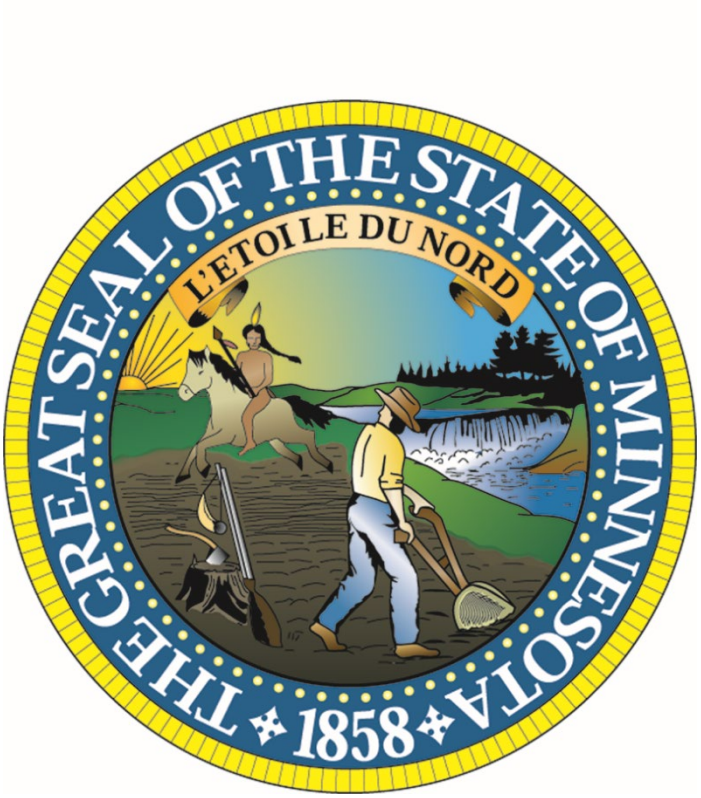
Putting the Promise of Olmstead into Practice: Minnesota's Olmstead Plan



March 2019 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	Go to: Mn.gov/Olmstead Click "Contact Us" and follow instructions for the online form
Email	Send an email to this address: MNOlmsteadPlan@state.mn.us
Mail	Send a letter to: Olmstead Implementation Office 400 Wabasha Street N, Suite 400 St. Paul, MN 55102
Phone	Speak to a staff member at the Olmstead Implementation Office, or leave your comment on voicemail: 651-296-8081

ADA Advisory	For accessible formats of this information or assistance with additional equal access, write to MNOlmsteadPlan@state.mn.us, call 651-296-8081, or use your preferred relay service. (ADA1 [9-15])
	For translations of this publication write to MNOlmsteadPlan@state.mn.us or call 651-296-8081.

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Minnesota Olmstead Subcabinet

March 29, 2019

On behalf of the Olmstead Subcabinet, I am proud to present this March 2019 revision of Minnesota's Olmstead Plan. At the core of this plan is the belief that to become a better Minnesota, we must become *One Minnesota*. All Minnesotans, regardless of disability or disability type, must have access to inclusive, community-based services and have meaningful opportunities to live, learn and work in integrated settings.

This year marks the 20th anniversary of the historic *Olmstead* Supreme Court decision. While tremendous progress has been made, there are still barriers that prevent people with disabilities from having opportunities in the most integrated settings. It is essential that the state continue to collaborate and forge ahead with this critical work.

As the new chair of the Olmstead Subcabinet, I am committed to working with people with disabilities and their families, along with the Walz-Flanagan Administration and state agencies, to continue to make progress on the principles of *Olmstead* and Minnesota's Olmstead Plan. We will work together to remove barriers, address areas of disparities in opportunities, and engage communities to improve health outcomes.

The March 2019 Olmstead Plan is the latest iteration of the state's Olmstead Plan, which was first adopted in 2015. It reflects the culmination of an amendment process that sought public input from people across the state and lays out a plan to create meaningful change that keeps the state accountable and upholds the letter and spirit of the *Olmstead* decision.

There is much work to be done, and I am excited about confronting the challenges ahead and working with people across the state to ensure that our state makes systemic changes to improve the lives of people with disabilities and to create a better Minnesota.

Jennifer Leimaile Ho, Chair
Olmstead Subcabinet

INTRODUCTION AND BACKGROUND INFORMATION

Introduction

The State of Minnesota is firmly committed to ensuring that people with disabilities experience lives of inclusion and integration in the community. We envision a Minnesota where people with disabilities have the opportunity, both now and in the future, to live close to their families and friends and as independently as possible, to work in competitive integrated employment, to be educated in integrated settings, and to participate in community life.

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

Background Information

An Olmstead Plan is a "public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings."[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 enacted by Congress in 1990. Congress recognized that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."[3] With those words, Congress equated segregation with discrimination and, in Title II of the ADA, 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:

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

[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"), http://www.ada.gov/olmstead/q&a_olmstead.htm, last visited December 16, 2016.
[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.R. §35.130(d).
[6] 28 C.F.R. pt. 35, App. A (2010)(addressing §35.130).
[7] *Olmstead v. L.C.,* 527 U.S. 581 (1999).

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

Why does Minnesota have an Olmstead Plan?

Minnesota has an Olmstead Plan to ensure that Minnesotans with disabilities have opportunities for lives of integration and inclusion. To this end, former Governor Mark Dayton issued Executive Orders in 2013 and 2015 that formed an Olmstead Subcabinet and charged the Subcabinet with developing and implementing an Olmstead Plan. On March 29, 2019, Governor Tim Walz issued Executive Order 19-13 to continue the role of the Subcabinet.[12] 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.*[13] *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).

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[8] *Olmstead,* 527 U.S. at 607.
[9] 28 C.F.R. §35.130(b)(7).
[10] *Olmstead,* 527 U.S. at 603.
[11] *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, http://www.justice.gov/crt/opa/pr/speeches/2012/crt-speech-120621.html, last visited December 16, 2016.
[12] Executive Orders 13-01, 15-03 and 19-13 are available on the Olmstead website, Mn.gov/Olmstead.
[13] *Jensen, et. al. v. Department of Human Services, et. al.,* Civil No. 09-cv-1775 (DWF/BRT).

Developing Minnesota's Olmstead Plan

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

In January 2013, former Governor Mark Dayton issued Executive Order 13-01 establishing a subcabinet to develop and implement a comprehensive plan supporting freedom of choice and opportunity for people with disabilities. In January 2015, Governor Dayton issued Executive Order 15-03 which further defined the role and nature of the Olmstead Subcabinet and the Olmstead Implementation Office (OIO).

In January 2019, Governor Tim Walz designated Commissioner Jennifer Leimaile Ho of the Minnesota Housing Finance Agency as the chair the Subcabinet.

On March 29, 2019, Governor Tim Walz issued Executive Order 19-13, to continue the role of the Subcabinet and expand its membership to include the Department of Public Safety, Department of Veterans Affairs, and the Metropolitan Council.

The Olmstead Subcabinet includes the following State agencies and entities:

- Department of Corrections
- Department of Education
- Department of Employment and Economic Development
- Department of Health
- Department of Human Rights
- Department of Public Safety
- Department of Human Services
- Department of Transportation
- Department of Veteran Affairs
- Metropolitan Council
- Minnesota Housing Finance Agency
- Office of the Ombudsman for Mental Health and Developmental Disabilities
- Governor's Council on Developmental Disabilities

Olmstead Subcabinet vision statement

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

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

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

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

Demographics and implications

To better understand how to make the Subcabinet's vision a reality, demographic information was reviewed about the State's population of people with a disability. Although this Olmstead Plan applies to people with disabilities as defined in the ADA,[14] available demographic data used a different definition of disability, one that excluded persons living in congregate settings.[15] 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;[16] and that the highest rates of disabilities among working-age Minnesotans are American Indians and U.S.-born African Americans.[17]

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 2015 study on homelessness in Minnesota, 60% of adults experiencing homelessness reported a serious mental illness, 51% reported a chronic physical health condition, 30% reported

[14] 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.
[15] Data from the American Community Survey and Decennial Census and Population Estimates, via Minnesota Compass, http://www.mncompass.org/demographics/.
[16] Ibid.
[17] Ibid.

evidence of a traumatic brain injury, and 21% reported a substance abuse disorder. 80% of adults reported at least one of these conditions.[18]

Recent media attention has focused on one disability that has increased dramatically. According to the Centers for Disease Control, autism has increased from a prevalence rate of 1 in 1,000 in 1970, to 1 in 150 in 2000, to 1 in 68 in 2012 to 1 in 59 in 2014.[19]

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

Plan development and public comments

The Olmstead Plan is a vital roadmap that will help the Subcabinet and State agencies realize the vision of people with disabilities living, learning, working and enjoying life in the most integrated settings. The dynamic nature of the Plan means that the Olmstead Subcabinet and State agencies are regularly examining the Plan goals and strategies to ensure they are the most effective means to achieve meaningful change. Public comment played an important role in the development of the Olmstead Plan and continues to inform and shape amendments to the Plan.

There have been several major phases in the development of the current Olmstead Plan:

- The development of the August 2015 Olmstead Plan
- The June 2016 Plan amendment to incorporate additional goals and strategies
- The first annual Plan review and amendment process, which resulted in a revised February 2017 Plan
- The second annual Plan review and amendment process, which resulted in the March 2018 Plan
- The third annual Plan review and amendment process, which resulted in this revised March 2019 Plan.

The August 2015 Plan

The Olmstead Subcabinet and State agencies solicited extensive public comment on the development of the August 2015 Olmstead Plan. Between June 2013 and June 2015, more than 400 public comments were received by the Olmstead Implementation Office. In addition the Olmstead Subcabinet conducted a number of listening sessions and the Olmstead Implementation Office conducted informational sessions that accepted public comments on the Plan.
All public comments were reviewed and distributed to the appropriate State agencies so that the agency teams would consider them in the drafting and implementation of the Plan. Several themes emerged from stakeholder comments.[20] The majority of the comments related to the 11 theme areas below.

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[18] Wilder Research, "2015 Minnesota Homeless Study Fact Sheet," 2015, 3. http://mnhomeless.org/pdfs/2015-homeless-study-initial-findings-fact-sheet.pdf, last accessed January 5, 2017.
[19] CDC, "Autism Spectrum Disorders: Data & Statistics." http://www.cdc.gov/ncbddd/autism/data.html, last accessed March 14, 2019.
[20] These themes were derived from the April 24, 2015 to June 19, 2015 Plan comment period. For a more detailed discussion of the public comments received in the development of the August 2015 plan and how these themes

Theme Definitions

1) **Options and Choices** – People expressed that a "one size fits all" plan will not work. An array of options needs to be funded and available for people to meet the needs and choices of individuals.

2) **Financial Resources** – People noted that rates for reimbursement of service and affordability of service are important. They also noted that there should be adequate funding for services.

3) **Quality Assurance/Accountability** – People expect agencies to be accountable for the goals within the Plan. Work needs to be transparent and consistent in order for the public to hold agencies accountable.

4) **Access** – People shared that not everyone can access the programs/services. This may be physical access, lack of awareness about programs/services, and/or policy barriers that prevent access.

5) **Risk** – People expressed concern about personal safety. People perceive the opportunity to try different things as a risk, particularly if there is no option to return to what they were doing previously.

6) **Person-Centered** – People felt strongly that individuals should be able to make informed decisions in all areas of their lives.

7) **Barriers/Disincentives** – People shared that there are many policies that prevent individuals, families and businesses from achieving the Olmstead vision.

8) **Engagement** – People said that individuals with disabilities should be meaningfully involved in the direction of those policies and other things that impact their lives.

9) **Data** – People are dissatisfied with many of the data sources being used. They expressed that data need to be robust and understandable. Many people felt that as a State we collect a great deal of data about our citizens.

10) **Training and Technical Assistance** – People said that training and technical assistance is needed for everyone.

11) **Accessible Communications** – People were dissatisfied with the level of accessibility in State communications. Providing accessible communications will lead to transparency and awareness.

The public comments helped to determine the scope of the Plan, the topics it contains, and what outcomes the Plan should achieve. The August 2015 Plan focused on setting measurable goals to both: 1) increase opportunities for people with disabilities to receive services that best meet their individual

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were incorporated into the Olmstead Plan, please see the August 2015 or June 1, 2016 Plans, available on the Olmstead website, Mn.gov/Olmstead.

needs in the most integrated setting; and 2) improve service delivery to promote a better quality of life. On September 29, 2015, the Court approved the State's August 2015 Olmstead Plan.

The Olmstead Plan was structured to contain measurable goals and broad strategies to achieve them. The detailed actions to implement the strategies are contained in separate workplans created by the responsible agencies. The Subcabinet and State agencies review progress on the workplans on a periodic basis. More information on the workplans is available in the Plan Management and Oversight section.

June 2016 Plan Amendment

Two topic areas remained under development when the Court approved the August 2015 Olmstead Plan— Assistive Technology and Preventing Abuse and Neglect. The Olmstead Subcabinet and State agencies, with assistance from the Court, developed proposed goals and strategies in those topic areas in the first half of 2016. After soliciting public comments on the proposed goal areas, the Subcabinet approved the new goals and strategies. The June 2016 Plan amendment incorporated those new goals and strategies and was approved by the Court on June 21, 2016.

First Plan Amendment Process: February 2017 Plan

The dynamic nature of the Plan means that it is important for the Subcabinet and State agencies to review and update the Plan regularly in light of progress made and lessons learned. The first year of Plan implementation resulted in new levels of coordination and collaboration among the State agencies as they worked to develop processes and mechanisms to make progress towards achieving Plan goals. The annual Plan amendment process is an opportunity to utilize both State agency experience over the past year as well as ongoing public comment to craft an updated Plan.

In the latter part of 2016, the Olmstead Subcabinet undertook the first annual Plan review and amendment process. An initial opportunity for public comments was provided from October 25 to November 14, 2016. This comment period focused on the 39 measurable goals in the Plan and sought to identify both barriers that hinder progress and opportunities to improve progress. Comments were accepted in a variety of formats, including at three public listening sessions. After the initial public comment period, the State agencies developed and the Subcabinet provisionally approved amendments to 15 of the measurable goals.

A second opportunity for public comment was provided from December 20, 2016 to January 19, 2017 regarding the proposed amendments to the measurable goals. The Subcabinet reviewed the public comments, the measurable goal amendments, and updates to the supporting Plan text at the January 30, 2017 Subcabinet meeting.

A final opportunity for public comments was provided from January 31, 2017 to February 7, 2017. During the three public comment periods, comments were received from 60 individuals or agencies. The 60 comments included approximately 180 recommendations or feedback on all fourteen topic areas. The topic areas that received the most attention were person-centered planning, transition services, housing, and employment.

Almost half of the 180 recommendations focused on direct service workforce issues either in general or as they related to person-centered planning, transition services, housing, and employment. These comments raised concern that without improvements to these workforce issues, improvement in the topic areas was unlikely.

After consideration of the public comments, the Olmstead Subcabinet reviewed and approved a revised February 2017 Plan on February 22, 2017.

Second Plan Amendment Process: March 2018 Plan

The Olmstead Subcabinet undertook a second annual Plan review and amendment process beginning in October 2017. The process began with a review by the Subcabinet of the 40 measurable goals and associated strategies in the Plan to determine if there was a justification to propose amendments. A draft of proposed amendments was reviewed by the Olmstead Subcabinet in December 2017.

An initial public comment period was held from December 20, 2017 to January 31, 2018. The public comment period included public listening sessions, focus groups, and written input in various formats. More than 200 people participated in the listening sessions and focus groups and more than 100 comments were received from people with disabilities, families, supporters, lead agencies, providers and others. Significant numbers of comments were received in the areas of Person-Centered Planning, Employment, Housing and Community Engagement.

The Olmstead Subcabinet considered public comment received in the initial public comment period and provisionally approved a revised set of proposed amendments in February 2018. A second public comment period was held from February 27, 2018 to March 13, 2018. The public comment period included a series of eight regionally based video conferences as well as opportunities to submit written comments. More than 71 comments were received during the second public comment period. Areas with the greatest response included Employment, Transportation and Community Engagement and general comments related to Services and Supports.

After consideration of public comments, the Olmstead Subcabinet reviewed and approved this March 2018 Plan on March 26, 2018. As a result of the approved changes, this March 2018 Plan contains 38 measurable goals.

Third Plan Amendment Process: March 2019 Plan

The Olmstead Subcabinet undertook a third annual Plan review and amendment process beginning in September 2018. The process began with a review by the Subcabinet of the 38 measurable goals and associated strategies in the Plan to determine if there was a justification to propose amendments. A draft of proposed amendments was reviewed by the Olmstead Subcabinet in December 2018.

An initial public comment period was held from December 20, 2018 to January 31, 2019. The public comment period included public listening sessions and written input in various formats. Approximately 150 individuals participated in the listening sessions or provided written comments. More than 200 comments were received from people with disabilities, families, supporters, service providers and others. Significant numbers of comments were received in the areas of Person-Centered Practices, Transition Services, Housing, Employment, Community Engagement and Communication.

The Olmstead Subcabinet considered public comment received in the initial public comment period and provisionally approved a revised set of proposed amendments in February 2019. A second public comment period was held from February 26, 2019 to March 11, 2019. The public comment period included two video conferences, a conference call, a focus group as well as opportunities to submit written comments. More than 49 comments were received during the second public comment period from 41 individuals. Areas with the greatest response included Housing, Education and Transportation.

After consideration of public comments, the Olmstead Subcabinet reviewed and approved this March 2019 Plan on March 25, 2019. As a result of the approved changes, this March 2019 Plan contains 38 measurable goals.

Where to learn more?

The Olmstead website at Mn.gov/Olmstead, contains:

- Information and documents related to the history of the Minnesota Olmstead Plan, including Executive Orders;
- Previous versions of the Olmstead Plan, including historical supporting documentation;
- Periodic reports reflecting current and ongoing progress on measurable goals; and
- Information and materials related to Olmstead Subcabinet meetings.

MEASURABLE GOALS

Topic Areas and Measurable Goals

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

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

Measurable goals

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

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

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

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

The following criteria were used for setting measurable goals:

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

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

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

- **Strategic**: Each measurable goal sets its outcomes and activities over a defined number of years.

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

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

Format of topic areas

Each topic area contains eight sections as described below:

- **Stakeholder comments**
  This section includes comments from stakeholders that voice the thoughts of people with disabilities on the topic area.
- **What this topic means**
  This section provides a narrative description of the topic area.
- **Vision statement**
  This section contains a vision statement that describes the State's aspirations for the topic area.
- **Measurable goals**
  This section contains one or more measurable goals that meet the criteria described above.
- **Rationale**
  This section includes statements that support the reasons that the particular measurable goals were selected to be the appropriate measurements for the activities within the topic area and the status of funding for the goals in the topic area.
- **Strategies**
  This section contains several key strategies that will need to be implemented to accomplish the measurable goals in that area. Responsible agencies develop workplans that include steps for implementing these strategies. 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 a defined number of years. More information about the specific goals is included in the topic area sections of the Plan. Agency acronyms are listed at the end of the table.

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 protocols. Protocols are based on the principles of person-centered planning and informed choice.	DHS, DEED, MDE, ADM
	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%	
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 **(A)** ICFs/DD; **(B)** nursing facilities; and **(C)** 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

Topic	Goals	Agency
Transition Services	**Goal Two:** By June 30, 2019, the percent of people under mental health commitment at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting will be reduced to 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%	DHS, DOC, MHFA
	Goal Three: By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital to a more integrated setting will increase to 10 individuals per month. **Annual Goals** to increase average monthly number of individuals leaving MSH: • By December 31, 2016 the number will increase to ≥ 7 • By December 31, 2017 the number will increase to ≥ 8 • By December 31, 2018 the number will increase to ≥ 9 • By December 31, 2019 the number will increase to ≥ 10	
	Goal Four: By June 30, 2020, 100% of people who experience a transition will engage in a process that adheres to the Person-Centered, Informed Choice and Transition protocol. Adherence to the transition protocol will be determined by the presence of ten elements from the My Move Plan Summary document listed below. [People who opted out of using the My Move Summary document or did not inform their case manager that they moved are excluded from this measure.]	
Housing and 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 5,569 (from 5,995 to 11,564 or about a 92% increase). **Annual Goals** to increase the number living in the most integrated housing: • By June 30, 2019 the number will increase by 5,569 over baseline	DHS, MHFA

Topic	Goals	Agency
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, ADM
	Goal Two: By June 30, 2020, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 5,000 over baseline to 11,137 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 to 7,637 • By June 30, 2018, the number will increase by 1,100 individuals to 8,737 • By June 30, 2019, the number will increase by 1,200 individuals to 9,937 • By June 30, 2020, the number will increase by 1,200 individuals to 11,137	
	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	
	Goal Four: By December 31, 2019, the number of Peer Support Specialists who are employed by mental health service providers will increase by 82. **Annual Goals** to increase the number of employed peer support specialists: • By December 31, 2017, the number will increase by 14 • By December 30, 2018, the number will increase by 30 • By December 30, 2019, the number will increase by 38	

Topic	Goals	Agency
Lifelong Learning and Education	**Goal One:** By December 1, 2021 the percent of students with disabilities, receiving instruction in the most integrated setting, will increase to 63%. **Annual Goals** to increase the percent of students with disabilities receiving instruction in the most integrated settings: • By December 1, 2019 the percent will increase to 62.5%. • By December 1, 2020 the percent will increase to 62.75%. • By December 1, 2021 the percent will increase to 63%.	MDE, DHS, DOC
	Goal Two: By June 30, 2020 the percent of students with disabilities who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase to 36% (from baseline of 31%). **Annual Goals** to increase the percent of students entering an integrated postsecondary education setting in the fall after graduating are: • By June 30, 2019 the percent will increase to 35% • By June 30, 2020 the percent will increase to 36%	
	Goal Three: By June 30, 2020, students with disabilities will have active consideration of assistive technology (AT) during the student's annual individualized education program (IEP) team meeting. Active consideration is based upon the "Special factors" requirement as described in Individuals with Disabilities Education Act (IDEA) of 2004. **(A) Annual Goal** to increase the number of school districts that completed training in active consideration of assistive technology (AT) • By June 30, 2019, the number will increase to 21 • By June 30, 2020, the number will increase to 31 **(B) Annual Goal** to increase the percent of students in school districts that have completed training in active consideration of assistive technology during their annual IEP team meeting: • By June 30, 2019, the percent will increase to 15% • By June 30, 2020, the percent will increase to 20%	

Topic	Goals	Agency
Timeliness of Waiver Funding	**Goal One:** Lead agencies will approve funding at a reasonable pace for persons: (A) exiting institutional settings; (B) with an immediate need; and (C) with a defined need for the Developmental Disabilities (DD) waiver. **(A) Persons exiting institutional settings will have funding approved at a reasonable pace, which means that:** • As people residing in an institutional setting are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person makes an informed choice of alternative community services that are more integrated, appropriate to meet their individual needs, and the person is not opposed to moving, and would like to receive home and community-based services. **(B) Persons with an immediate need will have funding approved at a reasonable pace, which means that:** • As people are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person meets criteria under Minn. Statutes, sections 256B.49, subdivision 11a(b) and 256B.092, subdivision 12(b)**.** **(C) For persons with a defined need will have funding approved at a reasonable pace, which means that:** • As people are assessed as having a defined need for waiver services within a year from the 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.	DHS
Transportation	**Goal One:** By December 31, 2020 accessibility improvements will be made to 6,600 curb ramps (increase from base of 19% to 49%) and 380 Accessible Pedestrian Signals (increase from base of 10% to 70%). By October 31, 2021 improvements will be made to 55 miles of sidewalks. **(A) Curb Ramps** • By December 31, 2020, accessibility improvements will be made to an additional 6,600 curb ramps. **(B) Accessible Pedestrian Signals** • By December 31, 2020, accessibility improvements will be made to an additional 380 APS installations. **(C) Sidewalk Improvements** • By October 31, 2021, improvements will be made to 55 miles of sidewalks.	MnDOT, Met Council

Topic	Goals	Agency
Transportation	**Goal Two:** By 2025, the annual number of service hours will increase to 1.71 million in Greater Minnesota (approximately 50% increase). **Annual Goals** to increase the annual number of service hours by 57,000 hours per year.	MnDOT, Met Council
	Goal Three: By 2025, expand transit coverage so that 90% of the public transportation service areas in Greater Minnesota will meet minimum service guidelines for access.	
	Goal Four: By 2025, transit systems' on time performance will be 90% or greater statewide.	

	Goal Five: By 2040, 100% percent of the target population will be served by regular route level of service for prescribed market areas 1, 2, and 3 in the seven county metropolitan area.
	
	• By 2025, the percent of target population served by regular route level of service for each market area will be:
	  • Market Area 1 will be 100%
	  • Market Area 2 will be 95%
	  • Market Area 3 will be 70%	

Healthcare and Healthy Living	**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 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. **(A) 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 **(B) 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.	

Topic	Goals	Agency
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
	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	
	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 June 30, 2019 the emergency use of mechanical restraints will be reduced to no more than 93 reports. **Annual Goals** to reduce the use of mechanical restraints: • By June 30, 2019, reduce to no more than 93 reports	

Topic	Goals	Agency
Positive Supports	**Goal Four:** By June 30, 2020, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 318 students or decrease to 1.98% of the total number of students receiving special education services. **Annual Goals** to reduce the number experiencing restrictive procedures at school: • By June 30, 2017, the number will be reduced by 80 or .02% of total students • By June 30, 2018, the number will be reduced by 80 or .02% of total students • By June 30, 2019, the number will be reduced by 79 or .02% of total students • By June 30, 2020, the number will be reduced by 79 or .02% of total students	DHS, MDE, MDH, DOC
	Goal Five: By June 30, 2020, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 2,251 or by 0.8 incidents of restrictive procedures per student who experienced the use of restrictive procedures in the school setting. **Annual Goals** to reduce number of incidents of restrictive procedures in school: • By June 30, 2017, the number of incidents will be reduced by 563 or 0.2 per student • By June 30, 2018, the number of incidents will be reduced by 563 or 0.2 per student • By June 30, 2019, the number of incidents will be reduced by 563 or 0.2 per student • By June 30, 2020, the number of incidents will be reduced by 562 or 0.2 per student	
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, 2019, 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 64% or more. **Annual Goals** to increase the percent of adults who remain in their community after a crisis: • By June 30, 2017, the percent will increase to 60% • By June 30, 2018, the percent will increase to 62% • By June 30, 2019, the percent will increase to 64%	

Topic	Goals	Agency
Crisis Services	**Goal Three:** By June 30, 2017, the number of people who discontinue waiver services after a crisis will decrease to 45 or fewer. (Leaving the waiver after a crisis indicates that they left community services, and are likely in a more segregated setting.) • The reporting period for this goal has ended. The Subcabinet approved the discontinuation of this measurable goal. DHS will continue to monitor this measure and annually report it to the Subcabinet.	DHS
	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. **(A) Annual Goals** to increase percent of people who are housed five months after discharge from the hospital: • By June 30, 2017, the percent of people will increase to 83% • By June 30, 2018, the percent of people will increase to 84% **(B) Annual Goals** to increase the percent of people receiving services within 30 days after being discharged from the hospital: • By June 30, 2017, the percent of people will increase to 90% • By June 30, 2018, the percent of people will increase to 91%	
	Goal Five: By June 30, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary, placement within ten days. **Annual Goals** to increase the percent of people receiving crisis services within ten days: • By June 30, 2018, the percent of people will increase to 87% • By June 30, 2019, the percent of people will increase to 88% • By June 30, 2020, the percent of people will increase to 90%	

Topic	Goals	Agency
Community Engagement	**Goal One:** By June 30, 2020, the number of individuals with disabilities who participate in Governor appointed Boards and Commissions, the Community Engagement Workgroup, Specialty Committee and other Workgroups and Committees established by the Olmstead Subcabinet will increase to 245 members. **Annual Goals** to increase the number of members with disabilities: • By June 30, 2018, the number will increase to 184 members • By June 30, 2019, the number will increase to 215 members • By June 30, 2020, the number will increase to 245 members	OIO
	Goal Two: By April 30,, 2020, the (A) number of individuals with disabilities to participate in public input opportunities related to the Olmstead Plan, and (B) the number of comments received by individuals with disabilities (including comments submitted on behalf of individuals with disabilities) will increase by 5% over baseline. • By April 30, 2019, a baseline will be established	OIO
	Goal Three: By March 31, 2022, the number of engagement activities for Olmstead Plan's measurable goals that are evaluated utilizing the Civic Engagement Evaluation Framework will increase by 5% over baseline. • By March 31, 2020, a baseline will be established	
Preventing Abuse and Neglect	**Goal One:** By September 30, 2016, the Olmstead Subcabinet will approve a comprehensive abuse and neglect prevention plan, designed to educate people with disabilities and their families and guardians, all mandated reporters, and the general public on how to identify, report and prevent abuse of people with disabilities, and which includes at least the following elements: • Information and training on the use of the Minnesota Adult Abuse Reporting Center (MAARC) • Recommendations regarding a "Stop Abuse" campaign • Recommendations regarding the feasibility for creating a system for reporting abuse of children • Analysis of data to develop materials for public awareness and targeted prevention activities • Timetable for implementation of each element of the abuse prevention plan • Recommendations for developing common definitions and metrics related to maltreatment Annual goals will be established based on the timetable set forth in the abuse prevention plan.	MDH, DHS, MDE, OMHDD

Topic	Goals	Agency
Preventing Abuse and Neglect	**Goal Two:** By January 31, 2022, the number of cases of vulnerable individuals being treated due to abuse and neglect will decrease by 30% compared to baseline. **(A) Annual Goals** to decrease the number of ER visits and hospitalizations due to abuse and neglect: • By April 30, 2019, a baseline will be established • By January 31, 2020, the number will be reduced by 10% • By January 31, 2021, the number will be reduced by 20% • By January 31, 2022, the number will be reduced by 30% **(B) Annual Goals** to decrease the number of medical treatments other than emergency room visits and hospitalizations due to abuse and neglect: • By April 30, 2019, a baseline will be established • By January 31, 2020, the number will be reduced by 10% • By January 31, 2021, the number will be reduced by 20% • By January 31, 2022, the number will be reduced by 30%	MDH
	Goal Three: By December 31, 2021, the number of vulnerable adults who experience more than one episode of the same type of abuse or neglect within six months will be reduced by 20% compared to the baseline. **Annual Goals** to reduce the number of people experiencing more than one episode of abuse • By December 31, 2018, the number of people will be reduced by 5% • By December 31, 2019, the number of people will be reduced by 10% • By December 31, 2020, the number of people will be reduced by 15% • By December 31, 2021, the number of people will be reduced by 20%	DHS
	Goal Four: By July 31, 2020, the number of students with disabilities identified as victims in determinations of maltreatment will decrease by 10% compared to baseline. **Annual Goals** to reduce the number of students with disabilities indentified as victims in determinations of maltreatment: • By July 31, 2019, the number will decrease by 5% from baseline to 19 • By July 31, 2020, the number will decrease by 10% from baseline to 18	MDE
Assistive Technology	• Lifelong Learning and Education Measurable Goal 3 relates to Assistive Technology.	

Agency Acronyms

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

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 respectful of his or her important relationships and goals.
- The context of a person's unique life circumstances includes: culture, ethnicity, language, religion, gender and sexual orientation. All aspects of the person's individuality, when expressed, are acknowledged, embraced, and valued in the planning process.

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

Vision statement

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

Measurable goals

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

Baseline: In state fiscal year 2014, 38,550 people were served on the disability home and community-based services. From July 1, 2016 – June 30, 2017 there were 1,201 disability files reviewed during the Lead Agency Reviews. For the period from April – June 2017, in the 215 case files reviewed, the eight required criteria were present in the percentage of files shown below.

1. The support plan describes goals or skills that are related to the person's preferences. (74%)
2. The support plan includes a global statement about the person's dreams and aspirations. (17%)
3. Opportunities for choice in the person's current environment are described. (79%)
4. The person's current rituals and routines are described. (62%)
5. Social, leisure, or religious activities the person wants to participate in are described. (83%)
6. Action steps describing what needs to be done to assist the person in achieving his/her goals or skills are described. (70%)
7. The person's preferred living setting is identified. (80%)
8. The person's preferred work activities are identified. (71%)

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.

(A) By 2017, increase the percent of people with intellectual and developmental disabilities (I/DD) who report they have input into major life decisions[21] 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%

(B) By 2017, increase the percent of people with intellectual and developmental disabilities who make or have input in everyday decisions[22] 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%

(C) By 2017, increase the percent of people with disabilities other than I/DD who are always in charge of their services and supports[23] 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%

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[21] 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.

[22] 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.

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

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.
- The National Core Indicator (NCI) 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 Quality of Life Survey has been validated across all ages, all settings, and all disability groups.
- There is sufficient funding to implement these goals.
- An important aspect for many people with disabilities is support through the use of assistive technologies. As part of the Person-Centered, Informed Choice and Transition Protocol, individuals are assessed to determine the need for materials, equipment, or assistive technology and, if an individual plan includes assistive technology, that technology will be acquired and tested in the environment where it will be used.
- In Fiscal year 2017 (July 2016 – June 2017), 47,272 individuals received disability home and community-based 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.
- Develop materials and training to guide professionals who inform people with disabilities about their rights and their individual abuse prevention plans to increase understanding of rights and the effectiveness of planning. [Note: professionals include providers (who are responsible for abuse prevention plans), case managers, qualified professionals overseeing Personal Care Assistance services, etc.]

Evaluate the Effectiveness of Person-Centered Planning Principles and Techniques

- Use the established protocols to measure the quality of plans and the extent to which they contain required elements of person-centered planning through regular county and state audits. These audits will include technical assistance and/or improvement plans as indicated.
- Through the MnCHOICES assessment tool, assess whether assistive technology will be considered as part of an individual's support plan, and at reassessments, monitor access to and effective use of technology.
- DHS will work with System of Technology to Achieve Results (STAR) Program on strategies to increase awareness of, and monitor effective use of assistive technology as a means to increase quality of life and outcomes for people with disabilities.

Incorporate Assistive Technology Assessment into Person-Centered Planning Processes

- Person-centered planning processes will be enhanced through a common process across DHS, MDE, DEED and ADM. This process will increase awareness of Assistive Technology, related services, resources and funding sources.

Expand, diversify and improve the pool of workers who provide direct care and support services in order to produce meaningful progress towards alleviating the direct care and workforce shortage in Minnesota

- Increase worker wages and/or benefits.
- Expand the worker pool to ensure that people with disabilities have the workforce they need to live, learn, work and enjoy life in the most integrated setting.
- Improve the workforce by enhancing training for direct care and support professionals.
- Increase job satisfaction (including quality of the job).
- Raise public awareness by promoting direct care and support careers.
- Promote service innovation.
- Enhance data collection.

Responsible Agencies

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

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.

Measurable goals

Goal One: By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings[24] will be 7,138.

Annual Goals for the number of people moving from: **(A)** ICFs/DD; **(B)** nursing facilities; and **(C)** other segregated housing to more integrated settings are set forth in the following table.

	2014 Baseline	June 30, 2015	June 30, 2016	June 30, 2017	June 30, 2018	June 30, 2019	June 30, 2020	Cumulative Total
(A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72*	84	84	84	72	72	72	468
(B) Nursing Facilities (NF) under age 65 in NF > 90 days	707*	740	740	740	750	750	750	4,470
(C) Segregated housing other than listed above	1,121	50	250	400	500	500	500	2,200
Total	**1,900**	**874**	**1,074**	**1,224**	**1,322**	**1,322**	**1,322**	**7,138**

* Calendar Year 2014

Goal Two: By June 30, 2019, the percent of people under mental health commitment at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting[25] will be reduced to 30% (based on daily average).

Baseline: In State Fiscal Year 2015, the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting was 36% on a daily average.

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%

[24]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.

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

Goal Three: By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital to a more integrated setting will increase to 10 individuals per month.

Baseline: In Calendar Year 2014, the average monthly number of individuals leaving Minnesota Security Hospital (MSH) to a more integrated setting was 4.6 individuals per month.

Annual Goals to increase the average monthly number of individuals leaving Minnesota Security Hospital to a more segregated setting:

- By December 31, 2016 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 7
- By December 31, 2017 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 8
- By December 31, 2018 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 9
- By December 31, 2019 the average monthly number of individuals leaving to a more integrated setting will increase to ≥ 10

Goal Four: By June 30, 2020, 100% of people who experience a transition will engage in a process that adheres to the Person-Centered, Informed Choice and Transition protocol. Adherence to the transition protocol will be determined by the presence of the ten elements from the My Move Plan Summary document listed below. [People who opted out of using the My Move Summary document or did not inform their case manager that they moved are excluded from this measure.]

Baseline: For the period from October 2017 – December 2017, of the 26 transition case files reviewed, 3 people opted out of using the My Move Summary document and 1 person did not inform their case manager that they moved. Of the remaining 22 case files, 15 files (68.2%) adhered to the transition protocol.

1. Where is the person moving?
2. Date and time the move will occur.
3. Who will help the person prepare for the move?
4. Who will help with adjustment during and after the move?
5. Who will take the person to new residence?
6. How the person will get his or her belongings.
7. Medications and medication schedule.
8. Upcoming appointments.
9. Who will provide support after the move; what they will provide and how to contact those people (include informal and paid support), including supporting the person to adjust to the changes.
10. Back-up plans for what the person will do in emergencies, such as failure of service provider to show up on schedule, unexpected loss of provider or mental health crisis.

Rationale

- Individuals exiting institutional settings may be included in the housing goal when they move into integrated housing.
- Individuals at AMRTC fall into one of two categories: 1) individuals under mental health commitment; and 2) individuals civilly committed after being found incompetent on a felony or gross misdemeanor charge (restore to competency). For individuals under mental health commitment, discharge planning and discharge are under the authority of the AMRTC and the lead agency. For individuals who were civilly committed after being found incompetent on a felony or gross misdemeanor charge, discharge planning and discharge are under the authority of the criminal court. For the AMRTC goal, progress will be measured only for those individuals under mental health commitment.
- Individuals leaving MSH may move to a more integrated setting, transfer to a treatment facility or transfer to a correctional setting. For the MSH goal, progress will be measured only for those individuals leaving to more integrated settings.
- It is projected that the census of ICFs/DD will decrease over time, therefore the number of people who leave an ICF/DD over time will also decrease.
- A standardized informed choice process is in place to determine how many individuals in segregated settings would choose or not oppose moving to a more integrated setting.
- The "Person-Centered, Informed Choice and Transition Protocol" was adopted in February 2016 and is being implemented.
- There are existing funds to support these goals.
- In June 2017, there were 1,383 individuals receiving services in an ICF/DD and there were 1,502 individuals with disabilities under age 65 who received services in a nursing facility for longer than 90 days.
- In Calendar Year 2017, 383 patients received services at AMRTC. This may include individuals who were admitted more than once during the year. The average daily census was 91.9.
- In Calendar Year 2017, 581 patients received services at MSH. This may include individuals who were admitted more than once during the year. The average daily census was 358.4.

Strategies

Improve Ability to Gather Information about Housing Choices

- The "Person-Centered, Informed Choice and Transition Protocol" was adopted in February 2016 and is being implemented for all people who receive long-term services and supports to determine the number of individuals who would choose or do not oppose moving to a more integrated setting.

Implement New Transition Protocols

- A "Person-Centered, Informed Choice and Transition Protocol" is being used with individuals moving to more integrated settings from segregated settings to ensure that planning includes what is important to the individual as well as for the individual. The protocol aligns with the Jensen Settlement Agreement, the five principles of transition planning, and relevant components of the final rule of Home and Community-Based Services standards.
- Implement the federal rule governing Home and Community-Based Services (HCBS) settings requiring assessment and person-centered planning practices.

Increase Service Options for Individuals Making Transitions

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

Monitor and Audit the Effectiveness of Transitions

- Develop materials to help people with disabilities, families and guardians understand options, answer questions and connect with those who can assist them in making an informed choice and planning for a transition.
- Lead agencies and the State will conduct audits of transition planning done by counties and providers to determine and gather the degree to which the transition meets the Person-Centered, Informed Choice and Transition protocol. DHS will monitor and report to the Subcabinet: the number of transition case files reviewed; the number of people opting out of the My Move Summary document; the number of people who did not inform their case manager of their move; the number of case files that had the My Move Summary document; and the number of those documents that included the ten required elements.
- DHS will focus technical assistance and other strategies toward the areas that have the lowest compliance.
- Monitor both the number and percent of AMRTC patients under civil commitment after being found incompetent on a felony or gross misdemeanor charge and those under civil commitment for mental health treatment.
- DHS, DEED and DOC will work together to ensure efficient and successful transitions for people leaving DOC facilities and entering community services.

Responsible Agencies

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

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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 this history of segregation and prejudice in order to ensure that individuals have an opportunity to make an informed choice. Such steps include providing information about the benefits of integrated settings; facilitating visits or other experiences in such settings; and offering opportunities to meet with other people with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers. Public entities also must make reasonable efforts to identify and address any concerns or objections raised by the individual or another relevant decision-maker." [26]

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.

[26] "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.", U.S. Department of Justice, Civil Rights Division, June 22, 2011, Question 5, pg. 2.

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 5,569 (from 5,995 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.[27] Over the last 10 years, 5,995 individuals with disabilities moved from segregated settings into integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing.[28]

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

- By June 30, 2019, there will be an increase of 5,569 over baseline to 11,564 (about 92% increase)

Rationale

- There were an estimated 38,079 people living in potentially segregated settings in State fiscal year 2014.
- At this time it not known how many of those individuals would choose or not oppose living in an integrated setting. Until that information is available, a subset of the 38,079 will be engaged through a set of flexible housing programs.
- There is sufficient funding authorized and forecasted to meet the target in the goal.
- Individuals accessing these housing options may include those exiting segregated settings such as: Anoka Metro Regional Treatment Center (AMRTC), 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.

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

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

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.

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 address any concerns or objections raised by the individual or another relevant decision-maker.

Employment Statistics

According to the Cornell University Yang-Tan Institute on Employment and Disability Status Report (data for 2017, published in 2019)[29]:

- The employment rate of working-age people (ages 21 to 64) with disabilities in Minnesota was 49.0%. For the general population it was 85.7%.
- The percentage of working-age people with disabilities who were unemployed and actively looking for work was 7.1%. For people without a disability who were actively looking for work it was 19.3%.
- The percentage of working-age people with disabilities working full-time/full-year was 26.9% with average annual earnings of $40,400. For working-age people without disabilities, 63.6% were working full-time/full-year with average annual earnings of $50,600.

Based on statistics reported by DEED from October 2015- September 2016:

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

- Vocational Rehabilitation Services (VRS) provided services to 17,674 persons under Title I of the Rehabilitation Act, all of whom were individuals with a significant disability.
- State Services for the Blind (SSB) provided vocational rehabilitation services to 1,027 persons who are blind, visually impaired, and DeafBlind.
- 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 12% received State Vocational Rehabilitation Services.
- For comparison, 20% 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.

Measurable goals

Goal One: By September 30, 2019 the number of new individuals[30] 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 working in competitive integrated employment will be 3,059

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

Goal Two: By June 30, 2020, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 5,000 over baseline to 11,137 in competitive integrated employment.

Baseline: In 2014, of the 50,157 people age 18-64 in Medicaid funded programs, 6,137 were in competitive integrated employment. Medicaid funded programs include: Home and Community-Based Waiver Services, Mental Health Targeted Case Management, Adult Mental Health Rehabilitative Services, Assertive Community Treatment and Medical Assistance for Employed Persons with Disabilities (MA-EPD).

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

- By June 30, 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, the number of individuals in competitive integrated employment will increase by 1,500 individuals over baseline to 7,637.
- By June 30, 2018, the number of individuals in competitive integrated employment will increase by 1,100 individuals over baseline to 8,737.
- By June 30, 2019, the number of individuals in competitive integrated employment will increase by 1,200 individuals over baseline to 9,937.
- By June 30, 2020, the number of individuals in competitive integrated employment will increase by 1,200 individuals over baseline to 11,137.

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 fiscal years 2015 and 2016 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 additional 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.

Goal Four: By December 31, 2019, the number of Peer Support Specialists who are employed by mental health service providers will increase by 82.

Baseline: As of April 30, 2016, there are 16 certified peer support specialists employed by Assertive Community Treatment (ACT) teams or Intensive Residential Treatment Services (IRTS) throughout Minnesota.

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

- By December 31, 2017, the number of employed peer support specialists will increase by 14
- By December 30, 2018, the number of employed peer support specialists will increase by 30
- By December 30, 2019, the number of employed peer support specialists will increase by 38

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 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.
- 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 the Minnesota Employment First Policy which encourages competitive integrated employment.

Utilize Data System to Measure and Evaluate Integrated Employment

- Agencies will continue to collaborate on efforts to determine the best ways to use data and common measures to evaluate employment services and measure increases in competitive integrated employment.

Reform Funding Policies to Promote Competitive Integrated Employment

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

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

- Adopt the evidence-based practice of engaging youth in paid work before exiting school.
- Build capacity at state/regional levels by expanding 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.
- Increase awareness of and education about ways that Assistive Technology products, services and resources can support competitive integrated employment outcomes. Increase employment opportunities for certified peer specialists by mental health service providers.

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

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

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

- Implement federal requirements regarding employment under the Centers for Medicare and Medicaid Services Home and Community-Based Services Rule, the federal rule that governs waivered services for individuals with disabilities.

Responsible Agencies

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

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

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

Vision statement

People with disabilities will experience an inclusive education system at all levels and lifelong learning opportunities that enable the full development of individual talents, interests, creativity, and mental and physical abilities. They will be educated in the most integrated educational setting from preschool through grade twelve and will transition to the most integrated post-secondary setting or employment.

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

Measurable goals

Goal One: By December 1, 2021 the percent of students with disabilities[32], receiving instruction in the most integrated setting[33], will increase to 63%.

Baseline: In 2013, of the 109,332 students with disabilities, 67,917 (62.1%) received instruction in the most integrated setting.

Annual Goals to increase the percent of students with disabilities receiving instruction in the most integrated settings:

- By December 1, 2019 the percent of students with disabilities receiving instruction in the most integrated setting will increase to 62.5%.
- By December 1, 2020 the percent of students with disabilities receiving instruction in the most integrated setting will increase to 62.75%.
- By December 1, 2021 the percent of students with disabilities receiving instruction in the most integrated setting will increase to 63%.

Goal Two: By June 30, 2020 the percent of students with disabilities who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase to 36% (from the 2016 baseline of 31%).

Baseline: Based on 2014 Minnesota's Statewide Longitudinal Education Data System (SLEDS), of the 6,749 students with disabilities who graduated statewide in 2014, a total of 2,107 (31%) enrolled in the fall of 2014 into an integrated postsecondary institution.

Annual Goals to increase the percent of students with disabilities enrolling in an integrated postsecondary education setting in the fall after graduating are:

- By June 30, 2019, the percent will increase to 35%
- By June 30, 2020, the percent will increase to 36%

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

Goal Three: By June 30, 2020, students with disabilities will have active consideration of assistive technology (AT) during the student's annual individualized education program (IEP) team meeting. Active consideration is based upon the "Special factors" requirement as described in Individuals with Disabilities Education Act (IDEA) of 2004.

There are two measures for this goal:

(A) School districts trained in active consideration

Baseline: From December 2016 to December 2018, fifteen school districts have completed MDE training in active consideration of assistive technology (AT) during the student's annual individualized education program (IEP) meeting to ensure education in the most integrated setting.

Annual Goals to increase the number of school districts that completed MDE training in active consideration of assistive technology (AT):

- By June 30, 2019, the number of school districts that completed AT training will increase to 21.
- By June 30, 2020, the number of school districts that completed AT training will increase to 31.

(B) Students with disabilities in districts trained in active consideration

Baseline: From December 2016 to December 2018, 11.1% (15,106 of 136,245) of students with disabilities statewide (K-12)are served in school districts that have completed MDE training in active consideration of AT during the student's annual individualized education program (IEP) team meeting to ensure education in the most integrated setting.[34]

Annual Goals to increase the percent of students with disabilities statewide in school districts that have completed training in active consideration of assistive technology during their annual IEP team meeting:

- By June 30, 2019, the percent of students with disabilities in school districts that have completed MDE training will increase to 15%.
- By June 30, 2020, the percent of students with disabilities in school districts that have completed MDE training will increase to 20%.

Rationale

Goal One

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

[34] Source: MDE 2017 Child Count data for trained school districts and the state total, not including intermediate school districts and educational cooperatives.

- Using a percentage measure more accurately reflects the proportion of students with disabilities receiving instruction in the most integrated setting based on the true annual number of students with disabilities each year. The annual number of students with disabilities changes every year, and as such poses a shifting denominator for the goal calculations. Using a percentage measurement adjusts for these annual shifts in the number of students with disabilities.
- The annual number of students with disabilities receiving instruction in the most integrated setting will also be reported for purposes of clarity and transparency, and will continue to be available to the public on the MDE Data Center website.

Goal Two

- Minnesota's Statewide Longitudinal Education Data System (SLEDS) data tracks the successful same-year transition of students from high school graduation directly into fall enrollment in institutions of higher education. The public SLEDS data also includes enrollment in accredited certificate and one year programs.
- Ideal performance for this goal is defined as students with disabilities enrolling in an accredited institution of higher education in the fall of the same year as their graduation (as opposed to delayed enrollment to the next year).
- Using a percentage more accurately reflects the proportion of students with disabilities enrolling in integrated postsecondary education based on the true annual number of students with disabilities graduating from high school in each year. The annual number of students with disabilities graduating from high school changes every year, and as such poses a shifting denominator for the goal calculations.
- The annual number of students with disabilities enrolling in integrated postsecondary education will continue to be reported to the Subcabinet, and will continue to be available to the public on the SLEDS data website.

Goal Three

- The Individuals with Disabilities Education Act (IDEA) requires states to ensure that, to the maximum extent appropriate, children with disabilities, are educated with children who are nondisabled (34 C.F.R. 300.114). Minnesota Rule requires school districts to ensure student are placed in the least restrictive environment and to include parents in any decisions concerning placement (Minnesota Rule 3525,3010). As part of the "special factors" requirement in the Individuals with Disabilities Education Act, IEP teams must "consider whether the child requires assistive technology devices and services." (34 C.F.R. §300.324(a)(2)(v)).
- Potential outcomes of active consideration of assistive technology in supporting education in the most integrated setting are:
    - The student is educated in the most integrated setting without the use of AT. No further action is needed.
    - The student is educated in the most integrated setting with the use of AT. The use of AT should be documented in the IEP and continued in use.
    - The student may or may not be using AT, but is not educated in the most integrated setting. The IEP team should explore other AT strategies that can be of benefit.
    - No one on the IEP team knows enough to determine if AT can be of benefit. The IEP team needs to add membership with information and knowledge of AT.

Strategies

Goal One

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

- Continue the expansion of the Positive Behavioral Interventions and Supports (PBIS) to improve the capacity of school districts to include students in integrated classrooms, and reduce the disciplinary removal of students from the classrooms. In 2016-2017, there were 137,601 students with disabilities, and 19,488 disciplinary actions involving students with disabilities (i.e. an out of school suspension for one day or more, expulsion or exclusion). MDE annually reviews disciplinary actions for disproportionality related to student disability and race/ethnicity, in an annual report to the legislature. During the 2018-2019 school year there are 690 or 33% of Minnesota schools implementing PBIS, impacting an estimated 335,598 students. (38.9% 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 partner with TRIO Student Support Services at institutions of higher education in order to increase postsecondary enrollment of recent high school graduates. MDE will continue to disseminate Minnesota Postsecondary Resource Guides and share on-line training resources. These resources are currently located on the Normandale Community College website at http://www.normandale.edu/osdresources.

Goal Three

Annually Evaluate Effectiveness and Impact of Current MDE Training and Technical Assistance for Active Consideration of AT to Ensure Education in the Most Integrated Setting

- Continue to host AT Teams Projects, designed to support school district AT Teams in providing services that are in alignment with legal standard and best practices in AT. Target districts for this goal will be AT Teams Project participants. There are currently 31 school districts actively participating in the AT Teams Project.
- Develop protocols for consideration of AT that includes documentation to record the four potential outcomes and to demonstrate that AT consideration was effective.
- Each target district will gather baseline data on the outcome of consideration of AT for the students on whose IEP team they serve. A matrix of potential determinations will be provided to each team member, which will then be provided to MDE as part of the team's agreement for participation in the AT Teams Project.
- It is a best practice to document the decision making process used to consider the student's need for assistive technology. For example a statement regarding the discussion of assistive technology needs may be documented in the minutes of the IEP meeting and may be included in other components of the IEP.
- MDE will develop an implementation fidelity and scale-up measures to evaluate the extent to which school districts apply MDE training for active consideration of AT in individualized education program (IEP) meetings. This data will be used to evaluate implementation and impact in school districts for students with disabilities.

Analyze Data to Determine Impact of Training on Active Consideration

- Compare the percentages of students with disabilities educated in the most integrated setting (Education Goal One) of school districts completing MDE training, compared to their own previous annual percentages, to measure impact of training within the school district.
- Compare the percentages of students with disabilities educated in the most integrated setting (Education Goal One) of school districts completing MDE training, compared to all other school districts, to measure impact of training within the school district and in annual state data,
- Annually review the effectiveness of current MDE training strategies for school districts to use active consideration of assistive technology as a strategy for ensuring the education of students with disabilities in the most integrated setting (Education Goal One).
- Develop alternative measures to evaluate the impact of AT training for students with disabilities who may remain in the same instructional setting, but may experience quality of life improvements as a result of the school district completing AT training.

Responsible Agencies

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

Timeliness of Waiver Funding

What this topic means

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

The urgency of each individual's need for waiver services varies. Some people are wanting to move from institutional settings; some people are at serious risk of institutionalization because they lack supports to remain in the community; some people in the community are not at risk of institutionalization, but will need waiver services within a year in order to remain in the community. Access to waiver funding and services is prioritized according to levels of urgency. Access to funding will move at a reasonable pace, according to urgency of need.

A new urgency categorization system for the Developmental Disabilities (DD) waiver waiting list was implemented on December 1, 2015. The new system categorizes urgency into three categories including Institutional Exit, Immediate Need, and Defined Need. Reasonable pace goals have been established for each of these categories.

Lead agencies receive monthly updates regarding the people who require waiver funding approval through a web-based system. Using this information, lead agencies can view the number of days since a person's assessment and whether reasonable pace goals are met. If reasonable pace goals are not met for people in the Institutional Exit or Immediate Need categories, DHS directly contacts the lead agency and seeks remediation. DHS prioritizes funding resources to lead agencies to support funding approval for people in the Institutional Exit and Immediate Need categories.
In this topic area, we will use statutory priorities for accessing waiver service planning and funding so that funding for waiver services moves at a reasonable pace according to urgency of need.

Vision statement

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

Measurable goals

Goal One: Lead agencies will approve funding at a reasonable pace for persons: (A) exiting institutional settings; (B) with an immediate need; and (C) with a defined need for the Developmental Disabilities (DD) waiver.

Baseline:
From January – December 2016, of the 1,500 individuals assessed, 707 individuals or 47% moved off the DD waiver waiting list at a reasonable pace. The percentages by urgency of need category were: Institutional Exit (42%); Immediate Need (62%); and Defined Need (42%).

Assessments between January – December 2016

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days
Institutional Exit	89	37 **(42%)**	30 (34%)
Immediate Need	393	243 **(62%)**	113 (29%)
Defined Need	1,018	427 **(42%)**	290 (28%)
Totals	**1,500**	**707 (47%)**	433 (29%)

(A) Persons exiting institutional settings will have funding approved at a reasonable pace, which means that:

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

(B) Persons with an immediate need will have funding approved at a reasonable pace, which means that:

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

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

(C) Persons with a defined need of requiring services within a year of assessment will have funding approved at a reasonable pace, which means that:

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

Rationale

- The CADI waiver waiting list was eliminated in October 2016. DHS will continue to monitor access to CADI waiver services.
- The reasonable pace guidelines outlined above were implemented on December 1, 2015. Lead agencies were trained on the new data system, urgency categories and reasonable pace guidelines.
- Limits on growth are based on legislative appropriations and the federally approved waiver plan. The federally approved DD waiver plan currently has a limit on funding growth of 300 persons/year.
- An individual will be identified as having a "future need" if, after assessment, the individual does not meet criteria for the other three categories (institutional exit, immediate need, and defined need) and instead identified a future need for services that is over a year from the assessment date. An individual with a future need will be placed on a waiver eligibility list, but will not be placed on the waiting list. People will be offered an assessment annually, or any time that their needs or situation change. At that point, the reasonable pace standards will be applied.
- Kentucky and Tennessee have implemented similar urgency categories for individuals. The experience from these states shows that people in the emergent categories have funding approved quickly. DHS anticipates that the urgency category populations will be similar to the experience of those states.

Strategies

Reform Waiver Funding Approval to Incorporate Urgency of Need

- Implement new urgency of need categorization system and report to the Subcabinet and the legislature as required.
- Due process protections available to people with disabilities will be modified as necessary, to reflect new protocols.
- DHS will complete an analysis of baseline data on urgency of need and reasonable pace. The analysis will consider the needs of persons waiting, potential options to meet their needs, and the evaluation of existing programs to determine if there are changes which would enable programs to be more effective.

Implement Initiatives to Achieve Reasonable Pace Guidelines

- Lead agencies receive monthly updates regarding the people who are pending funding approval for the DD waiver through a web-based system. Using this information, lead agencies can view the number of days since a person's assessment and whether reasonable pace goals are met. If reasonable pace goals are not met for people in the Institutional Exit or Immediate Need categories, DHS directly contacts the lead agency and seeks remediation. DHS continues to allocate funding resources to lead agencies to support funding approval for people in the Institutional Exit and Immediate Need categories.
- Lead agencies may encounter funding approval situations on an intermittent basis, requiring DHS to engage with each agency to resolve individual situations. When an issue arises, a lead agency may be unfamiliar with the reasonable pace funding requirement due to the infrequency of this issue at their particular agency. DHS continues to provide training and technical assistance to lead agencies as funding approval issues occur and has added staff resources to monitor compliance with reasonable pace goals.

Responsible Agency

- Department of Human Services

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Transportation

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

What this topic means

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

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

Vision statement

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

Measurable goals

Goal One: By December 31, 2020, accessibility improvements will be made to: (A) 6,600 curb ramps (increase from base of 19% to 49%); (B) 380 accessible pedestrian signals (increase from base of 10% to 70%); and (C) by October 31, 2021, improvements will be made to 55 miles of sidewalks.

(A) Curb Ramps

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

- By December 31, 2020 accessibility improvements will be made to an additional 6,600 curb ramps[35] bringing the percentage of compliant ramps to approximately 49%.

(B) Accessible Pedestrian Signals

Baseline: In 2009, 10% of 1,179 eligible state highway intersections with accessible pedestrian signals (APS) were installed. The number of intersections where APS signals were installed was 118.

- By December 31, 2020, an additional 380 Accessible Pedestrian Signals (APS) installations will be provided on MnDOT owned and operated signals bringing the percentage to 70%.

(C) Sidewalks

Baseline: In 2012, MnDOT maintained 620 miles of sidewalks. Of the 620 miles, 285.2 miles (46%) met the 2010 ADA Standard and Public Right of Way (PROW) guidance.

- By October 31, 2021 improvements will be made to an additional 55 miles of sidewalks bringing total system compliance to 60%.

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

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

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

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

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

Goal Three: By 2025, expand transit coverage so that 90% of the public transportation service areas in Greater Minnesota will meet minimum service guidelines for access.

Greater Minnesota transit access is measured against industry recognized standards for the minimal level of transit availability needed by population size. Availability is tracked as span of service, which is the number of hours during the day when transit service is available in a particular area. The measure is based on industry recognized standards and is incorporated into both the Metropolitan Council Transportation Policy Plan and the MnDOT "Greater Minnesota Transit Investment Plan." [36]

Baseline: In December 2016, public transportation in Greater Minnesota was meeting minimum service guidelines for access 47% on weekdays, 12% on Saturdays and 3% on Sundays.

Goal Four: By 2025, transit systems' on time performance will be 90% or greater statewide.

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

Baseline for on time performance in 2014 was:

- Transit Link – 97% within a half hour
- Metro Mobility – 96.3% within a half hour timeframe
- Metro Transit – 86% within one minute early – four minutes late
- Greater Minnesota – 76% within a 45 minute timeframe

Ten year goals to improve on time performance:

- Transit Link – maintain performance of 95% within a half hour
- Metro Mobility – maintain performance of 95% within a half hour
- Metro Transit – improve to 90% or greater within one minute early – four minutes late
- Greater Minnesota – improve to 90% within a 45 minute timeframe

Goal Five: By 2040, 100% percent of the target population will be served by regular route level of service for prescribed market areas 1, 2, and 3 in the seven county metropolitan area.

Baseline: The percentage of target population served by regular route level of service for each market area is as follows: Market Area 1 = 95%; Market Area 2 = 91%; and Market Area 3 = 67%.[37]

- By 2025, the percent of target population served by regular route level of service for each market area will be:
  - Market Area 1 will be 100%
  - Market Area 2 will be 95%
  - Market Area 3 will be 70%

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[36] Greater Minnesota Transit Investment Plan is available at www.dot.state.mn.us/transitinvestment.

[37] Transit Market Area I has the highest density of population, employment and lowest automobile availability in the region. These are typically Urban Center communities and has the highest potential for transit ridership in the region. Transit Market Area II has high to moderately high population and employment densities. Much of this area is categorized as Urban but has approximately half the ridership potential of TMA I. Transit Market Area III has moderate density. These areas are typically Urban with large portions of Suburban and Suburban Edge communities and has approximately half the ridership potential of TMA II.

Rationale

Goal One

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

Goal Two

- Service hours are a more effective metric for measuring the availability of transit service in Greater Minnesota than ridership. The MnDOT Office of Transit currently tracks and reports on the number of service hours by system in the Annual Transit Report. Beginning with the 2001 Greater Minnesota Transit Plan, the number of service hours of transit have been used in describing the future level of service to address the transit need/demand. This metric is also one of the factors mentioned in recent research that impacts the transit travel demand (ridership).
- The annual goals are incrementally ramped up each year by 57,000. Of the total 57,000 additional hours each year, 28,500 will be added to urban systems and 28,500 to small urban and rural transit systems combined. The 57,000 additional hours will provide service needed to increase ridership to meet the 90 percent of demand target by 2025.
- In addition to data on service hours, MnDOT reporting will also include data on passenger trips.
- MnDOT is monitoring emerging issues in alternatives to public transportation and the impact that such alternatives may have on public transportation.

Goal Three

- The goal is linked to the system expansion goal which appears in state statute and has a timeframe of ten years. Meeting the legislative goal is important to realizing the overarching vision of the Olmstead Plan because the availability of transit is consistently identified as important by the disability community as integral to living an independent, integrated life.
- The goal ensures that system expansion has appropriate geographic balance and service variety to provide for a variety of trip needs.
- Achieving the first four years of the goal is realistic based on current funding forecasts from Minnesota Management and Budget (MMB). In the fifth year and beyond, the goal will likely not be met without increased funding for Greater MN transit from the Minnesota legislature.
- The primary barriers in achieving the goal are: (1) budgetary; (2) not being able to determine at a population level the degree to which meeting public transit goals provides benefit to the Olmstead population; and (3) the impact of reduced capacity in program specific transportation to individuals' overall transportation access.

Goal Four

- The five year goals for on-time performance are consistent with the Metropolitan Council's long standing goal of 95%. The 95% goal is the performance goal used in Metropolitan Council's service contracts which is reported to the Federal Transit Administration.

Goal Five

- Metro Area Public Transit utilization is measured by distinct market areas for regular route level of service. This measure estimates demand potential for all users of the regular route system. The market area is created based on analysis that show the demand for regular route service is driven primarily by population density, automobile availability, employment density and intersection density (walkable distance to transit).
- This measure is based on industry standards incorporated into the Transportation Policy Plan's - Regional Transit Design Guidelines and Performance Standards. The Metro Area also provides non-regular route services in areas that are not suitable for regular routes, such as dial-a-ride transit.
- The percentage for each market area will be reported on an annual basis to determine if progress is being made toward the goals.

Strategies

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

- Accessibility improvements are included as part of any project meeting the alterations threshold, as required by the ADA, to ensure program consistency and ongoing investment. In general, the alteration threshold is met when there is a pavement project such as a mill and overlay, bridge rehabilitation, or signal replacement. The four year schedule of projects is found in MnDOT's State Transportation Improvement Plan (STIP).[38]
- 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 was updated in 2017 and the investment levels will be reassessed as part of the plan update. MnSHIP is developed with significant public input and sets investment targets, including those for accessibility improvements, for the agency based on system conditions and revenue.

Improve the Ability to Assess Transit Ridership by People with Disabilities

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

Improve Transit Services for People with Disabilities

- MnDOT, the Metropolitan Council, and local transit systems are the responsible parties with DHS providing a significant support and coordinating role. The agencies will collaborate through

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

established planning processes and contract oversight to ensure that continual progress to the targets is being made.

- On time performance efforts will be focused initially on those services with poor on time performance.

Responsible Agencies

- Department of Transportation
- Metropolitan Council

Healthcare and Healthy Living

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

What this topic means

Healthcare is "the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions." [39]

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." [40] 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. [41]

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.

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.

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[39] American Heritage Medical Dictionary, "Healthcare." Boston: Houghton Mifflin Harcourt Publishing, 2008, 236.
[40] 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.
[41] 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.

Measurable goals

Goal One: By December 31, 2018, the number/percent of individuals with disabilities and/or serious mental illness accessing appropriate preventive care[42] focusing specifically on cervical cancer screening will increase by 833 people compared to the baseline.

A specific indicator that individuals with disabilities are accessing appropriate care, cervical cancer screening will be tracked. This is an area where a health care outcome disparity has been identified. This will reduce disparities in cervical cancer screening by 10% (increase of 616 women being screened).

Baseline: In 2013, the number of women receiving cervical cancer screenings was 21,393.[43]

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.

(A) Children accessing dental care

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

(B) Adults accessing dental care

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.

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

[43] Baseline for this goal is from the 2013 "Olmstead Plan: Baseline Data for Current Care" Report.

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 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).
- 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 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

- Monitor the implementation of the increase in dental payment rates in January 2016 and thereafter. Increase in dental rates has historically resulted in increased access to dental care for people with disabilities.
- Implement the recommendations from the "Recommendations for Improving Oral Health Services Delivery System" Report and the follow up report, "Delivery System for Oral Health."
- Implement the "Minnesota Oral Health Plan."
- Increase the number of providers and the level of access of people with disabilities to providers.
- Monitor and report the number of enrollees (adults and children) who used an emergency department for non-traumatic dental services to give a more complete picture of the level of access of people with disabilities to dental care.

Expand the Use of Health Care Homes and Behavioral Health Homes

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

Improve Access to Health Care for People with Disabilities

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

Develop and Implement Measures for Health Outcomes

- Monitor and report the number and percentage of adult public program enrollees [with disabilities] who had an acute inpatient hospital stay that was followed by an unplanned acute readmission to a hospital within 30 days.

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

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

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

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

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

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

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

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

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

Vision statement

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

Measurable goals

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

Goal One: By June 30, 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 FY 2014 of the 35,668 people receiving services in licensed disability services, e.g., home and community-based services, the number of unique individuals who experienced a restrictive procedure was 1,076.

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[45], 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 June 30, 2019 the emergency use of mechanical restraints will be reduced to: no more than 93 reports.

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, 2019, reduce mechanical restraints to no more than 93 reports of mechanical restraint

Goal Four: By June 30, 2020, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 318 students or decrease to 1.98% of the total number of students receiving special education services.

Annual Baseline: During school year 2015-2016, school districts (which include charter schools and intermediate districts) reported to MDE that 3,034 students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting. In 2015-2016, the number of reported students receiving special education services was 133,742 students. Accordingly, during school year 2015-2016, 2.3% students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting.

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

- By June 30, 2017 the number of students experiencing emergency use of restrictive procedures will be reduced by 80 students or .02% of the total number of students receiving special education services.
- By June 30, 2018 the number of students experiencing emergency use of restrictive procedures will be reduced by 80 students or .02% of the total number of students receiving special education services.
- By June 30, 2019 the number of students experiencing emergency use of restrictive procedures will be reduced by 79 students or .02% of the total number of students receiving special education services.
- By June 30, 2020 the number of students experiencing emergency use of restrictive procedures will be reduced by 79 students or .02% of the total number of students receiving special education services.

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

Goal Five: By June 30, 2020, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 2,251 or by 0.8 incidents of restrictive procedures per student who experienced the use of restrictive procedures in the school setting.

Annual Baseline: During school year 2015-2016, school districts (which include charter schools and intermediate districts) reported 22,028 incidents of emergency use of a restrictive procedure in the school setting. In school year 2015-2016, the number of reported students who had one or more emergency use of restrictive procedure incidents in the school setting was 3,034 students receiving special education services. Accordingly, during school year 2015-2016 there were 7.3 incidents of restrictive procedures per student who experienced the use of a restrictive procedures in the school setting.

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

- By June 30, 2017, the number of incidents of emergency use of restrictive procedures will be reduced by 563 incidents, or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.
- By June 30, 2018, the number of incidents of emergency use of restrictive procedures will be reduced by 563 incidents or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.
- By June 30, 2019, the number of incidents of emergency use of restrictive procedures will be reduced by 563 incidents or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.
- By June 30, 2020, the number of incidents of emergency use of restrictive procedures will be reduced by 562 incidents or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.

Rationale

Goals One - Three

- Progress towards these goals will be measured through incident tracking from Behavioral Intervention Reporting Forms (BIRFs). Individuals who experience the use of a restrictive procedure while receiving services by a 245D licensed provider (a provider of disability services, for example: home and community-based services) will be identified through submitted BIRFs. Providers are required to submit BIRFs to DHS and the Ombudsman for Mental Health and Developmental Disabilities for any sort of behavioral intervention, including all restrictive procedures, within 3-5 days of their use.
- For the purposes of Goal One and Goal Two, the baseline includes reports of mechanical restraints, self-injury protection equipment, seat belt restraints, time-out, seclusion and penalty consequences. For Goal Three, the baseline includes only reports about mechanical restraints, self-injury equipment and seat belt restraints.
- 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[46], which implements the Minnesota Statute, Chapter 245D.)

- These measures are reasonable because they track every incident of restrictive procedures in their respective areas.
- Mechanical restraints are approved through a review process by a team of clinicians who also provide technical assistance and monitoring of the plans to reduce use of restraints.
- The Positive Supports Rule (Minn. Rule, part 6544) that went into effect in August 2015 for providers with 245A licenses who serve people with developmental disabilities also report through the BIRF system.
- DHS believes the targets to be realistic based upon the experience from other states and Minnesota's success following positive supports training.

Goals Four - Five

- Progress towards these goals will be measured through incident tracking from annual restrictive procedure summary reports.
- Baseline data includes students who experience the use of a restrictive procedure by school staff while in the school setting as well as the number of restrictive procedure incidents. A restrictive procedure includes physical holds and seclusions, as defined in Minnesota Statutes section 125A.0941. Summary student data will be identified by an annual restrictive procedure summary report submitted by school districts to the Minnesota Department of Education (MDE) on an annual basis. That data will be summarized in the annual legislative report submitted on February 1 of each year.
- The number of students receiving special education services varies each year. Reporting by number of incidents alone does not accurately reflect performance. A secondary measure of a percentage reduction is included to allow for fluctuations in the total number of students.
- The number of students experiencing restrictive procedures varies each year. Reporting by number of incidents alone does not accurately reflect performance. A secondary measure of a rate per student is being added to allow for fluctuations in the total number of students experiencing restrictive procedures.
- MDE and school districts provided training to staff to assure common definitions were used to make reporting more consistent. During this training it became evident that there were different definitions of reporting across school districts and across the State. MDE continues to work toward ensuring the accuracy of reporting.
- There is funding to support actions related to the current goals.

Strategies

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

- Continue to implement the Positive Supports Rule (Minnesota Rules Chapter 9544) which became effective on August 31, 2015. This rule prohibits the use of restrictive procedures except in emergencies. The rule also requires training, technical assistance, and mentoring to disability service providers on positive support practices and the statutory and rule requirements.
- Continue the expansion of the Positive Behavioral Interventions and Supports (PBIS) which improves the capacity of school districts to include students in integrated classrooms. During the 2018 - 2019 school year there are 690 or 33% of Minnesota schools implementing PBIS, impacting an estimated 335,598 students. (38.9% of total students)

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

- Continue to 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 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)[47] as appropriate for correctional settings.

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

- Monitor data systems that: (1) assess progress in the reduction of the emergency use of restrictive procedures; (2) assess the number of individuals experiencing restrictive procedures and the number of incidents or applications of restrictive procedures; and (3) to identify situations to be targeted for technical assistance.
- Improve data reporting tools to increase the accuracy, completeness and timeliness of the information.
- Annually evaluate progress and determine if there are additional measures to be taken to reduce the use of mechanical restraints that are used to prevent imminent risk of serious injury due to self-injurious behaviors. The external review committee provides oversight and technical assistance.
- Publish annual reports on the progress in reducing the use of restrictive procedures and recommendations.
- Work with the MDH to evaluate opportunities to coordinate tracking with DHS and reduce use of restrictive procedures for people with disabilities in MDH-licensed facilities.
- Continue to implement MDE's Statewide Plan to Reduce the Use of Restrictive Procedures and eliminate the use of seclusion.
- MDE will document progress in Statewide Plan implementation and summarize restrictive procedure data in the annual legislative report submitted by March 1 of each year. MDE will track individual uses of seclusion on students receiving special education services by requiring districts to submit quarterly reports to MDE about individual students who have been secluded. These reports will assist MDE and the Restrictive Procedures Work Group in identifying areas of concern and developing strategies for eliminating the use of seclusion.
- In alignment with the statewide plan, MDE will identify and recruit districts with the highest per capita use of physical holds and seclusion to partner with MDE to develop a district level team and conduct a district readiness assessment to initiate implementation of evidence-based practices that match the district's needs in an active implementation framework.
- Restrictive procedures may only be used in the school setting in an emergency, by licensed professionals, who have received training which includes positive behavioral interventions, de-escalation, alternatives to restrictive procedures, and impacts of physical holding and seclusion.
- MDE will provide evidence-based strategies to use with students with disabilities who have significant needs that result in self-injurious or physically aggressive behaviors.

[47] 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.

- MDE will collaborate with DHS to expand the list of effective evidence-based strategies for districts to use to increase staff capacity and reduce the use of restrictive procedures.

Reduce the Use of Seclusion in Educational Settings

- Engage the Restrictive Procedures Work Group[48] 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 legislature on how to eliminate the use of seclusion in schools for 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.
- MDE is working with a consultant to facilitate the Restrictive Procedures Stakeholder Work Group meetings for the purpose of increased stakeholder engagement in recommending to the Commissioner specific and measurable implementation and outcome goals for reducing the use of restrictive procedures.

Responsible Agencies

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

[48] 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.

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, 2019, 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 64% or more.

Baseline: From January to June 2016, of the 5,206 episodes, for persons over 18 years, the person remained in their community 3,008 times or 57.8% of the time.

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

- By June 30, 2017, the percent who remain in their community after a crisis will increase to 60%
- By June 30, 2018, the percent who remain in their community after a crisis will increase to 62%
- By June 30, 2019, the percent who remain in their community after a crisis will increase to 64%

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

Update on Progress of Goal Three

The reporting period for this goal has ended. The Subcabinet approved the discontinuation of this measurable goal. DHS will continue to monitor this measure and annually report it to the Subcabinet.

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.

There are two measures for this goal:

(A) Stable Housing

Baseline: From July 2014 – June 2015, 81.9% of people discharged from the hospital due to a crisis were housed five months after the date of discharge compared to 80.9% in the previous year.

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

- By June 30, 2017, the percent of people who are housed five months after discharge from the hospital will increase to 83%.
- By June 30, 2018, the percent of people who are housed five months after discharge from the hospital will increase to 84%.

(B) Community Services

Baseline: From July 2014 – June 2015, 89.2% people received follow-up services within 30-days after discharge from the hospital compared to 88.6% in the previous year.

Annual Goal to increase the percent of people who receive appropriate community services within 30-days after discharge from the hospital.

- By June 30, 2017, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 90%.
- By June 30, 2018, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 91%.

Goal Five: By June 30, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary placement within ten days.

Baseline: From July 2015 – June 2016, of the people on Medical Assistance who were referred for clinically appropriate crisis services, 85.4% received those services within 10 days. The average number of days was 2.3.

Annual Goals to increase the percent of people receiving crisis services within ten days:

- By June 30, 2018, the percent of people who receive crisis services within 10 days will increase to 87%.
- By June 30, 2019, the percent of people who receive crisis services within 10 days will increase to 88%.
- By June 30, 2020, the percent of people who receive crisis services within 10 days will increase to 90%.

Rationale

- The State will reform crisis services across programs and funding sources to create a system that delivers timely responses to crisis and reduces the unnecessary use of restrictive and segregated settings. Crisis services will address any diagnosis, including complex or multiple conditions. The goals measure impact of reform of services in three areas: children's mental health; adult mental health; and disability home and community-based waivers.
- Inadequate level of crisis services may result in people being unnecessarily hospitalized or placed in other segregated settings. Goal three measures the impact of improved crisis services on individuals receiving waiver services. Improvement in crisis services is projected to decrease the number of individuals who no longer receive waiver services. By expanding in home intervention and short term residential services, people will avoid unnecessary hospitalizations or other restrictive services.
- Crisis services do three things: (1) stabilize a person in their current setting; (2) triage to determine if more intensive services are necessary; and (3) divert people from unnecessarily accessing segregated settings. The most effective measure for crisis services is maintaining stability in their current setting. This can be influenced by timely and appropriate crisis services and increased capacity of community providers delivering positive supports strategies.
- $11.65 million additional state investment for mental health expansion was authorized in the 2017 legislative session.
- Timely access to crisis services which are clinically appropriate is a best practice.

Goals One - Three

Baselines and measurement of progress is based on people who receive a crisis service for the count of incidents and individuals. Whether or not a person remains in their community is determined in one of three ways.

- For children's mental health crisis services, where/how the incident is resolved is recorded and reported. Any resolution where the child remains at home or in school is considered "remaining in their community".
- Effective January 1, 2016, adult mental health crisis providers were required to report the location of residence after a crisis event into the Mental Health Information System (MHIS). Prior to January 1, 2016, mental health providers only reported if the individual was admitted to an inpatient psychiatric unit.

- For waiver services, an analysis was performed to measure whether or not the crisis service in each episode was a residential or community-based service and whether or not the person left the waiver (stopped community-based services) following a crisis episode. A person could go to the emergency room, and maybe even have a short period of hospitalization, and still be counted as remaining in the community, as long as they return in a short period of time and do not lose home and community-based waiver services.

Goal Four

- This goal uses two separate measures. The first measure represents the percent of people on Medical Assistance (MA) who received community services within thirty days after discharge from a hospital due to a crisis. The second measure includes the percent of people that were housed, not housed, or in a treatment facility, five months after their discharge date.
- The number of people served in crisis services carries yearly. Using a percentage measure allows for fluctuations in the total number of individuals receiving services in a year.

Goal Five

- This goal uses data that is reflective of people accessing crisis residential, crisis stabilization and inpatient hospital stays after receiving crisis service referrals with data from the Mental Health Information System (MHIS) and Medical Assistance (MA) claims data from MMIS.

Strategies

Evaluate Effectiveness of Crisis Services

- Monitor the utilization of crisis services to determine:
    - the number of individuals who use crisis services
    - the number of individuals demitted from where they live or work after a crisis episode
    - timeliness of crisis interventions
    - length of time crisis services are used, and
    - barriers to stable services, and permanent housing.

- Evaluate the capacity (strengths and barriers) of the crisis system to provide timely access to in home intervention and residential crisis services and identify solutions, including: development of additional crisis residential homes and mobile crisis services, increased specialized staffing and/or streamlined processes to efficiently authorize and access funding.
- Evaluate the length of time an individual remains in a residential crisis setting when stable, and reasons for delay in returning to their living situation. Identify solutions to expedite the development of permanent housing and service options to more quickly move people out of crisis homes when this level of service is no longer needed.

Implement Additional Crisis Services

- The implementation of the $50 million investment in mental health services began during the 2016-2017 biennium. The expansion resulted in:
    - Increase access to children's mental health crisis services in schools (Goals 1, 2, 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)

- Expansion of home and community-based crisis services is in process and will result in:
    - Development of residential crisis options throughout the state to have timely access to crisis services that are clinically appropriate.
        - Collaboration with counties will increase in-home respite capacity.
        - Development of additional crisis respite beds.
        - Development of additional mobile crisis intervention capacity and clinical expertise that supports providers and families so that people remain in their homes, jobs, and community.
        - Annual evaluation to determine the number of crisis respite beds that are necessary to meet the needs and develop additional capacity if necessary.
- DHS developed a single point of access and streamlined referral requirements to improve the quality of the crisis response outcomes for people with disabilities. The initial phase began September 1, 2015 and is targeted to persons with developmental or intellectual disabilities in crisis and at risk of losing their current placement.

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

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

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)*

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).

Community engagement is defined by the Community Engagement Workgroup as a process of working collaboratively with and through groups of people, primarily people with disabilities, their families, and friends to address issues affecting the lives and well-being of people with disabilities.

The Community Engagement Workgroup operates under a charter with the Subcabinet and is made up of community members. The Workgroup supports and guides the Olmstead Subcabinet and Olmstead Implementation Office (OIO) on implementation of the Olmstead Plan, to ensure a person-centered approach is utilized and that there is active community engagement. The strategic focus of the workgroup include:

- Creating recommendations and highlighting best practices for inclusive and accessible public input processes for the annual Plan amendment process;
- Supporting implementation of a communication plan for diverse communities with disabilities; and
- Strengthening community engagement between members of disability communities, the OIO, and Subcabinet agencies on matters impacting the implementation of the Olmstead Plan.

Community Engagement with the public ensures two-way communication which will provide critical feedback for implementation of the Olmstead Plan. The framework for achieving meaningful, effective and inclusive community engagement includes:

1. Humanity, Dignity and Empowerment
   "We are the experts of our own lives."
2. Person-Centered Listening and Learning
   "Listen to each individual person and what he/she dreams and hopes for their lives and communities."

3. Diversity, Accessibility and Equity
   "Be intentional and proactive about bringing under-represented communities to the decision-making table and taking down barriers to engagement and participation."
4. Transparency and Accountability
   "Be clear about how decisions are made, how our feedback informed those decisions, and who is accountable for implementing those decisions."
5. Active Leadership, Inclusion and Participation
   "People with disabilities must be involved in decision-making that directly affects our lives."

Vision statement

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

Measurable goals

Goal One: By June 30, 2020, the number of individuals with disabilities who participate in Governor appointed Boards and Commissions, the Community Engagement Workgroup, Specialty Committee and other Workgroups and Committees established by the Olmstead Subcabinet will increase to 245 members.

Baseline: Of the 3,070 members listed on the Secretary of State's Boards and Commissions website, 159 members (5%) self-identified as an individual with a disability. In 2017, the Community Engagement Workgroup and the Specialty Committee had 16 members with disabilities.

Annual Goals to increase the number of individuals with disabilities participating in Governor's appointed Boards and Commissions, Community Engagement Workgroup, Specialty Committee, and other Workgroups and Specialty Committees established by the Olmstead Subcabinet:

- By June 30, 2018, the number will increase to 184 members
- By June 30, 2019, the number will increase to 215 members
- By June 30, 2020, the number will increase to 245 members

Goal Two: By April 30, 2020, the (A) number of individuals with disabilities to participate in public input opportunities related to the Olmstead Plan, and (B) the number of comments received by individuals with disabilities (including comments submitted on behalf of individuals with disabilities) will increase by 5% over baseline.

- By April 30, 2019, a baseline will be established using 2018-2019 Public Input opportunities data.

Goal Three: By March 31, 2022, the number of engagement activities for Olmstead Plan's measurable goals that are evaluated utilizing the Civic Engagement Evaluation Framework will increase by 5% over baseline.

- By March 31, 2020, a baseline will be established.

Rationale

- Meaningful community engagement is individual and can be difficult to define. Community engagement is a process that recognizes the value of creating ongoing, long-term relationships for the benefit of the greater community. It brings an interactive, collective problem-solving element into the process that capitalizes on the collective strengths of the various stakeholders.
- There is a need for quality, meaningful and intentional engagement. Addressing the following questions will allow for measurement of opportunities for engagement and show progress in the goals.
    - How are Subcabinet agencies designing outreach efforts to reach people with disabilities?
    - What are the barriers that people with disabilities experience when participating in engagement efforts?
    - How can those barriers be addressed?
    - How can decisions affecting people with disabilities be more transparent?
    - How can people with disabilities have an impact when they participate in engagement activities?
    - How can Subcabinet agencies better communicate among themselves and people with disabilities?
    - How can Subcabinet agencies improve outreach to people with disabilities?
- The Civic Engagement Evaluation Framework includes major components of designing an engagement evaluation, how to think about applying those components in a particular engagement context and provides planning tools to design an evaluation. It is a blueprint for state and local agencies to design their own evaluation systems.

Strategies

- **Increase the Awareness of People with Disabilities of Opportunities to Participate on Governor Appointed Boards and Commissions**

- **Create a Process that Encourages Participation of People with Disabilities in Providing Input on the Olmstead Plan**

- **Strengthen communication among the Subcabinet, OIO, state agencies, people with disabilities and the general public to ensure messages are accessible and effective.**

- **The Community Engagement Workgroup will provide the OIO and Subcabinet with recommendations regarding key elements of the Olmstead Plan as specified by the charter.**

- **Adapt the Civic Engagement Evaluation Framework to measure civic engagement work with people with disabilities to increase statewide awareness and investment in the Minnesota Olmstead Plan.**

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Preventing Abuse and Neglect

What this topic means

Research shows that vulnerable adults and children (including individuals with disabilities) are at a higher risk for maltreatment (abuse and neglect[49]) than the population as a whole, and that allegations of maltreatment in this population are under reported. The Olmstead Plan website will include trend data on the occurrence of abuse and neglect and violent crimes.

This topic is about the prevention of abuse and neglect of people with disabilities in all settings, increasing the likelihood that potential abuse and neglect is reported, and taking care that these efforts do not inadvertently create barriers to reporting. Tracking and analysis of data will inform decision makers about setting priorities for public education campaigns. These campaigns will identify areas where prevention strategies can be applied that improve the safety and quality of life for people with disabilities wherever they may choose to live, learn, work and enjoy life.

Vision statement

The State of Minnesota declares as a top concern, the safety and quality of life of people with disabilities. It is the goal of the State that people with disabilities are free from abuse and neglect.

In this effort the State will utilize three strategies: prevention, reduction, and remediation.

- Prevention by education and public information to improve the awareness of the occurrence of abuse and neglect, and how to report it;
- Reduction of maltreatment by carefully monitoring trends of abuse and neglect and targeting abusers for prosecution and providing caregivers with effective education; and
- Remediation by addressing patterns and issues of occurrence both at the system level and the individual level.

Measurable goals

Goal One: By September 30, 2016, the Olmstead Subcabinet will approve a comprehensive abuse and neglect prevention plan, designed to educate people with disabilities and their families and guardians, all mandated reporters, and the general public on how to identify, report and prevent abuse of people with disabilities, and which includes at least the following elements:

- A comprehensive information and training program on the use of the Minnesota Adult Abuse Reporting Center (MAARC).
- Recommendations regarding the feasibility and estimated cost of a major "Stop Abuse" campaign, including an element for teaching people with disabilities their rights and how to identify if they are being abused.
- Recommendations regarding the feasibility and cost of creating a system for reporting abuse of children which is similar to MAARC.

[49] As defined in Minnesota Statutes 626.556 and 626.557. Examples of abuse may include: physical, verbal, emotional or sexual abuse or financial exploitation. Examples of neglect include: failure to provide with necessary food, shelter, supervision, health, medical or other care required for the individual's physical or mental health.

- Utilizing existing data collected by MDE, DHS, and MDH on maltreatment, complete an analysis by type, type of disability and other demographic factors such as age and gender on at least an annual basis. Based upon this analysis, agencies will develop informational materials for public awareness campaigns and mitigation strategies targeting prevention activities.
- A timetable for the implementation of each element of the abuse prevention plan.
- Recommendations for the development of common definitions and metrics related to maltreatment across state agencies and other mandated reporters.

Annual goals will be established based on the timetable set forth in the abuse prevention plan.

Update on Progress of Goal One
The Olmstead Subcabinet reviewed and accepted the Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities on January 29, 2018. Staff from DHS, MDH, MDE and OMHDD reviewed the recommendations and proposed new workplan items which were approved by the Subcabinet. In 2019, the Subcabinet expects to work with members of the Specialty Committee and others to identify recommendations that might be best addressed through broader community action.

Goal Two: By January 31, 2022, the number of cases of vulnerable individuals being treated due to abuse and neglect will decrease by 30% compared to baseline.

There are two measures for this goal:

(A) Emergency room visits and hospitalizations

Annual Goals to decrease number of emergency room visits and hospitalizations due to abuse and neglect

- By April 30, 2019, establish a baseline
- By January 31, 2020, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 10% compared to baseline
- By January 31, 2021, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 20% compared to baseline
- By January 31, 2022, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 30% compared to baseline

(B) Medical treatment(s) other than emergency room or hospital

Annual Goals to decrease number of medical treatments other than emergency room visits and hospitalizations due to abuse and neglect

- By April 30, 2019, establish a baseline
- By January 31, 2020, the number of medical treatments due to abuse and neglect will be reduced by 10% compared to baseline
- By January 31, 2021, the number of medical treatments due to abuse and neglect will be reduced by 20% compared to baseline
- By January 31, 2022, the number of medical treatments due to abuse and neglect will be reduced by 30% compared to baseline

Goal Three: By December 31, 2021, the number of vulnerable adults who experience more than one episode of the same type of abuse or neglect within six months will be reduced by 20% compared to the baseline.

Baseline: From July 2015 – June 2016, there were 2,835 individuals who experienced a substantiated or inconclusive abuse or neglect episode. Of those individuals, 126 (4.4%) had a repeat episode of the same type of abuse or neglect within six months.

Annual Goals to reduce the number of people who experience more than one episode of the same type of abuse or neglect:

- By December 31, 2018, the number of people who experience more than one episode will be reduced by 5% compared to baseline
- By December 31, 2019, the number of people who experience more than one episode will be reduced by 10% compared to baseline
- By December 31, 2020, the number of people who experience more than one episode will be reduced by 15% compared to baseline
- By December 31, 2021, the number of people who experience more than one episode will be reduced by 20% compared to baseline

Goal Four: By July 31, 2020, the number of students with disabilities statewide identified as victims in determinations of maltreatment will decrease by 10% compared to baseline.

Baseline: From July 2015 to June 2016, there were 20 students with a disability statewide identified as victims in determinations of maltreatment.

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

- By July 31, 2019, the number of students with disabilities identified as victims in determinations of maltreatment will decrease by 5% from baseline to 19 students.
- By July 31, 2020, the number of students with disabilities identified as victims in determinations of maltreatment will decrease by 10% from baseline to 18 students.

Rationale

- It is well-known that people with disabilities are subject to abuse and neglect at rates much greater than the population as a whole. It is also well-known that incidents of abuse and neglect are under-reported by the population as a whole, but particularly among people with disabilities. The advent of the MAARC system presents an opportunity for the State of Minnesota to not only have a centralized reporting protocol for all incidents of abuse and neglect in adults, but will provide the opportunity to analyze data from the reporting system that will allow for targeting information and remediation activities to the areas where they can have the biggest impact. The development of a comprehensive abuse prevention plan at this time will ensure that the state identifies opportunities for using this new resource in multiple ways to promote prevention of abuse and neglect and includes the best opportunities in future budgets and work plans.

- A key factor in reducing the level of abuse and neglect is to increase the ability of people with disabilities and their families to know their rights and to identify and report incidents of suspected abuse and neglect. A campaign targeted at informing the general public can be a major boost to turning around the current under-reporting of these incidents.
- The MAARC system provides a "one number" capability for anyone, including mandated reporters and the general public, to report suspected abuse or neglect and removes the confusing complexity of the multiple reporting point system that previously existed. It is reasonable to actively consider whether a similar centralized system for reporting suspected abuse or neglect for children under 18 can similarly improve the complicated child protection system.
- The Minnesota Hospital Association (MHA) currently tracks reasons for ER visits and hospitalizations by International Classification of Diseases (ICD) codes and by Universal Billing (UB) codes. These ICD and UB codes indicate incidents of abuse and neglect that resulted in an ER visit or hospitalization, as well as indicators of an individual's vulnerability. The MHA data, which is shared with MDH, captures information on any individual who receive services at a hospital; pre-baseline work is being conducted to review and update appropriate abuse and neglect codes as codes which better identify individuals who are vulnerable. This includes individuals who receive services licensed by either MDH or DHS.
- Five years of MHA data (2010-2014) were analyzed to determine the number of vulnerable individuals who received services from facilities licensed by either MDH or DHS, and had been treated at a hospital due to abuse or neglect. This data was analyzed to determine existing patterns and geographic areas which reflect a higher incidence of abuse or neglect. Preliminary analysis suggested that differential documentation is occurring among hospitals, limiting the usefulness of the original method. Reviewing and expanding both the abuse/neglect codes and codes indicating vulnerable individuals combined with training for hospital coders should resolve this issue. MDH anticipates needing adequate time to develop and incorporate this enhanced methodology.
- The baseline data for the measure in Goal Three was gathered through the MAARC system. This included the number of vulnerable adults who were the subject of a report of suspected maltreatment who were the subject of another report for the same type of maltreatment within a six month time period. This measure only includes reports where the allegation is determined to be substantiated or inconclusive following investigation. Additional data collected on the vulnerable adult by the MAARC includes age, race, ethnicity, gender, disability/impairment, and licensed services received.
- Baseline data from the 2015-2016 data year identified the number of students with disabilities statewide identified as victims in determinations of maltreatment at schools, as well as locations of those schools. The number of determinations (i.e. confirmed victim cases) will serve as an annual measure for this goal in subsequent years. Analysis of this data will continue to include identification of schools, specifically schools with multiple determinations of maltreatment.
- Schools that are identified as having multiple (more than one) determinations of maltreatment involving students with disabilities as victims annually will be offered MDE training and resources to improve awareness of child maltreatment issues and mandated reporting requirements. This assistance will provide staff with the technical skills and support to address challenging behaviors, and implement practices to prevent child maltreatment in the future.

Strategies

Goal One

Develop Educational Campaign for Mandated Reporters and Professional Caregivers

- Conduct an education campaign targeted to providers who serve individuals with disabilities. Since research shows that many vulnerable individuals have not been educated on how to recognize maltreatment, the campaign will focus on how to recognize abuse and neglect. In order to prevent future abuse and neglect, the campaign will focus on how to prevent maltreatment. The campaign will also include an effort to reduce barriers in reporting suspected maltreatment.
- Outreach to mandated reporters will include targeted online and videoconference trainings and print materials.

Develop Public Awareness Campaign

- Provide information and education on the prevention and reporting of abuse and neglect to all Minnesota communities including individuals with disabilities, families, and guardians.
- Collaborate with State agencies and other stakeholders on public education campaigns.
- The public awareness campaign for the MN Adult Abuse Reporting Center (MAARC), beginning in summer of 2016, focused on education regarding vulnerable adult maltreatment which includes abuse, neglect and financial exploitation.
    - The campaign encouraged individuals to take action by calling the MAARC, when vulnerable adult maltreatment is suspected.
    - The educational content targeted to the general public was delivered through radio shorts, brief online videos and print materials. Social media was also used to drive people to the educational content.
    - The goal was to reach a broad statewide audience with key messages to encourage reporting.

Goal Two

Use Data to Identify Victims and Target Prevention

- Analyze MHA data on vulnerable individuals who have been the victim of abuse and neglect.
- Analyze provider claims data and validate data from the electronic health records.
- Continue to train hospital and clinic-based health information management staff charged with coding clinicians' notes in order to improve accuracy of codes assigned.
- Identify patterns and geographic areas for targeted prevention efforts.

Monitor and Improve Accountability of Providers

- Report semi-annually to the Olmstead Subcabinet the number of citations issued to Intermediate Care Facilities for Individuals with Intellectual Disabilities that document failure to report abuse, neglect and other maltreatment. Also included will be the number of citations issued to Supervised Living Facilities that document failure to comply with the development of an individualized abuse prevention plan, as required Minnesota Statute 626.557 subd.14 (b).

Goal Three

Develop Remediation Strategies for Providers and Professional Caregivers

- Collect and review data on reports of repeat maltreatment of the same type, and additional data available from the MAARC.
    - Review data at individual-level to inform system level actions to remedy the effect of maltreatment.
    - Share remediation strategies effective at preventing repeat maltreatment.

- Effective remediation may prevent repeat maltreatment.
  - Examples of individual remediation: adult protective services; recovery of assets; emergency assistance; victim services (sexual assault, domestic violence); medical evaluation and services; restraining order for removal of the perpetrator; prosecution of perpetrator; case management services; guardianship and conservatorship services; mental health treatment; representative payee services; home and community-based services
  - Examples of systems remediation: license holder responsible: licensing sanctions including fine, conditional license, corrective action order, etc.; individual responsible: training, retraining, coaching, suspension or termination, referral to background studies for disqualification.
- Use data to identify patterns/ trends of abuse and neglect to inform communication alerts and remediation strategies.

Goal Four
Utilize School Tracking Database

- Utilize database to track and identify schools that have multiple determinations of maltreatment of students with a disability (i.e. confirmed victim cases.) This data will be used to provide those schools with focused MDE training and technical assistance. The number of schools in this category will continue to be annually reported to the Olmstead Subcabinet in a data table.
- Annual reporting to the Subcabinet of number of students with disabilities identified as victims in determinations of maltreatment will also include explanation of this number as a percentage of the state population of students with disabilities, and in relation to the number of reports received by MDE annually.

Continue and Expand Training for School Personnel

- Provide targeted MDE technical assistance, training, and support to schools through:
  - Annual training for schools on child maltreatment and mandated reporting requirements, PBIS, restrictive procedures, and discipline.
  - Develop web based trainings and informational materials on relevant topic areas (mandated reporting, child maltreatment, effective school and classroom discipline practices, etc.) to distribute to schools and incorporate into school/staff development trainings.

Improve School Accountability for Training

- Collect annual verification from school districts indicating all school employees have been trained on mandated reporter duties and protections from retaliation when a report is made in good faith. Targeted MDE technical assistance and training will be provided to schools that cannot provide annual verification.

Responsible Agencies

- Department of Health
- Department of Human Services
- Department of Education
- Ombudsman for Mental Health and Developmental Disabilities

Assistive Technology

What this topic means

This topic is about people of all ages, all disabilities, and all settings having access to assistive and other technologies that will improve their quality of life and support them, especially in integrated settings.

The timely access to assistive and other technologies will result in progress on measurable goals found elsewhere in the Olmstead Plan. It is expected that the results can be measured in improved quality of life and increased movement from segregated settings to integrated settings.

It is also about building program capacity, leveraging resources and increasing the efficiency and effectiveness of assistive technology services through coordination and collaboration among state agencies.

Definition of assistive technology

Assistive technology is "any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. This definition does not include a medical device that is surgically implanted, or the replacement of such a device." [50]

Assistive technology service is any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. This includes:

- The evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in the individual's customary environments;
- Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities;
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- Training or technical assistance for individuals with a disability or, if appropriate, that individual's family; and
- Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of that individual. [51]

Other Technologies will become more prevalent as Minnesota adopts 21st century technology to address the needs of Minnesotans with disabilities. Although the term *other technologies* has yet to be defined within the scope of this plan, it will likely reference such things as remote support services, telemedicine and telehealth systems.

Another influence in this topic area is the concept of universal design. Universal design is the design of products and environments for use by all people to the greatest extent possible without the need for adaptation or specialized design.

[50] 20 U.S.C. Chapter 33, Section 1401 (25)
[51] 20 U.S.C. Chapter 33, Section 1401 (26)

Collaboration with community partners – public and private – will be essential in order to innovate and integrate technologies and technology-enabled services that meet needs identified in person-centered plans.

Programs and services related to assistive technology

There are a number of agencies and programs providing information and services that make needed assistive and other technologies available to those they serve.

Department of Human Services

The majority of funding for assistive technology and modifications for people with disabilities is provided through Medical Assistance administered by the Department of Human Services (DHS). Nearly 160,000 Minnesotans with disabilities, older adults, and people with chronic health conditions receive assistive technologies, home modifications and durable medical equipment and supplies annually.

Technology for Home (TFH) offers at-home, in-person assistive technology (AT) consultation and technical assistance to help people with disabilities live more independently. Expert consultants, provided through the Technology for Home program:

- Consult with eligible people in their own homes, workplaces, or public locations,
- Connect people to resources that will help them live in their own homes,
- Conduct follow up to ensure effective training, set up and installation,
- Serve on the person's care team to develop and monitor a plan to assure that AT goals are met.

Since inception, the TFH program has assessed 851 individuals for AT, of which 398 were children and 453 were adults.

Individuals who are deaf or hard of hearing can access assistive technology such as the Telephone Equipment Distribution (TED) Program, which is administered through DHS.

Department of Education

- The Minnesota Department of Education (MDE) has published a Manual for Consideration of Assistive Technology (AT), which is available to Minnesotans as a download from the MDE website.
- MDE also sponsors an Assistive Technology Leadership Team, with cross-agency representation and representatives from each region of the state to develop resources and provide professional development statewide on topics related to AT.
- MDE hosts AT Teams Projects, designed to support school district AT Teams in providing services that are in alignment with legal standard and best practices in AT.
- MDE hosts an active list serve focusing on AT, with over 350 members.

Department of Employment and Economic Development, State Services for the Blind (SSB)

Assistive technology is available to individuals with disabilities accessing Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB). This includes evaluations, provision of necessary equipment and training to help ensure job and career success.

To ensure that transition aged customers are successful in their move from school to the adult world, the Workforce Development Unit at SSB has developed steps so that blind, visually impaired, and DeafBlind graduating high school students are prepared to engage in productive employment by:

- Completing a full technology assessment in the fall of their senior year to determine the necessary technology and training needed prior to entering further academic or vocational education

- Providing the identified technology and training during the course of the year so they are ready to enter a college or vocational institution fully able to use their technology
- Orient them to the campus website and the physical campus of their school

Department of Administration, STAR Program

The System of Technology to Achieve Results (STAR) Program is Minnesota's federally funded Assistive Technology Act program and serves Minnesotans of all ages and disabilities, including older adults with functional needs. STAR partners with other state agencies and community organizations to provide assistive technology demonstrations and device loans. There is no charge for these services.

Services provided by STAR include:

- **Device loans**: The four primary purposes for a short term (30 days or less) device loan are to:
  - Assist in decision making (device trial or evaluation)
  - Serve as a loaner during device repair or while waiting for funding
  - Provide an accommodation on a short term basis for a time-limited event/situation
  - Conduct training, self-education or other professional development activity

  During State Fiscal Year 2018, STAR loaned 623 assistive technology devices to 623 Minnesotans for short-term use. Of the device loans made, 513 were to assist the individual in determining if the AT met their needs. Of that group, 95% made a decision on whether it met their needs.

- **Device Demonstration:** Demonstrations allow consumers to compare features and benefits of a specific device or device category. The purpose of a demonstration is to assist with decision making. A demonstration may lead to a formal evaluation or a request for a short-term loan to trial a device. During State Fiscal Year 2018, STAR demonstrated 206 assistive technology devices to 297 Minnesotans. Of the 206 demonstrations conducted, 98% made a decision on whether the AT met their needs.

- **Open-Ended Device Loans:** In certain limited circumstances, open-ended device loans are for Minnesotans who need assistive technology in education, employment, and certain community environments, such as hospice or assisted living. Open-ended loans allow a borrower to keep a device for as long as it is needed. For many borrowers this is the only resource they have available. During State Fiscal Year 2018, 188 Minnesotans received AT through this program, saving consumers $275,069.

- **Minnesota's Guide to Assistive Technology website**: In June 2018, a cross-agency assistive technology workgroup launched Minnesota's Guide to Assistive Technology website[52] created to increase awareness of assistive technology and provide information to help Minnesotans with disabilities consider, select, and use assistive technology at home, school, work and in their communities.

Vision statement

People of all ages and all disability types will have assistive and other technologies necessary to support living, learning, working and enjoying life in the most integrated settings.

[52] Minnesota's Guide to Assistive Technology website is available at https://mn.gov/admin/at/

Measurable Goals and Strategies

The Assistive Technology topic area was added to the Olmstead Plan in June 2016. When the topic area was in development, stand-alone assistive technology measurable goals and strategies were considered. In light of the fundamental importance of assistive technology to a number of different topic areas in the Plan, it was decided that it would be more appropriate to add assistive technology goals and strategies throughout the Plan.

Measurable goals

Lifelong Learning and Education measurable Goal Three, relates to assistive technology.

Strategies

Strategies related to assistive technology are included in the following topic areas:

- Person-Centered Planning
- Transition Services
- Employment
- Lifelong Learning and Education

PLAN MANAGEMENT AND OVERSIGHT

Plan Management and Oversight

Olmstead Subcabinet and Olmstead Implementation Office

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

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

The Executive Order further directed the Subcabinet to adopt procedures that would include clarifying and defining the role of the OIO. The Subcabinet adopted procedures in March 2015 and has updated those procedures regularly since then, most recently in December 2018. The procedures establish a dual role for the OIO: (1) quality assurance and accountability, including compliance evaluation, verification and oversight; and (2) engagement with the community, especially people with disabilities, including on-going management of communications and the Quality of Life survey. On March 29, 2019, Governor Walz issued Executive Order 19-13, which continues the role of the OIO and the Subcabinet's ability to define its role through procedures.

As part of its primary role of providing direction and oversight of the development and implementation of the Olmstead Plan, the Subcabinet has a particular responsibility to monitor the impact of the activities being undertaken by State agencies and delivery agents such as counties 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 develop specific strategies and workplans. Each measurable goal is supported by several key strategies, which are articulated in the Plan. Key strategies are supported by workplans.

Workplans describe the action items that agencies will use to support the strategies and goals. For each strategy identified in the Plan, the workplans identify a series of key activities, expected outcomes, deadlines and the agency or agencies responsible for implementation. Workplans are the purview of the responsible State agencies. With the assistance of the OIO, the agencies develop the workplans to encompass anticipated action items over 1-2 years. Those workplans are submitted to, and approved by, the Olmstead Subcabinet and are 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. When new measurable goals or strategies are adopted by the Subcabinet, the agencies will develop accompanying workplans within a reasonable period of time and present them to the Subcabinet.

The OIO Director of Compliance maintains a schedule for reporting on the activities in the workplans. The frequency of reporting to OIO 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 is provided to the Subcabinet and available to the public on the Olmstead website. By regularly reviewing the progress of the workplans, both the Subcabinet and the public will be able to see that work is being done to support the achievement of the measurable goals in the Olmstead Plan.

Compliance evaluation, verification and oversight

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

The Subcabinet will hold regular meetings 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, which will be made available on the Olmstead website. 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 OIO Executive Director will have primary responsibility for the oversight of regular surveys of people with disabilities to determine quality of life. The Quality of Life survey is a tool to measure quality of life of people with disabilities over time. The survey examined:

- How well people with disabilities are integrated into and engaged with their community.
- How much autonomy people with disabilities have in day to day decision making.
- Whether people with disabilities are working and living in the most integrated setting that they choose.
- How effective assistive technology is for people with disabilities who use it.

The initial Quality of Life survey was based upon a face to face meeting between a person with a disability and a surveyor. The initial survey report was completed in March 2018 and included a sample of more than 2,000 respondents. This survey report provided important baseline data against which future surveys results can be measured.

In January 2019, the "Olmstead Plan Quality of Life Survey: First Follow-up 2018" report was completed. A total of 511 people completed the follow-up survey. Follow-up survey respondents were selected from a random sample of 2,005 baseline survey respondents. The goal is to track progress of quality of life over an extended period of time. Researchers caution noticeable change is difficult to detect in a short period. When comparing data from the baseline to the follow-up survey, which took place in the span of one year, the results have not yet significantly shifted. People with disabilities reported their overall quality of life to be "good" - Minnesota's average baseline score (76.6) and follow-up score (77.4) were similar. The scale was from "very bad" to "very good."

Researchers detected no definitive changes but some interesting information surfaced.

- The data showed the more people get out and are allowed to interact with the broader community, their quality of life increases. Outing interaction scores are low. Minnesota's baseline average score (37.7) and follow-up (36.5) were similar. This indicates people are generally segregated from the broader community during daily activities. Finding ways to further integrate daily activities will help to improve quality of life for the focus population.

- We now know there are differences in quality of life for different regions of the state. Depending on where people live, they will have different experiences. For example, while there are fewer outing interactions in the Metro Area, this area has a higher score for decision control. Variables impacting these scores may range from how agencies provide services to how providers network with each other.

- Respondents' perceived they have a moderate ability to make their own choices. Minnesota's average baseline score (66.2) and follow-up score (67.6) remained close. However, if you take a closer look, you find that respondents with guardians report less decision control and a lower quality of life than respondents without a guardian. This contrast is more pronounced when we examine the types of guardianships. People with public guardians tend to have a lower quality of life than those with private guardians.

Initial analysis of the follow-up survey results have shown the nature of a long-term study is valuable and has already helped to identify important characteristics affecting overall quality of life. Researchers recommend waiting a longer period of time before resurveying respondents.

The next survey is expected to be conducted in the summer of 2020. The 2020 survey will include analysis by race and ethnicity for the Quality of Life measures. The results of each 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 Quality of Life survey will be shared with the public.

Dispute referral and oversight

The OIO 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 State agencies, the OIO established a set of protocols for referring people with disabilities to the most appropriate offices. All referrals and agency responses are monitored for timeliness and responsiveness to the issues raised. The Executive Director will continue to work with State agencies to improve performance under the dispute resolution processes.

Updating and extending the Olmstead Plan

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

As the Subcabinet agencies continue to implement the processes and improvements described in the measurable goals, much will be learned regarding what practices are having a positive impact on the quality of life for people with disabilities. As improvements are made in the ability to gather and use

better data, there will likely be opportunities to adjust the goals to accomplish improvements more quickly or in a better way.

In addition to its on-going oversight of workplans, the Subcabinet and State agencies will undertake an annual review process to evaluate whether the measurable goals should be amended for future years. The Subcabinet will seek public comment regarding the existing measurable goals. Based on that feedback and the experience of the agencies over the preceding year, State agencies will develop a set of proposed amendments to the measurable goals and present them to the Subcabinet for review and approval. Any amendments that are provisionally approved by the Subcabinet will be posted for review by the public, and will allow for a specific public comment period of at least 30 days. Following the comment period, the Subcabinet will consider whether any changes to the proposed amendments are warranted as a result of the public comments. Any subsequent changes to the proposed amendments will be posted for a brief public review period prior to adoption of the amendments to the Plan by the Subcabinet.

In 2018, the Olmstead Subcabinet undertook a strategic review of the Plan. The strategic review considered results of the Quality of Life survey, achievements under the measurable goals, and feedback from a variety of stakeholders. The strategic review will help inform ongoing efforts to ensure that the Plan is effective.

Communications and public relations

The OIO 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 OIO 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 the Olmstead Plan is not a plan to eliminate certain options or close certain facilities.

The OIO will continue to implement the Communications Plan that guides the direct communication messages and activities of the OIO. OIO will establish Olmstead communication guidelines for materials developed by State agencies.

The Subcabinet and OIO 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.

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, the Subcabinet, OIO, and State agencies will continue to work together to develop and implement meaningful methods of cross-agency collaboration around these strategies.

Cross-agency coordination of legislative and funding strategies

Within each of the topic areas in this Olmstead Plan, there are activities described that are essential to the accomplishment of the outcomes described in the measurable goals. Each of these activities is subject to funding and policy directives that are the result of State or Federal appropriations and legislative and regulatory actions. Significant changes in the appropriations and regulatory processes at either the State or Federal level may impact the ability of State agencies to achieve Plan goals within the time frames specified in the Plan.

In order for certain changes in activity to occur, it may be necessary for State agencies to propose and pursue statutory changes or regulatory waivers. It may also be necessary for State agencies to request authorization to redirect funding or to request additional funding in order to accomplish certain outcomes. The need for such statutory, regulatory and funding requests may become apparent as more and better data is available to analyze the outcome of the activities anticipated by the Plan.

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

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	Go to: Mn.gov/Olmstead Click "Participate" and follow instructions for the online form
Email	Send an email to this address: MNOlmsteadPlan@state.mn.us
Mail	Send a letter to: Olmstead Implementation Office 400 Wabasha Street N, Suite 400 St. Paul, MN 55102
Phone	Speak to a staff member at the Olmstead Implementation Office, or leave your comment on voicemail. 651-296-8081

ADA Advisory	For accessible formats of this information or assistance with additional equal access, write to MNOlmsteadPlan@state.mn.us, call 651-296-8081, or use your preferred relay service. (ADA1 [9-15])
	For translations of this publication, write to MNOlmsteadPlan@state.mn.us, call 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 were implemented January 1, 2014.

Abuse and Neglect is defined in Minnesota Statutes 626.556 and 626.557. Examples of abuse may include: physical, verbal, emotional or sexual abuse or financial exploitation. Examples of neglect include: failure to provide with necessary food, shelter, supervision, health, medical or other care required for the individual's physical or mental health.

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

Assistive technology is "any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. This definition does not include a medical device that is surgically implanted, or the replacement of such a device." [See 20 U.S.C. Chapter 33, Section 1401 (25)]

Assistive technology service is any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. This includes:

- The evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in the individual's customary environments;
- Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities;
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- Training or technical assistance for individuals with a disability or, if appropriate, that individual's family; and
- Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are

otherwise substantially involved in the major life functions of that individual. [See 20 U.S.C. Chapter 33, Section 1401 (26)]

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

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

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

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

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

Disability: See persons/people with a disability

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

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

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

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

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

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

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

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

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

Informed choice: 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. [See 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.

Mandated reporter: "Mandated reporter" means a professional or professional's delegate while engaged in: (1) social services; (2) law enforcement; (3) education; (4) the care of vulnerable adults; (5) any of the occupations referred to in section 214.01, subdivision 2 (health care licensing board); (6) an employee of a rehabilitation facility certified by the commissioner of jobs and training for vocational rehabilitation; (7) an employee or person providing services in a facility as defined in subdivision 6; or (8) a person that performs the duties of the medical examiner or coroner. [See Minnesota Statutes §626.5572]

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

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

Minnesota Supplemental Aid (MSA) Housing Assistance: A state-funded income supplement for people who are eligible for Minnesota Supplemental Aid (MSA) and have high housing costs. MSA Housing Assistance provides financial support for MSA participants who are age 18 – 64 and are relocating from an institution, or eligible for self-directed PCA services, or are receiving home and community-based waiver services and have monthly housing costs of more than 40% of their income and have applied for rental assistance, if eligible.

MnCHOICES: MnCHOICES is a person-centered assessment to help people with long-term or chronic-care needs make care decisions and select support and service options.

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

Person-centered: This concept is described in the Person-Centered Planning measurable goals section of the Plan.

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

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

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

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

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

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

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

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

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

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

Segregated settings: Segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with people with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other people with disabilities. [See US Department of Justice, "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C," http://www.ada.gov/olmstead/q&a_olmstead.htm]

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

Subminimum wage: A wage less than the established federal minimum wage that may be permitted under an exemption in the Fair Labor Standards Act (FLSA) that provides for the employment of certain individuals at wage rates below the minimum wage, including individuals whose earning or productive capacity is impaired by a physical or mental disability. In order to pay a subminimum wage to an individual with a disability, the employer must obtain a certificate from the U.S. Department of Labor

and conduct periodic time and productivity studies to establish the rate of payment based on performance norms. [See http://www.dol.gov/compliance/topics/wages-subminimum-wage.htm]

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

Vulnerable adult: (a)"Vulnerable adult" means any person 18 years of age or older who: (1) is a resident or inpatient of a facility; (2) receives services required to be licensed under chapter 245A, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4); (3) receives services from a home care provider required to be licensed under section 144A.46; or from a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under section 256B.0625, subdivision 19a, 256B.0651, 256B.0653, 256B.0654, 256B.0659, or 256B.85; or (4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment. (b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual. [See Minnesota Statutes §626.5572]

Workforce Innovation and Opportunity Act (WIOA): WIOA is the federal Workforce Innovation and Opportunity Act signed into law on July 22, 2014. WIOA supersedes the Workforce Investment Act (WIA) of 1998 and amends the Rehabilitation Act of 1973, the Wagner-Peyser Act and the Adult Education and Family Literacy. Disability service and employment policy provisions that affect people with disabilities include a priority focus on youth with disabilities and their preparation for competitive integrated employment. At a state level, memorandums of understanding must be developed between Vocational Rehabilitation, Education, Assistive Technology and the Medicaid agency. WIOA also sets limits on the use of the Special Subminimum wage including new requirements for oversight and review. Most of the provisions in WIOA became effective July 1, 2015. The WIOA provisions on Subminimum wage provisions became effective on July 22, 2016. More information on WIOA can be found on the US Department of Labor website at: http://www.doleta.gov/wioa/

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Common Acronyms

ACT - Assertive Community Treatment

ADA – Americans with Disabilities Act

ADM – Department of Administration

AMRTC – Anoka Metro Regional Treatment Center

APS – Accessible Pedestrian Signals

AT – Assistive Technology

BIRF – Behavior Intervention Reporting Form

CADI - Community Access for Disability Inclusion

DCD – Developmental Cognitive Disabilities

DD – Developmental Disabilities

DEED – Minnesota Department of Employment and Economic Development

DHS – Minnesota Department of Human Services

DOC – Minnesota Department of Corrections

DOJ – United States Department of Justice

EE – Extended Employment

FACT - Forensic Assertive Community Treatment

HCBS – Home and Community-Based Services

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

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IPS – Individual Placement and Supports

MA – Medical Assistance

MAARC – Minnesota Adult Abuse Reporting Center

MA-EPD – Medical Assistance for Employed Persons with Disabilities

MCF - Minnesota Correctional Facility

MCOTA – Minnesota Council on Transportation Access

MDE – Minnesota Department of Education

MDH – Minnesota Department of Health

MDHR – Minnesota Department of Human Rights

MHCP – Minnesota Health Care Programs

MHFA – Minnesota Housing Finance Agency

MMB - Minnesota Management and Budget

MnDOT – Minnesota Department of Transportation

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