collections, Miscellaneous • Financial Transactions • Premium Payments/Collections • Primary Care Utilization Review • Spenddown	280	2.2%
ICF/DD Services	173	1.4%
HCBS Services: • HCBS Waiver Conversion/Diversion • DT&H • Alternative Community Services • Moving Home Minnesota Waiver Services • Respite Care • Semi-Independent Living Services Diversion	119	1.0%
Other Services: • Undetermined Services	116	0.9%

Table 8 displays the number and percentage of individuals living at home at the start of CADI or DD waiver services between 2011 and 2014.

Table 8

Calendar Year	Number of Individuals Living at Home at Start of Waiver Services	Percentage of Individuals Living at Home at Start of Waiver Services
2011	1,022	28.3%
2012	753	28.0%
2013	991	28.7%
2014	835	28.4%

Table 9 displays characteristics of individuals who are currently waiting to start CADI Waiver services. Service categories displayed indicate that an individual has received a service within the last year. For a description of what is included in service categories, see Table 7. These figures are current as of January 9, 2015.

Table 9

Total Number of Individuals on a CADI Waiver Waiting List	1,412 people
Percentage of Individuals on a CADI Waiver Waiting List who Reside at Home	21.3%
Average Age of Individual Currently Waiting for CADI Waiver	42.1 years old
Median Number of Days on CADI Waiver Waiting List Since Initial Assessment	829 days or 2.3 years
Number of People on a CADI Waiver Waiting list who have started the DD Waiver since September 2014	5 people
Number of Lead Agencies without anyone on a DD Waiver Waiting list	21
Percentage of Individuals Who Have Received Home Care Services	53.5%
Percentage of Individuals Who Have Received School-Based Services	28.4%
Percentage of Individuals Who Have Received Mental Health Services	25.4%
Percentage of Individuals Who Have Received Transportation Services	19.4%
Percentage of Individuals Who Have Received Case Management Services	19.0%
Percentage of Individuals Who Have Received Child & Teen Check-up Services	8.3%
Percentage of Individuals Who Have Received HCBS Services	5.7%
Percentage of Individuals Who Have Received Assessments	2.8%
Percentage of Individuals Who Have Received ICF/DD Services	1.9%
Percentage of Individuals Who Have Received Other Services	1.0%

Percentage of Individuals Who Have Received Administrative Services	0.9%
Percentage of Individuals Who Have Received Nursing Facility Services	0.6%
Percentage of Individuals Who Have Received Chemical Dependency Services	0.6%

Table 10 displays characteristics of individuals who are currently waiting to start DD Waiver services. Service categories displayed indicate that an individual has received a service within the last year. These figures are current as of January 3, 2015.

Table 10

Total Number of Individuals on a DD Waiver Waiting List	3,462 people
Percentage of Individuals on a DD Waiver Waiting List who Reside at Home	91.6%
Average Age of Individuals Currently Waiting for DD Waiver Services	15.4 years old
Median Number of Days on DD Waiver Waiting List Since Initial Assessment	2,012 days or 5.5 years
Number of People on DD Waiver Waiting List who have started the CADI Waiver since September 2014	8 people
Percentage of Individuals who have Received Case Management Services	99.2%
Percentage of Individuals who have Received School-Based Services	75.2%
Percentage of Individuals who have Received Home Care Services	34.1%
Percentage of Individuals who have Received County Funded Services	23.5%
Percentage of Individuals who have Received Family Support Grants	7.8%
Percentage of Individuals who have Received Respite Services (Not ICF/DD or NF)	5.0%
Percentage of Individuals who have Received CCB Waiver Services	3.0%
Percentage of Individuals who have Received Home Modifications or Equipment	2.6%
Percentage of Individuals who have Received ICF/DD Services	2.5%
Percentage of Individuals who have Received Jobs & Training Services	1.8%
Percentage of Individuals who have Received Other Services	0.5%
Percentage of Individuals who have Received Homemaker Services	0.3%
Percentage of Individuals who have Received Relocations	0.2%

Service Coordination	
Percentage of Individuals who have Received Adult Education Services	0.1%
Percentage of Individuals on DD Waiver Waiting List who have Received No Services	0.3%

Appendix C: Olmstead Wait List Workgroup Participants

Workgroup meetings held:
June 26, 2014
July 15, 2014
July 31, 2014
August 21, 2014

Stakeholders:
Sue Abderholden, National Alliance on Mental Illness – Minnesota
Rebecca Covington, Minnesota Consortium for Citizens with Disabilities
Andrew Ervin, Hennepin County
Sandra Foy, Ramsey County
Cindy Grosklags, Renville County
Carol Huot, Dakota County
Tim Jeffrey, Stearns County
Steve Larson, The Arc of Minnesota
Bud Rosenfield, Minnesota Disability Law Center
Bill Velte, Hennepin County

Minnesota Department of Human Services:
Alex Bartolic
Curtis Buhman
Patti Harris
Larraine Pierce
Colin Stemper
Nan Stubenvoll

Management Analysis & Development:
Renee Raduenz
Barbara Tuckner

Minnesota Employment First Policy

Adopted by the Olmstead Subcabinet on September 29, 2014

Policy Statement:

Employment First means raising the expectation that all working age Minnesotans with disabilities can work, want to work, and can achieve competitive integrated employment; and each person will be offered the opportunity to work and earn a competitive wage before being offered other supports and services.

Introduction:

The State of Minnesota is committed that all Minnesotans including those with disabilities have a wide range of employment opportunities within the general workforce. The Minnesota Employment First Policy guides state agencies in their planning, decision making, implementation, and evaluation of services and supports for Minnesotans with disabilities to make employment the first and expected option considered. The Minnesota Employment First Policy provides state agencies with:

- A clear statewide vision supporting transformational change and a long-range goal of working-age youth and adults with disabilities participating in the workforce at levels similar to their peers who do not have disabilities
- A guiding vision to increase public and business expectations about employing the abilities and capacities of all people with disabilities to work in the right job with the right level of support
- A policy framework that guides present and future decisions related to people with disabilities who receive public services
- Guidance to provide clarity on how this policy will be applied across state agencies
- Instruction to act to develop and implement plans to ensure the Employment First principles and informed choice are integrated into new and existing employment-related policies, services and supports for people with disabilities.

Vision, Values and Guiding Principles:

Vision

The Employment First Policy envisions a future where all people with disabilities can achieve competitive, integrated employment. Competitive employment means:

- Full-time, part-time, or self-employment with and without supports
- In the competitive labor force
- On the payroll of a competitive business or industry

- Pays at least minimum wage, 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.

This policy increases options and choices for people with disabilities by aligning policies, funding practices and collaborative efforts among state agencies. This will help people who choose to work to enter an integrated, competitive workforce or become self-employed.

Values

Three core values ground the Minnesota Employment First Policy. These core values reflect that people with disabilities, including people who have complex and significant disabilities:

- Want to work
- Can be competitively employed or self-employed, earning at least the minimum wage and benefits
- Should be fully integrated physically, functionally and socially within the workplace.

Guiding Principles

1. Integrated, competitive employment is the first and expected service option.
2. Employment is prioritized as an outcome of services and supports.
3. Employment and support services are grounded in informed choice practices, which include but are not limited to:
    - Community-based experiences on which to base decisions
    - Knowledge about the potential impact of employment on their quality of life
    - Information and support to understand their options related to employment
    - Understanding of how work affects public benefits and resources so that work can be part of the plan without fear of losing essential benefits.
4. Individuals with disabilities have increased control and direction over services and supports.
5. Effective interagency coordination will be demonstrated in the delivery of innovative employment, education, and support services, and improved employment outcomes.
6. State agencies will be accountable for monitoring and reporting progress and for establishing interagency quality assurance procedures.

Call to Action: Implementation Requirements for the Minnesota Departments of Education, Employment and Economic Development, and Human Services

1. State agencies are required to use these guiding principles to develop agency plans for transformational changes in the provision of employment services and supports for people with disabilities, including:
    - Identification and provision of supports and services to achieve employment
    - Incorporation of additional standards that adhere to Employment First principles into regulations, quality assurance, and agency program monitoring

- Expansion and promotion of the use of promising and best practices for employment supports.

2. The Minnesota Departments of Education, Employment and Economic Development and Human Services (MDE, DEED and DHS) must define, operationalize, and document a process to ensure a person-centered approach and informed choice is used without conflicts of interest or bias to work. Informed choice must include community exploration and experienced-based opportunities.
3. After an informed choice process has been followed and if a person chooses not to work, then, documentation will be maintained by the appropriate agency of the reason(s) for the decision. This will help MDE, DEED and DHS determine what, if any, changes are necessary to address barriers to employment that resulted in the choice not to work. People with disabilities may choose to reconsider their decision at any time. Additionally, MDE, DEED and DHS must establish a process to regularly review with the person his/her decision regarding work and any options to address barriers that may have existed in the past.
4. MDE, DEED and DHS will work together to align programs, funding and policies to support people with disabilities to choose, secure and maintain competitive and self-employment, including:
    - Provision of information, technical assistance and training opportunities to adopt policies and promising processes that improve the employment outcomes of working age youth and adults across educational and adult service systems
    - Incentives for innovation that increase competitive employment in the general work force
    - Expanding the flexibility in funding and services to increase competitive employment outcomes.
5. MDE, DEED and DHS must develop uniform data collection and reporting procedures, and make public data that documents implementation of the Employment First Policy, including outcome measures.

Successful implementation of this policy will be demonstrated by increased competitive employment of persons with disabilities in the most integrated community work setting.

"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." ---Subcabinet Vision Statement – MN Olmstead Plan (p. 21 plan version with proposed modification July 10, 2014).

Olmstead Plan Employment Goal: People with disabilities will have choices for competitive, meaningful, and sustained employment in the most integrated setting (p. 40 of July 10, 2014 plan version)

Minnesota will adopt an Employment First Policy and use these principles in service design and delivery... By September 30, 2014, the state will adopt an Employment First Policy (page 42 of the July 10, 2014 plan version, Employment Section under Action two: Align policies and funding)

MINNESOTA MDH DEPARTMENT OF HEALTH Oral Health Program

Minnesota Oral Health Plan

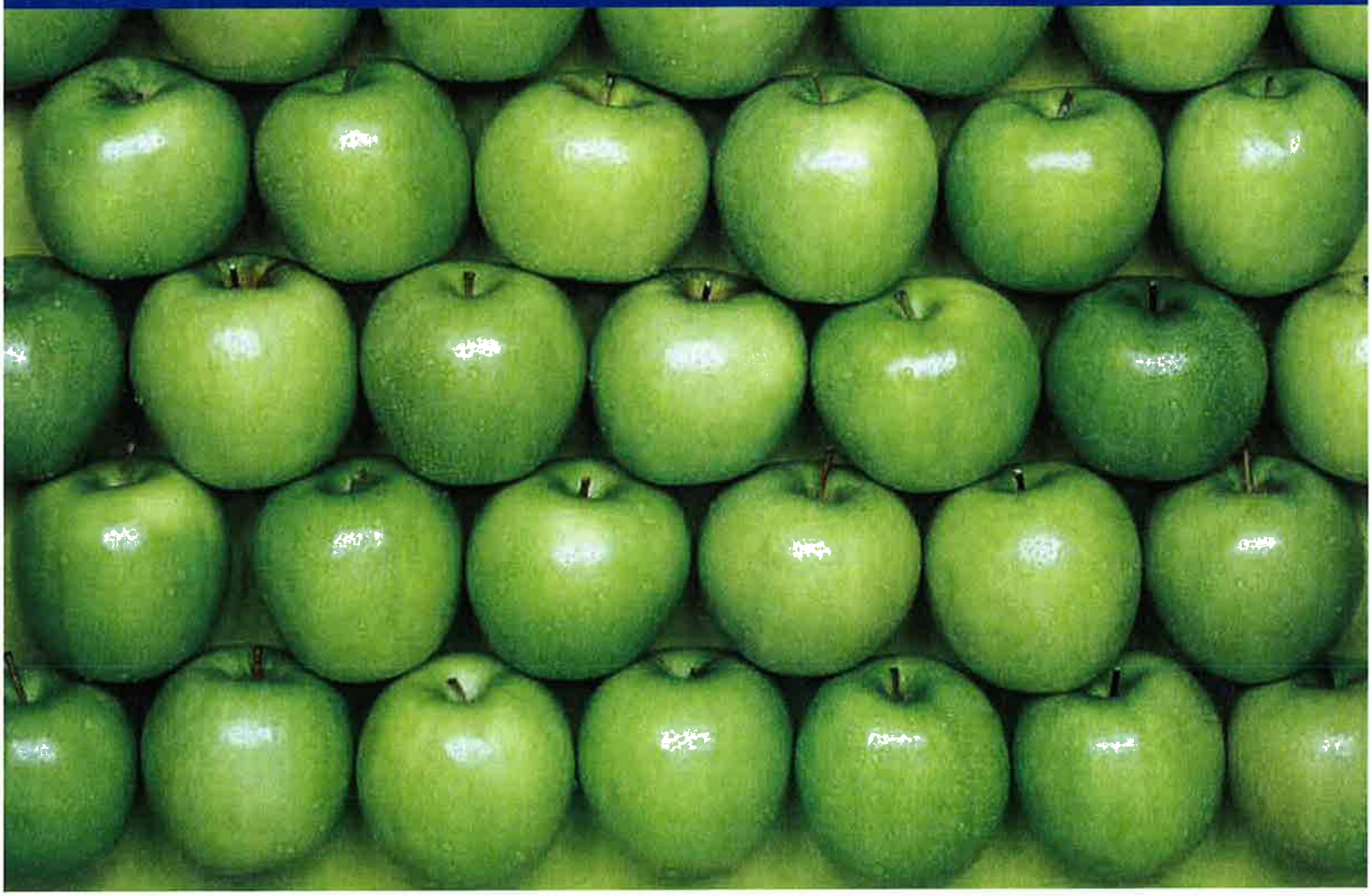
Advancing Optimal Oral Health for All Minnesotans

2013-2018

January 2013

"The past half century has seen the meaning of oral health evolve from a narrow focus on teeth and gingiva to the recognition that the mouth is the center of vital tissues and functions that are critical to total health and well-being across the life span."

Former United States Surgeon General Dr. David Satcher
Oral Health in America: A Report of the Surgeon General (2000)



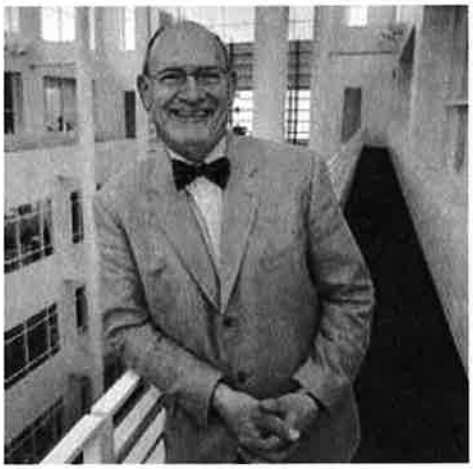
Minnesota Oral Health Plan 2013-2018
Minnesota Department of Health
Oral Health Program
PO Box 64882
85 E. Seventh Place
St. Paul, MN 55164-0882

Phone: 651-201-3749
Email: health.oral@state.mn.us
www.health.state.mn.us/oralhealth

Funding was made possible by grants to support statewide oral health related activities from the Health Resources and Services Administration, Award T12HP1465, and Centers for Disease Control Prevention, Cooperative Agreement Grant Number 5U58DP0011579.

MISSION: To promote, protect, maintain and improve oral health because it is integral to the health of all Minnesotans.

VISION: Advancing optimal oral health for all Minnesotans.



Dear Minnesotans,

It is a pleasure to present the state's first ever Minnesota Oral Health Plan. This strategic plan recognizes that oral health and overall health are inextricably linked. This plan also marks a turning point in how MDH will integrate oral health into its overall mission.

While Minnesotans enjoy good oral health when compared to the nation, still far too many residents needlessly suffer poor oral health because of the lack of routine oral health care, especially low-income children and adults, people of color, and the elderly. Oral health is fundamental to our quality of life; it impacts other chronic illnesses; affects children's growth and development and ability to learn; determines what foods we eat and whether we smile; and our very sense of self-worth. Untreated oral disease can even lead to death.

Fortunately, this plan identifies both the barriers to and solutions for improving the oral health of Minnesotans. Among the most effective solutions are school-based dental sealant programs and fluoridated water. Another promising solution includes increasing the public's access to affordable dental care through new workforce models like collaborative practice agreements between dentists and hygienists. These innovative approaches to improve oral health care are being rounded out by the cutting-edge work of establishing "health care homes" whereby a patient's total care is coordinated among dental, medical and behavioral health care providers across the health care system.

The Minnesota Oral Health Plan was developed through the hard work of MDH's Oral Health Program staff and our many partners and stakeholders who spent countless hours determining the state's burden of oral disease and the goals, objectives and strategies for reducing these diseases. One of our key collaborators in this endeavor has been the Minnesota Oral Health Coalition, which represents a cross-section of public health, oral health providers and payers, and educational and professional organizations. We thank all of these partners for making the Minnesota Oral Health Plan possible.

As we move forward to tackle the obstacles to oral health, these partnerships will be more critical than ever. We hope that as you review the strategies in this plan, you will identify areas that your organization will help support. By working together, we may indeed *achieve optimal oral health for all Minnesotans.*

Best of health,

Edward Ehlinger, MD, MSPH
Commissioner of Health

Acknowledgements

Thank you to our partner organizations and service providers:

3M
Apple Tree Dental
Century College
Children's Dental Services
Children's Dental Health Services
Community Dental Care
Delta Dental
Early Childhood Dental Network
HealthPartners
Just Kids Dental
LPaC Alliance, Halleland Habicht
Minnesota Analysis and Development
Minnesota Dental Association
Minnesota Dental Hygienists' Association
Minnesota Department of Human Services
Minnesota Oral Health Coalition
Normandale Community College
Northern Dental Access Center
Ronald McDonald House Charities
School Nurse Organization of Minnesota
University of Minnesota – School of Dentistry
Smiles Across Minnesota

Thank you to the Minnesota Oral Health Data Advisory Group:

Behavioral Risk Factor Surveillance System
Center for Health Statistics, Minnesota Student Survey
Environmental Impacts Analysis Unit, Birth Defect Information System
Environmental Health Division, Water Fluoridation Reporting System
Minnesota Cancer Surveillance System
Minnesota Department of Health
Office of Rural Health and Primary Care, Health Workforce Database
Pregnancy Risk Assessment Monitoring System

Special thanks to the efforts of the:

Transition Task Force
Work Group Chairs:
- Access to Care Work Group
- Prevention and Education Work Group
- Workforce Work Group

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Introduction

Over the past 50 years, the significant improvement in oral health of Americans is a public health success story, with community water fluoridation being one of the most effective public health initiatives of the twentieth century. Oral health is integral to overall health, as former United States Surgeon General Dr. David Satcher concluded in the groundbreaking report Oral Health in America: A Report of the Surgeon General (2000).

The report emphasizes that the mouth not only reveals signs of poor nutrition and diseases such as infections, immune disorders, injuries, and certain cancers, but research has shown associations between chronic oral infections and heart and lung diseases, stroke, low-birth-weight, premature births, as well as diabetes. Among the top risk factors for oral disease are high-sugar beverages and foods (which also contribute to obesity), along with tobacco and alcohol. Conversely, a healthy mouth can provide protection against chronic infection and disease.

Dr. Satcher also called for action to promote better access to oral health care for all Americans, especially vulnerable populations found to be at greatest risk for severe medical complications resulting from a lack of proper oral care and treatment.

There are several ways in which people suffer from pain and discomfort because of poor oral health: tooth decay; oral and craniofacial diseases; periodontal (gum) diseases; cleft lip and palate; oral and facial pain syndromes; traumatic injury; and oral and pharyngeal (mouth and throat) cancers. Many of these conditions and diseases are preventable.

Minnesotans in general enjoy a high level of oral health, ranking top in the nation for prevention and treatment of oral disease among third graders. In 2011, Minnesota also received a grade 'A' from The Pew Center on the States for achieving six of the eight oral health benchmarks, including enacting policies to improve access to dental care for children on Medicaid.

Despite these high ranks, there is room for improvement, especially among underserved populations who bear the brunt of oral diseases such as children and adults living in poverty, people of color, and the elderly. Through a Basic Screening Survey conducted in 2010, Minnesota children of color were found to be 12 percent more likely to experience caries (decay) and 7 percent more likely to have untreated caries when compared to their white peers.

The poorest adults, defined as making $15,000 or less yearly, were three times less likely to visit a dentist in the past year than adults making $50,000 or more. And among the elderly, a person without a high school degree was 10 times more likely to have all his or her teeth extracted than someone with a college degree.

Furthermore, the shortage of dental professionals serving high-risk populations combined with insufficient dental insurance is straining the health care system. With few means for affordable dental care, people seeking treatment for acute dental needs are forced to seek out the only option they have: hospital emergency department care. In Minnesota, the cost for hospital-treated "non-traumatic" conditions that could have been treated by a dentist was $148 million from 2008 to 2010.

To address these disparities and gaps in care, we must support the expansion of proven community-based disease prevention strategies across the state such as school-based dental sealant programs and ensuring optimal water fluoridation levels. Equally important is improving access to routine oral care through a more diverse dental workforce. Recruiting people from diverse backgrounds into the field of dentistry and providing incentives for working in rural areas will cultivate a workforce with the capacity to meet the needs of the underserved. In turn, providing more affordable dental care through new dental professional classifications such as dental therapists and advanced dental therapists and innovative workforce models like "collaborative agreements" between dentists and hygienists are increasing the public's options for better access to dental providers.

Additionally, transforming patient care through "health care homes" whereby dental and primary care providers work together to deliver integrated care to Minnesotans, and especially our most vulnerable populations, stands to significantly improve oral health while tamping down health care costs. The sooner oral health problems are diagnosed and treated, the less chance they will have to develop into more expensive chronic conditions that threaten people's lives and quality of life. While this health care model shows great promise, much work still needs to be done to raise the awareness among health care providers and policy makers about the social and environmental factors that are largely responsible for health inequities. Without full recognition for communities' economic and cultural needs, serious barriers to health will persist.

Minnesota's First Oral Health Plan

In 2009, the Minnesota Department of Health established a dedicated Oral Health Program to address disparities in oral health and to develop and implement the state's first Minnesota Oral Health Plan. The following plan is a result of a collaborative effort between the Minnesota Department of Health and many community partners. It is Minnesota's first comprehensive blueprint for improving oral health and reducing the prevalence of oral disease and provides a five-year strategic plan spanning from 2013 to 2018.

To establish a baseline to monitor the state's progress and focus resources, MDH carried out the first open-mouth screening of children in third grade through the Association of State & Territorial Dental Directors Basic Screening Survey in 2010. The Basic Screening Survey is based on a standardized set of data tools designed to collect:

- Information on the observed oral health of participants.
- Self-reported or observed information on age, gender, race and Hispanic ethnicity.
- Self-reported information on access to care for preschool, school-age and adult populations.

With these data in hand, Oral Health Program staff convened dentists, dental hygienists, educators, representatives from health plans and consumer groups, and other stakeholders to inform and prioritize efforts to improve Minnesotans' oral health. That teamwork produced the underpinnings of the Minnesota Oral Health Plan's top priority areas and goals as seen below, along with related objectives and strategies (see Appendix A for the full list).

Minnesota Oral Health Plan: Priority Areas and Goals

Priority Areas	Goals
1. Public Health Infrastructure	Goal 1: Minnesota's oral health infrastructure is stable and sustained.
2. Prevention and Education	Goal 2: Strategies are implemented that reduce oral disease and mitigate risks. Goal 3: Oral health literacy is increased across all ages and cultures.
3. Health Care Integration and Access to Oral Health Care	Goal 4: Professional integration is enhanced between oral health care providers and other providers in the broader health care system. Goal 5: Access is increased to preventive, restorative, and emergency oral health care services. Goal 6: The dental workforce is prepared for and addresses the oral health needs of all Minnesotans.
4. Surveillance	Goal 7: Access to population statistics, population-level oral health surveillance information, and aggregate data on oral health indicators is readily available to all.

Measuring Success: Leading Health Indicators

Healthy People 2020*

Increase by 10% the proportion of children, adolescents, and adults who used the oral health care system in the past 12 months: **baseline 45%** (2007); **target 49%** (2020).

Minnesota Oral Health Program

Increase by 10% the number of Minnesotans who receive evidence-based preventive dental care, with emphasis on preventive dental services for all children birth to five years of age: **baseline 36%** (2010); **target 40%** (2020).

Minnesota Department of Health

Increase by 5% the number of adults age 18 and older who report visiting a dentist or dental clinic within the past year for any reason: **baseline 79%** (2010); **target 83%** (2020).

Minnesota Department of Human Services

Increase by 10% the total eligible number of children birth through 20 years of age who receive preventive dental services (by or under the supervision of a dentist): **baseline 36%** (FFY2011); **target 40%** (FFY2020).

*Healthy People 2020 provides public health organizations across the nation with an evidence- based framework to improve the nation's health by setting 10-year benchmarks and monitoring progress on various health indicators.

Measuring Success

Healthy People 2020 provides an evidence-based framework to improve the nation's health by setting 10-year benchmarks and monitoring progress on selected health indicators. Significantly, Healthy People 2020 was the first time the framework included oral health as one of its leading health indicators (LHI).

This recent shift among the top echelon of public health leadership in emphasizing oral health and recognizing its critical role in general health presents an exciting opportunity for Minnesotans: the opportunity to enjoy a higher quality of life, one without needless pain and suffering and filled with broad, confident smiles.

As the Minnesota Oral Health Program moves forward to implement strategies to reduce the prevalence of oral disease, it will measure its success against Healthy People 2020's LHI for the nation:

Increase by 10 percent the proportion of children, adolescents, and adults who used the oral health care system in the past 12 months: baseline 45 percent (2007); target 49 percent (2020).

Three complementary indicators have been identified by the Minnesota Oral Health Program to measure progress locally. These indicators are from the Minnesota Oral Health Plan, Minnesota Chronic Disease and Injury Plan, and Minnesota Department of Human Services. Aligning strategies around indicators that address oral health in different population groups can move us closer to the Healthy People 2020 target.

The Minnesota Oral Health Program's oral health indicator is:

Increase by 10 percent the number of Minnesotans who receive evidence-based preventive dental care, with emphasis on preventive dental services for all children birth to five years of age: baseline 36 percent (2010); target 40 percent (2020).

While this indicator is focused on young children, it complements MDH's statewide strategic health improvement framework, Healthy Minnesota 2020: Chronic Disease

and Injury, which also includes the following oral health indicator for the first time ever:

Increase by 5 percent the number of adults age 18 and older who report visiting a dentist or dental clinic within the past year for any reason: baseline 79 percent (2010); target 83 percent (2020).

MDH's and the Oral Health Program's work also correspond with the Minnesota Department of Human Services' initiative to increase access to oral health care for low-income children and young adults eligible for Medicaid. This initiative seeks to:

Increase by 10 percent the total eligible number of children birth through 20 years of age who receive preventive dental services (by or under the supervision of a dentist): baseline 36 percent (FFY2011); target 40 percent (FFY2020).

MDH's Oral Health Program has been charged with convening stakeholders to implement strategies and evaluate progress as outlined in the Minnesota Oral Health Plan. To ensure forward momentum, program staff are working closely with key organizations such as the Minnesota Oral Health Coalition, which is composed of a broad cross-section of professionals representing dental, health care, educational, business, public health and non-profit sectors. It is only through this broad collaborative effort that we will be able to truly *advance optimal oral health for all Minnesotans.*

Minnesota Oral Health Highlights

Children

- 55% of 3rd graders experienced dental decay (caries experience) (2010)
- 18% of 3rd graders had untreated cavities (2010)
- Children of color were 12% more likely to experience caries and 7% more likely to have untreated caries as compared to white children (2010)
- Minnesota's 64% school-based sealant rate far exceeds the national average of 32% (2010)
- 59% of children with Medicaid coverage did not receive any dental services by or under the supervision of a dentist during Federal Fiscal Year 2011.
- 403 cases out of 361,109 births or 1 in 1,000 births had an orofacial defect such as clefting (2005-2009)

Adults and the Elderly

- 79% of adults 18 years and older reported visiting a dentist or dental clinic within the past year (2010)
- The poorest adults (<$15K) were 3 times less likely than their most affluent peers ($50K+>) to visit a dentist in the past year (2010)
- Natural teeth extractions fell by 50% for older adults as compared to 36% drop in the national rate (1999-2010)
- An older adult without a high school diploma was 10 times more likely to have all his/her teeth extracted than one with a college degree (1999-2010)

Cancer of the Oral Cavity and Pharynx

- Minnesota incidence rate is 11.2/100,000 population for oral and pharyngeal cancers compared to 10.9/100,000 population nationally (2004-2008)
- Minnesota mortality rate for oral and pharyngeal cancers is 2.0/100,000 population compared to 2.5/100,000 nationally (2004-2008)
- Oral and pharyngeal cancer is highest (23%) among Minnesota's American Indian men living on or near Indian reservations (2004 and 2008)

Emergency Department Visits and Hospitalizations

- Hospital treated non-traumatic dental emergencies – which could have been treated by a dentist – cost nearly $148 million from 2008-2010

Community Water Fluoridation

- 78% of Minnesotans received community fluoridated water compared to 64% of people across the nation (2010)
- Nearly all (99%) Minnesotans who were connected to public water supplies received fluoridated drinking water (2010)

Dental Workforce

- 47% of dentists were 55 years or older (2009-2010)
- Of the 3,908 dentists who renewed their Minnesota license, only 26% were practicing in rural areas (2010)
- Just over half (53%) of practicing dentists submitted at least one dental claim for patients on public programs to the Minnesota Department of Human Services (2010)
- Only 7% of dentists and 6% of hygienists work with a "collaborative agreement" (2009-2010)
- Only 23% of dentists are female (2010)
- Only 6% of dentists are people of color (African American, Native American, Asian or multiracial); 2% are Hispanic (2010)
- In 2009, Minnesota signed into law two new types of "mid-level" dental providers: dental therapist and advanced dental therapist

The Burden of Oral Disease in Minnesota

Optimal oral health allows us to speak, smile, smell, touch, taste, chew, swallow, cry out and have facial expressions without pain or discomfort. Conversely, oral diseases seriously affect our quality of life, diminishing our health, ability to enjoy food, smile and speak confidently, and the ability of children to focus on school learning and adults on their workplace jobs. Oral disease and infection can also lead to death.

Over recent decades, tremendous advances have been made in developing effective treatment and prevention programs such as dental sealants and fluoridated water. Yet, far too many Minnesotans needlessly suffer from tooth decay and tooth loss, gum disease, injuries, cancer and birth defects. Both nationally and in Minnesota, those who bear the greatest burden are low-income children and adults, people of color, and people with disabilities.

Barriers to oral health care, while still poorly understood, may include economic factors such as inadequate insurance coverage and an insufficient number of dental providers accepting public program patients. Other factors include a possible shortage of dental providers, especially in rural locations; overly-restrictive supervision of dental professionals who could otherwise provide services for people in need; transportation issues; dental health literacy; and cultural and language barriers.

The Minnesota Oral Health Plan provides a multitude of strategies for addressing many of the barriers experienced by vulnerable populations. The following account provides an overview of where the greatest oral health needs are among Minnesotans.

Children

Even though dental caries (tooth decay) is preventable, it is the most common chronic childhood disease and is five times more common than asthma. If unchecked, caries can result in the destruction of tooth structure, inadequate tooth function, unsightly appearance, pain, infection, and can affect nutrition, growth and weight gain, and can result in death. Nationally, students ages five to 17 years miss more than 1.6 million school days due to acute dental problems. Children from low-incomes families are nearly 12 times more likely to have restricted-activity days (e.g., missing school) than children from families with higher incomes due to dental problems. To assess the status of oral health among Minnesota's children, in 2010 MDH conducted the state's first baseline "open mouth" Basic Screening Survey (BSS) on students in third grade, the time when most children would have had sealants placed on a first molar by a dental provider. The BSS was conducted at 40 randomly selected public schools with a third-grade classroom size of 10 or more students. A total of 1,766 third graders were observed for the presence of sealants (on at least one molar) on treated and untreated cavities. The 2010 BSS results, combined with Healthy People 2010 (HP2010) health status indicators, Healthy People 2020 (HP2020) targets, and other measures can be used to monitor the state's progress in reducing oral diseases.

Even though dental caries (tooth decay) is preventable, it is the most common chronic childhood disease and is five times more common than asthma.

Data on previous caries experience and the presence of untreated caries can be used to better target future prevention and treatment efforts. When compared to the nation, Minnesota children fared well with only 18 percent of children surveyed having untreated caries, exceeding both the national HP2010 status and the HP2020 target of 26 percent (Figure 1).

However, 55 percent of Minnesota third graders had experienced caries, which was slightly higher than the nation (53 percent) for children six to eight years years (Figure 2). To meet the target for HP2020, Minnesota has to reduce caries experience in children by 6 percent.

In general, lower-income populations bear a disproportionate burden of oral diseases and conditions. Using a school's Free or Reduced Price Lunch (FRL) eligibility statistics as an indication of socio-economic status, the 2010 BSS data confirms that low-income children were far more likely to have dental caries experience than their more affluent peers. As seen in Figure 3, caries experience and untreated caries rise as income declines: the poorest children (>75% FRL) were almost one and a half times more likely to experience tooth decay and almost three times more likely to have their tooth decay go untreated than students at more affluent schools.

Likewise, race and ethnicity can be risk factors for compromised oral health. Minnesota children of color (non-white, non-Hispanic) were 12 percent more likely to experience caries and 7 percent more likely to have untreated caries as compared to their white counterparts (white non-Hispanic) (Figure 4). Hispanic children were almost on par (1 percent higher) with white children for untreated caries.

A majority of Minnesota third graders (64 percent) showed evidence of dental sealants on at least one permanent molar, which is two times higher than the national rate (32 percent) and supersedes the HP2020 goal of 28 percent (Figure 5). Troubling though, is Minnesota's high sealant rate drops steadily by income to the low rate of 42 percent when we look at the poorest children (>75% FRL). The dental sealant prevalence rate is lowest among Hispanic children both nationally and locally, with the gap between Hispanic and white children being almost twice as big at the national level than in Minnesota.

FIGURE 1
Untreated Caries in Children, Comparison of HP2010, HP2020 with MN Data

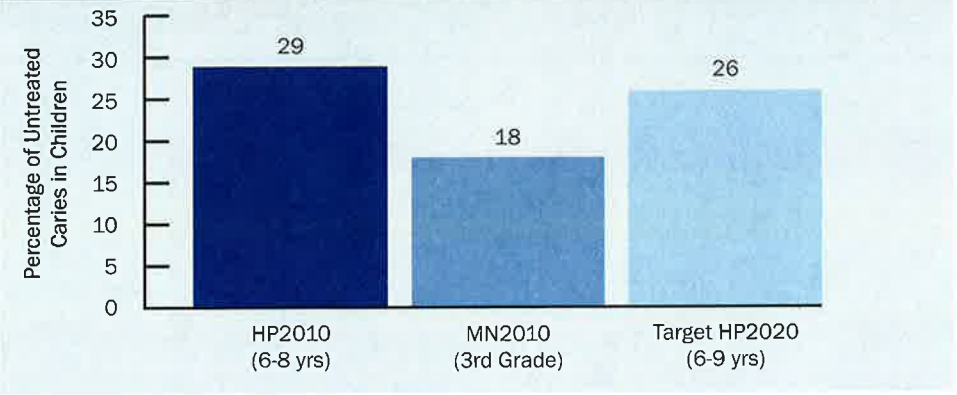


FIGURE 2
Dental Caries Experience in Children Comparison of HP2010, HP2020 with MN Data

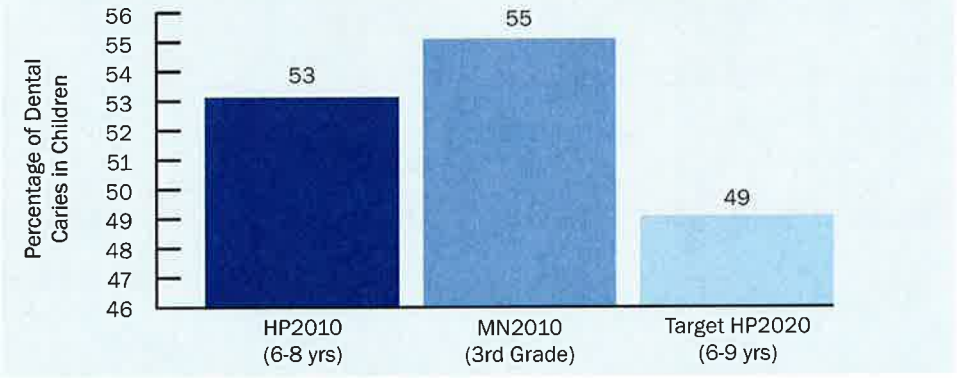
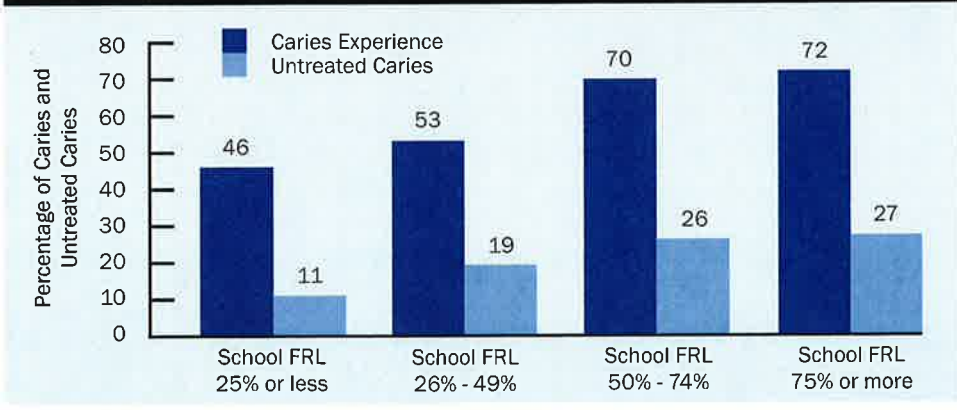


FIGURE 3
Caries Experience and Untreated Caries in Students in 3rd Grade by Free and Reduced Lunch Eligibility in Minnesota - BSS2010



When comparing rural versus urban areas, caries experience is 6 percent more prevalent among rural children (57 percent) than their urban counterparts (51 percent); untreated caries is 5 percent higher among rural children (20 percent) as compared to urban children (15 percent). Sealant rates, however, are nearly identical at 64 percent. This bright spot may point to the success of school-based sealant programs that focus on reaching children who do not have adequate access to dental care.

Adolescents

While Minnesota does not currently monitor the oral health status of adolescents, national data tell us that 56 percent of adolescents (15 year olds) had experienced caries, according to an HP2020 report. Data also show a higher prevalence of caries experience in females (60 percent) than males (53 percent). The national HP2020 target is to reduce the proportion of adolescents (13 to 15 years) with dental caries experience in their permanent teeth to 48 percent.

Adults

Most adults have suffered from tooth decay and gum disease, which are the most common oral diseases affecting both health and productivity. Nationally, 164 million hours of work are lost annually due to dental problems, with adults in lower paying jobs losing two to four times more work hours than higher-paid workers.

Nationwide, 28 percent of adults ages 35 to 44 years and 18 percent of adults age 65 years and older had untreated caries. In Minnesota, 79 percent of adults 18 years and older reported having visited a dentist or dental clinic within the past year. Despite this high rate, significant disparities exist across income levels. Minnesota's poorest adults (<$15K) were three times less likely than their most affluent counterparts ($50K+>) to visit a dentist in the past year (Figure 6). It is possible this disparity exists because public insurance programs provide limited dental benefits for low-income adults and eligible recipients may not be knowledgeable of, or seek out, these programs.

FIGURE 4
Caries Experience and Untreated Caries in Students in 3rd Grade by Race, Minnesota - BSS 2010

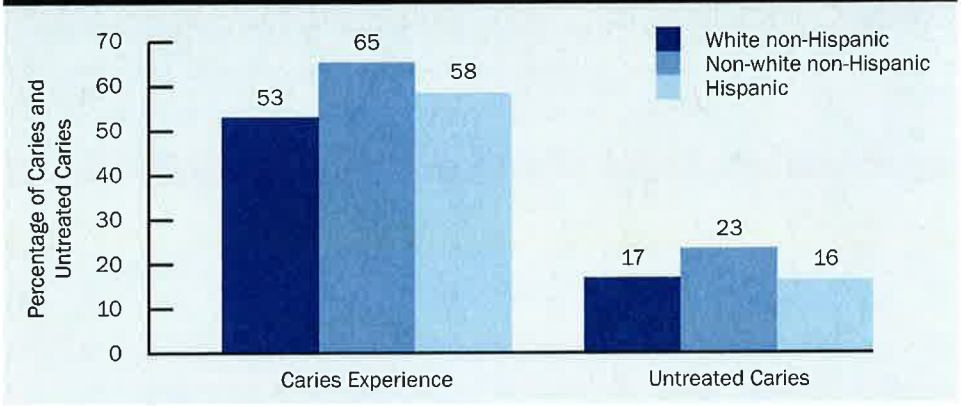


FIGURE 5
Minnesota and National Population Prevalence Estimates for Dental Sealant

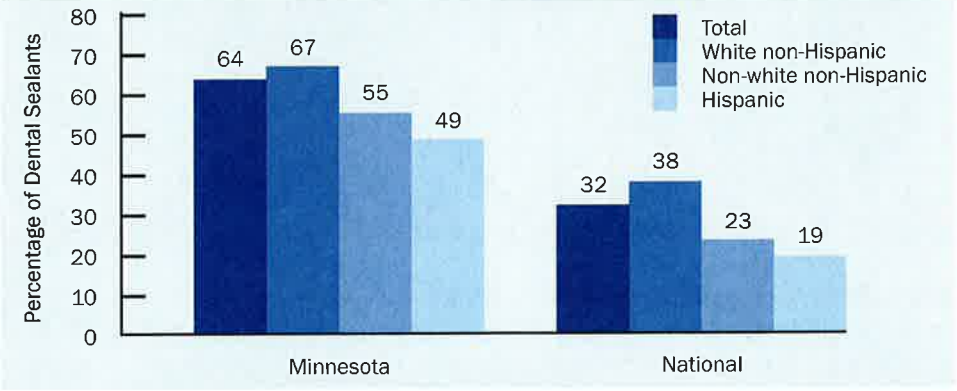


FIGURE 6
Adults 18+Who did not Visit a Dentist or a Dental Clinic in the Past Year by Income - BRFSS 2010

According to the Centers for Disease Control, almost half of all adults in the U.S. are affected by gum disease (periodontal disease). Periodontal disease is a bacterial infection that affects the gums and bone supporting

Through the benefits of water fluoridation and fluoride toothpastes, adults 60 years and older represent the first generation where the majority will keep their natural teeth over their lifetime.

the teeth. Gingivitis is the mildest form of periodontal disease and is often caused by inadequate oral hygiene. Gingivitis is reversible (health can be restored) with professional treatment and good oral home care. Gum disease can cause tooth loss if left untreated. Cigarette smoking is one of the leading risk factors of gum disease and inhibits the healing process; gum disease prevalence is three times higher in smokers than non-smokers.

Elderly

Historically, the elderly have been at higher risk for poor oral health due to their lack of preventive care when they were young and the lack of Medicare dental benefits for older adults. However, through the benefits of water fluoridation and fluoride toothpastes, adults 60 years and older represent the first generation where the majority will keep their natural teeth over their lifetime.

Both nationally and in Minnesota, the number of older adults (65+) missing all their natural teeth declined significantly in the past decade. From 1999 to 2010, natural teeth extractions fell by 50 percent for older Minnesotans, much higher than the national rate of a 36 percent drop (Figure 7). As of 2010, 17 percent of adults 65+ years across the nation had all their natural teeth extracted compared to 11 percent of Minnesotans.

FIGURE 7
Adults Aged 65+ Who Have Had All Their Natural Teeth Extracted BRFSS Data 1999 - 2010

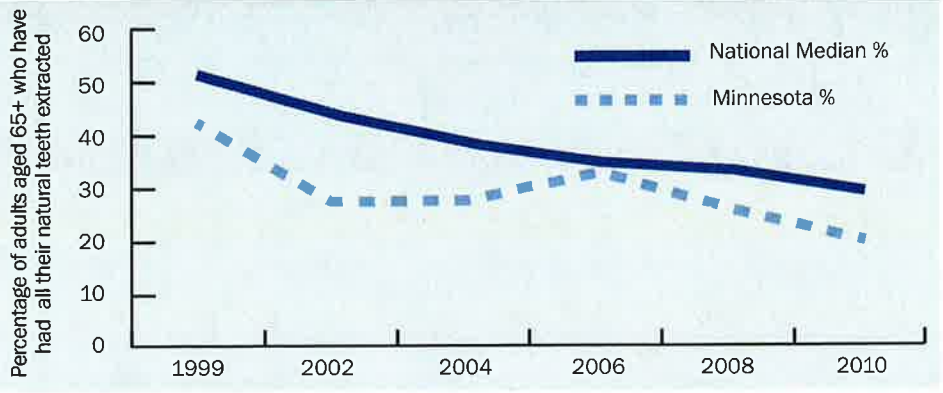
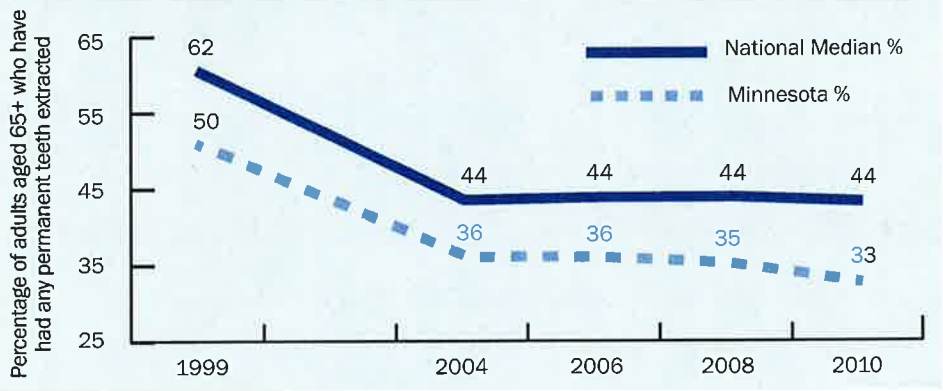
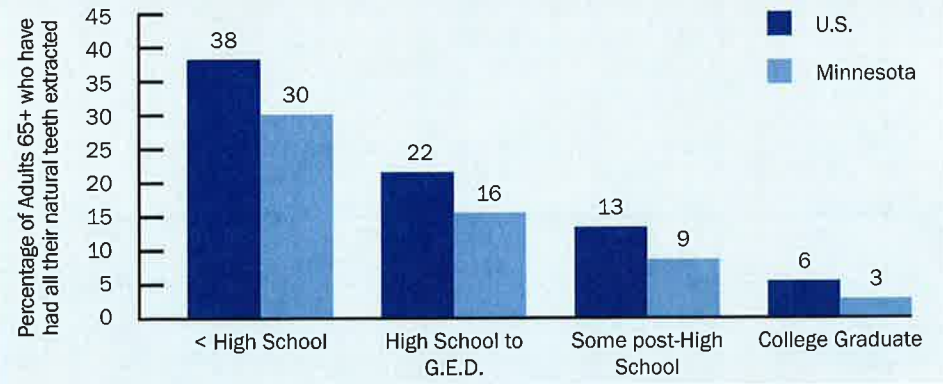


FIGURE 8
Adults Aged 65+ Who Have Had Any Permanent Teeth Extracted BRFSS Data 1999 - 2010



Note: Data between 1999-2004 is unavailable.

FIGURE 9
Adults Aged 65+ Who Have Had All Their Natural Teeth Extracted by Education Level, BRFSS Data 2010



Between 2004 and 2010, the rate of older Minnesotans who had any permanent teeth extracted declined slightly from 36 to 33 percent as national trends remained stagnant at 44 percent (Figure 8). While these downward trends are encouraging, with no Medicare dental benefits, older adults on fixed incomes are less likely to seek oral health care, compromising their quality of life and health.

Given persistent disparities, the lower a person's educational level the more likely his or her natural teeth will be extracted. In Minnesota, an older adult without a high school diploma was 10 times more likely to have all their teeth extracted than an older adult with a college degree. Minnesota's older adults without a high school degree did fare better than their national counterparts who were 8 percent more likely to have had all their natural teeth extracted (Figure 9).

Cleft Lip and Palate

Cleft lip and/or cleft palate is the fourth most common birth defect in the U.S., affecting about one child per 700 births. Cleft lip and cleft palate occur when a baby's lip or palate do not form properly. These conditions affect a child's ability to breastfeed, eat, talk, and can lead to ear infections, hearing loss, and jeopardize tooth health.

The exact cause of cleft lip and palate is not known; however, it is thought to be caused by a combination of genetic and risk factors such as environmental exposures, the mother's tobacco use and diet while pregnant, as well as certain medications. Women with diabetes have also been shown to be at higher risk of having a child with a cleft lip with or without cleft palate.

Cleft lip with and without cleft palate affects boys twice as much as girls whereas cleft palate without cleft lip affects girls twice as much as boys. In Minnesota, there were 403 cases of orofacial defects such as clefting recorded for births between 2005 and 2009; that is 403 cases out of 361,109 births or one case per 1,000 births. This number is likely higher as this figure is based on access to only 50 percent of birth records.

Women can take steps before and during pregnancy to reduce the risk of having a baby born with birth defects. Such steps include taking a daily multivitamin with

FIGURE 10
Incidence Rates for Cancer of Oral Cavity and Pharynx by Gender US and Minnesota Populations 1988-2008

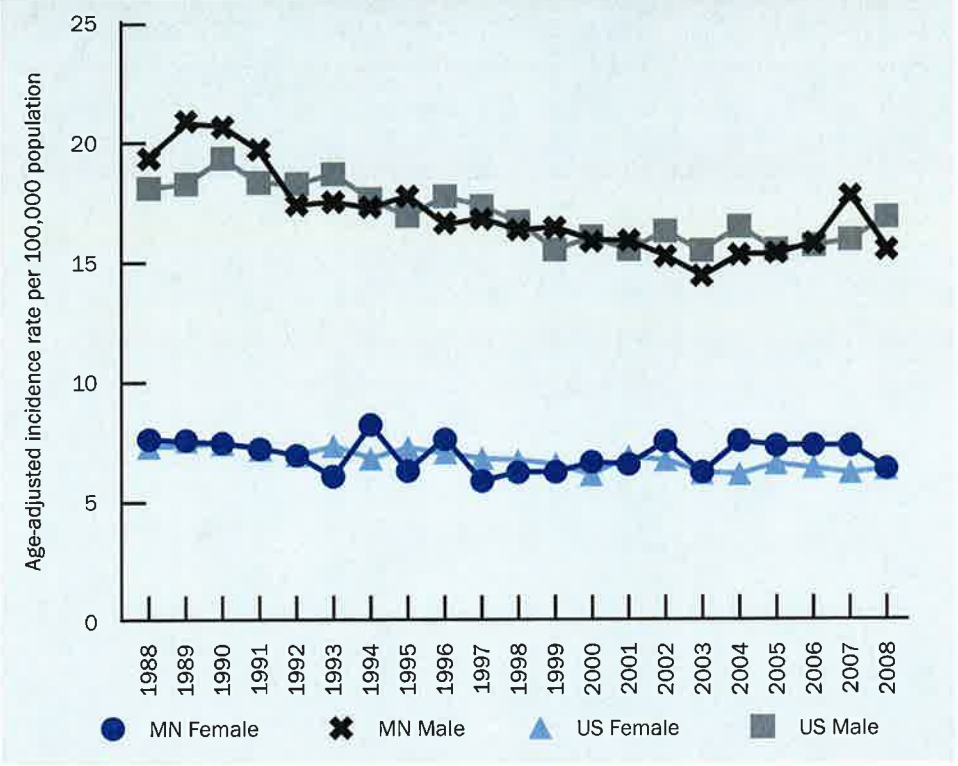
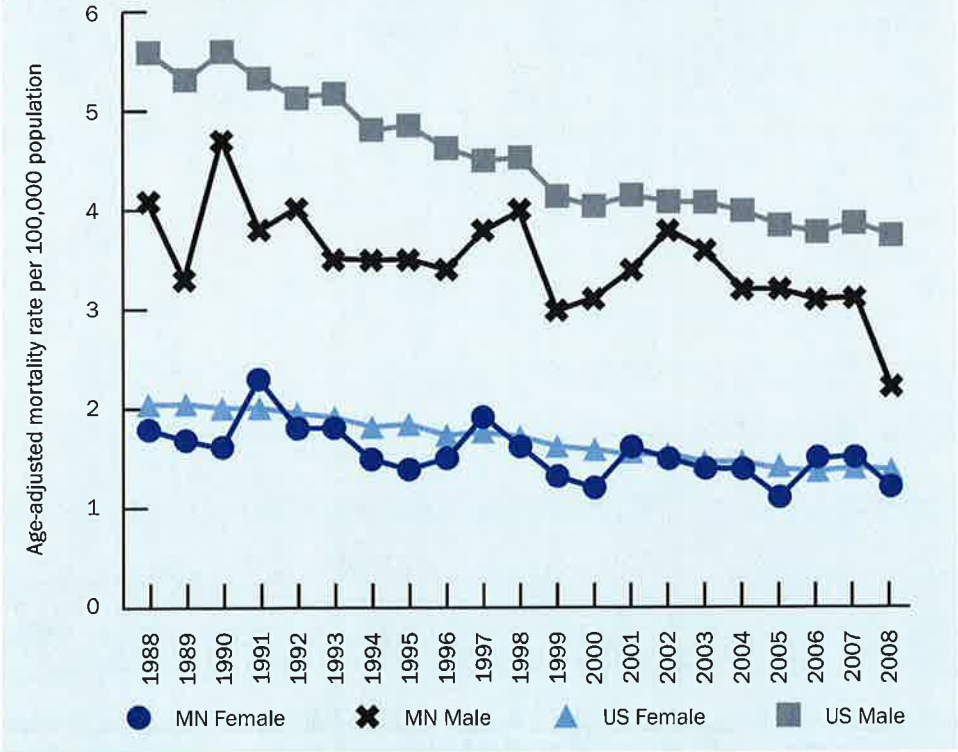


FIGURE 11
Mortality Rates for Cancer of Oral Cavity and Pharynx by Gender US and Minnesota Populations 1988-2008



folic acid (400 micrograms), not smoking, and not drinking alcohol during pregnancy.

Treatments and rehabilitation begins within the first few months of life. As the process involves multiple specialists and procedures, the average treatment costs for treating cleft lip or cleft palate per patient over their lifetime is estimated at $250,000.

Cancers of The Oral Cavity and Pharynx

The American Cancer Society estimates that 35,000 people get oral cavity and pharyngeal cancers each year and that 6,800 people will die from these cancers. These cancers affect males twice as much as females and most often occur in people ages 62 and older. Oral and pharyngeal cancer occur most often on the tongue, tonsils, and minor salivary glands while the remainder are found on the lips, gums, the floor of the mouth, and other sites.

Use of tobacco and heavy consumption of alcohol are widely considered major risk factors for oral and pharyngeal cancer. Recently, exposure to the human papillomavirus (HPV) and infection have been documented as strong risk factors for certain types of oral and pharyngeal cancer, particularly in men. Reducing exposure to tobacco and alcohol is the most effective strategy to lower the risk of developing these types of cancer.

FIGURE 12
Incidence of Cancer of Oral Cavity and Pharynx by Age and Gender, 2004-2008 (Source: MCSS)

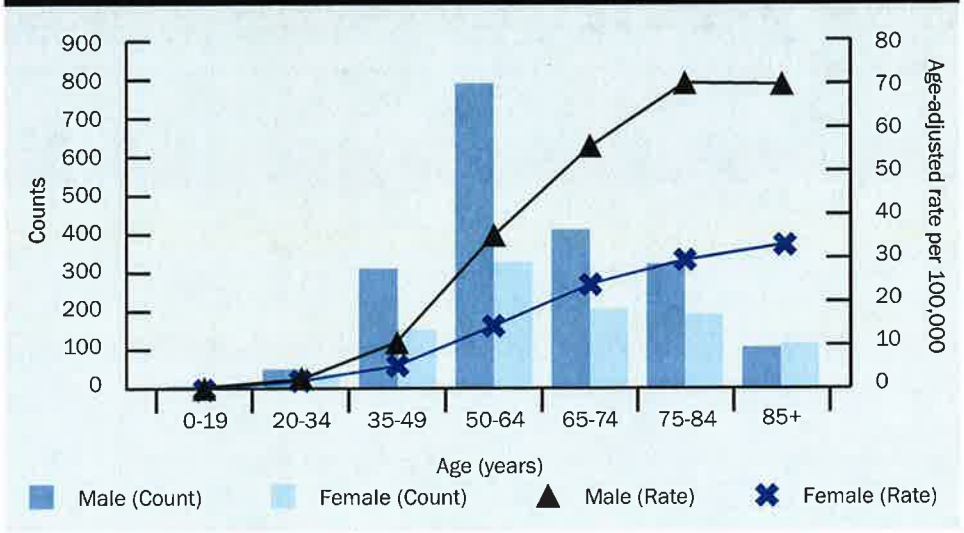
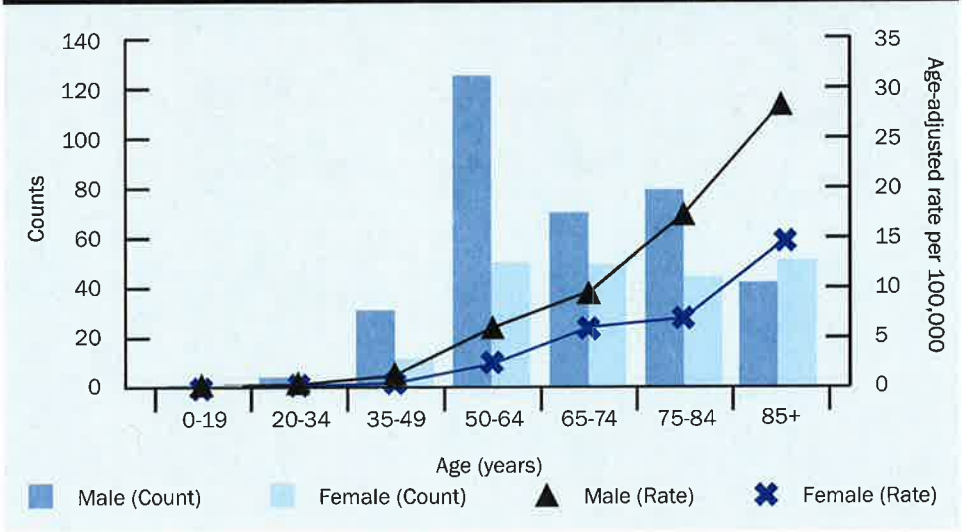


FIGURE 13
Incidence of Cancer of Oral Cavity and Pharynx By Age and Gender, 2004-2008, (Source: MCSS)



In Minnesota, from 2004 to 2008 an average of 603 cases of oral and pharyngeal cancer were diagnosed – 2.4 percent of all new cancer cases – resulting in 111 deaths and representing 1.2 percent of all cancer-related mortality. The average annual incidence for oral and pharyngeal cancer was 11.2 per 100,000 Minnesotans compared to 10.9 per 100,000 nationally; the mortality rate was 2.0 per 100,000 population, slightly lower than the average for the nation at 2.5. Oral cancer is devastating: although incidence rates are low compared to other cancers, one out of every six cases results in death.

Following national trends, the incidence rate was two times higher (15.9 per 100,000 males) among Minnesota males than females (7.1 per 100,000) (Figure 10). While the Minnesota incidence rate for oral and pharyngeal cancer in women has been stable, the rate among males fell by 20 percent from 1988 (19.6 per 100,000) to 2006 (15.7 per 100,000), with a slight increase in 2007 (17.8 per 100,000).

Oral and pharyngeal cancer mortality rates for the state decreased significantly among males since 1988. Through 2008, rates declined by 27.2 percent in the state for males as compared to national mortality rates. Mortality rates were consistently lower in the state for males (41.5 percent) and females (13.0 percent) as compared to national rates; Minnesota mortality rates for females were steady and closer to the national figures (Figure 11).

Incidence, Mortality and Lifetime Risk by Age, Gender and Race

In Minnesota, the median age for oral and pharyngeal cancer diagnosis for males is 61 years and 65 years for females. The incidence rate in both males and females increases with age and more than two-thirds of the new oral and pharyngeal cancer cases are identified after the age of 74 years (Figure 12). Incidence rates are two times higher in males than females. Starting in the 20 to 34 year range, both the number of cases and rate of oral and pharyngeal cancer between men and women begins to diverge with the biggest spread occurring between the ages of 50 and 64 years.

Mortality rates for oral and pharyngeal cancer increase sharply after age 64 years in both males and females (Figure 13). As with incidence rates, males have higher oral and pharyngeal cancer mortality rates than females.

Between 2004 and 2008, the occurrence of oral and pharyngeal cancer in Minnesota males was highest (23 percent) among American Indian men living on or near Indian reservations, followed by blacks (21 percent). Among females, American Indian females (12 percent) had the highest incidence rate. Interestingly, mortality rates were higher in Asian/Pacific Islander populations.

The average, annual incidence rate among Minnesota populations living on or near Indian reservations was 17 percent higher (23 new cases/100,000 population) than among American Indians (19 new cases/100,000 population) living outside these areas (Table 1).

Oral Diseases and Other Health Conditions

Over the past few decades, the rise in chronic disease has emerged as a major threat to the well-being of Americans, while costing the health care system billions of dollars. These factors reinforce the need for better integration between oral health care and general health care systems and for professionals to raise awareness, maximize resources and streamline efforts in the interest of achieving a common goal: improving the health of Minnesotans.

There is an inextricable relationship between oral and chronic diseases such as diabetes, cardiovascular diseases, stroke, and adverse pregnancy outcomes. Studies have shown that the mouth can signal the presence of diseases in other parts of the body as well as be a gateway for infections that can spread throughout the body. In addition, people with certain chronic diseases are at an increased risk for developing periodontal (gum) disease, further compromising their health and recovery.

Periodontal disease is often considered the "sixth complication of diabetes." Since people with diabetes are more susceptible to contracting infections, they are more likely to have periodontal disease than people without diabetes. Children with diabetes often develop gum diseases earlier in life than those without diabetes and show more plaque and gingival inflammation than non-diabetic children. Research also suggests the relationship goes both ways, as periodontal disease may make it more difficult for diabetic patients to control their blood sugar, increasing the risk for diabetic complications.

Additionally, while periodontal disease may not be conclusively linked as a causal agent for heart disease and stroke, a strong case can be made that risk factors for periodontal disease are shared with heart disease and stroke.

Another startling fact is that only 22 to 34 percent of women in the U.S. consult a dentist during pregnancy. According

TABLE 1

Oral Cavity and Pharyngeal Cancer Average Annual Rates in Minnesotans by Race and Ethnicity, 2004-2008

Race	Average Annual Incidence Rate		Mortality Rate	
	Male	Female	Male	Female
Contract Health Services Delivery Area*	23%	~	~	~
Blacks	21%	8%	~	~
American Indians	19%	12%	~	~
Non-Hispanic whites	16%	7%	2.8%	1.3%
Asian/Pacific Islanders	15%	8%	7.8%	~
Hispanic all races	6%	7%	~	~
All Races combined	16%	7%	2.9%	1.3%

* Contract Health Services Delivery Area: American Indians living on or near reservation
~ Race-specific rates based on fewer than 10 cases or deaths are not presented.

TABLE 2

Minnesota Indicators for Medicaid Recipients birth through the age of 20 years

	FFY2010		FFY2011	
	Number	Percent	Number	Percent
Total individuals eligible for EPSDT for 90 continuous days*	436,388	---	453,502	---
Total eligible receiving any dental services [any service by or under the supervision of a dentist]	181,137	42%	183,929	41%
Total who did not receive dental services	255,251	58%	269,573	59%
Total eligible receiving preventive dental services [by or under the supervision of a dentist]	162,986	33%	164,432	36%
Total eligible receiving dental treatment services [by or under the supervision of a dentist]	81,942	19%	79,335	17%
Total eligible (only children 6-9 years) receiving a sealant on a permanent molar tooth	14,273	17%	13,590	15%

TABLE 3

Charges for Minnesota Hospital-treated Oral Trauma and Non-Traumatic Conditions, 2008-2010

	Hospital-treated Oral Trauma			Hospital-treated		
	2008	2009-2010	Percent of Increase	Number	2009-2010	Percent of Increase
Mean	$453.16	$483	7%	$1,053.75	$1,148	9%
Median	$187	$208	11%	$242	$291	20%
Total	$11,720,194	$12,755,259	9%	$67,378,817	$80,356,318	19%

to the National Maternal and Child Oral Health Resource Center, most infants and young children acquire caries-causing bacteria from their mothers. Therefore it is essential for health professionals to provide pregnant women and new mothers with appropriate and timely oral education and health care. While the research is not conclusive, many studies have found periodontitis (inflammation of gums) to be associated with poor pregnancy outcomes including preterm birth, low birth weight, or both. What is clear is that oral health programs need to focus more on educating and improving prenatal education and oral health care for pregnant women. These conditions drive home the fact that to maximize a patient's health outcomes, a more coordinated approach is needed among dental and medical providers to use a shared risk factor approach to treat patients.

Oral Health Financing

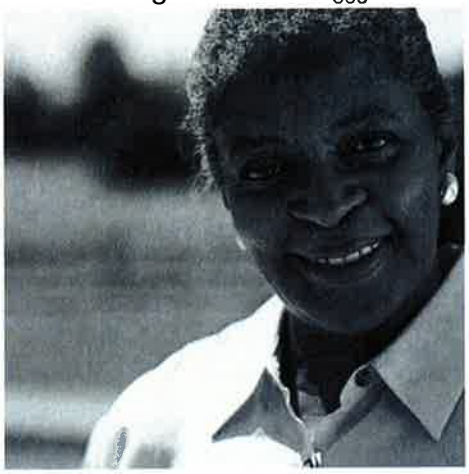
Increasing Use Rates of Public Insurance Programs for Children

Medicaid is a government-sponsored program that provides health and dental coverage for low-income children and vulnerable adults such as those with disabilities and refugees. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is the child health component of Medicaid. It is required in every state and is designed to improve the health of low-income children by financing appropriate and necessary pediatric services. Child and Teen Checkups (C&TC) is the name for Minnesota's EPSDT Program.

C&TC is a comprehensive child health program provided to children and teens from birth through the age of 20 who are enrolled in Medicaid or MinnesotaCare. Comprehensive and periodic screenings are the foundation of the C&TC program and delivered according to a set schedule, ensuring that health problems are diagnosed and treated early before they become more complex and treatment more costly.

Despite these resources, dental services continue to be under used by low-income children. In Federal Fiscal Year 2011 (FFY2011), of the 453,502 eligible EPSDT children in Minnesota, the vast majority (59 percent) did not receive dental services (Table 2). In Minnesota, there was a 4 percent increase in those under 21 years of age eligible for Medicaid from FFY2010 to FFY2011.

Hospital treated non-traumatic dental emergencies — which could have been treated by a dentist — cost nearly $148 million from 2008-2010.



According to the Pew Charitable Trusts, by 2014 an estimated 5.6 million more children will be eligible to receive Medicaid dental benefits under the Affordable Care Act.

The Centers for Medicare & Medicaid Services (CMS) reviewed the causes of low dental use rates among children on Medicaid and identified the following key barriers:

- Limited availability of dental providers
- Low insurance reimbursement rates to dental providers
- Lack of clear information for beneficiaries about dental health benefits
- Missed dental appointments
- Transportation
- Cultural and language barriers
- Need for consumer education about the benefits of dental care

To address these barriers, CMS developed national objectives in April of 2011 that are in line with the HP2020 oral health goals:

- To increase the rate of children ages one to 20 enrolled in Medicaid or Children's Health Insurance Program (CHIP) who receive any preventive dental service by 10 percentage points over a five-year period; and
- To increase the rate of children ages six to nine enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by 10 percentage points over a five-year period (this goal will be phased in during year two or three of the initiative).

Through its school-based sealant program, MDH's Oral Health Program and the Minnesota Department of Human Services are working together to ensure the CMS objectives are implemented. Currently, the Oral Health Program coordinates five school-based sealant programs and three sealant demonstration sites in at-risk schools (targeting second grade children) throughout the state.

TABLE 4

Profile of Minnesota Hospital Treated Patients with Oral and Dental Conditions, 2000-2010

	Traumatic (2000-2010)		Non-traumatic (2007-2010)	
	Number	Percent	Number	Percent
Total number of cases	32,553	---	136,982	---
Male	18,816	58%	65,340	48%
Female	13,737	42%	71,642	52%
Urban Residents	20,443	63%	74,655	55%
Rural Residents	12,110	37%	62,327	46%
Patients treated in Emergency Dept.	32,293	99%	131,914	96%
Patients hospitalized	260	1%	5,068	4%

Dental Care for the Uninsured and Under-insured

While Medicaid and CHIP provide dental coverage for low-income children, 30 percent of children across the nation with private health insurance do not have dental insurance. Across the nation, disparities between the insured and uninsured are significant: more than 80 percent of low-income children with health insurance (Medicaid and/or private insurance) in 2010 had a dental visit within the past 12 months compared to only half of low-income children without insurance.

In Minnesota, low-income children are eligible to receive dental benefits under Medicaid and low-income adults are eligible for limited dental benefits. According to CMS, in 2009 the national dental services expenditure was $102.2 billion with 42 percent of that amount spent on out-of-pocket payments. This gap in dental benefits coverage often discourages low-income adults and families from seeking dental care in the first place, which points to the need for more affordable treatment options.

The lack of adequate access to dental care has flooded hospital emergency departments (EDs) with patients suffering from dental problems. The main factors contributing to this situation are insufficient insurance benefits; lack of enough providers accepting uninsured or under-insured individuals; and a shortage of dental care providers. These gaps force children without insurance and uninsured or under-insured adults to seek treatment in EDs. Often, the care offered may result in additional visits and corrective procedures as ED staff are not generally trained in handling oral health problems.

Hospitals diagnose oral conditions as either "oral trauma" or "non-trauma." Hospital-treated oral trauma often occurs through injuries and includes broken teeth and open wounds in the mouth.

FIGURE 14

Hospital-treated Oral Non-trauma by Age, Minnesota 2000-2010 Rate/100,000 cases

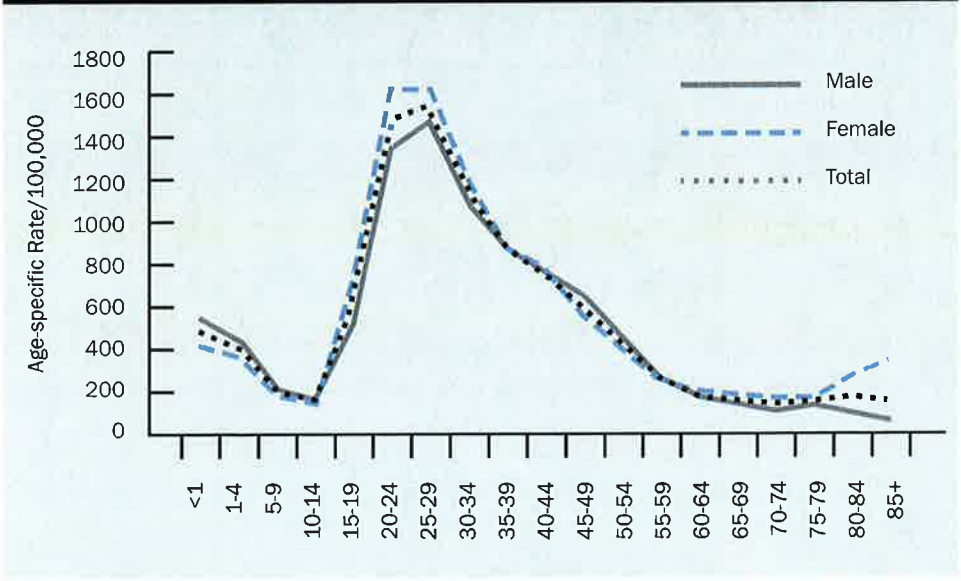


TABLE 5

Minnesota Hospital-treated Oral Non-trauma Rates by Age (2000-2010)

Age group	Rates in Males/100,000	Rates in Females/100,000	Rate differential
20-24	1,345	1,616	20% higher
25-29	1,468	1,610	10 % higher

Non-trauma conditions include tooth development and eruption disorders, abscesses, periodontal disease, gingivitis, dentofacial anomalies, malocclusion and other diseases of the internal structures of the mouth. Non-trauma conditions can best be treated by a dental provider, rather than in a hospital emergency room.

The increased use of EDs for preventive and less severe oral health problems (non-trauma) has serious financial implication to the overall health care system: hospital treatment of non-traumatic conditions cost nearly $148 million from 2008 to 2010 (Table 3). Within a two-year span in Minnesota, the average hospital charges increased significantly for both traumatic (7 percent) and non-traumatic (9 percent) conditions.

In Minnesota, the rate of hospital treatment is much higher for non-traumatic versus traumatic oral emergencies, which may be attributable to the under-insured/uninsured using hospital services for more regular dental care needs. Four times more people sought treatment for non-traumatic oral emergencies at hospitals as compared to those seeking treatment for traumatic conditions (Table 4). From 2000 to 2010, just over a third (37 percent) of patients visiting EDs with traumatic conditions were from rural communities – even though these areas are more sparsely populated – which may be due to the lack of enough dentists in rural locations.

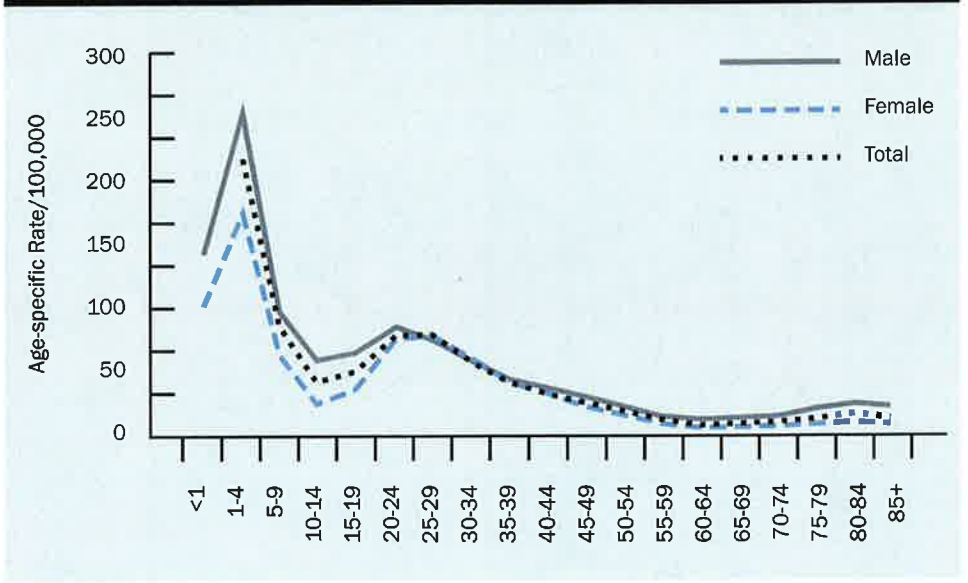
Significantly, people who sought treatment from a hospital for non-traumatic oral emergencies were four times more likely to be admitted to the hospital than those seeking treatment for oral trauma (Table 4). This may be due to preventable dental conditions having evolved into more complicated and costly ailments that needed hospitalization. When charges like this are not paid by uninsured or under-insured patients, the burden falls to the hospital or health care organization which in turn may pass the cost on to insured patients through higher health care charges.

The incidence of non-traumatic hospital-treated oral emergencies is higher among 20 to 29 year olds and is 20 percent higher in females 20 to 24 years old as compared to males in the same age group (Figure 14 and Table 5). The higher rate among this age group may be due to young adults no longer being eligible for coverage through their parents' insurance plans; still being in college without dental benefits; or employed in jobs without dental benefits. The rate in this age group may decline as the Affordable Care Act is implemented and provides coverage for young adults through age 26 on their parents' health care plan.

Minnesota hospital-treatment rates for dental conditions vary significantly by age, with oral trauma being highest in children ages one to four followed by adults ages 20 to 29 years; males and females show the same pattern (Figure 15).

FIGURE 15

Hospital-treated Oral Trauma by Age, Minnesota 2000-2010
Rate/100,000 cases



Public Health Infrastructure

Goal 1: Minnesota's oral health infrastructure is stable and sustained.

Prevention and Education

Goal 2: Strategies are implemented that reduce oral disease and mitigate risks.

Goal 3: Oral health literacy is increased across all ages and cultures.

Health Care Integration and Access to Oral Health Care

Goal 4: Professional integration is enhanced between oral health care providers and other providers in the broader healthcare system.

Goal 5: Access is increased to preventive, restorative, and emergency oral health care services.

Goal 6: The dental workforce is prepared for and addresses the oral health needs of all Minnesotans.

Surveillance

Goal 7: Access to population statistics, population-level oral health surveillance information, and aggregate data on oral health indicators is readily available to all.

Priority Areas: Oral Health Goals, Objectives and Strategies

The Minnesota Oral Health Plan defines specific goals, objectives and strategies for advancing oral health for all Minnesotans. These priority areas were identified by a cross-section of public health and oral health professionals and recognize that oral health is dependent on a complex, interrelated set of factors that range from good oral hygiene and optimal water fluoridation to providing more equitable access to oral health care services.

This overview of priority areas and goals below is followed by a more in-depth analysis of the factors impacting oral health and suggested strategies for dismantling barriers and bolstering health care integration in order to improve oral health for all Minnesotans.

Priority: Oral Health Infrastructure

To sustain continued progress in reducing the burden of oral diseases across Minnesota, it is imperative to devote attention to the status of oral health and amplify the prevention strategies that address them. Further embedding the Oral Health Program's mission with the Minnesota Department of Health's goals and objectives is a first step in that direction. The Minnesota Oral Health Plan also supports Minnesota's statewide health improvement framework: Healthy Minnesota 2020 which emphasizes common themes:

- A Healthy Start for All: capitalize on the opportunity to influence health in early childhood.
- An Equal Opportunity for Health: Assure that the opportunity to be healthy is available everywhere and for everyone.
- Communities Creating Health: Strengthen communities to create their own healthy futures.

Equally critical to this state-level integration is the continued development of collaborative partnerships with other public health and social welfare sectors, educational and health care organizations, and private organizations concerned with oral care. The establishment and continued support of the Minnesota Oral Health Coalition as an independent entity will provide the groundswell of action needed to prioritize and address the complexities of oral diseases.

Through this combined stable leadership, it will be possible to leverage and maximize resources, augment data collection, streamline interventions and address policy barriers while expanding oral health literacy among both professional sectors and the public at large. Working together, we may indeed achieve optimal oral health for all Minnesotans while reducing health care costs.

Goal 1: Minnesota's oral health infrastructure is stable and sustained.

Objective 1.1: Fully integrate the Oral Health Program into the Minnesota Department of Health infrastructure.

Suggested strategies

A. Increase the sustainability of the state oral health program and support the state oral health program as the central agency for oral health promotion.

B. Continue to apply for grants and increase the amount of grant money obtained.

C. Promote integration opportunities with other funded programs.

Objective 1.2: Support development of a strong Minnesota Oral Health Coalition that works closely with the Minnesota Department of Health.

Suggested strategies

A. Support the coalition in determining leadership structure and other administrative and organizational issues related to its development into a self-supporting organization.

   i. Obtain best practices guidance from more mature organizations, access assistance available from National Association of Oral Coalitions and coalition experts e.g. "Coalitions Work", etc.).

   ii. Sustainability of Oral Health Coalition; establish development fund.

   iii. Inform membership.

   iv. Summarize in-kind support from MDH.

B. Complete a vision, mission, goals (identity) process.

C. Work with the coalition leadership to explore pros and cons of establishing the Minnesota Oral Health Coalition as a non-profit organization (501 (C)3 status).

D. Utilize the CDC framework and other recognized coalition resources to increase diversity of the membership in the coalition.

E. Develop an independent, interactive web presence for the Minnesota Oral Health Coalition.

Objective 1.3: Develop and sustain collaborative partnerships to implement the Minnesota Oral Health Plan.

Suggested strategies

A. Create new partnerships that ensure diversified funding is available to implement the Minnesota Oral Health Plan.

B. Identify innovative action plans that are easily adopted by stakeholders.

Objective 1.4: Seek commitment for long-term data collection and surveillance on Minnesota's oral health indicators.

Suggested strategies

A. Investigate the cost (along with data and information technology experts and programmers) to create an interactive web-based data source known as the Minnesota Oral Health Surveillance System (MNOHSS).

B. Prepare planning and implementation process including data documentation to Minnesota Technology Services.

C. Approach potential funders or add to grant proposals to launch a full-scale sustainable interactive data portal.

Objective 1.5: Seek funding sources that support the review, professional evaluation, and updates to the current Minnesota Oral Health Plan.

Suggested strategies

A. Oral health leaders and stakeholders seek sustainable funding and program changes to implement the plan.

Objective 1.6: Assess opportunities for policy change through environmental analysis tools such as the environmental and policy scan and share results with decision makers.

Suggested strategies

A. Utilize resources available through the CDC to support a facilitated process for oral health stakeholders to join together to make decisions about priorities based on suggested criteria.

Priority: Prevention and Education

Prevention and education strategies work hand-in-hand to mitigate the risk of oral diseases. Protecting children and adults from developing caries is the first line of defense for related health complications such as tooth loss, infection and compromised immunity. Informing the public about the risk factors associated with oral cavity and pharynx cancers is also critical.

Two of the most effective and proven strategies for preventing the development of caries are dental sealants and fluoridated drinking water. These interventions, mixed with efforts to increase oral health literacy among the public through education campaigns and those working directly with vulnerable populations such as school nurses, prenatal and primary care providers, and public health workers are proven strategies to preventing most oral diseases.

Dental Sealant Programs

The risk of developing tooth decay can begin as early as when teeth first erupt in an infant's mouth. Tooth decay is caused by bacteria on teeth that break down foods and produce acid that destroys tooth enamel resulting in tooth decay. The best defenses against cavities are good oral hygiene, regular dental visits, a healthy diet low in sugary foods and beverages, fluoride, and dental sealants. Dental sealants are highly effective—nearly 100 percent – in preventing decay among vulnerable children and adults. Dental sealants are a thin coating bonded to the chewing surfaces of back teeth (molars) to protect them from decay.

Chewing surface before sealant

Tooth protected by sealant

Providing children with sealants through school-based sealant programs has been shown to be an efficient and cost-effective strategy for providing children in need with preventive oral health care. The State of Colorado estimated a $1.2 million per year saving if a statewide school sealant program were implemented.

The 2009 to 2010 Minnesota Basic Screening Survey (BSS) revealed that of those surveyed, 64 percent of third graders had sealants on at least one of their permanent molars, though that rate falls steadily with income levels to the low rate of 42 percent for Minnesota's poorest children (>75% FRL).

MDH is working closely with the Minnesota Department of Human Services and other partners to reach the goal set by the Centers for Medicare and Medicaid Services (CMS) of increasing the rate of dental sealants by 10 percent over a five-year period in children ages six to nine enrolled in Medicaid or or Child and Teen Checkups (Minnesota's Early and Periodic Screening, Diagnosis and Treatment Program). To this end, in 2011, MDH's Oral Health Program, in cooperation with federal agencies, 3M and Delta Dental, funded school-based sealant programs to reach children who did not have easy access to sealants.

Minnesota's coordinated sealant program targets second grade students at schools where more than 50 percent of students are eligible for the Free or Reduced Price Lunch Program (FRL). As seen in Table 6, in 2009 less than 25 percent of "high-risk schools" (>50% FRL) had sealant programs, but within a year's time that number climbed to 29 percent for the 2010 to 2011 school year as a result of the MDH-sponsored dental sealant program. Data from the program show that one-third (34 percent; n=6,356) of the children in second grade participated

Community water fluoridation has been recognized by the CDC as one of the 10 greatest public health achievements of the twentieth century.

and that, on average, three dental sealants were applied per student.

As part of MDH's sealant program, oral health education is also provided to parents, children and school staff through presentations, conferences, classroom activities, informational meetings, and other promotional methods. This approach to oral health care also resulted in referrals to partner clinics for continued care.

Fluoride Varnish

Fluoride varnish has also been found to be another cost-effective preventive treatment, reducing decay on tooth surfaces by 50 percent to 70 percent. Fluoride varnish is applied on high-risk teeth through a resin-based solution and must be reapplied at regular intervals to be effective.

Water Fluoridation

Fluoride is a naturally occurring mineral found in water, air and soil. At proper levels, fluoride provides significant health benefits by preventing tooth decay. Minnesota Statute 144.145 requires the fluoridation of water in all municipal water supplies except where natural levels are sufficient. By law, Minnesota is required to monitor drinking water fluoride concentrations to ensure optimal levels are maintained. Municipal water supplies monitor system performance, collect daily samples, and submit reports and results to MDH on a monthly basis, making adjustments to fluoride levels accordingly.

Community water fluoridation has been recognized by the CDC as one of the 10 greatest public health achievements of the twentieth century, providing one of the most cost-effective and equitable means to prevent tooth decay. Economic analysis conducted by the CDC found that in communities with more than 20,000 people, every dollar invested in water fluoridation yields $38 in savings for dental treatment costs. In states where more than half of the communities have fluoridated water, there is 26 percent less tooth decay among 12 year olds when compared to states with less than one-quarter of the communities with fluoridated water.

In 2010, approximately 78 percent of Minnesotans benefited from community water fluoridation compared to 64 percent of the population nationally, ranking Minnesota fourth in the nation after Kentucky, Maryland and Illinois. Nearly all (99 percent) Minnesotans who are connected to public water supplies receive fluoridated drinking water. While this is a great success, we must be vigilant in maintaining this high ranking while also addressing fluoridation needs for rural communities that rely on private wells that may not have the optimal amount of fluoride.

TABLE 6

Minnesota Elementary High-risk Schools, 2010-2011 School Year

	Number of Schools	Percent of Schools
Elementary schools	946	---
High-risk schools*	392	41%
High-risk schools with school-based dental sealant program	115	29%

* >50 percent rate of students on Free or Reduced Price Lunch Program

Goal 2: Strategies are implemented that reduce oral disease and mitigate risks.

Objective 2.1: Determine the baseline for the number of providers who use standardized, evidence-based oral disease risk assessment tools.

Suggested strategies

A. Implement an educational campaign that raises understanding of risk assessment, benefits of using risk assessment, and introduces tools used to assess risk.

B. Promote use of risk assessment (periodontal disease, diabetes, tobacco use, etc.) among medical and dental providers.

C. Collect data that is valid and reliable on current usage of tools for caries risk assessment in practice.

D. Choose a tested caries and periodontal disease risk assessment tool to use in Minnesota that is valid and reliable.

E. Use the Minnesota Oral Health Surveillance System (MNOHSS) as a clearinghouse for sharing standardized information on caries and periodontal disease risk in Minnesota.

Objective 2.2: Reduce caries experience in Minnesota children.

Suggested strategies

A. Partner with Maternal and Child Health, pre-school, Early Head Start and Head Start oral health programs, early care and education settings on tooth brushing promotion programs targeted toward pregnant women and children under the age of five (review National Association for the Education of Young Children accreditation standards for oral health).

B. Partner with Early Head Start and Head Start on oral health programs that help meet Head Start and Child and Teen Checkups (the Minnesota version of Early Periodic Screening, Diagnosis, and Treatment) requirements.

C. Develop and offer trainings for preschool staff, Head Start coordinators and home visitors to recognize signs of and identify risk factors for early childhood caries.

D. Promote fluoride varnish programs as part of immunization and well child visits.

E. Increase programmatic coordination between risk-reduction programs, e.g., preschool and Women, Infants and Children (WIC) programs.

F. Include oral health screening requirements in childhood screenings.

G. Educate caregivers of infants/toddlers about appropriate amounts of topical fluoride or fluoride toothpaste.

H. Increase availability and ease of access to oral health supplies.

School-based Dental Sealant Programs

Objective 2.3: Develop and coordinate comprehensive, statewide school-based prevention programs that target high-risk children.

Suggested strategies

A. Conduct the statewide third grade Basic Screening Survey at least once every five years.

B. Convene a school-based sealant work group that includes providers, school representatives, school nurses, public health professionals, health plans, Minnesota public programs representatives, Board of Dentistry, researchers, community representatives, parent representatives, and parent-teacher associations.

   i. Conduct a needs assessment and compile information on existing sealant activities in the state.

   ii. Seek and acquire sustainable financial support, i.e., foundations, Title V funding, industry (3M, dental supply companies), Smiles Across Minnesota, Oral Health America, etc.

   iii. Create and publish a comprehensive state sealant plan.

   iv. Create a variety of easily understood messages targeted to parents/caregivers about efficacy and safety of pit and fissure sealants, why they are needed and the importance of sealants in caries prevention.

C. Develop parameters for and post a request for proposal (RFP) for at least five school-based sealant mini-grant projects.

   i. Plan and conduct projects that provide documentation of components of successful sealant programs and identify barriers to sustainability.

   ii. Promote limited authorization/collaborative practice as a model for school-based programs.

D. Convene a transdisciplinary panel for review and development of a comprehensive coordinated plan for fluoride varnish programs and to develop quality improvement initiatives, i.e., through learning collaboratives and health care home initiatives.

E. Create an education campaign about how fluoride works and the importance of the appropriate use of fluoride varnish in caries prevention.

Water Fluoridation

Objective 2.4: Ensure that the percentage of public water supply systems providing fluoridated water are within the optimal range and meet the CDC optimal monitoring and surveillance requirements of meeting or exceeding 90 percent.

Suggested strategies

A. Collect community water fluoridation information and submit data to the CDC on 510 reports.

B. Identify ways to provide support to communities to maintain or update aging fluoridation equipment.

C. Support statewide educational campaigns that promote drinking tap water.

D. Educate water works operators about the importance of the water fluoridation process and its link to oral health.

E. Recognize water workers and engineers as oral health leaders on a consistent basis.

Objective 2.5: Ensure that at least 50 percent of Minnesota's schools have achieved oral health targets.

Suggested strategies

A. Remove cariogenic foods and beverages from vending machines.

B. Increase the number of non-cariogenic food items accessible outside the lunch program (vending machines, fund raisers, concessions, classroom celebrations and a la carte) in Head Start and school menus.

C. Increase tobacco use prevention/cessation and nutrition information in health education programs.

D. Provide resources to strengthen curricula that emphasize how healthy eating can improve and maintain oral health.

E. Reduce the impact of soda/beverage marketing by educating schools to resist marketing strategies.

F. Promote the understanding of the preventive properties of xylitol gum and xylitol products and their proper use.

G. Partner with the Minnesota School Nutrition Association and the Minnesota Department of Education to collect data on candy and pop available in schools in order to tailor oral health campaigns to school needs.

Objective 2.6: Promote awareness of the effect of diet and nutrition on oral health among hospital food service directors, older adult service establishments, and nutrition staff.

Suggested strategies

A. Partner with the Minnesota Hospital Association (MHA), hospital food service directors, and registered hospital dieticians to provide information about creating tooth-healthy menus and increasing health snack choices for patients, visitors, staff, and in vending machines.

B. Provide educational sessions at MHA conferences about the relationship of diet to dental disease.

C. Promote partnerships with assisted living and nursing home providers and organizations to increase understanding about the impact of diet on the oral health of older adults.

Public Education

Good oral hygiene combined with good nutrition are the building blocks to personal oral health. Bolstering oral health literacy as early as possible among both vulnerable populations and the general public can be done most effectively through those who work directly with children and their caregivers, especially pregnant women receiving prenatal and maternal health care. Through broad and consistent public education efforts to raise awareness, the risk factors associated with poor oral health can be decreased, leading to better health outcomes and significant health care cost savings.

Among the most significant risk factors jeopardizing oral health are tobacco use, along with the consumption of alcohol and sugared beverages. Tobacco use is a major risk factor in oral cavity and pharyngeal cancers. According to the American Academy of Periodontology, tobacco use may be one of the most significant risk factors in the development and progression of periodontal disease; smokers are four times more likely to develop gum diseases compared to non-smokers.

Over the past decade, smoking rates have been steadily decreasing for both teens and adults in Minnesota. In 2011, 26 percent of Minnesota high school students reported smoking cigarettes in the past 30 days, compared to 39 percent in 2000. Adult tobacco use rates have decreased from 22 percent in 1999 to 16 percent in 2000. No doubt this decline is due to the Minnesota's strong tobacco laws and prevention strategies implemented as a result of the landmark tobacco settlement won by the state of Minnesota and Blue Cross and Blue Shield of Minnesota against tobacco companies in 1998.

Alcohol use also shows an overall declining pattern among 12th graders, both nationally and in Minnesota. Since 1995, Minnesota alcohol use for this age group fell below the national level to 69 percent and has remained lower, declining steadily to 55 percent in 2010 compared to the national rate of 62 percent. Conversely, alcohol consumption among Minnesota adults is higher when compared to the nation, though rates have decreased fairly steadily in Minnesota from 67 percent in 2001 down to 60 percent in 2010 as compared to national rates in 2001 at 56 percent and 55 percent in 2010.

Excessive consumption of sugar sweetened beverages increases the risk of caries. In certain brands of soda, there is the equivalent of 10 teaspoons of sugar in a 12-ounce can. The combination of high sugar content and high level of acidity in soda significantly increases the risk of dental caries. Encouraging Minnesotans to drink tap water and milk instead of soda and other sugary drinks is another important way to decrease caries.

Goal 3: Oral health literacy is increased across all ages and cultures.

Objective 3.1: Increase oral health evaluation and caregiver education in early childhood screenings, vaccination visits, episodic care visits, prenatal, and Child and Teen Checkups.

Suggested strategies

A. Support health literacy and cultural competency training for health professionals in the community, including health care providers and public health officials.

B. Provide technical assistance to those interested in becoming proficient in patient-centered literacy skills.

C. Educate prenatal and maternal health care providers about the importance of increasing oral health literacy among pregnant women so they are well informed about caries etiology, caries prevention, and infant oral health care.

D. Create a campaign to increase understanding regarding the importance of tooth brushing and sponsor distribution of oral health information and materials in prenatal and maternal care programs.

Objective 3.2: Build awareness of oral disease prevention strategies and increase oral health knowledge in school-based health systems.

Suggested strategies

A. Strengthen partnerships with and provide resources to the Minnesota Department of Education and Minnesota school nurses to evaluate oral health curricula (including early childhood and after school programs) on evidence-based strategies.

B. Develop and disseminate information about the efficacy of pit and fissure sealants, water fluoridation, topical fluoride therapy and other strategies that prevent and control oral disease.

C. Investigate programs to introduce evidence-based xylitol therapy in early childhood programs and schools.

D. Partner with the Minnesota Department of Health Injury and

Violence Prevention Unit to develop promotional programs that focus on preventing and reducing oral injury.

E. Develop and disseminate information to parents and schools about fluoride varnish, sealants and the health care home.

Objective 3.3: Increase exposure to oral health knowledge through targeted and culturally sensitive campaigns that focus on prevention strategies.

Suggested strategies

A. Develop and disseminate fluoridation messages that provide culturally and age appropriate information to population groups, adults, and children. e.g. "safe to drink fluoridated tap water" messages.

B. Increase oral health literacy among young adults emphasizing smoking, diet, smokeless tobacco, alcohol and tobacco, periodontal disease and importance of oral care.

C. Increase oral health literacy among the elderly and their caregivers; emphasize medications that increase xerostomia (dry mouth), root caries etiology, periodontal disease and oral cancer.

D. Ensure educational materials are available in multiple languages, including visuals for the non-reading population.

E. Create electronic media and monitor hits/visits to web pages and internet sites.

Objective 3.4: Increase awareness of oral health among policy and decision makers about the benefits of oral disease prevention.

Suggested strategies

A. Engage legislators in an annual oral health initiatives forum.

B. Partner with the Minnesota Oral Health Coalition to support oral health promotion policies, tobacco control policies, and to promote policy change.

C. Identify and utilize oral health resources in the state to target areas of greatest need.

In Illinois, the state saved $140 million in 2009 through its health care home initiative.

D. Increase understanding of federal mandates and funding, or lack of funding.

Priority: Health Care Integration and Access to Oral Health Care

To truly prevent oral diseases, it is critical that changes are made upstream within the health care system and provider education programs to achieve a broader understanding among health care providers of the relationship oral health has to overall health. Building partnerships across care sectors — dental, primary care, dietary, public health, health plans, community health — to achieve a more patient-centered approach to health care will have the triple advantage of decreasing oral and other diseases, while slashing health care costs.

This holistic approach to health care, combined with efforts to provide more affordable dental care through new dental provider types and workforce models, will help reach more people who often lack adequate or any access to oral health care and treatment.

Health Care Home Model

The "health care home" is one of the most promising solutions to improving the health of Americans while significantly reducing health care costs. The development of health care homes in Minnesota is part of the ground-breaking 2008 Minnesota Health Care Reform Act to provide a patient-centered model focused on primary care and prevention that is culturally appropriate. Ideally, a health care home also connects a patient's dental and primary care records so that treatment and care is fully integrated. In turn, health care homes keep health care costs down by addressing adverse health conditions early so that expensive emergency department visits and hospital stays can be avoided. In Illinois, the state saved $140 million in 2009 through its health care home initiative.

To ensure oral health care is considered an essential component of a patient's overall health and is embedded in the health care home model, the concept that "the mouth is a part of the body" must be elevated in health education. A better understanding of the interrelatedness of oral and systemic health stands to improve a patient's overall health. Both dental and non-dental professionals must be educated in this concept: obstetrics, family practice, pediatrics, internal medicine, nurses, dietitians, health plan case managers, community health workers, social workers, and others. In time, this health care integration will give rise to a team of people working together to better meet the health needs of all Minnesotans, especially the underserved.

This increased appreciation for oral health across sectors should also extend to medical providers in private practice and hospital settings, along with long-term care facilities. Integrating oral disease assessment into medical protocols will also ensure that everyone is receiving the best care possible.

Public Health and Health Integration

The environmental strategies employed by the public health sector present numerous partnership opportunities with oral health agencies. The links between oral disease and chronic disease have been well documented; they also share common risk factors such as poor nutrition, tobacco and alcohol use.

Increasing awareness among local public health agencies of the interrelatedness of oral health to other preventable diseases widens the field for greater collaboration to meet common health goals. Including oral health in public health agencies' missions is an important step in integrating proven oral health prevention strategies that lead to total health.

Banding together, public health and oral health agencies can speak with one voice to address policies that create barriers to health. Together, they can also more effectively heighten awareness among health care providers and policy makers of the social and environmental factors that are largely responsible for health inequities.

Goal 4: Professional integration is enhanced between oral health care providers and other providers in the broader health care system.

Objective 4.1: Promote the understanding and development of the health care home concept.

Suggested strategies

A. Create and nurture non-traditional partnerships in oral health to establish a coordinated strategic direction.

B. Gather information and evaluate the effect of reimbursements/incentives for improving care.

C. Increase training opportunities in oral health for non-dental professionals (public health nurses, dietitians, health plan case managers, community health workers, and interpreters) that build patient-centered skills (preventive, therapeutic, and remedial) and provide technical assistance for working with patients, clients and the public.

D. Increase the number of local public health agencies that address oral health.

E. Increase integration activities and partnerships with nutrition, obesity, tobacco, alcohol, etc. (i.e., American Dietetic Association, American Lung Association, American Heart Association).

F. Plan demonstration projects that create innovative health care home models.

G. Work with educators to investigate the potential role of teledentistry and policy makers to address payment issues.

Objective 4.2: Increase the number of non-dental provider education programs (physician's assistant, nurse practitioner, dietitians, medical schools, and nursing schools) that incorporate oral health into their curriculum.

Suggested strategies

A. Partner with the Minnesota and American Pediatric Association and work to determine current continuing medical education curriculum that encompasses an oral health component.

B. Work with the University of Minnesota College of Continuing Education to create continuing medical education curriculum focused on oral health.

C. Use evidence-based strategies to develop core competencies in oral health within educational settings.

D. Provide one conference in each of the next two years for oral health and medical providers that focuses on:

   i. Oral and systemic health interrelatedness.

   ii. Understanding and promoting risk assessment of oral and systemic health.

   iii. Participate in "Many Faces Conference" and Accountable Care Conference with medical and dental professionals.

Objective 4.3: Develop collaborative opportunities throughout the health care community by educating and training physicians, dentists, nurses, hygienists, nurse practitioners, dental assistants, dental therapists, and social workers to work as a single team addressing oral health disparities and unmet dental needs of the underserved.

Suggested strategies

A. Promote research on the impact of oral health on overall health.

B. Support the development and evaluation of programs that promote disease prevention and increase collaborative health care.

C. Provide incentives for allied dental personnel to work in medical settings under collaborative supervision by a licensed dentist.

D. Reduce barriers to dental hygienists working in public health agencies and other settings.

E. Move primary oral health care into every obstetrics, primary care, family practice, pediatrics, and internal medicine practice in Minnesota by incorporating "The mouth is a part of the body" concept.

F. Investigate further development of innovative collaborative strategies for serving elderly and youth populations with different provider types.

G. Explore the development of a centralized network for identifying excess capacity, sharing resources, and communicating needs that utilizes the public health infrastructure.

Objective 4.4: Promote collaboration among dental providers and medical care providers that increase information sharing, understanding of eligibility requirements, and access to and utilization of oral health care benefits.

Suggested strategies

A. Create demonstration projects that gather and analyze preventive services utilization data and propose new models that coordinate collaboration between dental and medical providers and eliminate disparities.

Objective 4.5: Promote the adoption and meaningful use of the electronic dental record.

Suggested strategies

A. Disseminate information about the Office of the National Coordinator efforts to create standardized guidelines for the utilization of Health Information Technology and reporting.

B. Improve collaboration and follow up by aligning with at least two objectives of the local and national Office of the National Coordinator for Health Information Technology.

C. Seek funding to create incentives for private and public health dental and medical systems to create and adopt centralized network tools.

Objective 4.6: Call for the development and promotion of clinical preventive oral health guidelines for use in settings outside the dental office: medical and long-term care, prison, juvenile, and hospital settings.

Suggested strategies

A. Support and promote the development and use of dental diagnostic codes.

B. Develop partnerships that integrate oral health into the current case management system.

C. Promote public health research, standardized protocols for care, and use of evidence-based practices.

D. Promote inclusion of oral evaluation in care guidelines for the aging and persons with diabetes and special health care needs.

E. Create a web-based tracking and referral mechanism for oral health information and treatment.

F. Promote Health Insurance Portability and Accountability Act compliant communications between dental providers and primary care providers (family medicine, obstetrics, pediatrics, internal medicine, etc.) and allied health professionals, (dieticians, pharmacists, etc.) when assessing and referring for medical conditions and non-dental issues.

Objective 4.7: Increase the number of primary care medical providers who integrate prevention of oral disease as part of overall health care by 10 percent for patients of all ages.

Suggested strategies

A. Create a recognizable symbol and/or standardized message that captures the concept of the interrelatedness of oral health and overall health.

B. Develop a marketing campaign targeted to medical providers that promotes oral health as integral to overall health.

C. Determine a baseline number (early adopters) and evaluate barriers to the utilization of oral disease prevention strategies by medical practitioners.

D. Develop an integrated approach among medical and dental providers that promotes oral exams/evaluation, referral, and access to oral health care by age one.

E. Promote treatment and diagnostic information sharing between pediatricians, physicians and dentists.

Access to Oral Health Care

Inadequate access to oral health care is due to a variety of complex factors including a shortage of dental providers, especially in rural areas; not enough providers willing to accept people on medical assistance due to low reimbursement rates; and a gap in affordable insurance options. The need for more accessible and affordable dental care has led people to seek oral health care in emergency departments and hospitals, resulting in exorbitant health care costs that could be prevented.

Health Professional Shortage Area (HPSA) is a designation given by the Department of Health and Human Services (DHHS) to identify shortages of primary medical, dental or mental health providers within a geographic area, population group or facility. The designation uses a provider-to-population ratio based on the available primary care provider FTE (full-time equivalent) serving the specified area, population or facility, as well as the availability of health care resources in contiguous areas. For instance, a dental HPSA for a geographic area requires a ratio of dentist FTE-to-population ratio of 1:5000 or greater in addition to lack of contiguous services available to the area.

A population HPSA, based on a specific population subset within a geographic area, uses only dentist FTE serving the specified population subset. For example, the ratio for a low-income population designation would be based on the

dentist FTE serving Medicaid and/or low-income patients to the population with income status at or below 200 percent of the Federal Poverty Level. The ratio threshold for a population HPSA is 1:4000 or greater. Additionally, the designation requires that the percentage of the population with incomes at or below 200 percent of the Federal Poverty Level be at 30 percent or higher and that contiguous services are unavailable. An exception is that Native American and Alaskan Native Tribal populations have been afforded automatic population HPSA designations by Congress.

Health Professional Shortage Area (HPSA) is a designation given by the Department of Health and Human Services (DHHS) to identify shortages of primary medical, dental or mental health providers within a geographic area, population group or facility.

As of September 2012, there were 112 dental HPSAs in Minnesota. The majority of these HPSAs are located in rural parts of the state. There are 13 HPSAs designated in Hennepin County (four population and nine facilities) and five in Ramsey County (two population and three facilities). In five other metropolitan counties (Anoka, Washington, Carver, Dakota and Scott), there are two correctional facilities and one Native American tribal population designations.

More than half (66 out of 112) of the dental HPSAs in Minnesota are low-income population designations. Based on the dentist FTE data serving Medicaid and/or low-income populations in these areas, DHHS estimates that 166,200 people have access to dental services and 362,569 experience barriers to accessing dental care. (See Appendix C for the map of Minnesota Health Professional Shortage Areas - Population/ Low-Income Dental Care Designation).

To meet the increasing oral health needs of Minnesotans, the workforce capacity must be bolstered through more innovative strategies to recruit, prepare, retain and equitably distribute oral health care providers. According to the Pew Charitable Trusts, by 2014 an estimated 5.6 million more children will be eligible to receive Medicaid dental benefits under the Affordable Care Act. This, coupled with the looming tidal wave of retiring baby boomers will further strain the capacity of the dental care system to serve Minnesotans, especially low-income people and residents in rural areas.

Minnesota has been a trailblazer in sanctioning mid-level dental professionals such as dental therapists and advanced dental therapists and collaborative practice agreements between dentists and hygienists.[1] Yet, to truly maximize the potential in these workforce models, a concerted effort needs to be made to better promote these professional opportunities and encourage more dentist to negotiate collaborative/ management agreements with hygienists and therapists.

Better preparing the next generations of oral health professionals is essential to retaining qualified providers willing to work with underserved communities. Strategies such as mentorship programs and teledentistry, whereby patients receive diagnostic and basic primary care through video teleconferencing and health professionals receive continued educational opportunities, can offer needed support to professionals who might feel isolated in more rural settings.

The dental workforce must also become more versed in meeting the needs of a more diverse population by incorporating cultural competency into the curriculum of oral health provider education programs. There is also a dire need to recruit more people of color and women into the field of dentistry, especially as dentists.

A more diverse workforce enriches oral health care delivery as people tend to be more comfortable seeking treatment from people of their own ethnic or racial background. Caregivers from diverse backgrounds are also more likely to serve underserved populations. In a 2010 survey of Minnesota dentists (1,867 out of 3,908 responders), the following dental provider demographics were gathered:

- 23% are female; 77% are male
- 47% of dentists are 55 years or older
- 50% of dentists under age 35 are female
- 94% of dentists are white; the remaining 6% of dentists identified themselves as African American, Native American, Asian or multiracial; 2% identified their ethnicity as Hispanic.

Taken together, strategies to increase access can do much toward reinforcing the Minnesota oral health workforce and improving care across the state.

1. Alaska was the first state to use dental therapists in 2005, but was established under federal law and is limited to native villages through the Alaska Native Tribal Health Consortium. Minnesota is the first and only state to license dental therapists under a 2009 law; see statutes 150A.105 (law on dental therapists) and 150A.106 (law on certification for advanced dental therapist).

Dental Workforce Capacity

As of 2010, there were 3,908 Minnesota dentists who renewed their licenses with 3,244 practicing in the state providing 61 dentists per 100,000 population (Table 7). Most of the dentists (57 percent) planned to practice in Minnesota for more than 10 years. Based on a 2010 MDH licensee survey, 47 percent of dentists were 55 years or older indicating that the gap in services will increase over the next decade as dentists begin to retire.

One-third (74 percent) of dentists were practicing in urban areas, whereas only 7 percent worked in small rural areas. Solo practice is the most common type of dental practice especially in rural areas (44 percent) followed by small group practice (37 percent), leaving rural populations with fewer options when solo practitioners are unavailable or retire.

According to the Minnesota Department of Human Services, in 2011 just over half (53 percent) of practicing dentists had submitted at least one dental claim for patients on public programs. This figure may serve as a proxy indictor for the number of Minnesota dentists seeing Medicaid patients.

In 2011, Minnesota had only 77 certified pediatric dental specialists; approximately 6 pediatric dentists per 100,000 children (Table 7). Pediatric dental services are available in fewer than 20 of Minnesota's 87 counties, which are clustered in and around the seven-county Minneapolis/St. Paul metropolitan area and in larger cities such as Duluth, Rochester, St. Cloud, and Mankato. Very few pediatric dentists, if any, are located in rural Minnesota.

Dental hygienists are licensed dental professionals who specialize in preventive dental and periodontal care. As of 2009, a total of 3,594 practicing dental hygienists provided approximately 68 dental hygienists per 100,000 people in the state (Table 7). In 2012, the Minnesota Office of Rural Health and Primary Care reported that there is an excess capacity in the dental hygienist workforce with more than three times as many dental hygiene graduates than available jobs. Based on preliminary findings, 18 percent of the dental hygienists working in Minnesota are seeking different or additional employment.

Dental assistants are licensed dental practitioners who work with supervision by a licensed dentist. A total of 7,146 dental assistants renewed their licenses from 2008 to 2009, according to the Minnesota Board of Dentistry licensing data; 6,288 (88 percent) were practicing in Minnesota (Table 7). The vast majority (73 percent) were working in urban areas with only 8 percent located in rural areas.

Enhancing Workforce Models and Creating New Providers

Minnesota is leading the nation in providing one of the best solutions to the dental workforce shortage and bridging gaps in dental care by creating new licensed "mid-level" dental providers such as advanced dental therapists and dental therapists, and supporting new workforce models such as hygienists working under "collaborative agreements" with dentists. These leading-edge workforce solutions have been hailed nationally by leaders in public health as a viable means to close the gap in affordable dental care.

In 2009, Minnesota became the first and only state to establish licensed dental therapists and dually licensed advanced dental therapists (ADTs) (licensed as both a dental hygienist and a dental therapist) to better serve underserved populations. These new dental professionals offer evaluative (ADTs only), preventive,

TABLE 7

Ratio of Dental Provider Types per 100,000 Population

Dental Professionals	*Minnesota: Number per 100,000 population	**National: Number per 100,000 population
Dentists (practicing)	3,244 (61 dentists per 100,000)	195,628 (63 dentists per 100,000)
Collaborative Agreement Dentists	274 (5 dentist per 100,000)	~
Pediatric Dental Specialists	77 (6 dentists per 100,000 children <18 years)	6,181 (8 dentists per 100,000 children <18 years)
Advanced Dental Therapists	~	~
Dental Therapists	16 (3 per 1,000,000)	~
Hygienists (practicing)	3,594 (68 per 100,000)	152, 000 (49 per 100,000)
Collaborative Agreement Hygienists	276 (5 per 100,000)	~
Dental Assistants (practicing)	6,288 (119 per 100,000 pop)	297,200 (96 per 100,000)

*Total Minnesota population: 5,303,925; children under 18 years (24%): 1,267,638
**U.S. Population: 308,745,538; children under 18 years (24%): 73,172,69

In 2009, Minnesota became the first and only state to establish licensed dental therapists and dually licensed advanced dental therapists (ADTs) (licensed as both a dental hygienist and a dental therapist) to better serve underserved populations.

restorative, and minor surgical dental care with dentist supervision and a collaborative management agreement. The first wave of dental therapy students graduated in 2011 and it is anticipated there will be between 70 to 75 graduates in the next five years.

While dental hygienists must work under the general supervision of a dentist, the Minnesota dental law also provides the opportunity for hygienists with a collaborative agreement with a dentist to work without the dentist first seeing the patient, in turn expanding the reach of dental care into more settings, e.g., elementary schools. Despite this opportunity for workforce expansion, when surveyed only 6 percent of hygienists were actively practicing under a collaborative agreement; 20 percent did not know if they were practicing under a collaborative agreement or not.

Increased awareness about these new dental providers and the opportunity for collaborative agreements is needed. While these new job classifications and dental workforce models offer promise for providing more people with better access to more affordable disease prevention and treatment care, not enough dentists have entered into these collaborative opportunities: only 7 percent of Minnesota dentists had a collaborative agreement with a dental hygienist.

Goal 5: Access is increased to preventive, restorative, and emergency oral health care services.

Objective 5.1: The legislative intent to increase the supply and distribution of dental services through creation of new dental providers and appropriate utilization of the entire dental team is achieved.

Suggested strategies

(See Minnesota statutes 150A.10 Subd.1a., 150A.105 and 150A.106)

A. Maximize the opportunity that Minnesota has to provide positive leadership in creating new oral health care providers and innovative workforce models.

B. Support and engage with other agencies to research the impact of new and existing oral health care providers on improved access to services by collecting and analyzing outcomes data.

C. Increase the number of dentists, health care facilities, programs, or nonprofit organizations that employ dental hygienists with collaborative agreements.

D. Develop relationships with providers in older adult services settings (e.g., nursing homes, assisted living) to connect providers with elderly populations.

Objective 5.2: Increase by 10 percent the number of underserved Minnesotans who receive evidence-based preventive dental care, with emphasis on children under age one, low-income uninsured adults, people with developmental disabilities, pregnant women, children with special health care needs, low income and immigrant populations, those with chronic diseases, and individuals in long-term care facilities.

Suggested strategies

A. Educate general dentists to be more comfortable caring for infants and toddlers (birth to three years old), making appropriate referrals, and using best practices.

B. Work with state agencies and commissions to analyze issues (including funding) regarding care for children, adults, the aging, developmentally disabled, and special health care needs populations, low income and under insured, and participate in developing policy recommendations.

C. Use Basic Screening Survey results to determine preventive service initiatives.

D. Encourage local and county public health agencies to utilize dental hygienists in prevention programs.

E. Identify and work with agencies engaged in dental programs to explore alternative delivery systems that improve communication with local dentists, improve sustainability, and increase continuity of care.

F. Partner with agencies on a centralized website or helpline for the public to increase access to referral information and information on current systems in place for Minnesota health care programs and the uninsured.

G. Develop compliance initiatives that increase comprehensiveness of oral health programs for children under age one, uninsured adults, people with developmental disabilities, children with special health care needs, and individuals in long-term care facilities.

Objective 5.3: Reduce the proportion of Minnesotans who experience difficulties, delays, or barriers to restorative oral health care service by 20 percent.

Suggested strategies

A. Partner with state agencies that have been mandated to document the impact of existing and new Minnesota oral health care workforce models on improved access to restorative services using outcome data.

B. Establish baseline information on barriers to oral health care involving target populations by conducting a statewide survey and adding questions to both the Basic Screening Survey and Behavioral Risk Factor Surveillance System regarding Minnesota's accessibility to dental care.

C. Investigate best practices for sustainability of public health and safety net clinics.

Objective 5.4: Reduce the number of emergency room visits for dental related reasons by 15 percent.

Suggested strategies

A. Develop and disseminate materials that educate caregivers about dental injuries and the appropriate response.

B. Collaborate with hospitals and providers in older adult service settings to provide information on local public health dental programs so that patients presenting in emergency departments are provided with appropriate referral and preventive education information.

C. Develop a campaign to educate the public about seeking professional dental care and guidance after an oral injury has occurred.

D. Develop a campaign focused on oral injury prevention and promoting the appropriate use of mouth-protecting equipment in sports, e.g., mouth guards.

E. Collaborate with hospital medical staff to ensure diagnostic codes are utilized for non-traumatic dental related emergency department visits and are coded correctly in order to establish baseline data.

Objective 5.5: Increase the number of individuals who receive oral and pharyngeal cancer screenings by 10 percent.

Suggested strategies

A. Determine a baseline number of dental and medical professionals that currently integrate oral and pharyngeal cancer screenings into comprehensive exams.

B. Emphasize the importance of screening for oral and pharyngeal cancer and how it can affect critical functions, such as speaking, swallowing and eating.

C. Increase the number of health care providers who deliver consistent and appropriate messages to help people quit smoking.

D. Partner with the National Cancer Institute on developing health care provider competencies in prevention, diagnosis, and management of oral and pharyngeal cancers.

E. Aid the American Cancer Society in incorporating oral and pharyngeal cancer screenings in the "Welcome to Medicare" physical examination.

F. Promote the development of a community-based oral cancer prevention and early detection program.

Objective 5.6: Increase the proportion of local health departments that have an oral health program focused on prevention.

Suggested strategies

A. Build capacity in local health departments by providing technical expertise and evidence-based oral health information.

B. Determine a baseline number of local health departments that currently have an oral health care program.

C. In collaboration with existing local oral health care program personnel, identify local health departments that do not have an oral health program and offer resources and guidance in creating and structuring their own oral health component.

D. Partner with the Local Public Health Association of Minnesota to convene a conference on integrating oral health into local public health systems.

Objective 5.7: Promote policies and programs that ensure that 95 percent of Minnesotans have access to a dental care provider within a 90-minute drive or by public transportation from their place of residence.

Suggested strategies

A. Conduct at least one public health/nonprofit clinic pilot project to investigate and gather data on current equitable distribution of services.

B. Promote school-based programs and older adult service settings.

C. Determine existing excess provider capacity and transportation services available to patients, including the uninsured and public programs patients.

D. Work with local safety net programs in supporting existing and creating new volunteer programs that provide patients transportation to and from dental and health appointments.

E. Convene a conference focused on policy tools that will help achieve equity in population health, featuring best practices and expert panel presentations, moderated discussions, as well as working groups.

F. Reduce supervision barriers and increase utilization of collaborative agreements.

Objective 5.8: Increase partnerships that explore effective policy initiatives to stabilize the availability of oral health care services to the most vulnerable populations.

Suggested strategies

A. Develop a planning checklist to move forward strategically once consensus about priorities is achieved.

B. Increase data and information gathering efforts that support policy decisions among stakeholders, oral health care providers and primary care providers.

C. Promote philanthropic programs among specialty dental organizations.

Goal 6: The dental workforce is prepared for and addresses the oral health needs of all Minnesotans.

Objective 6.1: Promote innovative and effective oral health care delivery practice models for rural populations.

Suggested strategies

A. Continue to work with Area Health Education Centers to explore and strengthen strategies that will achieve better retention and distribution of oral health care providers graduating from state supported institutions.

B. Develop mentoring programs for the dental workforce.

C. Investigate the role of teledentistry.

Objective 6.2: Promote broader discussion of ways the social compact between dentistry and society can be reinforced.

A. Develop a Patient Centered Principles document.

   i. Create a document that states principles and objectives that are patient centered.

   ii. Develop bullet points about what patients need for oral care as part of general health care.

   iii. Create a list of evidence-based studies that support oral health effects on general health.

B. Convene workshops with medical providers.

C. Promote continuing education programs.

D. Encourage the creation of at least one internship opportunity for students and one work experience for professionals.

Objective 6.3: Collaborate with agencies and educational institutions to gather and disseminate information on practice models, collaborative agreement dental hygiene practice, and the dental therapist/advanced dental therapist management agreement.

Suggested strategies

A. Maximize utilization of tools available: support infrastructure for collaborative agreement hygienists and restorative function allied personnel, dental therapist and advanced dental therapist.

   i. Develop a checklist on payment protocols and credentialing.

   ii. Develop a fact sheet/resource sheet describing definition of, roles of, and scope of practice levels of all oral health professionals to be used by the profession, payers, and the public to understand the current state of oral health care delivery.

B. Convene an educational forum or summit of collaborative practice hygienists and dentists to promote collaborative practice.

C. Develop a conference on advancing the implementation of workforce models.

D. Identify and develop a method for tracking current collaborative practice agreements and collaborative management agreements in order to increase networking and information sharing among collaborative providers.

Objective 6.4: Ensure that at least 90 percent of oral health provider education programs incorporate health literacy concepts and cultural competency training into curriculum.

Suggested strategies

A. Promote the CDC health literacy certification program.

B. Disseminate information about health literacy and promote the use of a usability checklist that ensures that oral health information meets health literacy principles.

C. Partner with professional associations to create continuing education courses for oral health professionals focused on health literacy and cultural competency concepts.

D. Seek ways to enhance or support opportunities for community health workers to promote culturally sensitive oral disease prevention strategies in their communities.

Objective 6.5: Increase cultural competency training related to oral health in health professional education programs.

Suggested strategies

A. In collaboration with existing local cultural organizations, develop and disseminate cultural competency educational materials for health professionals.

B. Encourage the Board of Dentistry to focus a self-assessment on the subject of cultural competency.

C. Partner with Minnesota state-supported higher education institutions to provide community outreach and cultural center personnel with a basic oral health education course.

Objective 6.6: Encourage all oral health provider education programs to focus on recruiting classes that reflect the state's population diversity.

Suggested strategies

A. Strengthen existing and develop new outreach programs that recruit future dental professionals from diverse backgrounds.

B. Seek funding for the expansion of dental education scholarships and loan repayment efforts.

Priority: Surveillance

Monitoring the status of oral diseases among Minnesotans is the underpinning to improving oral health. Public health surveillance is the ongoing, systematic collection, analysis, interpretation and dissemination of data regarding a health related event. In turn, data inform policy development and target public health initiatives to improve the health of all Minnesotans.

While baseline data for third graders is now available through the 2010 Basic Screening Survey, the state must continue to monitor the status of oral health to continually evaluate and refine prevention programs. In addition, there are large data gaps that hamstring efforts to better target resources. The most significant lack of data is on caries incidence, service coverage, and disease estimates in certain pockets of the population. Better data is needed on dental caries prevalence and untreated caries among very young children and adolescents, along with the adult population, particularly the older adults living in elder care facilities. Data is limited on the burden of disease among migrant and native populations, school-based sealant coverage, oral birth defects, and pregnant women.

Despite these gaps, several indicators related to the objectives outlined in this plan are collected through existing surveillance systems. The Minnesota Oral Health Surveillance System (MNOHSS) is the state's main mechanism for monitoring trends in morbidity in early childhood caries, edentulism (being toothless), and oral and pharyngeal cancer. In addition, MNOHSS data informs the efficacy of preventive services such as dental sealants, community water fluoridation and the use of dental services. MNOHSS uses the following secondary sources to generate oral health indicators:

- Behavioral Risk Factor Surveillance System (BRFSS)
- Dental workforce data from Office of Rural Health and Primary Care (Minnesota Department of Health)
- Hospital discharge records from Minnesota Hospital Association
- Medicaid data from Department of Human Service (DHS)
- Medical and Expenditure Panel Survey (MEPS)
- Minnesota Birth Defects Information System (BDIS)
- Minnesota Cancer Surveillance System (MCSS)
- Minnesota Student Survey (equivalent of National Youth Risk Behavior Surveillance System (YRBSS)
- Pregnancy Risk Assessment and Monitoring System (PRAMS)
- U.S. Census Bureau (demographic data)
- Water Fluoridation Reporting System (WFRS)

To assist public health efforts across the state, the Oral Health Program has been developing a public, web-based data system to assess and monitor the status of oral disease in Minnesota based on the following set of oral health indicators:

- Demographic data including state population by age
- Percentage of population below 100% and 200% of poverty level; total number of schools
- Percentage of schools with 50% or more of students eligible for the free and reduced price meal program
- Percentage of total county population enrolled in a Minnesota Health Care Program
- Number and percentage of Minnesota Health Care Programs enrolled-population with a dental visit
- Percentage of population served by optimally fluoridated water
- Number of licensed dental professionals
- Ratio of Minnesota Health Care Program enrollees to dentists who treat them
- Number of Dental Health Professional Shortage Areas based on "facility"

To address the data gaps in the current system, efforts are being made to convene partners and stakeholders to identify and prioritize data needs and mapping out ways to disseminate this information to policy makers and public health officials.

Goal 7: Access to population statistics, population-level oral health surveillance information, and aggregate data on oral health indicators is readily available to all.

Objective 7.1: Collaborate with data partners and key stakeholders to identify key oral health indicators and to increase the visibility and effectiveness of the Minnesota Oral Health Surveillance Advisory Group.

Suggested strategies

A. Convene the Advisory Group annually.

B. Develop and maintain data sharing agreements with partners.

C. Acquire and analyze data, and interpret findings.

D. Prepare and publish the Minnesota Surveillance Plan and the Burden of Oral Disease in Minnesota documents.

E. Review, update and publish the Burden of Oral Disease document regularly.

F. Evaluate progress, trends and direction.

Objective 7.2: Develop a secure data system that identifies and tracks key oral health indicators and has the capability to provide specific data affecting policy and existing programs upon request.

Suggested strategies

A. Develop quality assurance measures to ensure accuracy.

B. Continue to develop and implement the Minnesota Oral Health Surveillance System (MNOHSS).

C. Share summarized surveillance information with local public health, educational institutions, insurers, social services, policy makers, community-based organizations, community health clinics, and other partners as appropriate.

D. Increase the capacity of the MDH Oral Health Program to serve as a primary resource for oral health information by providing links to educational materials, oral health initiative information, and oral health curriculum.

E. Monitor and respond to data requests.

F. Ensure data security/confidentiality.

G. Explore use of (or develop) a secure web-based data entry portal (i.e., a web page for sealant grantees to enter data).

Objective 7.3: Increase capacity of the Minnesota Oral Health Program to collect data and conduct surveillance activities.

Suggested strategies

A. Investigate ways to sustain the surveillance activities of the oral health program.

B. Provide staff and stakeholder training opportunities that increase the ability of the program to manage large data projects.

C. Evaluate surveillance and outcome data.

D. Increase support for acquiring data and increase demand for oral health data.

Future Action: Next Steps

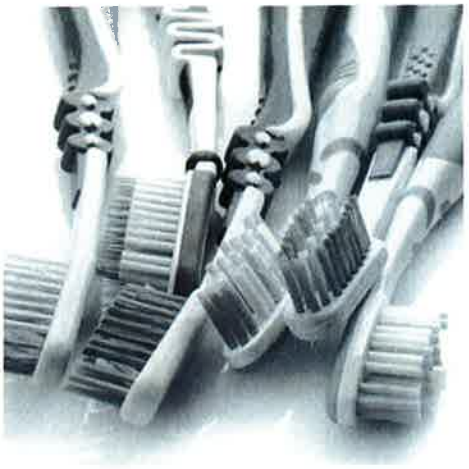
Minnesota is well poised to meet the oral health needs of its residents. As this report has shown, oral health is dependent on multifaceted, interrelated factors that range from personal care and awareness to the changing role of dental and health providers, and from the complexities of the health care system to a more integrated approach to total health. As we move forward to reduce both the prevalence and disparities of oral diseases, a full deployment of a varied dental workforce combined with proven prevention strategies and integration with other health organizations will be critical.

To implement the Minnesota Oral Health Plan, MDH's Oral Health Program is working closely with the Minnesota Oral Health Coalition and other key partners. Working groups have been organized to advance the strategies outlined in this plan while creating a process for the continuous review and revision of the plan. Pressing issues are being addressed to move the work forward in the following key areas.

Dental Sealants

The Minnesota school-based sealant program is a proven strategy that prevents caries among young children. The program targets high-risk, second grade students at schools where more than 50 percent of students are eligible for the Free or Reduced Price Lunch Program (FRL), a proxy for identifying low-income children. The Oral Health Program is working to expand and improve the program by:

- Identifying schools that need sealant programs and have the greatest need (>50% FRL) so school-based dental sealant providers can target their services to those schools.



- Fostering relationships with school-based dental sealant service providers to help families navigate both the dental insurance and dental care systems so children receive their dental benefits and are connected to a "dental home" for ongoing care and treatment.

- Communicating with school boards, district superintendents and school nurses to smooth the way for establishing sealant programs at their schools.

- Establishing a strong relationship with the local dental community to facilitate the ongoing dental care needs of children.

- Securing additional funding to reach more high-needs children across the state.

Water Fluoridation

In collaboration with stakeholders and other MDH programs, the Oral Health Program is working to maintain the state's high community water fluoridation status. Grant programs are increasing the number of Minnesotans who receive the oral health benefits of optimally fluoridated drinking water. The grants enable community public water systems to: improve aging fluoride treatment

infrastructures; improve or replace aging analytical equipment; and assist with fluoridation implementation. Efforts include:

- Ensuring Minnesota communities are receiving proper levels of fluoridated water by securing and providing funding to municipalities to upgrade or replace water fluoridation equipment. More than 50,000 people are being better served in Bayport, Centerville, Murdock, North Mankato, and Victoria as a result of MDH funding and technical assistance. MDH is continuing to seek sustainable funding sources to provide additional communities with equipment updates on an ongoing basis.
- Supporting quality assurance by providing technical training to community water operators and engineers statewide so they can keep pace with the latest engineering, operation, and management practices for maintaining new fluoridation water systems.
- Highlighting the critical role water fluoridation has in public health by convening a panel of fluoridation experts (educators, scientists, water workers, providers, communications) to develop a plan to raise awareness among dental and public health professionals, policy makers, the public, and even water fluoridation operators themselves about the importance of water fluoridation to oral and overall health.

Increasing Public Insurance Programs Use Rates

To ensure low-income children are getting the dental care they need, the Oral Health Program is working with the Minnesota Department of Human Services and the Centers for Medicare & Medicaid Services to develop training materials and provide technical assistance to health care providers. These programs focus on improving diagnostic dental services, early referral, primary care integration, and guidance on prevention strategies during well child visits. These efforts will help the state meet the national and local leading health indicators for increasing dental visits and use of the oral health care system by low-income children. Specific strategies include:

- Advocating for Child and Teen Checkups' protocols that assess children's dental health status and needs by age one and establishing a "dental home" for them through immediate referrals to a dentist.
- Providing technical support to child health consultants and training materials for Child and Teen Checkups to enable primary care and dental providers to increase the rates of fluoride varnish applications among at-risk children.
- Working with dental providers to become more comfortable in pediatric dentistry and proficient with working with very young patients (aged one to three years).

Health Care Integration

The advent of the "health care home" concept is a promising model for providing more integrated and effective health care for underserved populations. Health care homes are focused on early detection and addressing the spectrum of patients' health needs (physical, dental, mental), while lowering health care costs. Health integration is also accomplished through other strategies that work to change policies to reduce risk factors to oral disease. To ensure that oral health is considered a high-priority, work is focused on:

- Raising awareness of the importance of oral health to overall health among health care and public health leaders by meeting with stakeholders and finding opportunities to integrate oral health into their strategic plans, policies and protocols.
- Collaborating with state-level, obesity initiatives to decrease access to sugar-sweetened beverages through policies that would increase taxes and pricing on these beverages and encourage drinking tap water.
- Working with the Minnesota Physical Activity and Nutrition Program to include height and weight measurements of third graders in the Minnesota Basic Screening Survey to investigate and analyze data on the relationship of healthy weight to oral health.
- Funding a pilot project with Head Start, an early childhood education program for low-income children, to embed on-site dental prevention services and referral system to a "dental home" for ongoing care.

New Dental Providers and Workforce Models

Minnesota has developed innovative solutions to improving access to dental care through the creation of new dental provider types and expanding how and where dental treatment and preventive services can be delivered. However, many barriers still exist in maximizing these dental care options so that low-income children, adults and the elderly get the care they need. To this end, the Oral Health Program is:

- Increasing awareness and addressing misperceptions among dentists, hygienists, dental therapists (DTs), and advanced dental therapists (ADTs) about how collaborative agreements and new service models can be integrated into their practice; resources include free, online courses addressing these issues.
- Promoting to dental professionals and policy makers the Oral Health Program's "Collaborative Agreement Dental Hygiene Assessment" report which includes findings and recommendations for increasing the use of this dental service model to improve access to preventive dental services.
- Ensuring that advanced dental therapist (ADT) services are widely available to those in greatest need by funding the development of a refresher course for ADT graduates to attain their advanced dental therapy certification so they can deliver dental care.
- Seeking funding to create incentives for dentists to partner in innovative employment models for DTs and ADTs.
- Assessing whether the penetration of DTs and ADTs into the workforce will indeed improve Minnesotans' access to more affordable dental care or if barriers persist that need to be addressed.

- Funding outreach programs through the University of Minnesota School of Dentistry to recruit more people from diverse backgrounds into dental careers by working with Area Health Education Centers, Minneapolis Public Schools, rural communities, and providing dental students with rotation experiences through Community Health Centers and underserved rural dentistry clinics.

Surveillance

Identifying and addressing the barriers to oral health is a complex process requiring a variety of integrated solutions involving private-public partnerships and a commitment to prevention. To assist state and local health agencies to work more efficiently and effectively, the Oral Health Program has been developing the state-wide Minnesota Oral Health Surveillance System (MNOHSS). MNOHSS provides easily accessible county-level data on more than a dozen oral health indicators with mapping functionality that uses Health Professional Shortage Area (HPSA) data. To ensure this dynamic tool is employed to its full capacity, the Oral Health Program is:

- Working to widely promote MNOHSS to public health professionals, health care providers and other stakeholders.
- Providing technical assistance and learning opportunities to organizations on how to use MNOHSS to inform policy and practice, set benchmarks, implement evidence-based interventions, and measure impact.
- Leveraging funding to fill in data gaps and to continually refine intervention strategies to better meet the needs of underserved populations. The most pressing data gaps are dental caries incidence and prevalence among toddlers and adolescents; older adults living in elder care facilities; migrant and native populations; school-based sealant coverage; and pregnant women.

To stay the course on these initiatives, the Minnesota Oral Health Program is committed to regularly reporting on the progress of these efforts and will convene stakeholders to address the changing oral health needs of Minnesotans across the state. The Minnesota Oral Health Program looks forward to partnering with even more organizations in *advancing optimal oral health for all Minnesotans.*

Appendices

Appendix A: Minnesota Oral Health Plan Goals, Objectives and Strategies

Goal 1: Minnesota's oral health infrastructure is stable and sustained.

Objective 1.1: Fully integrate the Oral Health Program into the Minnesota Department of Health infrastructure.

Suggested strategies

A. Increase the sustainability of the state oral health program and support the state oral health program as the central agency for oral health promotion.

B. Continue to apply for grants and increase the amount of grant money obtained.

C. Promote integration opportunities with other funded programs.

Objective 1.2: Support development of a strong Minnesota Oral Health Coalition that works closely with the Minnesota Department of Health.

Suggested strategies

A. Support the coalition in determining leadership structure and other administrative and organizational issues related to its development into a self supporting organization.

   i. Obtain best practices guidance from more mature organizations, access assistance available from National Association of Oral Coalitions and coalition experts e.g. "Coalitions Work", etc.).

   ii. Sustainability of Oral Health Coalition; establish development fund.

   iii. Inform membership.

   iv. Summarize in kind support from MDH.

B. Complete a vision, mission, goals (identity) process.

C. Work with the coalition leadership to explore pros and cons of establishing the Minnesota Oral Health Coalition as a non-profit organization (501 (C)3 status).

D. Utilize the CDC framework and other recognized coalition resources to increase diversity of the membership in the coalition.

E. Develop an independent, interactive web presence for the Minnesota Oral Health Coalition.

Objective 1.3: Develop and sustain collaborative partnerships to implement the Minnesota Oral Health Plan.

Suggested strategies

A. Create new partnerships that ensure diversified funding is available to implement the Minnesota Oral Health Plan.

B. Identify innovative action plans that are easily adopted by stakeholders.

Objective 1.4: Seek commitment for long-term data collection and surveillance on Minnesota's oral health indicators.

A. Investigate the cost (along with data and information technology experts and programmers) to create an interactive web-based data source known as Minnesota Oral Health Surveillance System (MNOHSS).

B. Prepare planning and implementation process including data documentation to Minnesota Technology Services.

C. Approach potential funders or add to grant proposals to launch a full-scale sustainable interactive data portal.

Objective 1.5: Seek funding sources that the support review, professional evaluation, and updates to the current Minnesota Oral Health Plan.

Suggested strategies

A. Oral health leaders and stakeholders seek sustainable funding and program changes to implement the plan.

Objective 1.6: Assess opportunities for policy change through environmental analysis tools such as the environmental and policy scan and share results with decision makers.

Suggested strategies

A. Utilize resources available through the CDC to support a facilitated process for oral health stakeholders to join together to make decisions about priorities based on suggested criteria.

Goal 2: Strategies are

implemented that reduce oral disease and mitigate risks.

Objective 2.1: Determine the baseline for the number of providers who use standardized, evidence-based oral disease risk assessment tools.

Suggested strategies

A. Implement an educational campaign that raises understanding of risk assessment, benefits of using risk assessment, and introduces tools used to assess risk.

B. Promote use of risk assessment (periodontal disease, diabetes, tobacco use, etc.) among medical and dental providers.

C. Collect data that is valid and reliable on current usage of tools for caries risk assessment in practice.

D. Choose a tested caries and periodontal disease risk assessment tool to use in Minnesota that is valid and reliable.

E. Use the Minnesota Oral Health Surveillance System (MNOHSS) as a clearinghouse for sharing standardized information on caries and periodontal disease risk in Minnesota.

Objective 2.2: Reduce caries experience in Minnesota children.

Suggested strategies

A. Partner with Maternal and Child Health, pre-school, Early Head Start and Head Start oral health programs, early care and education settings on tooth brushing promotion programs targeted toward pregnant women and children under the age of five (review National Association for the Education of Young Children accreditation standards for oral health).

B. Partner with Early Head Start and Head Start on oral health programs that help meet Head Start and Child and Teen Checkups (the Minnesota version of Early Periodic Screening, Diagnosis, and Treatment) requirements.

C. Develop and offer trainings for preschool staff, Head Start coordinators and home visitors to recognize signs of and identify risk factors for childhood caries.

D. Promote fluoride varnish programs as part of immunization and well child visits.

E. Increase programmatic coordination between risk-reduction programs, e.g., preschool and Women, Infants and Children (WIC) programs.

F. Include oral health screening requirements in childhood screenings.

G. Educate caregivers of infants/toddlers about appropriate amounts of topical fluoride or fluoride toothpaste.

H. Increase availability and ease of access to oral health supplies.

School-based Dental Sealant Programs

Objective 2.3: Develop and coordinate comprehensive, statewide school-based prevention programs that target high-risk children.

Suggested strategies

A. Conduct the statewide third grade Basic Screening Survey at least once every five years.

B. Convene a school-based sealant work group that includes providers, school representatives, school nurses, public health professionals, health plans, Minnesota public programs representatives, board of dentistry, researchers, community representatives, parent representatives, and parent-teacher associations.

   i. Conduct a needs assessment and compile information on existing sealant activities in the state.

   ii. Seek and acquire sustainable financial support, i.e., foundations, Title V funding, industry (3M, dental supply companies), Smiles Across Minnesota, Oral Health America, etc.

   iii. Create and publish a comprehensive state sealant plan.

   iv. Create a variety of easily understood messages targeted to parents/caregivers about efficacy and safety of pit and fissure sealants, why they are needed and the importance of sealants in caries prevention.

C. Develop parameters for and post a request for proposal (RFP) for at least five school-based sealant mini-grant projects.

   i. Plan and conduct projects that provide documentation of components of successful sealant programs and identify barriers to sustainability.

   ii. Promote limited authorization/ collaborative practice as a model for school-based programs.

D. Convene a transdisciplinary panel for review and development of a comprehensive coordinated plan for fluoride varnish programs and to develop quality improvement initiatives, i.e., through learning collaboratives and health care home initiatives.

E. Create an education campaign about how fluoride works and the importance of the appropriate use of fluoride varnish in caries prevention.

Water Fluoridation

Objective 2.4: Ensure that the percentage of public water supply systems providing fluoridated water are within the optimal range and meet the CDC optimal monitoring and surveillance requirements of meeting or exceeding 90 percent.

Suggested strategies

A. Collect community water fluoridation information and submit data to the CDC on 510 reports.

B. Identify ways to provide support to communities to maintain or update aging fluoridation equipment.

C. Support statewide educational campaigns that promote drinking tap water.

D. Educate water works operators about the importance of the water fluoridation process and its link to oral health.

E. Recognize water workers and engineers as oral health leaders on a consistent basis.

Objective 2.5: Ensure that at least 50 percent of Minnesota's schools have achieved oral health targets.

Suggested strategies

A. Remove cariogenic foods and beverages from vending machines.

B. Increase the number of non–cariogenic food items accessible outside the lunch program (vending machines, fund raisers, concessions, classroom celebrations and a la carte) in Head Start and school menus.

C. Increase tobacco use prevention/cessation and nutrition information in health education programs.

D. Provide resources to strengthen curricula that emphasize how healthy eating can improve and maintain oral health.

E. Reduce the impact of soda/beverage marketing by educating schools to resist marketing strategies.

F. Promote the understanding of the preventive properties of xylitol gum and xylitol products and their proper use.

G. Partner with the Minnesota School Nutrition Association and the Minnesota Department of Education to collect data on candy and pop available in schools in order to tailor oral health campaigns to school needs.

Objective 2.6: Promote awareness of the effect of diet and nutrition on oral health among hospital food service directors, older adult service establishments, and nutrition staff.

Suggested strategies

A. Partner with the Minnesota Hospital Association (MHA), hospital Food Service Directors, and Registered Hospital Dieticians to provide information about creating tooth-healthy menus and increasing health snack choices for patients, visitors, staff, and in vending machines.

B. Provide educational sessions at MHA conferences about the relationship of diet to dental disease.

C. Promote partnerships with assisted living and nursing home providers and organizations to increase understanding about the impact of diet on the oral health of older adults.

Goal 3: Oral health literacy is increased across all ages and cultures.

Objective 3.1: Increase oral health evaluation and caregiver education in early childhood screenings, vaccination visits, episodic care visits, prenatal, and Child and Teen Checkups.

Suggested strategies

A. Support health literacy and cultural competency training for health professionals in the community, including health care providers and public health officials.

B. Provide technical assistance to those interested in becoming proficient in patient-centered literacy skills.

C. Educate prenatal and maternal health care providers about the importance of increasing oral health literacy among pregnant women so they are well informed about caries etiology, caries prevention, and infant oral health care.

D. Create a campaign to increase understanding regarding the importance of tooth brushing and sponsor distribution of oral health information and materials in prenatal and maternal care programs.

Objective 3.2: Build awareness of oral disease prevention strategies and increase oral health knowledge in school-based health systems.

Suggested strategies

A. Strengthen partnerships with and provide resources to the Minnesota Department of Education and Minnesota school nurses to evaluate oral health curricula (including early childhood and after school programs) on evidence-based strategies.

B. Develop and disseminate information about the efficacy of pit and fissure sealants, water fluoridation, topical fluoride therapy and other strategies that prevent and control oral disease.

C. Investigate programs to introduce evidence-based xylitol therapy in early childhood programs and schools.

D. Partner with the Minnesota Department of Health Injury and Violence Prevention Unit to develop promotional programs that focus on preventing and reducing oral injury.

E. Develop and disseminate information to parents and schools about fluoride varnish, sealants and the health care home.

Objective 3.3: Increase exposure to oral health knowledge through targeted and culturally sensitive campaigns that focus on prevention strategies.

Suggested strategies

A. Develop and disseminate fluoridation messages that provide culturally and age appropriate information to population groups, adults, and children. e.g. "safe to drink fluoridated tap water" messages.

B. Increase oral health literacy among young adults emphasizing smoking, diet, smokeless tobacco, alcohol and tobacco, periodontal disease and importance of oral care.

C. Increase oral health literacy among the elderly and their caregivers; emphasize medications that increase xerostomia (dry mouth), root caries etiology, periodontal disease and oral cancer.

D. Ensure educational materials are available in multiple languages, including visuals for the non-reading population.

E. Create electronic media and monitor hits/visits to web pages and internet sites.

Objective 3.4: Increase awareness of oral health among policy and decision makers about the benefits of oral disease prevention.

Suggested strategies

A. Engage legislators in an annual oral health initiatives forum.

B. Partner with the Minnesota Oral Health Coalition to support oral health promotion policies, tobacco control policies, and to promote policy change.

C. Identify and utilize oral health resources in the state to target areas of greatest need.

D. Increase understanding of federal mandates and funding, or lack of funding.

Goal 4: Professional integration is enhanced between oral health care providers and other providers in the broader health care system.

Objective 4.1: Promote the understanding and development of the health care home concept.

Suggested strategies

A. Create and nurture non-traditional partnerships in oral health to establish a coordinated strategic direction.

B. Gather information and evaluate the effect of reimbursements/incentives for improving care.

C. Increase training opportunities in oral health for non-dental professionals (public health nurses, dietitians, health plan case managers, community health workers, and interpreters) that build patient-centered skills (preventive, therapeutic, and remedial) and provide technical assistance for working with patients, clients and the public.

D. Increase the number of local public health agencies that address oral health.

E. Increase integration activities and partnerships with nutrition, obesity, tobacco, alcohol, etc. (i.e., American Dietetic Association, American Lung Association, American Heart Association).

F. Plan demonstration projects that create innovative health care home models.

G. Work with educators to investigate the potential role of teledentistry and policy makers to address payment issues.

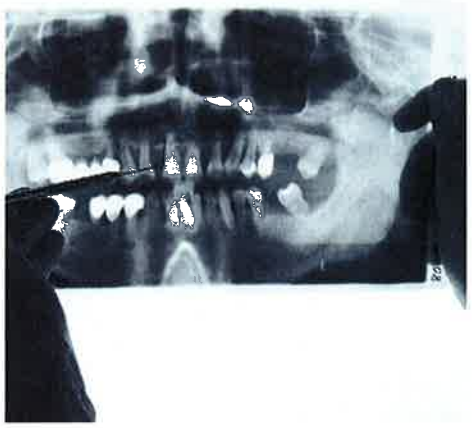
Objective 4.2: Increase the number of non-dental provider education programs (physician's assistant, nurse practitioner, dietitians, medical schools, and nursing schools) that incorporate oral health into their curriculum.

Suggested strategies

A. Partner with the Minnesota and American Pediatric Association and work to determine current continuing medical education curriculum that encompasses an oral health component.

B. Work with the University of Minnesota Continuing Education Division to create continuing medical education curriculum focused on oral health.

C. Use evidence-based strategies to develop core competencies in oral health within educational settings.



D. Provide one conference in each of the next two years for oral health and medical providers that focuses on:

   i. Oral and systemic health interrelatedness.

   ii. Understanding and promoting risk assessment of oral and systemic health.

   iii. Participate in "Many Faces Conference" and Accountable Care Conference with medical and dental professionals.

Objective 4.3: Develop collaborative opportunities throughout the health care community by educating and training physicians, dentists, nurses, hygienists, nurse practitioners, dental assistants, dental therapists, and social workers to work as a single team addressing oral health disparities and unmet dental needs of the underserved.

Suggested strategies

A. Promote research on the impact of oral health on overall health.

B. Support the development and evaluation of programs that promote disease prevention and increase collaborative health care.

C. Provide incentives for allied dental personnel to work in medical settings under collaborative supervision by a licensed dentist.

D. Reduce barriers to dental hygienists working in public health agencies and other settings.

E. Move primary oral health care into every obstetrics, primary care, family practice, pediatrics, and internal medicine practice in Minnesota by incorporating "The mouth is a part of the body" concept.

F. Investigate further development of innovative collaborative strategies for serving elderly and youth populations with different provider types.

G. Explore the development of a centralized network for identifying excess capacity, sharing resources, and communicating needs that utilizes the public health infrastructure.

Objective 4.4: Promote collaboration among dental providers and medical care providers that increase information sharing, understanding of eligibility requirements, and access to and utilization of oral health care benefits.

Suggested strategies

A. Create demonstration projects that gather and analyze preventive services utilization data and propose new models that coordinate collaboration between dental and medical providers and eliminate disparities.

Objective 4.5: Promote the adoption and meaningful use of the electronic dental record.

Suggested strategies

A. Disseminate information about the Office of the National Coordinator efforts to create standardized guidelines for the utilization of Health Information Technology and reporting.

B. Improve collaboration and follow up by aligning with at least two objectives of the local and national Office of the National Coordinator for Health Information Technology.

C. Seek funding to create incentives for private and public health dental and medical systems to create and adopt centralized network tools.

Objective 4.6: Call for the development and promotion of clinical preventive oral health guidelines for use in settings outside the dental office: medical and long-term care, prison, juvenile, and hospital settings.

Suggested strategies

A. Support and promote the development and use of dental diagnostic codes.

B. Develop partnerships that integrate oral health into the current case management system.

C. Promote public health research, standardized protocols for care, and use of evidence-based practices.

D. Promote inclusion of oral evaluation in care guidelines for the aging and persons with diabetes and special health care needs.

E. Create a web-based tracking and referral mechanism for oral health information and treatment.

F. Promote Health Insurance Portability and Accountability Act compliant communications between dental providers and primary care providers (family medicine, obstetrics, pediatrics, internal medicine, etc.) and allied health professionals, (dieticians, pharmacists, etc.) when assessing and referring for medical conditions and non-dental issues.

Objective 4.7: Increase the number of primary care medical providers who integrate prevention of oral disease as part of overall health care by 10 percent for patients of all ages.

Suggested strategies

A. Create a recognizable symbol and/or standardized message that captures the concept of the interrelatedness of oral health and overall health.

B. Develop a marketing campaign targeted to medical providers that promotes oral health as integral to overall health.

C. Determine a baseline number (early adopters) and evaluate barriers to the utilization of oral disease prevention strategies by medical practitioners.

D. Develop an integrated approach among medical and dental providers that promotes oral exams/evaluation, referral, and access to oral health care by age one.

E. Promote treatment and diagnostic information sharing between pediatricians, physicians and dentists.

Goal 5: Access is increased to preventive, restorative, and emergency oral health care services.

Objective 5.1: The legislative intent to increase the supply and distribution of dental services through creation of new dental providers and appropriate utilization of the entire dental team is achieved. (See Minnesota statutes 150A.10 Subd.1a., 150A.105 and 150A.106)

Suggested strategies

A. Maximize the opportunity that Minnesota has to provide positive leadership in creating new oral health care providers and innovative workforce models.

B. Support and engage with other agencies to research the impact of new and existing oral health care providers on improved access to services by collecting and analyzing outcomes data.

C. Increase the number of dentists, health care facilities, programs, or nonprofit organizations that employ dental hygienists with collaborative agreements.

D. Develop relationships with providers in older adult services settings (e.g., nursing homes, assisted living) to connect providers with elderly populations.

Objective 5.2: Increase by 10 percent the number of underserved Minnesotans who receive evidence-based preventive dental care, with emphasis on children under age one, low-income uninsured adults, people with developmental disabilities, pregnant women, children with special health care needs, low income and immigrant populations, those with chronic diseases, and individuals in long-term care facilities.

Suggested strategies

A. Educate general dentists to be more comfortable caring for infants and toddlers (birth to three years old), making appropriate referrals, and using best practices.

B. Work with state agencies and commissions to analyze issues (including funding) regarding care for children, adults, the aging, developmentally disabled, and special health care needs populations, low income and under insured, and participate in developing policy recommendations.

C. Use Basic Screening Survey results to determine preventive service initiatives.

D. Encourage local and county public health agencies to utilize dental hygienists in prevention programs.

E. Identify and work with agencies engaged in dental programs to explore alternative delivery systems that improve communication with local dentists, improve sustainability, and increase continuity of care.

F. Partner with agencies on a centralized website or helpline for the public to increase access to referral information and information on current systems in place for Minnesota health care programs and the uninsured.

G. Develop compliance initiatives that increase comprehensiveness of oral health programs for children under age one, uninsured adults, people with developmental disabilities, children with special health care needs, and individuals in long-term care facilities.

Objective 5.3: Reduce the proportion of Minnesotans who experience difficulties, delays, or barriers to restorative oral health care service by 20 percent.

Suggested strategies

A. Partner with state agencies that have been mandated to document the impact of existing and new Minnesota oral health care workforce models on improved access to restorative services using outcome data.

B. Establish baseline information on barriers to oral health care involving target populations by conducting a statewide survey and adding questions to both the Basic Screening Survey and Behavioral Risk Factor Surveillance System regarding Minnesota's accessibility to dental care.

C. Investigate best practices for sustainability of public health and safety net clinics.

Objective 5.4: Reduce the number of emergency room visits for dental related reasons by 15 percent.

Suggested strategies

A. Develop and disseminate materials that educate caregivers about dental injuries and the appropriate response.

B. Collaborate with hospitals and providers in older adult service settings to provide information on local public health dental programs so that patients presenting in emergency departments are provided with appropriate referral and preventive education information.

C. Develop a campaign to educate the public about seeking professional dental care and guidance after an oral injury has occurred.

D. Develop a campaign focused on oral injury prevention and promoting the appropriate use of mouth-protecting equipment in sports, e.g., mouth guards.

E. Collaborate with hospital medical staff to ensure diagnostic codes are utilized for non-traumatic dental related emergency department visits and are coded correctly in order to establish baseline data.

Objective 5.5: Increase the number of individuals who receive oral and pharyngeal cancer screenings by 10 percent.

Suggested strategies

A. Determine a baseline number of dental and medical professionals that currently integrate oral and pharyngeal cancer screenings into comprehensive exams.

B. Emphasize the importance of screening for oral and pharyngeal cancer and how it can affect critical functions, such as speaking, swallowing and eating.

C. Increase the number of health care providers who deliver consistent and

appropriate messages to help people quit smoking.

D. Partner with the National Cancer Institute on developing health care provider competencies in prevention, diagnosis, and management of oral and pharyngeal cancers.

E. Aid the American Cancer Society in incorporating oral and pharyngeal cancer screenings in the "Welcome to Medicare" physical examination.

F. Promote the development of a community-based oral cancer prevention and early detection program.

Objective 5.6: Increase the proportion of local health departments that have an oral health program focused on prevention.

Suggested strategies

A. Build capacity in local health departments by providing technical expertise and evidence-based oral health information.

B. Determine a baseline number of local health departments that currently have an oral health care program.

C. In collaboration with existing local oral health care program personnel, identify local health departments that do not have an oral health program and offer resources and guidance in creating and structuring their own oral health component.

D. Partner with Local Public Health Association of Minnesotato convene a conference on integrating oral health into local public health systems.

Objective 5.7: Promote policies and programs that ensure that 95 percent of Minnesotans have access to a dental care provider within a 90-minute drive or by public transportation from their place of residence.

Suggested strategies

A. Conduct at least one public health/ nonprofit clinic pilot project to investigate and gather data on current equitable distribution of services.

B. Promote school-based-programs and older adult service settings.

C. Determine existing excess provider capacity and transportation services available to patients, including the uninsured and public programs patients.

D. Work with local safety net programs in supporting existing and creating new volunteer programs that provide patients transportation to and from dental and health appointments.

E. Convene a conference focused on policy tools that will help achieve equity in population health, featuring best practices and expert panel presentations, moderated discussions, as well as working groups.

F. Reduce supervision barriers and increase utilization of collaborative agreements.

Objective 5.8: Increase partnerships that explore effective policy initiatives to stabilize the availability of oral health care services to the most vulnerable populations.

Suggested strategies

A. Develop a planning checklist to move forward strategically once consensus about priorities is achieved.

B. Increase data and information gathering efforts that support policy decisions among stakeholders, oral health care providers and primary care providers.

C. Promote philanthropic programs among specialty dental organizations.

Goal 6: The dental workforce is prepared for and addresses the oral health needs of all Minnesotans.

Objective 6.1: Promote innovative and effective oral health care delivery practice models for rural populations.

Suggested strategies

A. Continue to work with Area Health Education Centers to explore and strengthen strategies that will achieve better retention and distribution of oral health care providers graduating from state supported institutions.

B. Develop mentoring programs for the dental workforce.

C. Investigate the role of teledentistry.

Objective 6.2: Promote broader discussion of ways the social compact between dentistry and society can be reinforced.

Suggested strategies

A. Develop a Patient Centered Principles document.

   i. Create a document that states principles and objectives that are patient centered.

   ii. Develop bullet points about what patients need for oral care as part of general health care.

   iii. Create a list of evidence-based studies that support oral health effects on general health.

B. Convene workshops with medical providers.

C. Promote continuing education programs.

D. Encourage the creation of at least one internship opportunity for students and one work experience for professionals.

Objective 6.3: Collaborate with agencies and educational institutions to gather and disseminate information on practice models, collaborative agreement dental hygiene practice, and the dental therapist/advanced dental therapist management agreement.

Suggested strategies

A. Maximize utilization of tools available: support infrastructure for collaborative agreement hygienists and restorative function allied personnel, dental therapist and advanced dental therapist.
   i. Develop a checklist on payment protocols and credentialing.
   ii. Develop a fact sheet/resource sheet describing definition of, roles of, and scope of practice levels of all oral health professionals to be used by the profession, payers, and the public to understand the current state of oral health care delivery.
B. Convene an educational forum or summit of collaborative practice hygienists and dentists to promote collaborative practice.
C. Develop a conference on advancing the implementation of workforce models.
D. Identify and develop a method for tracking current collaborative practice agreements and collaborative management agreements in order to increase networking and information sharing among collaborative providers.

Objective 6.4: Ensure that at least 90 percent of oral health provider education programs incorporate health literacy concepts and cultural competency training into curriculum.

Suggested strategies

A. Promote the CDC health literacy certification program.
B. Disseminate information about health literacy and promote the use of a usability checklist that ensures that oral health information meets health literacy principles.
C. Partner with professional associations to create continuing education courses for oral health professionals focused on health literacy and cultural competency concepts.
D. Seek ways to enhance or support opportunities for community health workers to promote culturally sensitive oral disease prevention strategies in their communities.

Objective 6.5: Increase cultural competency training related to oral health in health professional education programs.

A. In collaboration with existing local cultural organizations, develop and disseminate cultural competency educational materials for health professionals.
B. Encourage the Board of Dentistry to focus a self-assessment on the subject of cultural competency.
C. Partner with Minnesota state-supported higher education institutions to provide community outreach and cultural center personnel with a basic oral health education course.

Objective 6.6: Encourage all oral health provider education programs to focus on recruiting classes that reflect the state's population diversity.

Suggested strategies

A. Strengthen existing and develop new outreach programs that recruit future dental professionals from diverse backgrounds.
B. Seek funding for the expansion of dental education scholarships and loan repayment efforts.

Goal 7: Access to population statistics, population-level oral health surveillance information, and aggregate data on oral health indicators is readily available to all.

Objective 7.1: Collaborate with data partners and key stakeholders to identify key oral health indicators and to increase the visibility and effectiveness of the Minnesota Oral Health Surveillance Advisory Group.

Suggested strategies

A. Convene the Advisory Group annually.
B. Develop and maintain data sharing agreements with partners.
C. Acquire and analyze data, and interpret findings.
D. Prepare and publish the Minnesota Surveillance Plan and the Burden of Oral Disease in Minnesota documents.
E. Review, update and publish the Burden of Oral Disease document regularly.
F. Evaluate progress, trends and direction.

Objective 7.2: Develop a secure data system that identifies and tracks key oral health indicators and has the capability to provide specific data affecting policy and existing programs upon request.

Suggested strategies

A. Develop quality assurance measures to ensure accuracy.
B. Continue to develop and implement the Minnesota Oral Health Surveillance System (MNOHSS).
C. Share summarized surveillance information with local public health, educational institutions, insurers,

social services, policy makers, community-based organizations, community health clinics, and other partners as appropriate.

D. Increase the capacity of the MDH Oral Health Program to serve as a primary resource for oral health information by providing links to educational materials, oral health initiative information, and oral health curriculum.

E. Monitor and respond to data requests.

F. Ensure data security/confidentiality.

G. Explore use of (or develop) a secure web-based data entry portal (i.e., a web page for sealant grantees to enter data).

Objective 7.3: Increase capacity of the Minnesota Oral Health Program to collect data and conduct surveillance activities.

Suggested strategies

A. Investigate ways to sustain the surveillance activities of the oral health program.

B. Provide staff and stakeholder training opportunities that increase ability of the program to manage large data projects.

C. Evaluate surveillance and outcome data.

D. Increase support for acquiring data and increase demand for oral health data.

Appendix B: Minnesota Populations by Race and Hispanic Ethnicity

Racial Groupings	2010 Census	Percentage of population	Change 2000-2010
White	4,524,062	85.3%	+2.8
Blacks, African American	274,412	5.2%	+58.9
American Indian Alaskan Native	60,916	1.1%	+10.8
Asian	214,234	4.0%	+50.9
Native Hawaiian/Other Pacific Islander	2,156	0.04%	+8.9
Other race	103,000	1.9%	+56.5
Two or more races	125,145	2.4%	+51.2
Ethnic Origin			
Hispanic or Latino origin*	250,258	4.7%	+74.5
Non-Hispanic or Latino	5,053,667	95.3%	+5.8
Total	5,303,925	100%	+ 7.8

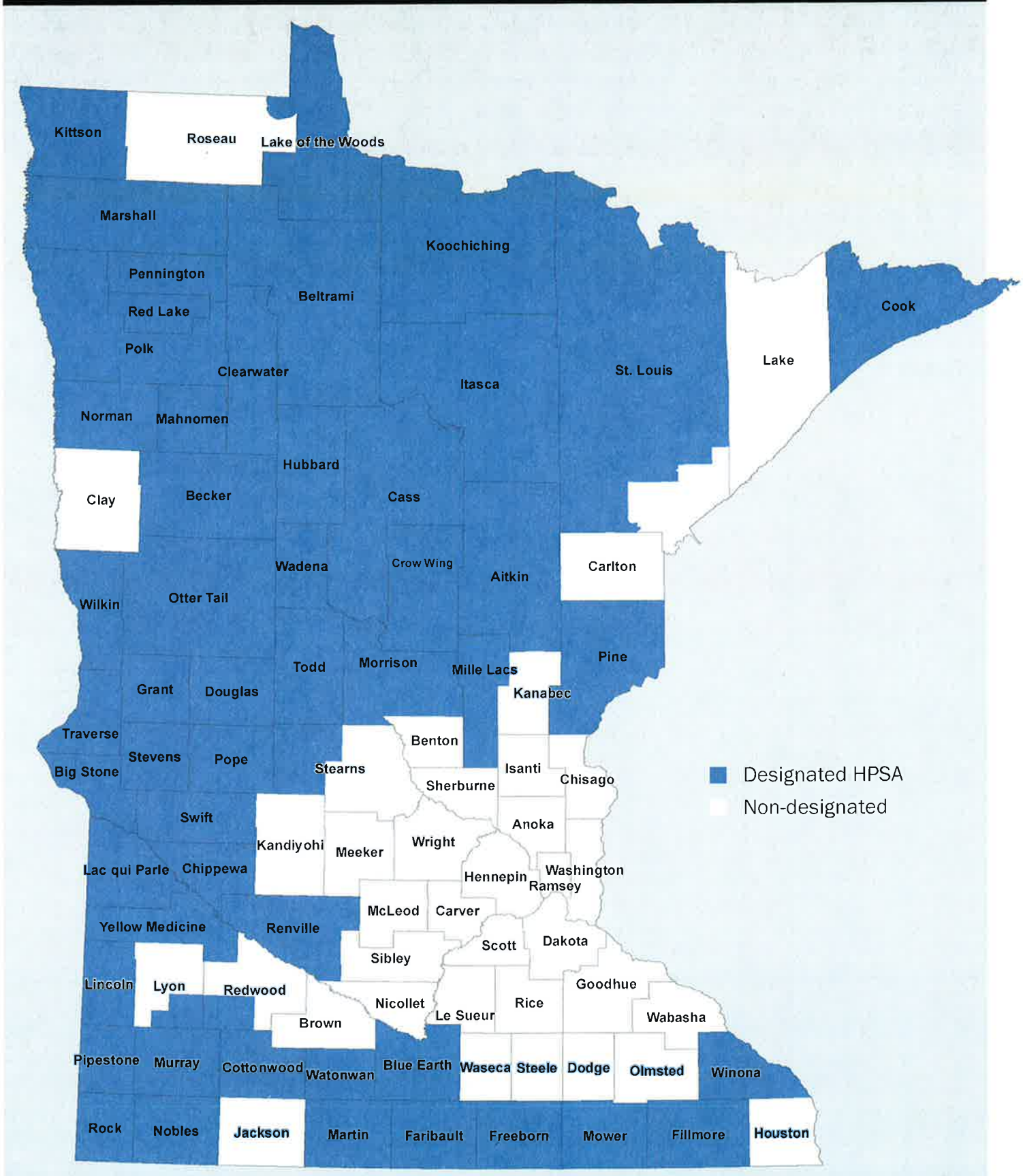
*People of Hispanic ethnicity may be of any race
Source: Minnesota Department of Administration. Office of Geographic and Demographic Analysis. Office of the State Demographer / U.S Census; 2010

Appendix C: Minnesota Health Professional Shortage Areas – Population/Low-Income Dental Care Designation

Note: HPSA designations reflected in the following map only include those based on a geographic area and low-income population designations which are still bound by a geographic service area.

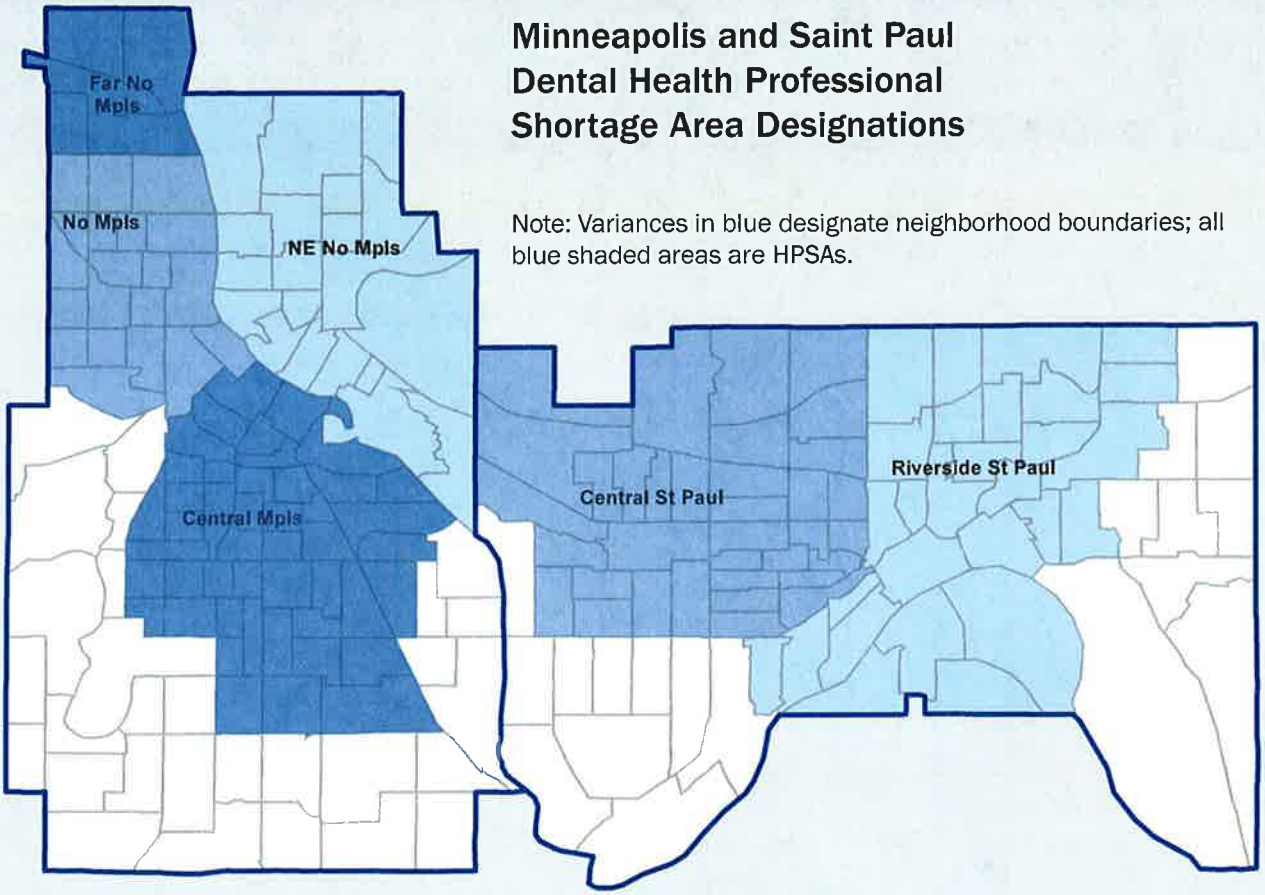
Designations not reflected in the map include any facility (e.g. comprehensive health center, correctional facility, rural health clinic) and tribal designations. For further information about Minnesota HPSA, please visit the Minnesota Department of Health Office of Rural Health and Primary Care website: www.health.state.mn.us/divs/orhpc

Map 1: Minnesota Health Professional Shortage Areas (by county) – Population/Low-income Group Dental Care Designation (identified in blue)



Data Source: Minnesota Department of Health, Office of Rural Health and Primary Care, State DD HPSA May 2012.

Map 2: Minneapolis-St. Paul Health Professional Shortage Areas – Population/Low-income Group Dental Care Designation (identified in blue)



Data Source: Minnesota Department of Health, Office of Rural Health and Primary Care, September 2010

Minneapolis Neighborhoods:

- Far North
- North
- Northeast-North
- Central

St. Paul Neighborhoods:

- Central
- Riverside

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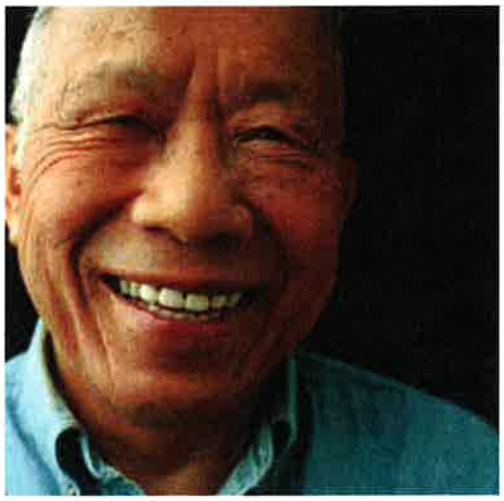
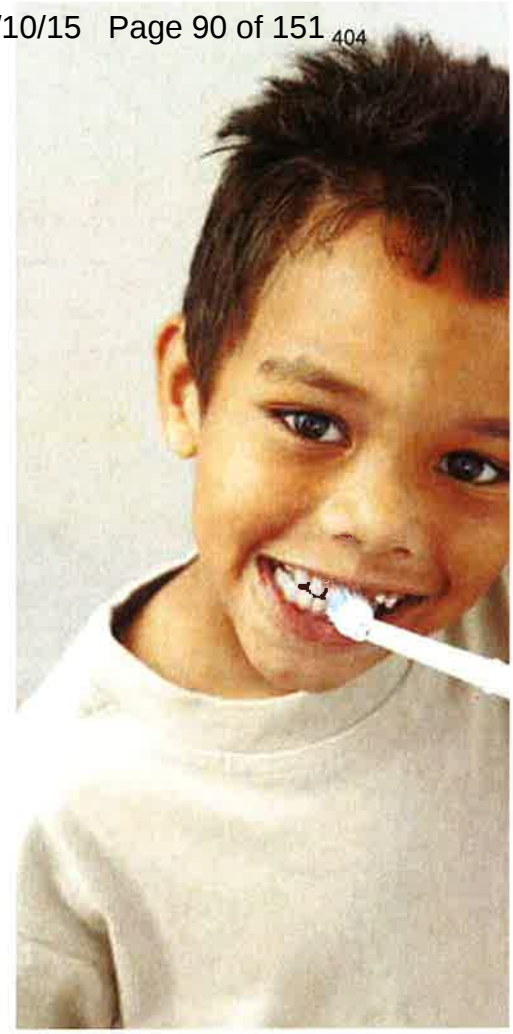
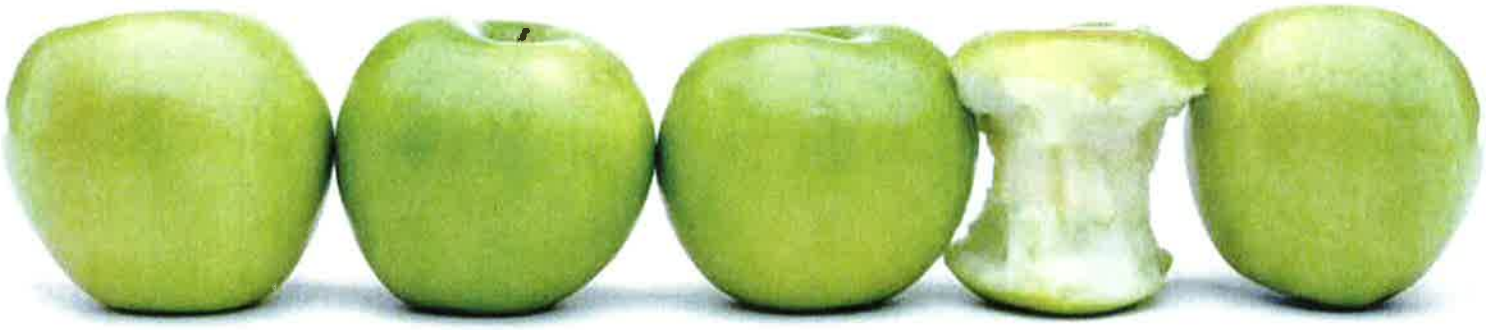
For a copy of the complete Minnesota Oral Health Plan, please contact us or visit our website.







MINNESOTA MDH DEPARTMENT OF HEALTH Oral Health Program

Minnesota Department of Health, Oral Health Program
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Funding was made possible by grants to support statewide oral health related activities from the Health Resources and Services Administration, Award T12HP1465, and Centers for Disease Control Prevention, Cooperative Agreement Grant Number 5U58DP0011579.

Minnesota Council on Transportation Access

Minnesota Transit Funding Primer

Technical Report

Prepared for:
Minnesota Council on Transportation Access

January 2015

Prepared by:
Hubert H. Humphrey School of Public Affairs University of Minnesota

Introduction

In the state of Minnesota, state and federal funding for public transit systems is administered by a number of different agencies, with coordination efforts encouraged by the Minnesota Council on *Transportation Access (MCOTA). The Minnesota Legislature established MCOTA in 2010.* MCOTA was established in order to "study, evaluate, oversee, and make recommendations to improve the coordination, availability, accessibility, efficiency, cost-effectiveness, and safety of transportation services provided to transit public[1]". MCOTA is tasked with duties related to the following key areas: vehicle and client sharing, cost sharing and purchasing, communication and coordinated planning, reporting and evaluation, and research and demonstration[2].

This MCOTA Research Project is aimed at providing an inventory of the transportation funding programs available from the federal and state government in Minnesota, including funding levels and details about the administration of each program. The goal is to identify opportunities for coordination.

What is Human Services transportation (community-based transportation)?

Human Services transportation includes broad range of transportation services for transportation-disadvantaged population; primarily persons with disabilities, veterans, seniors, low-income individuals, and children. Since Human Service transportation is not centrally coordinated in Minnesota, the goal of this report is to more fully understand all sources that fund this service. As stated on MCOTA's website, "While there have been significant investments in transit at the federal, state, and local levels, serious gaps in service exist in many communities. Unfortunately, a multitude of funding programs and requirements across dozens of departments and agencies make transportation coordination and communication a daunting task."

What are the purposes of human Services transportation?

In order to support and increase transportation options for transportation-disadvantaged people, funding would be allocated to different organizations with various transportation purposes. Transportation-disadvantaged people have different needs and require a variety of transportation services with different trip purposes. Based on the survey results, most trip purposes would be as following:

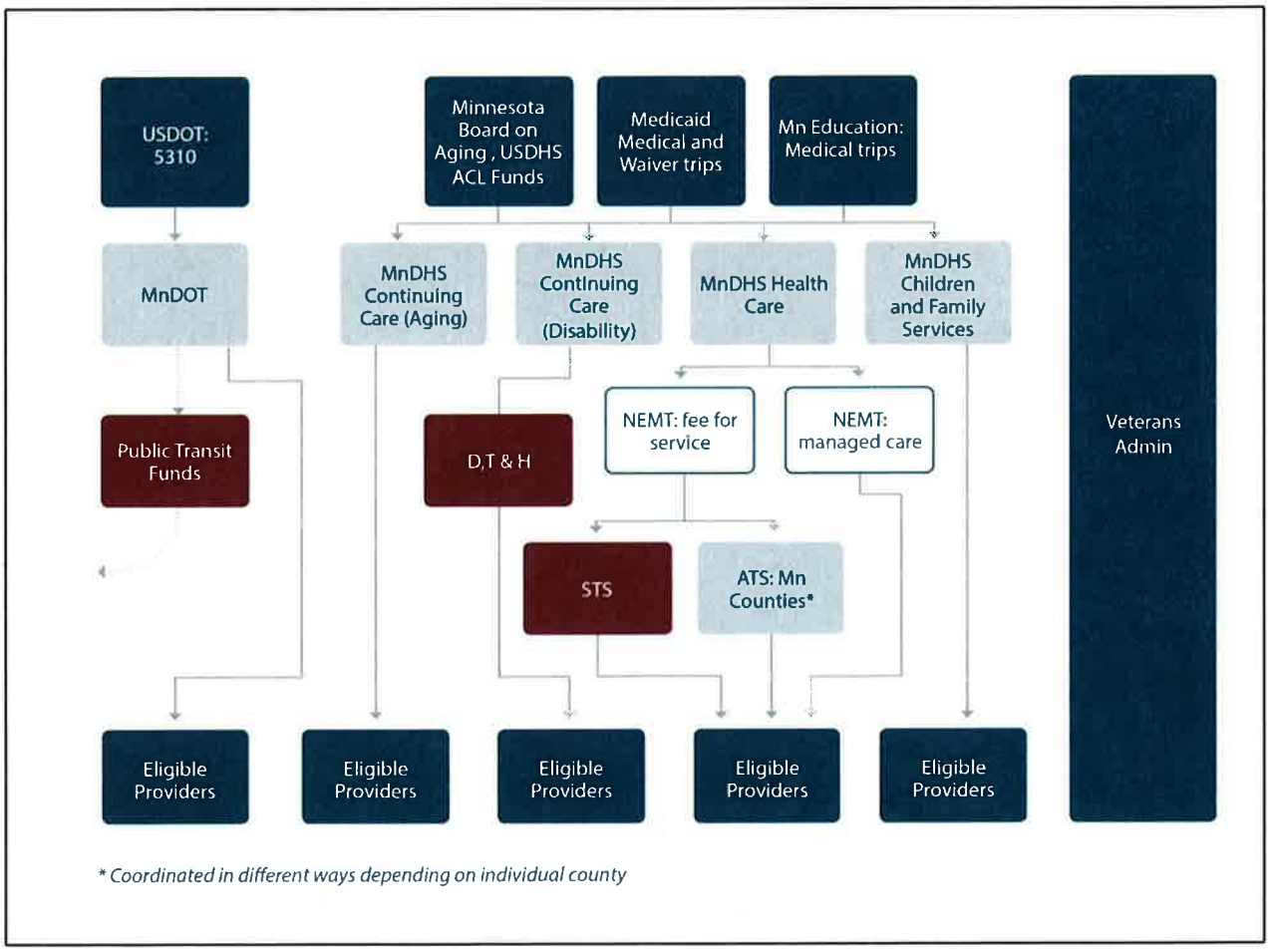
-Health/medical (e.g., single or periodic trips to doctor, clinic, drug store, treatment center)
- Health maintenance (e.g., dialysis or other recurring and frequent trips that require regular transport)
- Nutrition
- Income maintenance (e.g., trips to food stamp or social security office)
- Social trip (e.g visit to friends/relatives)
- Recreation (e.g., trip to cultural or athletic events)
- Education/ training
- Employment (e.g., trips to work, including job interviews. welfare-to-work trips)
- Social services (e.g., trips to meet with counselors, social workers, and other staff related to the receipt of social services)
- K-12 education (school children)

What types of organizations are eligible to receive funding for Human Services transportation?

Organization that might be eligible to receive funding for their transportation services to transportation-disadvantaged people could fall in different categories. Primarily there are public transportation operator, human services agencies, private for profit or private nonprofit organizations.

Who are the Federal and State Agencies funding Human Services transportation?

The following agencies are involved in funding transit in Minnesota.



United States Department of Transportation
The mission of the United States Department of Transportation is to "serve the United States by ensuring a fast, safe, efficient, accessible and convenient transportation system that meets our vital national interests and enhances the quality of life of the American people, today and into the future"[3].

MAP-21

Section 5310 formula grants for the enhanced mobility of elderly individuals and individuals with disabilities. MAP-21 consolidated the Section 5317 New Freedom program (a formula-based federally-funded program established under SAFETEA-LU. The goal of the New Freedom grant program is to provide additional tools to overcome existing barriers facing Americans with disabilities seeking integration into the workforce and full participation in society) into the Section 5310 program.

Section 5310 Elderly Individuals and Individuals with Disabilities Program (a capital program as a part of the amended Federal Transit Act of 1991, that provides grant funds for the purchase of accessible vehicles and related support equipment for private non-profit organization to serve elderly and/or disabled people, public bodies that coordinate services for elderly and disabled, or any public body that certifies to the state that non-profits in the area are not readily available to carry out the services) provides capital and operating assistance grants for organizations that serve elderly and/or persons with disabilities. Section 5310 funding is approximately $2,483,572.

Section 5310 pays for vehicles and other capital equipment for elderly individuals and individuals with disabilities. After the consolidation of Section 5317 New Freedom program, Section 5310 allows for additional funds used to provide transportation for low-income individuals.

Minnesota Department of Transportation
The mission of the Minnesota Department of Transportation is to "plan, build, operate and maintain a safe, accessible, efficient and reliable multimodal transportation system that connects people to destinations and markets throughout the state, regionally and around the world"[4]. "In creating the Department of Transportation in 1976, the Legislature determined that the Minnesota Department of Transportation would be the principal agency to develop, implement, administer, consolidate and coordinate state transportation policies, plans and programs"[5].

The Minnesota Department of Transportation allocates funding to both public transit and to eligible providers that provide services to individuals covered under the United States Department of Transportation 5310 funding programs.

State funding for public transit is appropriated from the general fund and from a percentage of motor vehicle sales tax revenue. For Greater Minnesota Transit, the public transit assistance

general fund is $16,451,000 in 2014. The Twin Cities Metro Area Transit public transit assistance general fund was $107,889,000 in 2014.

The Minnesota Department of Transportation "disburses funds for Greater Minnesota transit through the Public Transit Participation Program[6]" . State law requires local participation in funding public transit services in Greater Minnesota. A statutory fixed share funding formula sets a local share of operating costs by system classification as follows: elderly and disabled 15%, rural 15%, small urban 20%, and urbanized 20%[7].

United States Department of Health and Human Services
The United States Department of Health and Human Services is the government's "principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves"[8]. The United States Department of Health and Human Services is responsible for approximately 25 percent of all federal outlays and administers the largest amount of grant money in comparison to all other federal agencies[9].

Administration for Community Living
The United States Department of Health and Human Services' Administration for Community Living. The mission of the Administration for Community Living is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers.

The Administration for Community Living "brings together the efforts and achievements of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the Health and Human Services Office on Disability to serve as the Federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan"[10].

Minnesota Board on Aging
The Minnesota Board on Aging is the "gateway to services for Minnesota seniors and their families"[11]. The Minnesota Board on Aging allocates funding that is established by the Older Americans Act. The Older Americans Act authorizes "grants to states for community planning, services, research, and demonstration and training projects in the field of aging". The Older Americans Act also provides grants for local needs identification, planning and funding of services[12].

The Minnesota Board on Aging distributes money to the 7 Minnesota Area Agencies on Aging that award the money to partners at the local level.

Minnesota Department of Human Services
The Minnesota Department of Human Services "helps people meet their basic needs so that they can live in dignity and achieve their highest potential"[13]. The Minnesota Department of Human Services oversees Continuing Care for both aging and disability. The Minnesota Department of Human Services also oversees heath care and children and family services.

Continuing Care

The Continuing Care Administration of the Minnesota Department of Human Services' goals are to: "support and enhance the quality of life for older people and people with disabilities, manage an equitable and sustainable long-term care system that maximizes value, continuously improve how we administer services, promote professional excellence and engagement in their work"[14].

For the aging and the disabled, Continuing Care distributes its funds directly to eligible providers.

Medicaid Medical Trips

Medicaid Waiver Trips
Medicaid waivers are "vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid[15]".

The Disability Services division oversees four Medicaid disability waivers. Medicaid disability waivers include: BI Waiver-Brain Injury Waiver for people with a brain injury who would otherwise need neuro-behavioral hospital care or a specialized nursing facility care, CAC Waiver- Community Alternative Care for medically fragile people who otherwise would need hospital care, CADI Waiver- Community Alternatives for Disabled Individuals Waiver for people with a disability that would need nursing facility care, DD Waiver- Developmental Disability Waiver for people with a developmental disability for people who would otherwise need an intermediate care facility level of care.

The Aging and Adult Services Division oversees elderly waiver (a Medicaid waiver) which extends transportation for fee-for-service expenditures. The Aging and Adult Services also oversees alternative care which extends transportation for fee-for-services expenditures.

Section 1115 Research and Demonstration Projects waivers are waivers that Minnesota can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid. Section 1915(b) Managed Care Waivers are waivers that Minnesota can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers. Section 1915(c) Home and Community-Based Services Waivers are waivers that Minnesota can apply for waivers to provide long-term care services in home and community settings rather than institutional settings. Concurrent Section 1915(b) and 1915(c) Waivers are waivers that Minnesota can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met[16].

Medicaid Waiver trips allocate funding to both the Continuing Care for those with disabilities and to Health Care.

Health Care
Minnesota Department of Human Services' Health Care programs include medical assistance, MinnesotaCare, Minnesota Family Planning Program, Home and community-based waiver programs, and Medicare Savings programs. These programs may help pay for all of part of health care costs for those who do not have insurance, cannot get affordable health insurance

through a job, have a disability or chronic condition and need assistance paying for care and services to stay in one's home, need help paying for care in a nursing home, hospital or other medical facility, have other insurance or Medicare but need help paying the premiums, deductibles and copays or need services not covered [17]. Minnesota Health Care allocates funding to both NEMT fee for service and managed care.

NEMT
Non-Emergency Medical Transportation refers to non-emergency transportation services provided to Medicaid recipients so they can obtain covered medical services from health care providers outside their home. The type of Non-Emergency Medical Transportation assistance generally covers the cost of transportation and other costs associated with travelling to health service providers, such as meals and overnight accommodations.

In Minnesota, Non-Emergency Medical Transportation services are provided through the state's MA program. About two-thirds of MA recipients in Minnesota are enrolled in managed healthcare plans (Managed MA) and generally receive NEMT through these plans. The balance of recipients are covered by a fee-for service system operated by the Department of Human Services.

Non-Emergency Medical Transportation fee-for service allocates funding through Minnesota Counties, which then provide funding to eligible providers.

Non-Emergency Medical Transportation managed care allocates funding directly to eligible providers.

Counties
Counties report their social services expenditures to Minnesota Department of Human Services through the quarterly Social Services Expenditure and Grant Reconciliation Report.

Minnesota Education

School districts in Minnesota receive general education basic revenue in which there is an amount earmarked for transportation. In addition, districts receive state funding for certain situations including special education transportation and homelessness.

The Minnesota Department of Human Services administers the claims that school districts make for reimbursement for transporting students to medical assistance programs.

Children and Family Services

The Minnesota Department of Human Services' Children and Family Services allocates funding directly to eligible providers.

Veterans Administration
The United States Department of Transportation awarded $1.19 million to Minnesota Department of Transportation under a Veterans Transportation and Community Living Initiative

discretionary grant in late 2011. Using these funds, Minnesota Department of Transportation, Minnesota Department of Veterans Affairs, Minnesota Board on Aging, and Minnesota Department of Human Services are partnering to enhance the existing MinnesotaHelp Network, a virtual call center and website that facilitates referrals among human service agencies using a common communications platform. This project will extend this technology to transportation providers and veterans' organizations that provide rides to veterans, enabling these partners to easily refer customers to other agencies in the network or to call center staff who can provide customers individual assistance.

Although the Minnesota Department of Veterans Affairs is collaborating with other agencies through MinnesotaHelp Network, the Minnesota Department of Veterans Affairs has generally separated its services to vulnerable adults from the services of other non-Veteran individuals. The existence of the Minnesota Department of Veterans Affairs separate statutory chapter and language regarding vulnerable adults supports the Minnesota Department of Veterans Affairs' commonly practiced risk averse policies and actions related to vulnerable adults in the transportation provided solely to vulnerable adults with Veteran status.

Federal Funding

5310 (elderly persons and person with disabilities) Statewide	$2,483,572
5316 (job access) Greater Minnesota	$ 751,000
5316 (job access) MET Council	$1,169,463
5317 (new freedom) Greater Minnesota	$ 552,000
5317 (new freedom) Met Council	$ 415,324
Veterans Transportation	$1,100,000
5311 (non-urbanized area grant) Greater Minnesota	$ 8.2 M
5311 (non-urbanized area grant) MET Council	$ 642,668
5307 (urbanized) Greater Minnesota	$ 3.5 Million
Older American Act Title III - Statewide	$1,000,000

State Funding

MVST	$ 225,127,379+ $24.6 m (OP)+$ 6.2m (CAP)
Public transit assistance	$ 152,255,021+ $14.2m (OP) + $ 800,000 (CAP)

Others

Medical Assistance	$6,300,000
Non-Emergency Medical Transportation	$24,000,000
Extended Transportation & Disability Waivers	$31,900,000

Funding Based on Recipients (Estimations based on Survey Responses)

Persons with disabilities	$40.7 M
Elderly	$18.2 M

[1] http://www.coordinatemntransit.org/MCOTA/
[2] http://www.coordinatemntransit.org/MCOTA/documents/MCOTA_Overview_Jun2011.pdf
[3] http://www.dot.gov/mission/about-us.
[4] http://www.dot.state.mn.us/vision/
[5] Minn. Stat. Ch. 174.
[6] 2013 MnDOT transit report.
[7] 2013 MnDOt transit report
[8] http://www.hhs.gov/about/
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Minnesota's Olmstead Plan Quality of Life Survey Pilot Study Report

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Quality of Life Survey Pilot Study Executive Summary

Purpose of the Study

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

Survey tool

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

Methodology

Samples and Settings

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

Disability populations

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

Pilot Results

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

Key Recommendations

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

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

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

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

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

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

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

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

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

Background

About Olmstead

The Olmstead Decision

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

The Jensen Settlement

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

Minnesota's Olmstead Plan

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

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

About the Olmstead Quality of Life Project

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

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

About Quality of Life Survey Tool

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

The Quality of Life survey will measure:

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

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

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

About the Pilot

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

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

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

- Interviewer recruitment and training

Key Players in the Olmstead Quality of Life Survey Pilot Study

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

Olmstead Implementation Office

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

The Improve Group

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

The Olmstead Team

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

Funder

The study was funded by the Minnesota Housing Finance Agency.

About the Report

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

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

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

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

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

Planning Phase

Selecting the Survey Tool

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

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

Population

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

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

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

Settings

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

The settings included in the pilot were:

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

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

Timeline

Original Plan

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

TABLE 1: PILOT STUDY TIMELINE

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

What Really Happened

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

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

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

TABLE 2: TIME TO SCHEDULE AND COMPLETE INTERVIEWS BY SETTING

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

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

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

Design Phase

Research Approvals and Human Subjects Protection

Original Plan

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

What Really Happened

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

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

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

Internal Review

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

Informed Consent

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

Data Security

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

- storing project materials in locked cabinets

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

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

Preparing the tool

Original Plan

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

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

What Really Happened

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

Changes to the survey

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

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

Preparing the tool for administration

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

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

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

Accessibility

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

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

Translation and Interpretation

Original Plan

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

What Really Happened?

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

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

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

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

Sampling Strategy

Original Plan

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

The nine settings to be included in the sample were:

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

The proposed secondary selection criteria were:

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

Demographic and other characteristics tertiary selection criteria included:

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

What Really Happened

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

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

Setting

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

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

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

Disability Type

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

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

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

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

Demographic and Other Characteristics

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

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

Working with State Agencies

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

Department of Employment and Economic Development

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

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

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

Challenges

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

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

Department of Human Services

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

The process for selecting the DHS sample is as follows:

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

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

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

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

Challenges

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

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

Minnesota Department of Education

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

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

The process for selecting the MDE sample was as follows:

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

Challenges

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

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

Advisory Group

Original Plan

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

The ideal advisory group member would:

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

What Really Happened

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

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

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

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

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

Reporting Abuse and Neglect

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

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

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

Administration Phase

Working with Providers and School Districts

Original Plan

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

What Really Happened

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

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

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

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

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

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

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

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

Recruitment and Communication Strategies

Original Plan

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

What Really Happened

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

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

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

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

Consent Process

Original Plan

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

What Really Happened

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

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

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

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

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

Survey Administration

Original Plan

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

What Really Happened

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

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

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

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

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

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

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

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

Special Populations

Survey Administration in Greater Minnesota

Original Plan

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

What Really Happened

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

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

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

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

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

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

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

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

Blind or Visually Impaired or Deaf and Hard of Hearing

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

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

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

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

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

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

Analysis and Reporting

Pilot Results

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

Qualitative Analysis

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

Survey Tool Questions

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

Pilot Review Questionnaire

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

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

Interviewer Reflections

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

Quantitative Analysis

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

Response Rate

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

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

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

TABLE 3: RESPONSE RATE BY SETTING

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

Survey Completion

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

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

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

TABLE 4: SURVEY COMPLETION BY SETTING (PERCENT COMPLETED)

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

Survey Completion Time

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

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

TABLE 5: SURVEY LENGTH BY SETTING (MINUTES)

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

Respondent Characteristics

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

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

TABLE 6: PRIMARY RACE AND ETHNICITY

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

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

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

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

TABLE 7: DISABILITIES AND PERCEIVED SIGNIFICANCE

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

Lessons learned by setting

Working in Different Settings

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

The process for working with providers in each setting follows.

Adult Foster Care

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

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

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

Boarding Care

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

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

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

Board & Lodge with Special Services

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

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

Center-Based Employment

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

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

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

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

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

Day Training and Habilitation

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

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

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

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

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

Intermediate Care Facilities for Persons with Developmental Disabilities

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

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

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

Nursing Homes and Assisted Living

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

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

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

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

Segregated School Settings

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

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

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

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

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

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

Supervised Living Facilities

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

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

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

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

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

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

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

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

Recommendations to Tweak the Survey Tool

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

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

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

Prescreening

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

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

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

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

Content

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

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

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

Community Integration and Engagement: Integrative Activities Scale

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

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

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

Decision Control Inventory

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

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

Elements of Person-Centered Planning

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

Interviewer Training

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

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

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

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

First Steps for the Baseline Survey Planning Phase

Access to Data

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

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

Finalize Sampling Strategy

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

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

Plain Language Definitions of Settings

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

Translation of Survey Materials

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

Lead Agency Roles

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

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

Recommendations for Baseline and Follow-Up Survey Administration

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

Recommendations for the Planning Phase

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

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

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

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

Recommendations on Human Subjects Protections

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

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

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

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

Recommendations on Preparing the Tool

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

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

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

Recommendations on Translation and Interpretation

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

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

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

Recommendations on Sampling Strategy

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

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

Recommendations on Working with State Agencies

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

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

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

Recommendations on the Advisory Group

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

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

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

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

Recommendations on Reporting Abuse or Neglect

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

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

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

Recommendations on Working with Providers and School Districts

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

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

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

Recommendations on Recruitment and Communication Strategies

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

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

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

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

Recommendations on the Consent Process

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

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

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

Recommendations on Survey Administration

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

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

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

Recommendations on Survey Administration in Greater Minnesota

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

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

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

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

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

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