UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

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

Civil No. 09-1775 (DWF/FLN)

Plaintiffs,

v.

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

Defendants.

Minnesota Olmstead Subcabinet Report to the Court

STATUS UPDATE
September 1, 2014 – October 31, 2014

Report Number 5

Contents

I. PURPOSE

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

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

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

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

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

On September 18, 2014, the court ordered:

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

The Olmstead Implementation Office has adopted this schedule to report to the subcabinet, court monitor, court and the public on the status of work being done by state agencies to implement the Plan. Each bi-monthly report will cover action items that were to be completed for a two month period as noted on the cover page of each report. Additionally, a preview of activities associated with action items for the following four months is included to inform on progress and potential issues. This report provides status updates on Olmstead Plan action items with deadlines in September and October 2014. Additional information is provided in **Appendix 5-A** on action items with deadlines through February 28, 2015.

Proposed Modifications to the Olmstead Plan

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

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

On August 20, 2014 the Court issued an order directing that the State modify the Plan in compliance with the Court Monitor's Reports. On September 18, 2014 the Court directed that the State submit a revised Olmstead Plan to the Monitor by November 10, 2014. The revision is to include measurable goals and address accurate reporting on the number of people who have moved from segregated to more integrated settings; the number of people who are no longer on the waiting list; and the quality of life measures. On November 10, 2014, the State submitted proposed measurable goals to the Court Monitor and that document is included as **Exhibit 5-2.**

II. OLMSTEAD PLAN IMPACT ON LIVES OF INDIVIDUALS

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

The following table indicates the number of individuals who moved from various segregated settings to integrated settings. Additionally it reports the number of individuals who have moved from the home and community-based services waiting list.

During this reporting period, the combined number of individuals who:	
• Moved from segregated to integrated settings	106
• Moved from the wait list	453

Movement from Segregated to Integrated Settings

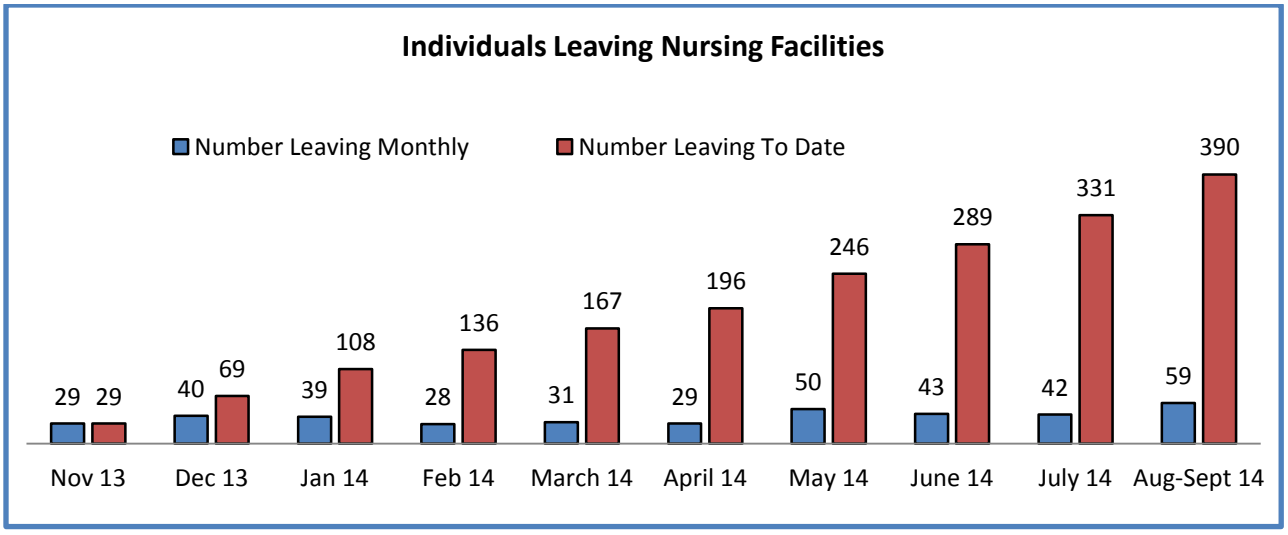
The Plan action items with movement goals are summarized below. The action item is included to show progress toward the goal. A status update is provided for the current reporting period. The graphs are used to show progress over the last twelve months in the movement from segregated settings to integrated settings. Detailed data for each action item is included in **Exhibit 5-1**.

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

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

Status: During August and September 59 people under age 65 (who had been in nursing facilities longer than 90 days) transitioned to community services.

During the same timeframe there were 13 transfers and 15 deaths. The number of people in a nursing facility under the age of 65 who had been there for at least 90 days in August was 1,539 and September was 1,522.

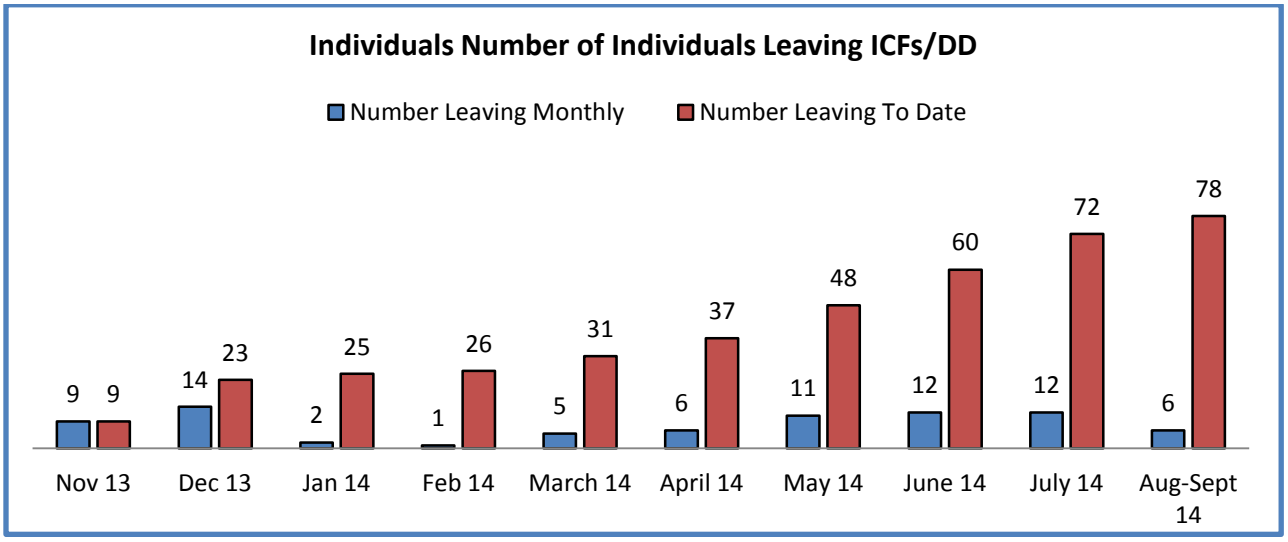


SS 2C - For individuals in Intermediate Care Facilities for Persons with Developmental Disabilities(ICFs/DD) and people under 65 who have been in nursing facilities longer than 90 days

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

Status: During August and September the number of people who transitioned to community services from Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD) was 6.

Between November 2013 and September 2014, the total number of individuals leaving an ICF/DD for a community setting was 78. During the same timeframe there were 78 admissions or readmissions, 24 transfers and 5 deaths. The number of individuals receiving services in an ICF/DD is 1,646[1].



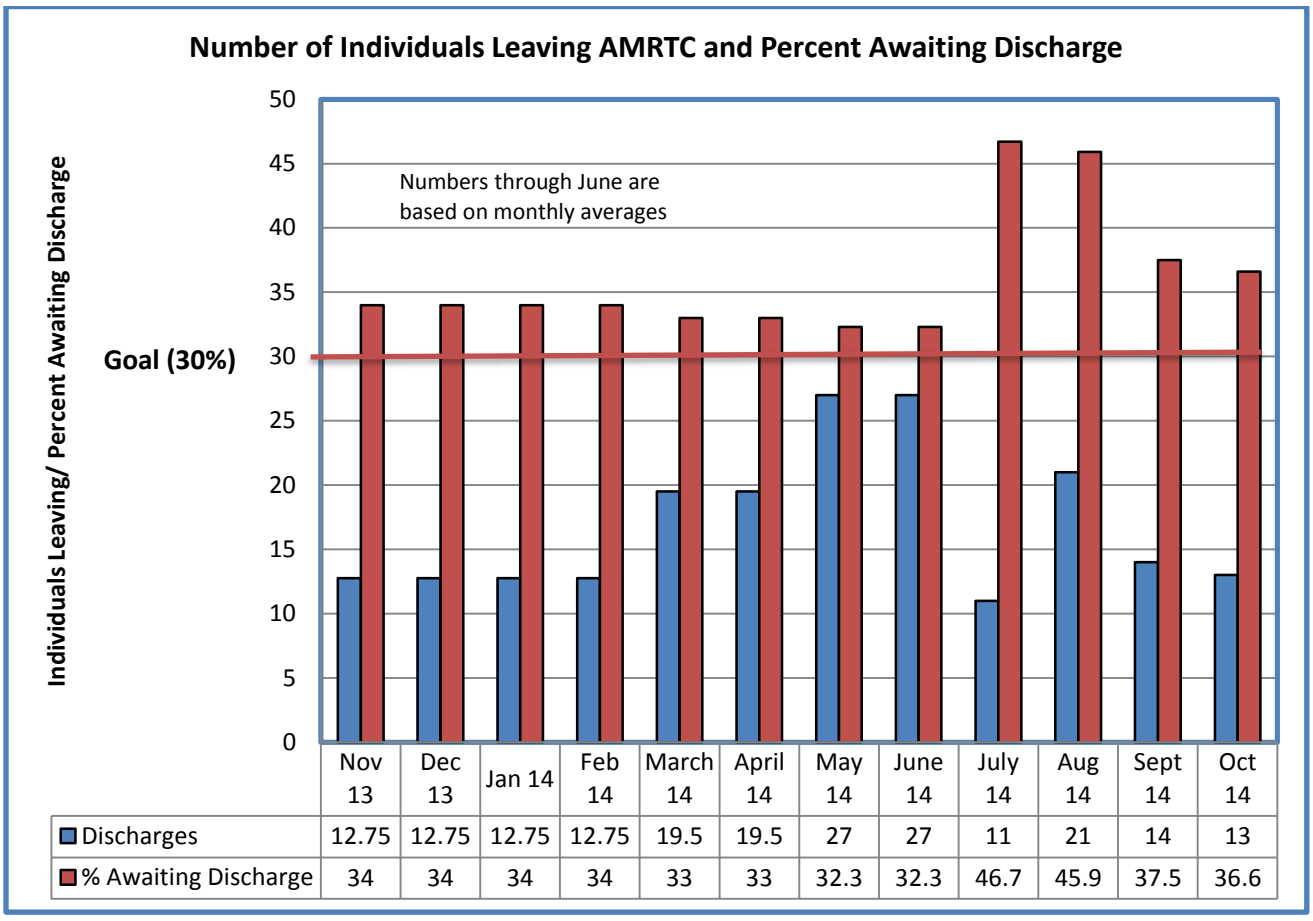
[1] 2015 projection

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

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

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

Status: In October the 36.6% of individuals awaiting discharge improved from the previous 2 months and from the baseline of 40%, however the goal of 30% has not yet been met. In the months of September and October there were 27 individuals discharged from AMRTC to most integrated settings. During that same timeframe there were 28 transfers, zero deaths, 46 admissions and 4 readmissions. The average daily census was 108 in August and 102.3 in October.

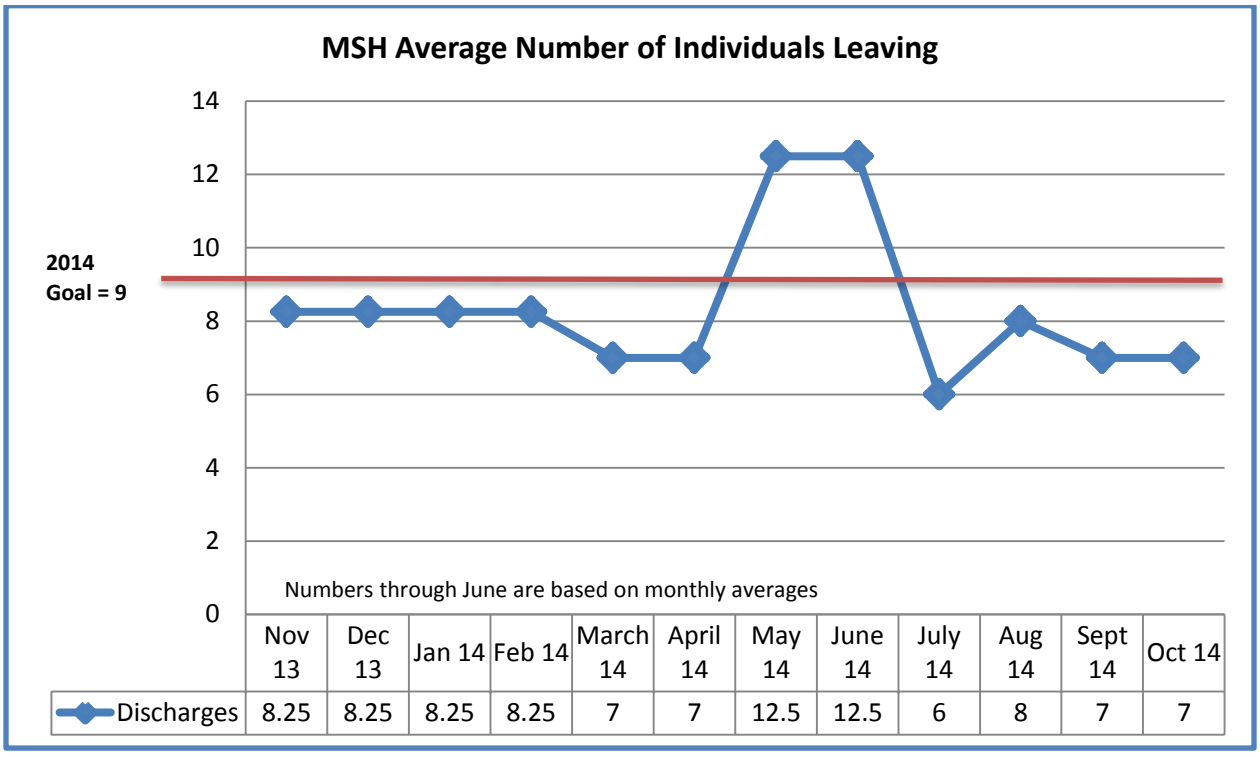


	Nov 13	Dec 13	Jan 14	Feb 14	March 14	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14
Discharges	12.75	12.75	12.75	12.75	19.5	19.5	27	27	11	21	14	13
% Awaiting Discharge	34	34	34	34	33	33	32.3	32.3	46.7	45.9	37.5	36.6

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

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

Status: As of October 31 2014 the average monthly discharge rate is 8.33. The goal of 8 has not yet been met. In the months of September and October there were 14 discharges, 1 transfer and 1 death. During that same timeframe there were 25 admissions and zero readmissions. The average daily census was 374.3 in August and 373.5 in October.

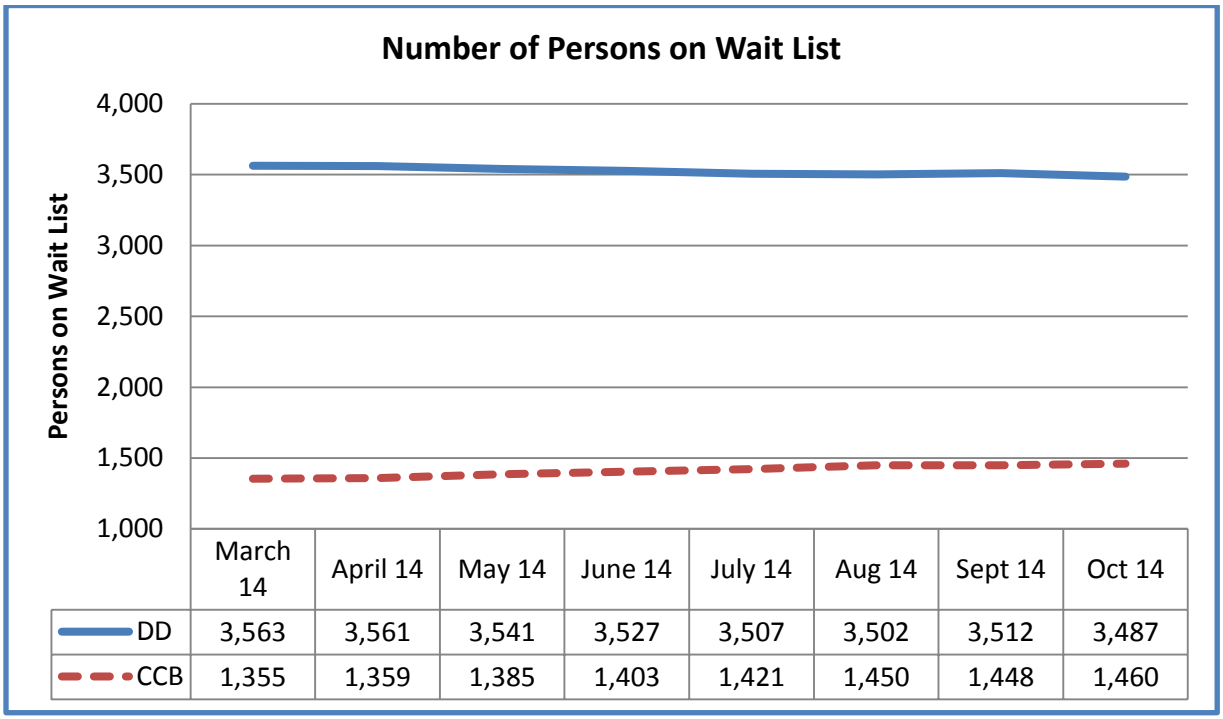


	Nov 13	Dec 13	Jan 14	Feb 14	March 14	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14
Discharges	8.25	8.25	8.25	8.25	7	7	12.5	12.5	6	8	7	7

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

Status: The graphs below provide the information that is currently available on the disability waivers wait list. It includes the number of individuals on wait lists for disability waivers[2], the number of individuals beginning waiver services and the number of individuals moving from the wait list. This data does not include levels of urgency nor does it report the pace at which an individual moves off the wait list. A report submitted to the subcabinet included recommendations to establish urgency categories for waiting lists and parameters for measuring whether individuals are moving off the wait list at a reasonable pace.

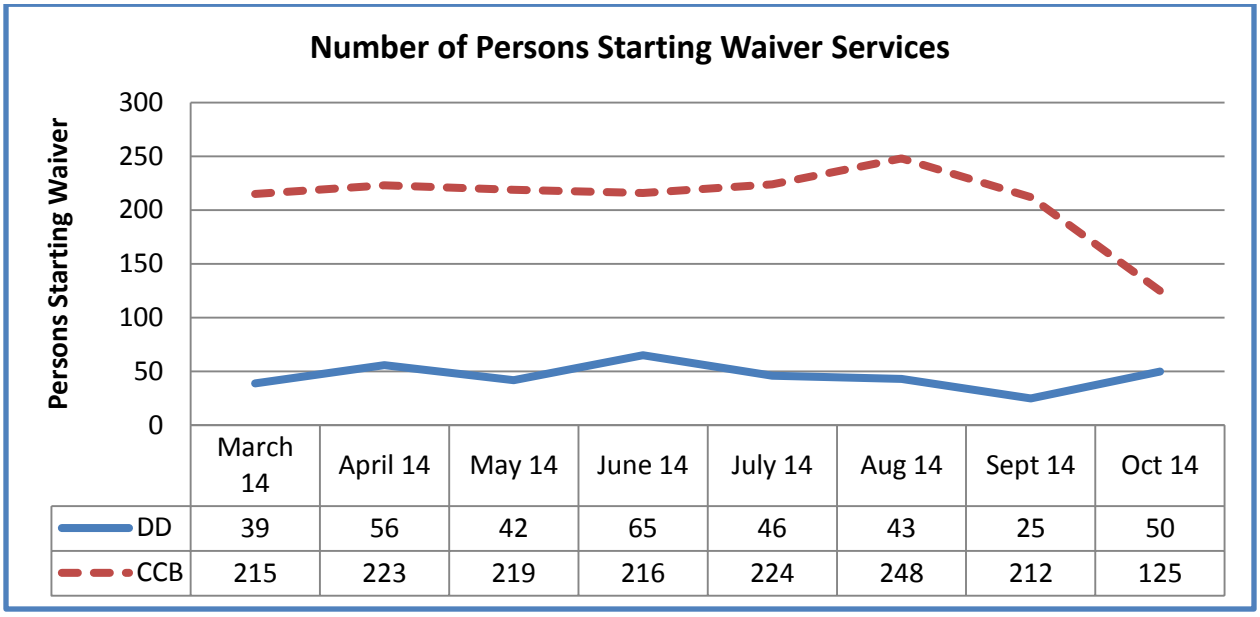
The first graph shows that the number of persons on the DD waiver wait list has decreased by 76 over the 8 month period (76) while the number of persons on the CCB Waivers has increased by 105 over the same timeframe.



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

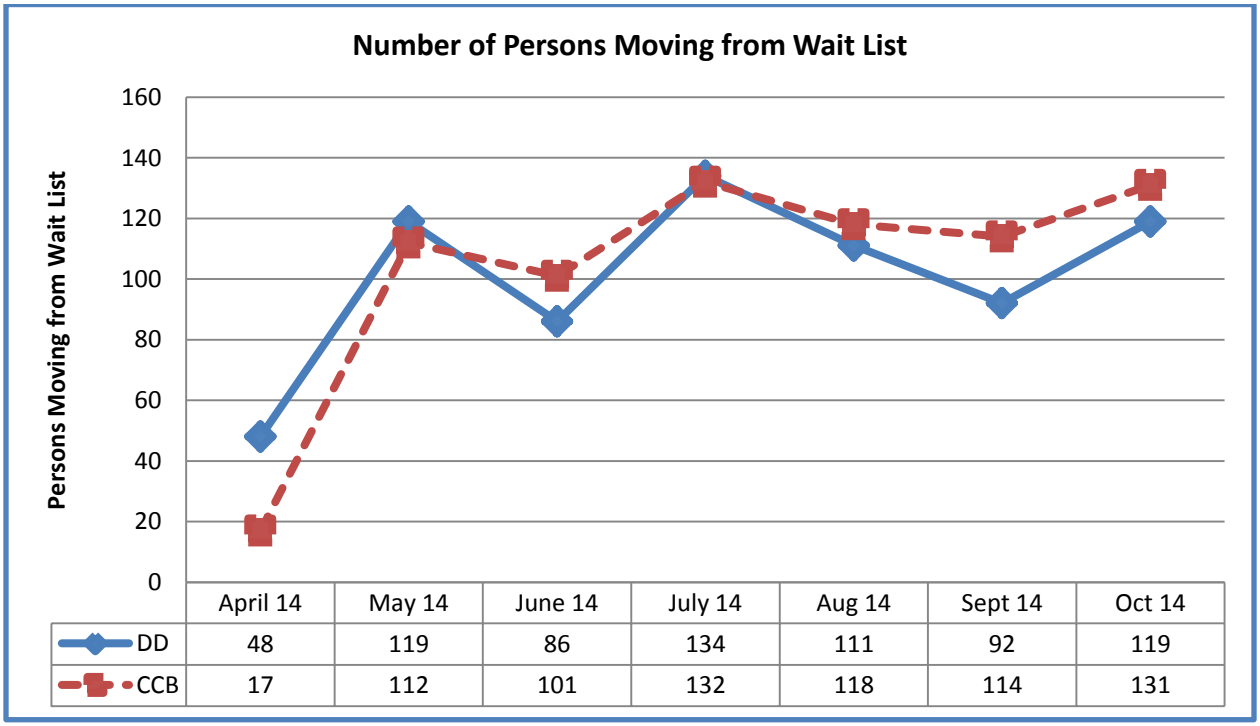
[2] Disability Waivers include DD and CCB. DD means Developmental Disabilities, CCB is made up of 3 waivers = Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC) and Brain Injury (BI). CADI is the only CCB waiver with a wait list. CAC and BI do not have wait lists.

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



	March 14	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14
DD	39	56	42	65	46	43	25	50
CCB	215	223	219	216	224	248	212	125

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

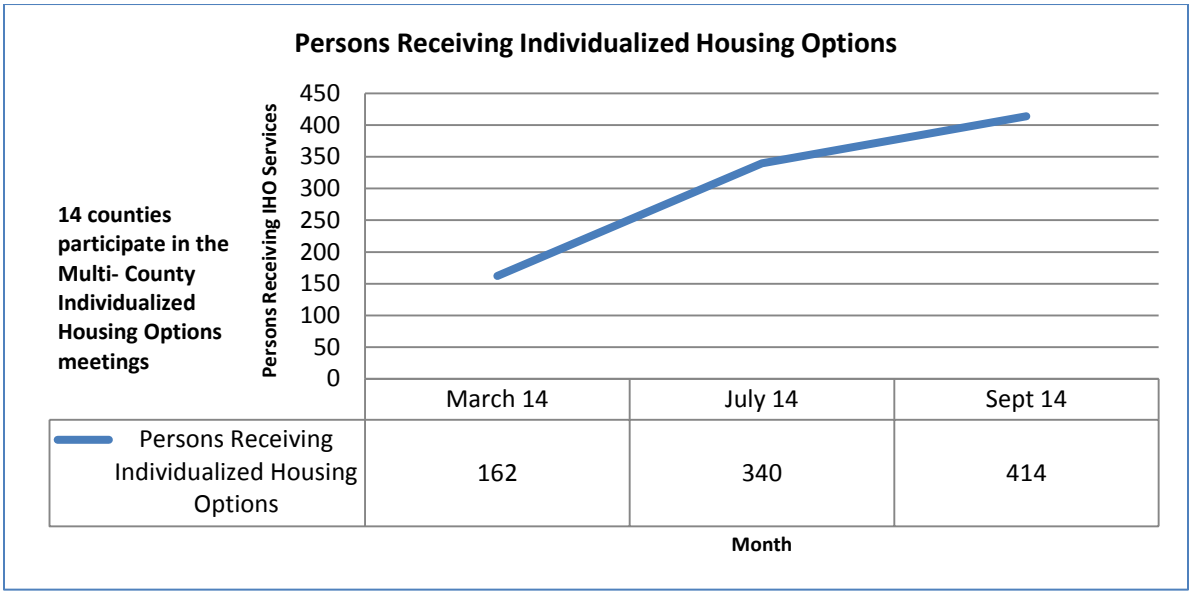


	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14
DD	48	119	86	134	111	92	119
CCB	17	112	101	132	118	114	131

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

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

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



Quality of Life Assessments

Quantitative Measure

The Quality of Life survey pilot is on track for completion by December 31, 2014. More details are included in **Appendix 5-A** for the status update for action item QA 1C.

Qualitative Measure

Personal stories about individuals who moved to an integrated setting are included as **Exhibit 5-1**.

III. OLMSTEAD PLAN ACTION ITEMS STATUS UPDATE

The table below indicates the timeliness of the completion of action items due during the two month reporting period. Each action item is determined to be Early, On Time, Late/Completed, or Late/In Process. The goal is to have all action items verified as completed Early or On Time.

Item	Deadline	Brief Description	Early	On Time	Late-Comp	Late-In Process
QA 4A	9/30/14	Olmstead Quality Improvement Plan				X
EM 1G.1	9/30/14	Establish baseline and goals to increase competitive employment for adults			X*	
EM 1G.2	9/30/14	Set annual deadlines for increasing competitive employment			X*	
EM 1I.1	9/30/14	Implement local placement partnership model for employment services (metro)		X		
EM 2C	9/1/14	Implementation plan to increase integrated competitive employment		X		
EM 2D	9/30/14	Adopt an Employment First Policy		X		
EM 2E.1	9/30/14	Memorandum of Agreements across state agencies to assure integrated competitive employment		X		
EM 2F.1	10/1/14	Establish baseline and policy to provide all vocational rehabilitation purchased services in most integrated setting		X		
EM 3B	9/30/14	Train employment service providers on single point of contact framework		X		
EM 3C	9/30/14	Training to federal contractors on federal employment goal		X		
EM 3D	9/30/14	Establish plan to provide cross-agency training on motivational interviewing		X		
HS 1A	9/30/14	Gather & analyze demographic data (related to housing) on people with disabilities who use public funding		X		
HS 4A	9/30/14	Consult with persons with disabilities to improve HousingLink		X		
HS 4B	9/30/14	Develop a plan to educate the public on HousingLink		X		
TR 1A	9/30/14	Establish a baseline of services and transit spending across public programs				X
TR 1B	9/30/14	Review practices and implement changes to encourage broad cross state agency coordination in transportation				X
TR 1C & 2C	10/31/14	Establish timelines and measures to demonstrate increased access to integrated transportation			X*	

Item	Deadline	Brief Description	Early	On Time	Late-Comp	Late-In Process
SS 2G	9/30/14	Identify a list of other segregated settings; establish baselines, targets, and timelines for moving individuals to more integrated settings		X		
SS 2G.1	9/30/14	Set goals and timelines for moving individuals in other segregated settings to most integrated settings		X		
SS 4B	9/30/14	Recommendations on improving the home and community-based supports and services waiting list		X		
SS 4D	9/30/14	Establish goals and timelines to develop assertive community treatment teams for individuals with disabilities who are transitioning from prison to community			X*	
ED 4A.1	9/1/14	Increase the number of students entering integrated postsecondary education and training programs by 50		X		
HC 2D	9/30/14	Identify data needed to measure health outcomes and establish data sharing agreements			X	
HC 2I	9/30/14	Develop plan to address barriers in healthcare transitions from youth to adult			X	

- Early = verified as completed prior to the due date
- On Time = verified as completed on the due date
- Late/Completed = verified as completed after the due date
- Late/In Process = not completed by the due date; has a stated date for completion

More detailed information of the status of each action item is provided below.

*These measurable goals were approved by the subcabinet and submitted to the court monitor on November 10, 2014. This was in accordance with the September 18, 2014 court order.

ITEMS DUE IN SEPTEMBER AND OCTOBER 2014

The purpose of this section is to report the status of action items under each topic area that are due during this reporting period.

QUALITY ASSURANCE AND ACCOUNTABILITY

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

  Status: The September 30, 2014 deadline was not met. A proposal for completing this action item will be presented to the subcabinet at the December 15th meeting.

EMPLOYMENT

- **EM 1G.1 -** By September 30, 2014 establish a baseline for the measures and establish measurable goals to demonstrate progress in increasing competitive employment for adults with disabilities.

  Status: Baselines and measurable goals were drafted and approved by the subcabinet on November 3, 2014. They were submitted to the Court Monitor for consideration on November 10, 2014. The goals are detailed on pages 6-9 of **Exhibit 5-2**.

- **EM 1G.2 -** By September 30, 2014 set annual deadlines beginning in 2015 to achieve goals for a defined significant portion of the population affected. The measureable goals will be related to demonstrating benefits to the individuals intended to be served.

  Status: Baselines and measurable goals were drafted and approved by the subcabinet on November 3, 2014. They were submitted to the Court Monitor for consideration on November 10, 2014. The goals are detailed on pages 6-9 of **Exhibit 5-2**.

- **EM 1I.1 -** By September 30, 2014 fully implement local placement partnership model for providing professional employment services to Minnesotans with significant disabilities in the metropolitan area.

  Status: The North Metro Placement Partnership (NMPP) model for providing professional placement services in the metro area is fully implemented. NMPP is an ongoing collaborative group comprised of Vocational Rehabilitation Services (VRS) job placement staff and job placement staff of non-profit employment services providers. The NMPP meets biweekly and has representatives from ten different entities. **Exhibit 5-3** includes an informational brochure about NMPP.

- **EM 2C -** Beginning September 1, 2014, implementation plans will be developed to provide access to most integrated settings in our service, standards and funding priorities as identified in Interagency Employment Panel in order to increase integrated competitive employment outcomes.

Status: The Interagency Employment Panel identified three priorities to increase integrated competitive employment outcomes. They include: provide training and technical assistance for service providers; design a clear package of services; and develop a state-wide data collection system. Agency workgroups drafted implementation plans for each area. Stakeholder feedback was solicited throughout the process. The final Implementation Plans approved by the Interagency Employment Panel are included in **Exhibit 5-4**.

- **EM 2D -** By September 30, 2014 the state will adopt an Employment First policy.

  Status: The Olmstead Subcabinet adopted the Employment First policy on September 29, 2014. The policy is included in **Exhibit 5-5**.

- **EM 2E.1 -** By September 30, 2014, key agencies will be convened and will establish a process and timeline to develop Memorandums of Agreement/ Memorandums of Understanding (MOA/MOUs) to ensure the implementation of policy and practices that support integrated competitive employment and Employment First Principles.

  Status: An interagency workgroup reviewed MOA/MOU's from several states and outlined the common components of interagency MOA/MOU's. The workgroup and the Interagency Employment Panel are recommending one MOU for all items related to employment in the Olmstead Plan that will require interagency work and establishing individual working agreements for separate action items. The workgroup created a process and timelines for MOA/MOUs which were approved by the Interagency Employment Panel. **Exhibit 5-6** includes the process and timelines.

- **EM 2F.1 -** By October 1, 2014 Vocational Rehabilitation (VR) purchased services baseline will be established and policy will be developed to provide all VR purchased services in most integrated setting.

  Status: A policy requiring that the scope of services purchased under VR be provided in integrated settings was developed July 14, 2014 for the Vocational Rehabilitation Services Policy Manual. This policy was formally implemented effective October 1, 2014. Implementation will include providing technical assistance and information to both VR staff and provider staff on integrated setting standards. Additionally, VRS staff will monitor to ensure that purchased services are directed to employment in the most integrated setting. **Exhibit 5-7** includes the policy.

- **EM 3B -** By September 30, 2014 Disability Employment Specialists will provide training to employment service providers on single point of contact framework, labor market trends, and localized approaches to demand-driven strategies.

  Status: Statewide training is in process and has been incorporated into ongoing training provided several times throughout the year to placement professionals. **Exhibit 5-8** includes an outline of training materials.

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

  Status: Section 503 training materials have been completed. Training curriculum will be presented by Placement Professionals to any employer or employer group that is looking for information and resources for hiring individuals with disabilities. **Exhibit 5-9** includes the agenda of the meeting where the training materials were presented.

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

  Status: Motivational interview training will be incorporated into the expansion of Individual Placement and Supports (IPS) employment. The Plan calls for this expansion to begin June 30, 2015.

HOUSING

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

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

- **HS 4A -** By September 30, 2014 persons with disabilities will be consulted to determine what features should be added to HousingLink's resources to improve its usefulness.

  Status: HousingLink conducted 18 feedback sessions throughout the state to solicit input from people with disabilities regarding their experience when searching for rental housing. To ensure access from those unable to attend a feedback session, an online survey was conducted. HousingLink used information gathered to create a document which outlines changes need to improve the HousingLink website**.** **Exhibit 5-10** includes details about the sessions, a copy of the survey and summary recommendations.

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

  Status: HousingLink used a combination of web-based and in-person strategies to inform and educate people with disabilities, case workers, providers and advocates about HousingLink. This included 18 feedback sessions throughout the state and 10 additional events for the specific purpose of educating and informing communities. **Exhibit 5-10** includes details about the sessions, a copy of the survey and summary recommendations.

TRANSPORTATION

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

  Status: The September 30, 2014 deadline was not met. The Center for Transportation Studies (CTS) has been working with DOT and DHS to obtain data on transportation expenditures of both agencies. A schematic of funding and a detailed table of funding sources have been developed. The study is in draft format and a final draft will be submitted with the February bimonthly report.

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

  Status: The September 30, 2014 deadline was not met. The review of administrative practices is in draft form. A final draft will be submitted with the February bimonthly report.

- **TR 1C/2C -** By October 31, 2014 using developed baselines from this action and Action Two (below), establish timelines and measures to demonstrate increased access to integrated transportation for people with disabilities. Measures will be implemented to assess transportation options for accessibility, cost effectiveness and reliability.

  Status: The October 31, 2014 deadline was not met. This goal requires additional funding. An update will be provided in the February bimonthly report following publication of the Governor's budget in late January. A second update will be provided after the legislative session is over and actual funding appropriations are known. This item is included on page 10 of **Exhibit 5-2** that was submitted to the Court Monitor for consideration on November 10, 2014.

SUPPORTS AND SERVICES

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

  Status: A report detailing the demographic analysis, setting counts, targets and timelines is included as **Exhibit 5-11.** The subcabinet accepted the report. Review and approval of the report will occur at the February subcabinet meeting. Baselines and measurable goals were drafted and approved by the subcabinet on November 3, 2014. They were submitted to the Court Monitor for consideration on November 10, 2014. The goals are detailed on pages 11 and 12 of **Exhibit 5-2**.

- **SS 2G.1 -** By September 30, 2014 DHS will review this data and other states' plans for developing most integrated settings for where people work and live. Based on this review DHS will establish

measurable goals related to demonstrating benefits to the individuals intended to be served and timelines for moving those individuals to the most integrated settings.

Status: A review was done on other states' plans and is included in the report referred to above in SS 2G and included as **Exhibit 5-11.**

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

  Status: A working group was convened to complete a report to address the waiting list. The report was submitted to the subcabinet on September 29, 2014 and is included as **Exhibit 5-12**. Preliminary review showed the need for additional discussion and modifications to the recommendations. The subcabinet accepted the report. Review and approval of the report will occur at the February subcabinet meeting. Baselines and measurable goals were drafted and approved by the subcabinet on November 3, 2014. They were submitted to the Court Monitor for consideration on November 10, 2014. The goals are detailed on page 14 of **Exhibit 5-2**.

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

  Status: The September 30, 2014 deadline was not met. This goal requires additional funding. An update will be provided in the February bimonthly report following publication of the Governor's budget in late January. A second update will be provided after the legislative session is over and actual funding appropriations are known. This item is included on page 15 of **Exhibit 5-2** that was submitted to the Court Monitor for consideration on November 10, 2014.

LIFELONG LEARNING AND EDUCATION

- **ED 4A.1 -** Based on the Minnesota Post School Outcome Survey data, beginning September 1, 2014 and each subsequent year, there will be an increase of a minimum of 50 students with disabilities per year entering integrated postsecondary education and training programs within one year of exiting secondary education.

  Status: There was an increase of 98 students with disabilities over the previous year that entered integrated postsecondary education and training programs within one year of exiting secondary education. Baselines and measurable goals were drafted and approved by the subcabinet on November 3, 2014. They were submitted to the Court Monitor for consideration on November 10, 2014. The goals are detailed on pages 18 and 19 of **Exhibit 5-2**.

HEALTHCARE AND HEALTHY LIVING

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

  Status: The September 30, 2014 deadline was not met. The disability data source to be analyzed has been identified. It has been determined that no data sharing agreements will be needed to complete the analysis.

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

  Status: The September 30, 2014 deadline was not met. On October 8, 2014 an Olmstead report for describing barriers for youth with special health needs transitioning to adult health care was completed. The report identifies problem areas and strategies for improvement and is included as **Exhibit 5-13.**

COMMUNITY ENGAGEMENT

There were no action items due for this topic area during this reporting period.

FOLLOW UP TO ITEMS DUE IN PREVIOUS MONTHS

This section includes status updates and follow up to action items that were due in previous months.

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

  Status: The June 30, 2014 deadline was not met. A proposal for completing this action item will be presented to the subcabinet at the December 15th meeting.

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

  Status: The August 31, 2014 deadline was not met. The report will be presented to the subcabinet at the February 2015 meeting.

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

Status: The June 30, 2014 deadline was not met. Baselines and measurable goals were drafted and approved by the subcabinet on November 3, 2014. They were submitted to the Court Monitor for consideration on November 10, 2014. They are detailed on page 5 of **Exhibit 5-2**.

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

  Status: The August 31, 2014 deadline was not met. Several metro counties have agreed to start using the curriculum, "Make Work Part of the Plan." Training is expected to happen by March 31, 2015.

- **EM 3M -** By July 1, 2014 establish an outreach plan for families illustrating the impact of integrated competitive employment on individual benefits through the use of DB101 and Work Incentives.

  Status: The process is being modified to ensure that it is accessible for adults as well as youth. Multiple strategies are being used to reach as many people as possible. Many parts of the outreach plan tie to other Olmstead action items related to employment.

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

  Status: The July 1, 2014 deadline was not met. A facilitated conversation between Department of Human Services (DHS) and Minnesota Department of Education (MDE) took place on October 2nd to identify policies and best practices related to positive practices and use of restraint, seclusion and other practices which may cause physical, emotional, or psychological pain or distress. A report was submitted on October 22nd to the subcabinet that identifies areas where gaps exist and plans and timelines to address the gaps. The report "Minnesota's Statewide Plan" is included as **Exhibit 5-14**.

  The working groups that created Minnesota's Statewide Plan and the Crisis Triage report from SS 3I below are meeting to make sure there is alignment between the processes and recommendations included in the two reports. The final report and recommendations will be submitted to the subcabinet in February for review and approval.

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

  Status: The July 1, 2014 deadline was not met. This action item was done in coordination with SS 3C and SS 3E. See the status update for SS 3C above.

- **SS 3E** - By August 1, 2014 the state will develop, across state agencies, a common definition of incidents, including emergency use of manual restraint, that are to be reported, and create common data collection and incident reporting processes.

  Status: The August 1, 2014 deadline was not met. This action item was done in coordination with SS 3C and SS 3D. See the status update for SS 3C above.

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

  Status: The "Crisis Triage and Hand-off Process" report was submitted to the subcabinet in the October 2014 bimonthly report. The working groups that created this report and Minnesota's Statewide Plan in SS 3C, SS 3D, and SS 3E above are meeting to make sure there is alignment between the processes and recommendations included in the two reports. The final report and recommendations will be submitted to the subcabinet in February for review and approval.

PREVIEW OF ITEMS DUE IN NEXT FOUR MONTHS

A preview of Olmstead Plan action items that are due from November 1, 2014 through February 28, 2015 are included in **Appendix 5-A**.

IV. ACTIONS TAKEN BY SUBCABINET

1. The SS 2G - Report on Other Segregated Settings (**Exhibit 5-11**) was accepted by the subcabinet at the December 15, 2014 meeting. It will be reviewed and approved at the February 9, 2015 meeting.
2. The SS 4B - Wait List Report (**Exhibit 5-12**) was accepted by the subcabinet at the September 29, 2014 meeting. It will be reviewed and approved at the February 9, 2015 meeting.
3. The SS 3C-SS 3E Statewide Plan (**Exhibit 5-14**) was accepted by the Subcabinet at the December 15, 2014 meeting and will be reviewed and approved at the February 9, 2015 meeting.
4. The subcabinet approved the December Bimonthly Report to the Court.

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INDEX OF APPENDICES AND EXHIBITS

APPENDIX 5-A: PREVIEW OF NOVEMBER–FEBRUARY ACTION ITEMS

Key to abbreviations used in Grid:

TOPIC AREAS

CE = Community Engagement

ED = Lifelong Learning and Education

EM = Employment

HC = Healthcare and Healthy Living

HS = Housing

OV = Overarching Strategic Actions

QA = Quality Assurance and Accountability

SS = Supports and Services

TR = Transportation

RESPONSIBLE AGENCY

DEED = Department of Employment and Economic Development

DHS = Department of Human Services

DOC = Department of Corrections

MDE = Minnesota Department of Education

MDH = Minnesota Department of Health

MDHR = Minnesota Department of Human Rights

MHFA = Minnesota Housing Finance Agency

MnDOT = Minnesota Department of Transportation

OIO = Olmstead Implementation Office

SC = Subcabinet

Appendix 5-A - Preview of Action items for November – February 2015 (in alphabetical order)

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
CE	1A	12/31/2014	Develop a plan to increase opportunities for people with disabilities to meaningfully participate in policy development	83	SC	Consultation is ongoing with persons with disabilities and advocacy groups. Current practices by state agencies for engaging people with disabilities are being reviewed. The resulting feedback and analysis will be used to develop plan.
CE	1B	12/31/2014	Assess the size and scope of peer support and self-advocacy programs; set annual goals for progress.	83	SC	Existing programs, funding sources and capacity for expansion are being reviewed to create a baseline and establish baseline and measurable goals.
CE	2A	12/31/2014	Evaluate, revise as necessary, and disseminate guidelines and criteria when public dollars are used for ensuring that people with disabilities are incorporated in public planning processes.	83	SC	Review, evaluate and analyze current practices and what other states use as criteria in this area. Develop guidelines and criteria for review by subcabinet.
ED	1D	11/30/2014	Stakeholders will discuss and recommend revisions to Minnesota Statutes §125A.0942 subd. 3 (8) to clarify that prone restraint will be prohibited by August 1, 2015 in Minnesota school districts and will apply to children of all ages.	72	MDE	MDE is involved in the grant and RFP process based upon a one- time legislative appropriation of $250,000 to help school districts with students experiencing a high use of prone restraint. The RFP is on schedule to be published on November 24, 2014. Funds will be distributed to eligible school districts via grants and to a contractor to develop training models to address strategies to reduce the use of restrictive procedures involving students with disabilities with complex needs. MDE has reviewed and approved grants to six districts and is in the process of distributing those funds.
ED	1E	2/1/2015	Report to the legislature on districts' progress in reducing the using of restrictive procedures in Minnesota schools and on stakeholder recommendations regarding Minnesota Statutes §125A.0942 subd. 3 (8)	72	MDE	Restrictive procedures workgroup meeting schedule has been set for the 2014/2015 school year. The workgroup will provide recommendations related to the prohibition of prone restraint and work plan activities to be included in the February 1, 2015 legislative report.

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
EM	2G	1/1/2015	Clarify cross-agency employment service planning and coordination to expand competitive employment in the most integrated setting.	43	DHS, DEED, MDE	The Interagency Employment Panel identified program and funding priorities for this legislative session. Legislative proposals have been developed. These proposals leverage existing funding streams and support innovation and interagency coordination.
EM	3F	1/1/2015	Provide technical assistance and support to non-integrated/facility-based employment programs to develop and design new business models that lead to competitive employment in the most integrated setting	44	DHS, DEED, MDE, MDHR	Currently there are 16 agencies and 51 individuals that have completed training in customized employment. A contract has been extended to continue training to a larger audience.
EM	3J	12/31/2014	Publicize statistics, research results and personal stories illustrating the contributions of persons with disabilities in the workplace	44	DHS, DEED, MDE, MDHR	VRS will publish, distribute and post online an annual report that includes statistics, results and personal stories about individuals with disabilities in the workplace. The report for FFY 2014 will be published at the end of December.
EM	3L.1	1/1/2015	Distribute findings, policy interpretations and recommendations from Interagency Employment Panel (annual)	45	DHS, DEED, MDE, MDHR	Interagency Employment Panel continues to meet on a regular basis. The report will be completed in January 2015.
HC	1A	1/1/2015	Establish baselines and targets to increase number of teams that are able to provide integrated, person-centered primary care for persons with disabilities	76	DHS, MDH	As a first step to establishing a baseline, MDH is working with DHS to determine the number/ percentage of people with disabilities within the Medicaid program that receive primary care services from Health Care Homes. Preliminary data is being analyzed. The next step includes discussions with Health Care Homes across the state to determine the extent to which the care they provide to this population meets best practices.

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
HC	1C	12/31/2014	Design framework and develop implementation plan for healthcare for adults with serious mental illness and children with serious emotional disturbance	77	DHS, MDH	DHS is working to implement behavioral health homes as a first step in development of a framework to provide services in a person-centered system of care that facilitates access to and coordination of the full array of primary, acute, and behavioral health care. The population of Medical Assistance recipients to be served under this model is adults and children with serious mental illness (SMI). DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality.
HC	2G	12/31/2014	Establish baseline data for current care (medical, dental, chiropractic and mental health) of people with disability; develop an implementation plan to further assess, develop, and respond.	79	DHS, MDH	Data sources and basic approach have been defined; Meetings being held with a work group to better operationalize disabilities for children and seniors. Initial test runs of reports using the definition for adults conducted and under review. Initial data run on children's definition and measures conducted.
HC	2J.1	12/31/2014	50% of Minnesota's transition age youth with disabilities will receive the services necessary to make transitions to adult health care.	80	DHS, MDH	Family Voices of Minnesota is working together with MDH in developing the tool kit. There are currently four medical clinics providing input and testing the tools. Staff meets regularly with Family Voices to discuss the tool kit which will be online by the end of 2014 and presented to Health Care Homes in May of 2015. There are ongoing monthly meetings with DHS, DEED and MDE to develop a cross agency focus on successful transitions to adulthood for children and youth with special health needs.
HS	1B	1/30/2015	Develop timeframe for completing individual assessments and facilitating moves into more integrated housing settings	50	DHS	This action item is related to item SS 2G. Using the demographics report completed in SS 2G work is underway to design individual assessments.

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
HS	1E	12/31/2014	Develop a process to track the number of individuals with disabilities exiting state correctional facilities and their access to appropriate services and supports	50	DOC, DHS	An information systems change will need to be made in order to denote individuals who have a disability. DOC leads have been identified. DHS and DEED contacts are needed who can inform how to track the referenced population's "access to appropriate services and supports." Draft of finished work product will be created on December 8th during a small group meeting.
HS	2A	12/31/2014	Baseline and targets established for number of new affordable housing opportunities created, the number of people with disabilities accessing affordable housing opportunities in the community, and the number of people with disabilities with their own lease, and (for people who move to more integrated settings) measures related to housing stability.	51	DHS, MHFA	MHFA has identified the number of housing opportunities financed in the previous 5 years. This includes information on differing levels of rent restrictions, and the volume of units financed. The next step will be to determine how DHS and MHFA will collect the number of people accessing affordable housing in the community, number with their own lease, and housing stability. DHS and MHFA staff will plan to meet and discuss throughout December to develop a plan with timelines to gather this information.
HS	3A	1/6/2015	Prepare proposals for legislative proposals for the 2015 session, giving priority to changes that promote choice and access to integrated housing settings	52	DHS	Group Residential Housing (GRH)/Minnesota Supplemental Aid (MSA) legislative proposal is complete and is currently being reviewed within the DHS budget process.
HS	5B.1	12/31/2014	The number of counties participating in Individualized Housing Options will increase to 17	54	DHS	Individualized Housing Options (IHO) is a county-led initiative to help more persons with disabilities live in the community setting of their choice. Services and supports are designed on an individual basis to help persons live as independently as possible. Currently 14 counties have participated in IHO meetings.
OV	1A	12/31/2014	Define an individual planning service to assist people with disabilities in expressing their needs and preferences about quality of life; establish plan to initiate service	31	SC	A legislative proposal for the 2015 session has been drafted to create a new service under the Medicaid state plan which would make individual, person-centered “life planning” available to eligible individuals. The proposal is currently being reviewed within the DHS budget process.

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
OV	2B	12/31/2014	Identify barriers to integration that are linked to state and federal legislation, regulation, or administrative procedures; identity options to address them	32	SC	Contracted with MAD for assistance in survey and evaluation. Survey was sent to internal and external stakeholders to help identify barriers to integration. Meeting held with disability stakeholder group comprised of representatives from the Governor appointed disability councils to review survey submissions. Draft report and recommendations completed by December 31, 2014.
OV	3A	12/31/2014	Leadership opportunities for people with disabilities to be involved in leadership capacities in all government programs that affect them will be identified and implemented	32	SC	The OIO has begun conversations with various people with disabilities to serve on advisory committees. Further contacts will be made. A plan is being drafted on how to structure this activity.
QA	1C	12/31/2014	Conduct a pilot of the quality of life survey	34	SC	The survey instrument and contract initiated on May 20th. The pilot study will test the feasibility of statewide sampling of individuals in a range of setting; analysis of the tool and delivery; and implementation strategy. Preliminary report on the pilot will be provided at the December 15, 2014 subcabinet meeting.
SS	1B	1/1/2015	Establish characteristics and criteria that define best practices in person-centered planning and the Olmstead requirements, to be used by state agencies to evaluate and revise their assessment and plan content	62	SC	Reviewing the work done on person-centered planning when completing the July draft of the Plan. Working with agency staff and stakeholder to define criteria.

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
SS	2A.2	1/1/2015	For all individuals leaving certain settings for the most integrated settings, designated protocols and processes to support individuals will be used	63	DHS	Anoka Metro Regional Treatment Center (AMRTC), MSH-St. Peter and LifeBridge (formerly MSHS-Cambridge has begun implementing transition protocols. These protocols consist of the use of a defined transitioning summary tool and the policies/ procedures that surround the use of that tool. Work continues on the tool for Persons with Developmental Disabilities (ICF/DD) and people under 65 in nursing homes for more than 90 days. Identified team members from those areas continue to work together to agree on the tool and its implementation.
SS	2A.3	1/31/2015	Develop a method to measure and track individuals transitioning from certain settings to assess transition success and stability and to identify problems.	63	DHS	A tool was developed and used by the Institute for Community Integration (ICI) to measure how well the transition from MSHS Cambridge into the community went. This tool focuses on the five broad indicators of the MN Olmstead Plan and measures the core of what the transition protocols are supposed to be accomplishing. A current revision of the tool is being considered and discussions are still occurring as to how to implement reviews.
SS	2C	12/31/2014	For individuals in Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs) and people under 65 who have been in nursing facilities longer than 90 days: 90 people will have transitioned to community services	63	DHS	This item is reported on in **Exhibit 5-1.**
SS	2D.1	12/31/2014	Reduce % of people at Anoka Metro Regional Treatment Center who do not require hospital-level of care and are awaiting discharge to 30%	63	DHS	This item is reported on in **Exhibit 5-1.**
SS	2F.2	12/31/2014	Increase average monthly discharge rates at Minnesota Security Hospital from 8 individuals per month to 9 individuals per month	64	DHS	This item is reported on in **Exhibit 5-1.**

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
SS	2H	1/31/2015	Make a legislative request in support of the movement of the individuals in other segregated settings within established timelines	64	DHS	A number of legislative proposals for the 2015 session have been drafted and are currently being reviewed within the DHS budget process.
SS	2J	1/6/2015	Develop a legislative initiative to fund an electronic health record system to assist with release of individuals from corrections facilities to community settings with appropriate levels of support	65	DHS, DOC	A legislative request for funding for electronic health records has been completed, and is currently moving through the Governor's budget process.
SS	3J	12/1/2014	Identify best practices, set service standards, and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions	66	DHS, MDE	Representatives from various affected state agencies have been identified. The University of Minnesota Institute on Community Integration has agreed to facilitate and assist with the action items related to positive practices. Rachel Freeman, a nationally recognized leader in positive practices and supports is working with them on this project.
SS	3J.1	1/15/2015	Complete the necessary analysis and planning to expand crisis services, diversion, and early intervention services to persons at risk of experiencing a crisis situation; set dates for implementation	67	DHS	Legislative proposals have been developed to expand mobile mental health crisis services to serve persons with disabilities and to develop regional Positive Behavior Supports and Person-Centered Planning communities of practice to develop system-wide capacity for early intervention services.
SS	4C	12/31/2014	Develop a plan to expand the use of assistive and other technology in Minnesota to increase access to integrated settings; set goals and timelines for expanding the use of technology that increases access to integrated settings	68	SC	The OIO is working with the STAR program (System of Technology to Achieve Results) to explore and develop a plan to expand the awareness, access to and use of assistive technology.
SS	4E	1/6/2015	Develop a legislative initiative to build capacity and/or expand services for an assertive community treatment team for individuals leaving corrections facilities	69	DHS, DOC	A legislative proposal for the 2015 session has been drafted and is currently being reviewed within the budget process.

Topic Area	Action #	Deadline	Brief Description of Action	Page	Agency	Current Status and Next Steps
TR	1D	1/6/2015	Prepare proposals for legislative proposals for the 2015 session; priority to changes that will increase funding flexibility to support increased access to integrated transportation	57	DHS	Legislative proposals have been drafted relating to non-emergency protected transportation and increasing transportation outstate. They are currently under review within the budget process.

EXHIBIT 5-1: OLMSTEAD PLAN IMPACT ON LIVES OF INDIVIDUALS

INDIVIDUALS MOVING FROM SEGREGATED TO INTEGRATED SETTINGS

SS 2C - Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD) and Nursing Facilities (for persons under 65 in facility longer than 90 days)

The tables below contain information about the movement of individuals through the segregated settings of ICFs and Nursing Facilities (NF). It includes Medicaid recipients only and is based on Medical Assistance billing databases. Revisions may be made in subsequent months due to billing and accounting practices. This data exclude people who were admitted to ICFs and NFs for respite, generally staying for 2-3 days at a time and who have a permanent community residence.

Intermediate Care Facilities for Persons with Developmental Disabilities

Month	Moved to community[3]	Total moved to date	Admissions/ Readmits	Transfers	Deaths
Nov 13	9	9			0
Dec 13	14	23			0
Jan 14	2	25			0
Feb 14	1	26			0
March 14	5	31			1
April 14	6	37			0
May 14	11	48	Nov 13 –	Nov 13 -	2
June 14	12	60	Sept 14	Sept 14	0
July 14	12	72			0
Aug-Sept 14	6	78	78	24	5

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

Month	Moved to community[4]	Total moved to date	Admissions/ Readmits*	Transfers	Deaths
Nov 13	29	29	*	45	**
Dec 13	40	69	*	45	**
Jan 14	39	108	*	67	**
Feb 14	28	136	*	57	**
March 14	31	167	*	49	**
April 14	29	196	*	46	**
May 14	50	246	*	60	**
June 14	43	289	*	54	**
July 14	42	331	*	65	**
Aug-Sept 14	59	390	*	13	15

*Unable to complete calculation of this data

**During this time MA/MA Pending and non-MA deaths could not be separately reported

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

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

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

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

Month	Discharges	% Awaiting discharge	Deaths	Admissions	Readmits*	Avg. Daily census	Transfers*
Nov 13-Feb 14	51	34%					
March-April 14	39	33%	0	62		108	
May-June 14	54	32.3%	0	61		106	
July 14	11	46.7%	0	23		108	
Aug 14	21	45.9%	0	33		108	
Sept 14	14	37.5%	0	27	2	104.7	16
Oct 14	13	36.6%	0	19	2	102.3	12

SS 2F - Minnesota Security Hospital (MSH)

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

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

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

SS 4B - WAIT LIST INFORMATION

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

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

Disability Waiver[1]	**March 2014**	**April 2014**
	Recipients on waivers	
DD	15,279	14,206
CCB	18,930	17,668

	March 14	**April 14**	**May 14**	**June 14**	**July 14**	**Aug 14**	**Sept 14**	**Oct 14**
	Number of persons on wait lists for disability waivers							
DD	3,563	3,561	3,541	3,527	3,507	3,502	3,512	3,487
CCB*	1,355	1359	1,385	1,403	1,421	1,450	1,448	1,460
	Number of persons beginning waiver services							
DD	39	56	42	65	46	43	25	50
CCB	215	223	219	216	224	248	212	125
	Number of persons moving from wait list[2]							
DD		48	119	86	134	111	92	119
CCB*		17	112	101	132	118	114	131

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

*CADI is the only CCB waiver with a wait list. CAC and BI do not have wait lists.

[1] Disability Waivers include DD and CCB. DD means Developmental Disabilities, CCB is made up of 3 waivers = Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC) and Brain Injury (BI)

[2] It is important to note that a person with urgent need does not go on a waiting list but goes directly to receiving waiver services.

RECEIVING INDIVIDUALIZED HOUSING OPTION SERVICES (HS 5B)

Baseline information from March 2014

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

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

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

Quality of Life – Individual Stories

AMY'S STORY

Amy Gardner lives with cerebral palsy and has been in a wheelchair her entire life. She was born in St. Louis Park, Minnesota and grew up in the Mound area with her mom, dad and "awesome older brother!" Amy, now 28, regularly sees her family and they remain actively involved in her life. They assist her in setting, planning and working toward her goals.

During her school years, Amy took a mix of integrated and special education classes. "I was the only one in a wheelchair in my entire high school," she recalled. Amy had support staff to help with her class load. As an avid sports fan, her favorite class was gym. Amy played multiple sports throughout school including floor hockey, softball, basketball and soccer. "I grew up around sports," she said, so it was a natural path for her to take. In 2013, Amy received the Wilma Rudolph Award for Courage and Inspiration because of her contributions to girls and women's sports at Mound Westonka High School.

In 2009, Amy first moved from her parents' home to Hammer Residences' Merrimac group home in Plymouth. For five years, Amy enjoyed the camaraderie of her roommates, gaining life skills and developing more independence. Yet, she always knew she wanted an apartment of her own, so a few years ago Amy and her support team started the process to make such a move a reality. "It took a very long time!" Amy recounts with a tinge of annoyance. All told, finding an accessible apartment, implementing necessary supports, and convincing others that this was a good move, took more than two years to complete.

As of October, 2014 Amy now has her own apartment at Hammer's Avana Apartment Program in St. Louis Park. The challenge now is finding the funding to make some final renovations, particularly in the bathroom, to maximize accessibility and independence for Amy. Overall, the move has noticeably improved her quality of life and she could not be happier.

Following high school, Amy attended Intersect and Vector, transition programs designed to build and increase job readiness skills. Amy now works five days a week at Opportunity Partners in Bloomington where she boxes and labels items. She ideally would like to find a job that pays better and allows her to do "something more independent." She voiced dissatisfaction with her job status and would "appreciate more help getting me a regular job."

Outside of work and her new apartment, Amy is active in Special Olympics, participating in bowling, floor hockey, track, and bocce ball. She has been an avid participant in Special Olympics for nine years now. Amy also attends church on a regular basis where she enjoys time with her boyfriend of six years. Additionally, Amy likes spending time with her brother, sister in-law and nephew. "We usually go out to dinner and they pay" she said with a big smile.

When going out, Amy receives ride support from staff at her apartment or uses Metro-Mobility. She is still learning the scheduling process for Metro-Mobility, but can already cancel rides without any assistance. Amy generally doesn't have issues with Metro-Mobility but does think they could improve their timeliness. She appreciates the options of traveling on her own or having staff help her get around.

Amy is a bright young woman with many opportunities and dreams on her horizon. She sets goals for herself and has the persistence and patience to turn them into reality. Amy meets challenges head on with a positive, can-do attitude that is infectious to those around her. In fact, Amy's next big goal is to attend Twin's training camp in Florida so she can see her favorite player, Joe Mauer.

Anthony's Story

Anthony Lott was born in Minnesota and grew up in the metro area with his mom, dad and three siblings. Now 38, Anthony is the oldest of three siblings and has lived in Minnesota his whole life. Anthony describes his parents as involved and supportive of his goals, but from a young age, he realized he would also need to advocate for himself. They help him discuss his goals such as living independently. "My parents love it, they are very proud of me," he states.

Growing up, Anthony attended school with his peers in a mix of integrated and special education classrooms. Although Anthony does not recall choosing his own classes, he does remember that staff tried getting him into classes he enjoyed, like art and gym. Anthony liked to draw and animate his comic art. He was also an avid floor hockey player in high school. Anthony fondly remembers many long-term friends including Justin, Tom, David and Peter. "Like anyone, I liked to hang out with my friends and have a good time," Anthony recalled of his youth. While he hasn't had much contact with these friends since high school, Anthony has made many new friends at work, in his apartment building and other areas of the community.

After moving out of his parents' home, Anthony first lived in an Intermediate Care Facility (ICF) with five others. He had the opportunity to learn and work on many of the skills he now depends on, including cleaning and budgeting, but he still wanted more independence. While in the ICF, Anthony made a big decision – to move to an apartment. He informed his family and case worker that this was his goal. Despite some initial opposition, he took the initiative and began working at obtaining the supports and services he would need to make such a move – especially securing a waiver. It took roughly two years for Anthony to get that waiver, yet throughout the arduous and often confusing time, he remained committed to his goal. During this lengthy process, Anthony continued taking classes to help him live successfully on his own. "It took patience," Anthony said regarding the length of time to make the move from the group home to his own apartment.

Anthony has been living in his own apartment at Hammer Residences' Broadmoor Apartment Program in Eden Prairie for three years now and he couldn't be happier about it. Anthony has two orange tabby cats, Mickey and Star, who live with him. He makes sure they have food, a clean litter box and he also takes them to the vet for their shots. Along with taking care of his animals, Anthony is responsible for cleaning his apartment and is working to become a better cook. Since moving to an apartment program, he has become more open to the idea of healthy eating and getting more fruits and vegetables into his diet. Anthony researches healthy recipes on his phone before grocery shopping and cooking his lunches for the week. "I love being a chef!"

When going out, Anthony uses a combination of regular public transit and schedules his own use of Metro-Mobility. He also takes the Greyhound bus to visit family. Anthony buys his Greyhound tickets online, and while he still gets some assistance from staff to complete this process, he does the majority of it himself. Aside from buses, Anthony also rides a bicycle. In fact, last summer, he purchased his own bicycle. It is a green bike, which is one of Anthony's favorite colors. He always wears a helmet for safety. Because "the streets are too dangerous," he mainly rides on the trails in the area.

At the moment, Anthony has two life goals: he wants to be his own guardian and would also like to be an auto mechanic. He is working on that first goal and is making progress toward the second by looking for a new math tutor to prepare for the entrance exam at Hennepin Technical College. His first attempt on the math test was “kind of hard…but it takes practice to know math, and she (the tutor) had confidence in me.”

Anthony works at Stratasys, a 3D printing and production company, with support from his job coach, Tiffany. His responsibilities include counting, organizing and placing 3D printing products on pallets for international shipment. When not working, Anthony enjoys spending time on his computer watching movies. He also enjoys challenging himself and has started a martial arts class. He has a test for his white belt in early December, and is confident he will do well. Anthony also likes to travel. He has been to New York City where he saw the Statute of Liberty by boat and met Jon Stewart at a taping of the Daily Show. He is planning his next trip to San Diego in March. Anthony sees travel as a great way to see new places and experience new things. He works hard to save money to be able to afford such experiences.

Anthony is a people person who enjoys being around others. He sets goals for himself and has the persistence and patience to turn those goals into reality. Anthony meets every challenge with positivity and enjoys the opportunities independent living provides. He loves where he lives, is proud of his abilities and wouldn’t change anything in his life.

Katie Jo's Story

Katie Jo Houtman was born in Illinois where she lived for fourteen years before moving to Orono, Minnesota with her family. Katie Jo is the oldest of three; she has a brother and sister. Animals have always been a part of in her life and she considers them family as well. Katie Jo describes her parents as involved and supportive of her goals. They help her by discussing important life decisions and setting rules that help her to be successful.

Katie Jo has Prader-Willi syndrome which creates challenges for her in maintaining a healthy weight. Prader-Willi syndrome is a rare genetic disorder characterized by a chronic feeling of hunger that can lead to excessive eating and life threatening obesity.

Growing up, Katie Jo first experienced some challenges with the transition to middle school. "It was tough, because they didn't understand that I was special ed.," Katie Jo recalled. In Illinois, Katie Jo had been in one classroom, benefitting from the relationship she'd developed with her teacher, but in Minnesota, she had multiple, regular classes with peers. Teachers didn't understand why she wasn't "getting it." It took some time, but she and her mother successfully advocated and Katie Jo finally got the supports she needed to thrive, particularly in high school. Katie Jo graduated from Mound Westonka High School and even took general education classes at Normandale Community College. She has thought about maybe going back to college but says that she would need additional supports set up in order to do that.

In 2002, Katie Jo moved out of her parents' home. Initially, she lived in a cottage next door to her family. "Losing weight was the most challenging struggle for me living on my own." In fact, multiple times over the years Katie Jo had to move into nursing home care due to health issues related to her disability. "That didn't feel very good; it wasn't a good place for anyone to live in," remembers Katie Jo about those times. "I felt that my life was taken away from me, and I had lost everything." Katie Jo next moved into a small apartment with in-home assistance, but it still wasn't the right mix of supports and independence. She also missed the familiarity of the cottage, so she convinced her parents that she could be more successful this time. "It was my choice to decide to move." However, because of her disability, Katie Jo once again admitted to needing additional supports in order to lead a healthy life. She realized that having more supervision and support helps her to be healthy and to "stay on my program." It ultimately keeps her out of the nursing home or other institutional setting. Now happily living in Hammer Residences' Vicksburg Village Apartments in Plymouth, Katie Jo says that these supports have been critical to her ongoing success, and even though she might not have liked them in the beginning she realizes she needs them in her life.

Katie Jo continues to work hard to manage her weight and works out at least one-hour each day. She also plans her own workouts. For example, she enjoys participating in a Zumba class two-three times a week. She also participates in dance aerobics, line dancing and swimming. Katie Jo also uses the gym that is available in her Vicksburg apartment complex as well as nearby trails for walking.

Katie Jo continues to make thoughtful choices in her life that help her to be healthy. As a result of her dedication and determination, and with the right supports, Katie Jo has lost an incredible amount of

weight. While private about that information, she says she is very close to achieving her goal weight of 166 pounds.

Katie Jo uses the transportation built into her apartment program. She simply lets staff know that she wants to go somewhere, usually a day in advance. She can use Metro-Mobility as well, but doesn't find that to be a very reliable transportation mode. She gets additional help with transportation from her parents and other friends and can also use the city bus. "I have a big village that can take care of me."

Katie Jo is an energetic young woman with many skills and talents. She is active in her church, where she teaches the Kindergarten Sunday school and vacation bible school. She also works with Project Sew, making various types of bags. In addition, Katie Jo volunteers at a local nursing home calling bingo. Katie Jo also enjoys traveling to visit her siblings in Georgia and North Carolina.

EXHIBIT 5-2: MEASURABLE GOALS SUBMITTED TO MONITOR

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EXHIBIT 1

MEASURABLE GOALS
for action items
through October 31, 2014

(submitted to Court Monitor
on November 10, 2014)

INTRODUCTION

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

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

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

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

EMPLOYMENT GOALS

Action item EM 1A – Page 40

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

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

MEASURABLE GOALS:

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

NOTES:

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

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

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

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

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

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

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

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

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

EMPLOYMENT GOALS

Action item EM 1B – Page 41

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

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

MEASURABLE GOALS:

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

NOTES:

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

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

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

EMPLOYMENT GOALS

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

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

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

MEASURABLE GOALS:

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

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

NOTES:

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

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

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

EMPLOYMENT GOALS

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

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

MEASURABLE GOALS:

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

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

NOTES:

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

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

EMPLOYMENT GOALS

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

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

MEASURABLE GOALS:

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

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

NOTES:

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

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

EMPLOYMENT GOALS

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

BASELINE:

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

MEASURABLE GOALS:

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

NOTES:

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

TRANSPORTATION GOALS

Action item TR 1C – Page 58

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

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

MEASURABLE GOALS:

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

NOTES:

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

SUPPORTS AND SERVICES GOALS

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

- For individuals in other segregated settings:
  - By September 30, 2014 DHS will identify a list of other segregated settings, how many people are served in those settings, and how many people can be supported in more integrated settings. [SS 2G]
  - By September 30, 2014 DHS will review this data and other states'[7] plans for developing most integrated settings for where people work and live. Based on this review DHS will establish measurable goals related to demonstrating benefits to the individuals intended to be served and timelines for moving those individuals to the most integrated settings. [SS 2G.1]

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

MEASURABLE GOALS:

For individuals living in segregated settings:

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

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

MEASURABLE GOALS:

For individuals who are in segregated day settings:

- By June 30, 2015, the number of individuals who spend their days in more integrated settings will be 50
- By June 30, 2016, the number of individuals who spend their days in more integrated settings will be 150
- By June 30, 2017, the number of individuals who spend their days in more integrated settings will be 200
- By June 30, 2018, the number of individuals who spend their days in more integrated settings will be 500
- By June 30, 2019, the number of individuals who spend their days in more integrated settings will be 500

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

NOTES:

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

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

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

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

Residential settings/services delivered in segregated settings include:

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

Day/employment services delivered in segregated settings:

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

SUPPORTS AND SERVICES GOALS

Action item SS 3I –Page 68

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

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

MEASURABLE GOALS:

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

NOTES:

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

SUPPORTS AND SERVICES GOALS

Action item SS 4B – Page 70

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

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

MEASURABLE GOALS:

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

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

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

NOTES:

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

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

SUPPORTS AND SERVICES GOALS

Action SS 4D – Page 70

FACT is an adaptation of the evidence-based model of Assertive Community Treatment. It is a program that provides treatment, rehabilitation, and support services to individuals who have schizophrenia, schizoaffective disorder, or bipolar disorder and who have significant and persistent functional impairments (homelessness, repeated hospitalizations, unemployment) which contribute to high system use. In the case of forensic assertive community treatment, individuals also have significant involvement in the corrections system. Treatment and rehabilitation services are delivered by a multi-disciplinary team and works by reducing symptoms, meeting basic needs, securing necessary benefits, increasing skills and functioning in areas such as employment, interpersonal skills, community navigation, and activities of daily living. The key to a successful FACT team is the monitoring of its fidelity to the ACT model, along with on-going technical assistance.

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

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

MEASURABLE GOALS:

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

NOTES:

In the seven metro counties (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington) during 2013, there were 62 individuals released from custody with a diagnosis of Serious and Persistent Mental Illness (SPMI). These individuals were identified through a brief screening. It is anticipated that a more extensive screening evaluation process may identify a larger number of individuals over time who meet the SPMI criteria. Approximately 8 individuals are represented in the 62 count twice due to re-incarceration and subsequent release.

Because this is a new service, the baseline is zero. The goals will be based on best practices for starting a new high fidelity ACT program.

LIFELONG LEARNING AND EDUCATION GOALS

Action item ED 1A.1 – Page 73

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

- By June 30, 2014 and each subsequent year, districts will report summary data on their use of restrictive procedures to the department, in a form and manner determined by the Commissioner of the Minnesota Department of Education (MDE) [ED 1A.1 - 1A.3]

BASELINE: During the 2013-2014 school year, the number of students with disabilities whom school districts reported experienced restrictive procedures was 2,707 students. The number of incidents of restrictive procedures school districts reported was 19,409. Of those, 13,116 were physical holds and 6,301 were seclusion.

During the 2013-2014 school year, there were 15 school districts that reported using prone restraint one or more times. There were 837 incidents of prone restraints. The number of students with disabilities who experienced one or more prone restraints was 159.

MEASURABLE GOALS:

- By June 30, 2015
  - the number of students who experience a restrictive procedure will be reduced by 108
  - the number of reported restrictive procedure incidents will be reduced by 776

- By August 1, 2015, the number of students who experience prone restraint will be zero

- By June 30, 2016
  - the number of students who experience a restrictive procedure will be reduced by 104
  - the number of reported restrictive procedure incidents will be reduced by 745

- By June 30, 2017
  - the number of students who experience a restrictive procedure will be reduced by 100
  - the number of reported restrictive procedure incidents will be reduced by 715

- By June 30, 2018
  - the number of students who experience a restrictive procedure will be reduced by 96
  - the number of reported restrictive procedure incidents will be reduced by 687

- By June 30, 2019
  - the number of students who experience a restrictive procedure will be reduced by 92
  - the number of reported restrictive procedure incidents will be reduced by 659

NOTES:

Once the goals are achieved, the number of students who experience a restrictive procedure will have been reduced by 500 below baseline to 2,207 students. The number of restrictive procedures will have been reduced by 3,589 below baseline to 19,402 restrictive procedures.

The number of prone restraints will have been reduced by 837 to 0 prone restraints. The number of students who experience one or more prone restraints will have been reduced by 159 to 0 students.

The baseline for these goals was determined by identifying both: 1) the number of students with disabilities whom school districts reported experienced restrictive procedures in the 2013-2014 school year, a baseline of 2,707 students; and, 2) the number of incidents of restrictive procedures school districts reported were used with students with disabilities in the 2013-2014 school year, a baseline of 19,409.

In addition during the 2013-2014 school year, there were 15 school districts that reported using prone restraint one or more times. There were 837 incidents of prone restraints. The number of students with disabilities who experienced one or more prone restraints was 159.

The goals were set based on: 1) the statutory prohibition against prone restraint going into effect August 1, 2015; and, 2) an existing $250,000.00 legislative appropriation for training and technical assistance to district staff. The goals may be affected by changing demographics in enrollment and movement of students between districts and out of state.

LIFELONG LEARNING AND EDUCATION GOALS

Action item ED 4A.1 - Page 75

- Based on the Minnesota Post School Outcome Survey data, beginning September 1, 2014 and each subsequent year, there will be an increase of a minimum of 50 students with disabilities per year entering integrated postsecondary education and training programs within one year of exiting secondary education. [ED 4A.1 – 4A.3]

BASELINE: The number of students with disabilities who entered integrated postsecondary education and training programs within one year of exiting secondary education is 254.

MEASURABLE GOALS:

The number of students with disabilities entering integrated postsecondary education and training programs within one year of exiting secondary education per year will increase

- By September 1, 2015 the number of individuals will increase by 50
- By September 1, 2016 the number of individuals will increase by 50
- By September 1, 2017 the number of individuals will increase by 50
- By September 1, 2018 the number of individuals will increase by 50
- By September 1, 2019 the number of individuals will increase by 50

NOTES:

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

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

Using post school outcome data from school year 2012-2013 as a baseline, a total of 74 districts and 1,529 students with disabilities who had graduated, aged out or dropped out could participate in the Minnesota Post School Outcome Survey. The number of completed surveys was 783. Of the 783 individuals, 32.4% or 254 students with disabilities were enrolled in higher education one year post

graduation. Once the goals are achieved, the number of students who are competitively employed one year post graduation will have increased by 250 above the baseline of 254.

Certain items on the survey ask the student to respond to only one option that would indicate if the student was enrolled in higher education. These results are then summarized and calculated and used for the measurement on this goal.

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

School Year	09-10	10-11	11-12	12-13
Percentage	29.1%	33.0%	26.7%	32.4%
Number	162	187	159	254
TOTAL Number Completed Surveys	557	567	596	783
TOTAL Number Leavers in Annual Sample	1,252	1,321	1,324	1,529
Response Rate	44.5%	42.9%	45.0%	51.2%

Minnesota uses the definition for enrolled in higher education adopted from National Post School Outcome Center. Enrolled in higher education means youth have been enrolled on a full- or part-time basis in a community college (2-year program), or college/university (4- or more year program) for at least one complete term, at any time in the year since leaving high school.

The number of completed surveys is not a static number. There will be fluctuation in the numbers of completed surveys from year to year. To date, the number of completed surveys has increased from 557 in 2010 to 783 in 2013. As the number of completed surveys increases and the interagency collaboration between DEED and DHS improves, it is expected that the number of students enrolled in higher education will increase by 50 in 2015 and each subsequent year. The number of completed annual surveys will change over time which will affect the number/percent of the enrolled in higher education outcomes. Labor market trends and economic growth in Minnesota will impact transition-age youth enrolled in higher education.

LIFELONG LEARNING AND EDUCATION GOALS

Action item ED 5A - Page 75

- By June 30, 2014 review current data on this student population and develop prototype reintegration plans to transition students to more integrated settings. Establish measurable goals and timelines for actions to be taken to benefit students [ED 5A]

BASELINE: Work is currently underway to establish the baseline.

MEASURABLE GOALS:

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

NOTES:

There were 256 students at Minnesota Correctional Facilities at Red Wing and Togo (under age 21) in 2012 -2013. Of the 256 students at the two juvenile correctional facilities, 180 or 70% had an Individualized Education Program (IEP).

On December 1, 2014 the Department of Corrections (DOC) will begin collecting data on adolescents with IEPs in Minnesota Correctional facilities at Red Wing, Togo and Lino Lakes. This will include tracking individuals being released to determine if they return to their home school district.

HEALTHCARE AND HEALTHY LIVING GOALS

Action item HC 2C – Page 79

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

- By June 30, 2014 using information from this study, develop a plan for implementation including timelines and measurable goals. [HC 2C]

BASELINE: The total number of adults with disabilities receiving Medicaid who did not receive at least one dental service during calendar year 2013 was 86,520 individuals.

MEASURABLE GOAL:

- By July 1, 2016 the number of individuals with disabilities who receive dental services will increase by 335.

NOTES:

The baseline for this goal was determined by identifying the total number of adults with disabilities receiving Medicaid who did not receive at least one dental service during calendar year 2013, a baseline of 86,520 individuals. Data was extracted from Medicaid billing systems. Confirmation of the number of individuals receiving dental services may not be available until at least December 31, 2016.

The goal was set based on a legislatively approved rate change for dental services that will take effect in 2016. The goal is reasonable because it is based upon trends experienced in other states that have raised dental payment rates.

At this time it is not clear of the actual impact of the rate changes. It is also not clear how the legislature will act during the 2015 session on the recommendations made in the legislative report of 2014. Therefore, goals will be set on an annual basis until these variables until these variables are better understood.

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EXHIBIT 5-3: EM 1I.1 – NORTH METRO PLACEMENT PARTNERSHIP BROCHURE

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About North Metro Placement Partnership

NMPP provides expert, professional employment services to help businesses find skilled and qualified job candidates.

NMPP is a broad network of public sector and private sector agencies with decades of success in recruiting, hiring, supporting, and retaining diverse candidates for employment.

Talent in Every Field

NMPP can offer access to more than 300 pre-screened, skilled and qualified candidates to meet your needs. Select from candidates who offer skills in all career fields and have educational attainments ranging from GED to Ph.D.

NMPP recruits from a deep pool of talented candidates who reflect the rich diversity of the North Metro workforce.

NMPP talent-matching services are first-rate. We know our candidates. We know their skills, strengths, aptitudes and interests. Our role is to introduce you to a job candidate who fits your unique needs, and to assist in any way we can during the recruitment and hiring process.

AND WE CHARGE NO FEES... EVER.

Recruitment, Hiring & Retention

NMPP Listens

With the North Metro Placement Partnership you make just one call to your employment consultant. We'll listen and learn about your business needs and what skills and qualities you're seeking in a job candidate.

NMPP Works

Once we know what you're looking for, we'll tap into our network to find candidates who fit your needs. You'll conduct the interviews and make the hiring decision.

NMPP Follows Through

If you make a job offer, your employment consultant can provide retention supports if they're needed to ensure success.

NMPP Services

Besides offering recruitment and hiring assistance, NMPP employment consultants can provide other human resource services — or refer you to providers on topics such as these:

- Americans with Disabilities Act (ADA) and Accommodations
- Ergonomics
- Hiring Incentives
- Disability Awareness
- Education and Resources on Disability and Diversity

no fees...ever

One Call Gets You Started

One call puts you in touch with top North Metro vocational consultants — partnering, collaborating and networking to help you locate skilled and qualified candidates.

MARCI JASPER
1201 89th Avenue NE
Blaine, MN 55434
763-279-4364
marci.jasper@state.mn.us

MARY STEINMETZ
8406 Sunset Road NE
Spring Lake Park, MN
763-783-2833
msteinmetz@rise.org

The employment consultants in the North Metro Placement Partnership represent well-established and highly effective organizations in both the public sector and the private sector. Collectively, they bring decades of experience and success in bringing together talented candidates for employment and the businesses that seek to employ them.

NMPP can help your business diversify your workforce by providing access to skilled and qualified candidates.

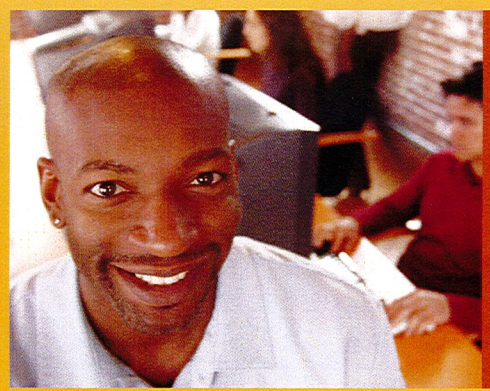
You save time — because we help find the candidates you need.

And you save money — because there's never a charge for partnering with NMPP.

ONE CALL. THAT'S ALL IT TAKES.

North Metro Placement Partnership Network

- Goodwill — Easter Seals Minnesota
- LJ & A Employment Counseling and Placement Services
- Lifetrack
- Midwest Special Services
- Opportunity Partners
- Opportunity Services
- Rise, Inc.
- State of Minnesota Vocational Rehabilitation Services
- State Services for the Blind
- U.S. Department of Veterans Affairs



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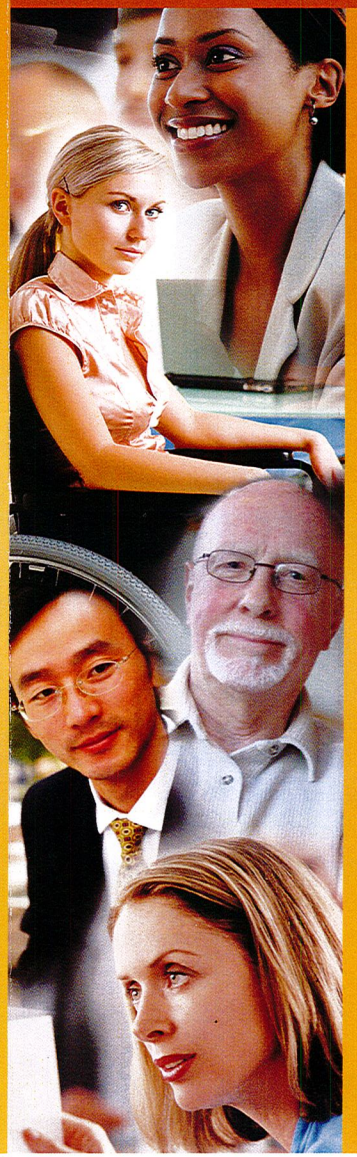
North Metro Placement Partnership



Recruiting & Hiring Solutions for Twin Cities North Metro Businesses

EXHIBIT 5-4: EM 2C – EMPLOYMENT IMPLEMENTATION PLAN

	Employment Implementation Plan - Provide Access to Most Integrated Settings in order to increase Integrated, Competitive Employment Outcomes	Date Color Key: Olmstead Plan date / Legislative Proposal date / IEP Priorities date		
	Work Streams and Milestones	**Responsible**	**Start**	**End**
EM2C	**Beginning September 1, 2014, using service, standards and funding priorities identified in the Interagency Employment Panel, develop implementation plans to provide access to most integrated settings in order to increase integrated, competitive employment outcomes.**	DHS, DEED, MDE, MDHR	**Sep-14**	
IE Panel Priority	**Provide training and technical assistance for service providers who currently have business models structured around segregated and non-competitive employment to transition their service delivery model to integrated, competitive employment models.**	DHS, DEED, MDE, MDHR	**Jan-15**	
1	**Training and Techncial Assistance Implementation Plan**	DHS, DEED, MDE, MDHR		
1.1	**Design and establish a management structure and process for the coordination and communication of the TTA work plan aligning with other Olmstead action plans**	IEP	Nov-14	Jan-15
1.2	**Determine how to optimize current TTA plans to support integrated, competitive employment goals in the near term**	TTA Design Team	Nov-14	Jan-15
1.2A	**Develop interim strategy for providing Training and technical assistance for non-integrated employment programs to design new business models**	TTA Design Team	Dec-14	**Jan-15**
1.2B	**Develop improvement strategy on state and local level for educators and families regarding integrated, competitive employment**	TTA Design Team	Dec-14	**Jun-15**
1.3	**Develop interim funding strategy**	TTA Design Team	Nov-14	Jan-15
1.4	**Address MOU/MOA and Work Agreement requirements as necessary**	TTA Design Team	Jul-15	ongoing
1.5	**Conduct plan review at 6 month intervals to ensure coordination with overall Olmstead progress - review and modify as necessary**	TTA Design Team	Jul-15	ongoing
1.6	**Define/clarify Olmstead criteria (competitive employment) - relative to Training and Technical Assistance - identify common language and shared goals**	TTA Design Team	Jul-15	**Dec-15**
1.7	**Develop long term funding strategy**	TTA Design Team	Jan-15	Jan-16
1.8	**Research other state training and technical assistance models to service provider organizations and gather input from Stakeholders**	TTA Design Team	Jul-15	Jan-16
1.9	**Compare model to current Training and Technical Assistance approach/services and identify changes and additions - gap analysis**	TTA Design Team	Jan-16	Jul-16
1.10	**Compare and align Training and Technical Assistance approach/entity recommendations with other Olmstead action plans**	TTA Design Team	Mar-16	Sep-16
1.11	**Identify/design Training and Technical Assistance approach/entity**	TTA Design Team	Mar-16	Sep-16
1.12	**Finalize model and formalize implementation plan**	TTA Design Team	Sep-16	Jul-17
1.13	**Implement the TTA plan and modify based on feedback/results**	TTA Design Team	Jul-17	Jul-18
1.14	**Evalutate results and modify for continuous improvement**	TTA Design Team	Jul-18	ongoing

	Employment Implementation Plan - Provide Access to Most Integrated Settings in order to increase Integrated, Competitive Employment Outcomes	Date Color Key: Olmstead Plan date / Legislative Proposal date / IEP Priorities date		
	Work Streams and Milestones	**Responsible**	**Start**	**End**
IE Panel Priority	**A clear package of services designed to result in competitive employment for transition-aged people with disabilities (transitioning from school to work) with the most significant disabilities. Features to include clearly defined roles and responsibilities of each state agency (MDE-DEED-DHS), clearly defined eligibility criteria, what supports and funding each agency will provide (and an MOU), system navigators, a consumer-directed option, use of informal supports, long-term wrap-around to include services like transportation & respite to "fill in the gaps" of a work week.**	DHS, DEED, MDE, MDHR	**Sep-14**	
2	**Package of Services and System Navigation Implementation Plan**	DHS, DEED, MDE, MDHR		
2.1	**Design and establish a management structure and process for the coordination and communication of the Package of Services work plan aligning with other Olmstead action plans**	DHS, DEED, MDE, MDHR	Nov-14	Jan-15
2.2	**Determine how to optimize current programs to support competitive employment goals**	POS Design Team	Dec-14	Jun-15
2.3	**Develop interim funding strategy**	POS Design Team	Dec-14	Jul-15
2.4	**Address MOU/MOA and Work Agreement requirements as necessary**	POS Design Team	Jul-15	ongoing
2.5	**Conduct plan review at 6 month intervals to ensure coordination with overall Olmstead progress - review and modify as necessary**	POS Design Team	Jul-15	ongoing
2.6	**Define/clarify Olmstead criteria (competitive employment) - relative to package of services and navigation pathways- identify common language and shared goals**	POS Design Team	Jan-15	**Dec-15**
2.7	**Develop long term funding strategy**	POS Design Team	Jul-15	Jul-16
2.8	**Research other service and delivery models and gather input from Stakeholders**	POS Design Team	Jul-15	Jul-16
2.9	**Compare Olmstead criteria to current services offered, system navigation, roles and responsibilities by agency and identify changes and additions - Gap Analysis**	POS Design Team	Jul-16	Jan-17
2.10	**Compare and align service and delivery recommendations with other Olmstead action plans**	POS Design Team	Jul-16	Jan-17
2.11	**Identify and design Package of Services and system navigation model**	POS Design Team	Jan-17	Sep-17
2.12	**Finalize model and formalize implementation plan**	POS Design Team	Sep-17	Jul-18
2.13	**Implement the plan and modify based on feedback/results**	POS Design Team	Jul-18	Jul-19
2.14	**Evalutate results and modify for continuous improvement**	POS Design Team	Jul-19	ongoing

	Employment Implementation Plan - Provide Access to Most Integrated Settings in order to increase Integrated, Competitive Employment Outcomes	Date Color Key		
		Olmstead Plan date		
		Legislative Proposal date		
		IEP Priorities date		
	Work Streams and Milestones	**Responsible**	**Start**	**End**
IE Panel Priority	**Development of a State-wide data collection system to collect data on competitive employment outcomes per the directive of the Olmstead Plan**	DHS, DEED, MDE, MDHR		**Jul-18**
3	**State-wide Data System Implementation Plan**	DHS, DEED, MDE, MDHR		
3.1	**Design and establish a management structure and process for the coordination and communication of the Data System work plan aligning with other Olmstead action plans**	IEP	Nov-14	Jan-15
3.2	**Determine interim data measurement and reporting plan and how to optimize current data systems and reporting**	Data Design Team	Sep-14	Jun-15
3.3	**Develop interim funding strategy**	Data Design Team	Dec-14	Jun-15
3.4	**Address MOU/MOA and Work Agreement requirements as necessary**	Data Design Team	Jul-15	ongoing
3.5	**Conduct plan review at 6 month intervals to ensure coordination with overall Olmstead progress - review and modify as necessary**	Data Design Team	Jul-15	ongoing
3.6	**Define/clarify Olmstead Criteria (Employment) - relative to data collection system requirements - common language and share goals**	Data Design Team	Jan-15	**Dec-15**
3.7	**Develop long term funding strategy**	Data Design Team	Jul-15	**Jul-16**
3.8	**Research and analyse information and data elements of other developing state-wide systems for people with disabilities**	Data Design Team	Jul-16	Jun-17
3.9	**Compare to Olmstead model (requirements) to current data state and identify changes and additions - Gap Analysis**	Data Design Team	Jul-17	Jun-18
3.10	**Compare and align database recommendations with other Olmstead action plans**	Data Design Team	Jul-17	Jun-18
3.11	**Develop the data element standards and requirements and begin designing the data collection system**	Data Design Team	Jul-17	Jun-18
3.12	**Complete the building of the database system, field test, evaluate and revise as necessary**	Data Design Team	Jul-18	Jun-19
3.13	**Launch full implementation of the database system, conduct ongoing maintenance and performance improvement modifications**	Data Design Team	Jul-19	Jun-20

EXHIBIT 5-5: EM 2D – EMPLOYMENT FIRST POLICY

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Minnesota Employment First Policy

Adopted by the Olmstead Subcabinet on September 29, 2014

Policy Statement:

Employment First means raising the expectation that all working age Minnesotans with disabilities can work, want to work, and can achieve competitive integrated employment; and each person will be offered the opportunity to work and earn a competitive wage before being offered other supports and services.

Introduction:

The State of Minnesota is committed that all Minnesotans including those with disabilities have a wide range of employment opportunities within the general workforce. The Minnesota Employment First Policy guides state agencies in their planning, decision making, implementation, and evaluation of services and supports for Minnesotans with disabilities to make employment the first and expected option considered. The Minnesota Employment First Policy provides state agencies with:

- A clear statewide vision supporting transformational change and a long-range goal of working-age youth and adults with disabilities participating in the workforce at levels similar to their peers who do not have disabilities
- A guiding vision to increase public and business expectations about employing the abilities and capacities of all people with disabilities to work in the right job with the right level of support
- A policy framework that guides present and future decisions related to people with disabilities who receive public services
- Guidance to provide clarity on how this policy will be applied across state agencies
- Instruction to act to develop and implement plans to ensure the Employment First principles and informed choice are integrated into new and existing employment-related policies, services and supports for people with disabilities.

Vision, Values and Guiding Principles:

Vision

The Employment First Policy envisions a future where all people with disabilities can achieve competitive, integrated employment. Competitive employment means:

- Full-time, part-time, or self-employment with and without supports
- In the competitive labor force

- On the payroll of a competitive business or industry
- Pays at least minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by workers without a disability.

This policy increases options and choices for people with disabilities by aligning policies, funding practices and collaborative efforts among state agencies. This will help people who choose to work to enter an integrated, competitive workforce or become self-employed.

Values

Three core values ground the Minnesota Employment First Policy. These core values reflect that people with disabilities, including people who have complex and significant disabilities:

- Want to work
- Can be competitively employed or self-employed, earning at least the minimum wage and benefits
- Should be fully integrated physically, functionally and socially within the workplace.

Guiding Principles

1. Integrated, competitive employment is the first and expected service option.
2. Employment is prioritized as an outcome of services and supports.
3. Employment and support services are grounded in informed choice practices, which include but are not limited to:
    - Community-based experiences on which to base decisions
    - Knowledge about the potential impact of employment on their quality of life
    - Information and support to understand their options related to employment
    - Understanding of how work affects public benefits and resources so that work can be part of the plan without fear of losing essential benefits.
4. Individuals with disabilities have increased control and direction over services and supports.
5. Effective interagency coordination will be demonstrated in the delivery of innovative employment, education, and support services, and improved employment outcomes.
6. State agencies will be accountable for monitoring and reporting progress and for establishing interagency quality assurance procedures.

Call to Action: Implementation Requirements for the Minnesota Departments of Education, Employment and Economic Development, and Human Services

1. State agencies are required to use these guiding principles to develop agency plans for transformational changes in the provision of employment services and supports for people with disabilities, including:
    - Identification and provision of supports and services to achieve employment
    - Incorporation of additional standards that adhere to Employment First principles into regulations, quality assurance, and agency program monitoring
    - Expansion and promotion of the use of promising and best practices for employment supports.

2. The Minnesota Departments of Education, Employment and Economic Development and Human Services (MDE, DEED and DHS) must define, operationalize, and document a process to ensure a person-centered approach and informed choice is used without conflicts of interest or bias to work. Informed choice must include community exploration and experienced-based opportunities.

3. After an informed choice process has been followed and if a person chooses not to work, then, documentation will be maintained by the appropriate agency of the reason(s) for the decision. This will help MDE, DEED and DHS determine what, if any, changes are necessary to address barriers to employment that resulted in the choice not to work. People with disabilities may choose to reconsider their decision at any time. Additionally, MDE, DEED and DHS must establish a process to regularly review with the person his/her decision regarding work and any options to address barriers that may have existed in the past.

4. MDE, DEED and DHS will work together to align programs, funding and policies to support people with disabilities to choose, secure and maintain competitive and self-employment, including:
    - Provision of information, technical assistance and training opportunities to adopt policies and promising processes that improve the employment outcomes of working age youth and adults across educational and adult service systems
    - Incentives for innovation that increase competitive employment in the general work force
    - Expanding the flexibility in funding and services to increase competitive employment outcomes.

5. MDE, DEED and DHS must develop uniform data collection and reporting procedures, and make public data that documents implementation of the Employment First Policy, including outcome measures.

Successful implementation of this policy will be demonstrated by increased competitive employment of persons with disabilities in the most integrated community work setting.

"The opportunity and freedom for meaningful choice, self-determination, and increased quality of life, through: opportunities for economic self-sufficiency and employment options; choices of living location and situation, and having supports needed to allow for these choices." --- Subcabinet Vision Statement –MN Olmstead Plan (p. 21 plan version with proposed modification July 10, 2014).

Olmstead Plan Employment Goal: People with disabilities will have choices for competitive, meaningful, and sustained employment in the most integrated setting (p. 40 of July 10, 2014 plan version)

Minnesota will adopt an Employment First Policy and use these principles in service design and delivery… By September 30, 2014, the state will adopt an Employment First Policy (page 42 of the July 10, 2014 plan version, Employment Section under Action two: Align policies and funding)

EXHIBIT 5-6: EM 2E.1 – MOU PROCESS/TIMELINE

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Integrated Memorandum of Agreements (MOA/MOUs)
MN Olmstead Plan Employment Action Item 2E.1
MOU Development Process and Timeline - September 19, 2014

Action Item: "By September 30, 2014, establish a process and timeline for integrated Memorandum of Agreements (MOA/MOUs) across state agencies to assure the implementation of Interagency Employment Panel recommendations and to ensure the implementation of policy and practices that support integrated employment and Employment First principles." (Fully executed MOU/MOUs due July 1, 2015)

Recommended Approach:
Establish MOU/MOA(s) to spell out the commitment of Agency leadership to hold each of their staff members accountable for collaboratively ensuring implementation of Interagency Employment Panel (IEP) recommendations and the implementation of policy and practices that support integrated employment and Employment First principles.

Elements to be included in the MOU/MOA(s) are: purpose, including people to be served; agencies involved; term of agreement; conditions for modifying or terminating the agreement; dispute resolution process for any breakdown in collaboration: and authorization (signatures).

MOU/MOA(s) will be actualized through "Working Agreements" that outline specific purpose, roles and responsibilities by agency as interagency policies, processes and practices are developed in accordance with the Olmstead Plan's "Employment Implementation Plan." As new policies, processes and/or practices are developed, a standard step in the review and approval process will be to determine the need for a "Working Agreement" and establish them where the need is indicated.

If an additional MOU is deemed necessary as work plans are implemented and further details regarding required actions emerge, the MOU drafting team will be reconvened and follow the process below to establish the required MOU/MOA.

Detailed process and timeline:

Action Item	Responsible	Completion Date
MOU drafting team identified representing the Agencies responsible for the Olmstead Plan integrated, competitive employment initiatives: DHS, DEED, MDE	Dean Ritzman – DHS Jayne Spain – MDE Alyssa Klein - DEED	Completed
Draft Olmstead Plan Employment MOU/MOA(s)	MOU drafting Team	Jan 31, 2015
Identify stakeholders & develop process for broad review and input	Interagency Employment Panel	Feb 15, 2015
Distribute draft MOU/MOA(s) and collect feedback	MOU drafting Team	Mar 15, 2015
Review input and finalize draft MOU/MOA(s) for presentation to IEP and Agency leadership	MOU drafting Team	Apr 1, 2015
IEP and Agency leadership provide feedback	IEP/Agency Leaders	Apr 30, 2015
Adjust and develop final draft	MOU drafting Team	May 15, 2015
Prepare documentation and present to Agency commissioners for approval/authorization	MOU drafting Team	May 30, 2015
MOU/A fully executed	Commissioners	Jun 30, 2015

Action Item	Responsible	Completion Date
Establish a standard template, criteria and expectation for "working agreements" that articulate measurable outcomes, activities to be covered and resources needed. The "working agreement" template will be designed to ensure clarity of accountability, responsibilities and service level expectations within/between involved agencies for all changes/additions to policy, procedures or practices that are developed as part of the Olmstead Plan's "Employment Implementation Work Plan."	MOU drafting Team	Feb 15, 2016
Develop "Working Agreements" per Implementation plan steps as needed	Impacted agencies	Ongoing

EXHIBIT 5-7: EM 2F.1 – VR PURCHASED SERVICES POLICY

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SCOPE OF VOCATIONAL REHABILITATION SERVICES

As appropriate to the vocational rehabilitation needs of each individual and consistent with each individual's informed choice, the Vocational Rehabilitation Services program will ensure that the following vocational rehabilitation services are available to assist the eligible consumer in an open priority category in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice:

- Assessment for determining eligibility and priority for services by a qualified Vocational Rehabilitation Counselor, including, if appropriate, an assessment by personnel skilled in rehabilitation technology. (See Policy Chapter 1: Qualifying For Services)

- Assessment for determining vocational rehabilitation needs by qualified personnel, including, if appropriate, an assessment by personnel skilled in rehabilitation technology. (See Policy Chapter 2: Assessment of Vocational Rehabilitation Needs and Employment Plan)

- Vocational rehabilitation counseling and guidance, including information and support services to assist an individual in exercising informed choice. (See Guidance Materials Chapter 4H: Vocational Counseling and Guidance)

- Referral and other services necessary to assist applicants and eligible individuals to secure needed services from other agencies, including other components of the statewide WorkForce Center system, and to advise those individuals about the Client Assistance Project. (See Policy Chapter 18: Information and Referral)

- Physical and mental restoration services, to the extent that financial support is not readily available from a source other than the Vocational Rehabilitation Services program (such as through health insurance or other comparable service or benefit. (See Policy Chapter 4B: Physical and Mental Restoration)

- Vocational and other training services, including personal and vocational adjustment training, books, tools, and other training materials, except that no training or training services in an institution of higher education may be paid unless maximum efforts have been made by Vocational Rehabilitation Services and the individual to secure grant assistance in whole or in part from other sources to pay for that training. (See Policy Chapter 4A: Postsecondary Training)

- Maintenance for added costs associated with an approved plan for employment. (See Policy Chapter 5A: Maintenance)

- Transportation in support of other primary services required by an approved plan for employment. (See Policy Chapter 5B: Transportation)

- Vocational rehabilitation services to family members of an applicant or eligible individual if necessary to enable the applicant or eligible individual to achieve an employment outcome.

- Interpreter services, including sign language and oral interpreter services, for individuals who are deaf or hard of hearing by qualified personnel. (See Policy Chapter 4F: Auxiliary Aids and Services for Effective Communication)

- Job-related services, including job search and placement assistance, job retention services, follow-up services, and follow-along services.

- Supported employment services. (See Policy Chapter 6: Supported Employment)

- Personal assistance services when needed to support other services under an approved plan for employment, including training in the management of these services. (See Policy Chapter 5C: Personal Assistant Services)

- Post-employment services. (See Policy Chapter 9: Post-Employment Services)

- Occupational licenses, tools, equipment, initial stocks, and supplies.

- Rehabilitation technology, including vehicle modification, telecommunications, sensory, and other technological aids and devices and training in the management of these services. (See Policy Chapter 4C: Rehabilitation Technology)

- Transition services. (See Policy Chapter 7: School-To-Work Transition Services)

- Technical assistance and other consultation services to conduct market analyses, develop business plans, and otherwise provide resources, to the extent those resources are authorized to be provided through the statewide workforce investment system, to eligible individuals who are pursuing self-employment or telecommuting or establishing a small business operation as an employment outcome. (See Policy Chapter 4D: Small Business)

- Other goods and services determined necessary to assist an individual achieve an employment outcome

The above mentioned services must be provided in the most integrated setting possible. Integrated setting, with respect to the provision of services, is defined as a setting typically found in the community in which the consumer interacts with non-disabled individuals, other than non-disabled individuals who are providing him/her services.

As appropriate, the above mentioned services can be obtained from either an in-state or out-of-state provider. If a consumer chooses an out-of-state provider at a higher cost than an in-state provider, if either provider would meet the individual's rehabilitation needs, Vocational Rehabilitation Services is not responsible for those costs in excess of the cost of the in-state service.

Through appropriate modes of communication, each consumer must be given the information necessary to make informed choices. Individuals with cognitive impairments or other disabilities who need help in exercising informed choice must be told that support services are available.

EXHIBIT 5-8: EM 3B – SINGLE POINT OF CONTACT

What is Single Point of Contact (SPOC)?

A business model in which a designated person (or persons) from the VR community has a relationship with the business and is the conduit or facilitator between the business and the entire VR community. The SPOC assists the business in the areas of recruitment, hiring, and disability training or resource needs.

SPOC concept involves developing business relationships with a long-term goal in mind for continued partnership with the business. The model requires the Placement Professional to take the time to listen to the business's needs and develop a deep understanding of their company, positions, culture, hiring needs and values.

The goals of the SPOC model are: Build relationships which lead to increased hiring of people with disabilities; meet the business needs by referring qualified candidates for positions; eliminate having multiple placement coordinators repeatedly contacting the same business. In a sense, the SPOC allows the placement person to augment or be an extension of a business's HR department in the area of recruiting qualified candidates.

Some key components:

- Listening, asking questions and taking time to thoroughly understand the business's needs
- Offering screened and qualified candidates and follow up services, resources/services
- Developing long-term trusting relationships, then building on the relationship (move from hiring to implementing job tryouts or on-the-job trainings and serving as a resource regarding disability information and education)
- Speaking the same language as the business, understanding that their need is a Positive Return on Investment, dispelling myths and fears
- Responding with sense of urgency and the speed at which business operates

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History/Philosophy

SPOC stems from the "Business is our Customer" model that some VR agencies nationwide are transitioning to as a result of extensive research and feedback from businesses. The Minnesota VR Community views businesses as a key customer in our work and to achieving our mission.

The goal is to develop trusting, long-term relationships which leads to repeat business and a win-win relationship. Some businesses prefer to work with a SPOC within the VR community. This service should be on the "menu" of services we offer to businesses.

EXHIBIT 5-9: EM 3C – 503 TRAINING AGENDA

Placement Advisory Group (PAG)
Thursday, September 25, 2014 9:00 am – 2:30 pm
North Minneapolis WFC
1200 Plymouth Ave N, Minneapolis, MN 55411
N Mpls WFC Main Line 612-520-3500

Agenda

9:00 Welcome/RSA Update /Pilot Updates/SGA	Chris McVey
10:00 Placement Partnership Updates	PAG Members
Break	
11:00 OJT / JTO Refresher	Maureen McAvoy / Marci Jasper
11:30 Placement Strategies for Serving Job Seekers who are Deaf / Hard of Hearing	Ron Adams / Roberta Johnson
Break / Networking / Lunch (ordering Jimmy John's)	
1:00 503 PowerPoint Presentation	Maureen McAvoy / Evie Wold
1:45 Marketing Materials	Maureen McAvoy

EXHIBIT 5-10: HS 4A/HS 4B – HOUSINGLINK

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HousingLink Listing Sessions

6/25/14 - Multiple Sclerosis Society of Minnesota (serves all of MN)

7/1/14 - National Alliance on Mental Illness Minnesota (serves all of MN)

7/2/14 – Minnesota State Council on Disabilities (serves all of MN)

7/8/14 – Vail Place (serves those in the metro area)

7/17/14 – Northwest MN Continuum of Care (serves NW Minnesota – Greater MN)

7/23/14 – Dakota County Affordable Housing Coalition (serves Dakota County)

7/24/14 – Southwest MN Continuum of Care (serves southwest MN – Greater MN)

8/5/14 – Central MN Continuum of Care (serves communities in central MN and included agencies serving Northeast MN as well – Greater MN)

8/6/14 – Minneapolis Continuum of Care (serves Minneapolis and metro area)

8/13/14 – Washington County Housing Collaborative (serves Washington County)

8/14/14 – Scott Carver Housing Coalition (serves Scott & Carver counties)

8/14/14 – West Central Continuum of Care (serves West Central MN – Greater MN)

8/21/14 – Southeast MN Continuum of Care (serves SE Minnesota – Greater MN)

8/26/14 – Guild, Incorporated (serves Ramsey County and the metro area)

8/29/14 – Metro Health Plan (serves the metro area)

9/2/14 – Alexandra House (serves the metro area)

9/2/14 – Bloomington Housing & Redevelopment Authority (serves Bloomington)

9/9/14 – Keystone Community Services (serves Ramsey County)

Engagement & Awareness Sessions

7/17/14 – Northwest MN Continuum of Care (serves NW Minnesota – Greater MN)

7/24/14 – Southwest MN Continuum of Care (serves southwest MN – Greater MN)

8/5/14 – Central MN Continuum of Care (serves communities in central MN and included agencies serving Northeast MN as well – Greater MN)

8/14/14 – West Central Continuum of Care (serves West Central MN – Greater MN)

8/21/14 – Southeast MN Continuum of Care (serves SE Minnesota – Greater MN)

9/15/14 – Minnesota Coalition for the Homeless Conference (Rochester, MN)

9/24/14 – Minnesota Financial Workers and Case Aids Association Conference (St. Cloud, MN)

9/25/14 – Minnesota Social Service Association NW District Conference (Moorhead, MN)

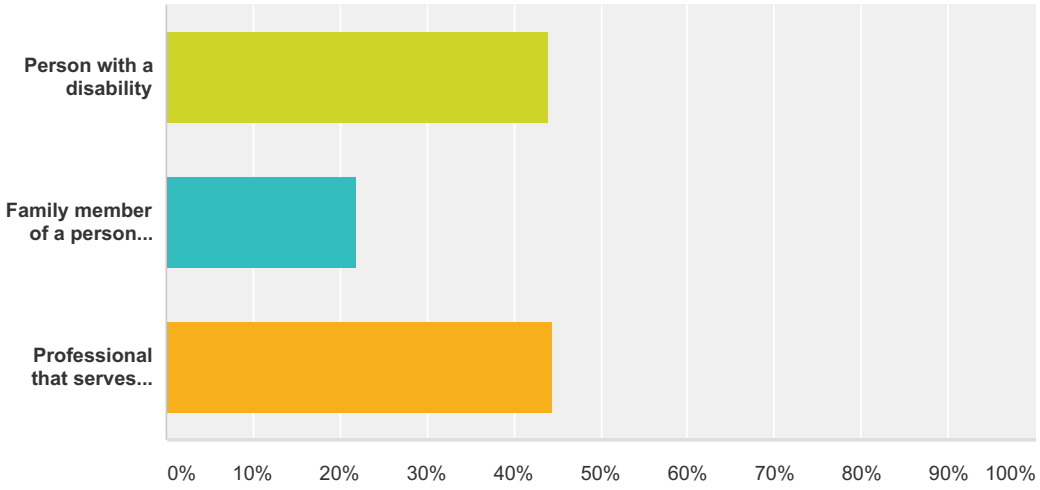
9/26/14 – Minnesota Social Service Association Region 9 Conference (Mankato, MN)

10/8/14 – St Louis County Health and Human Services Conference (Duluth, MN)

Accessibility Survey

Q1 Tell us about who you are. I am a...

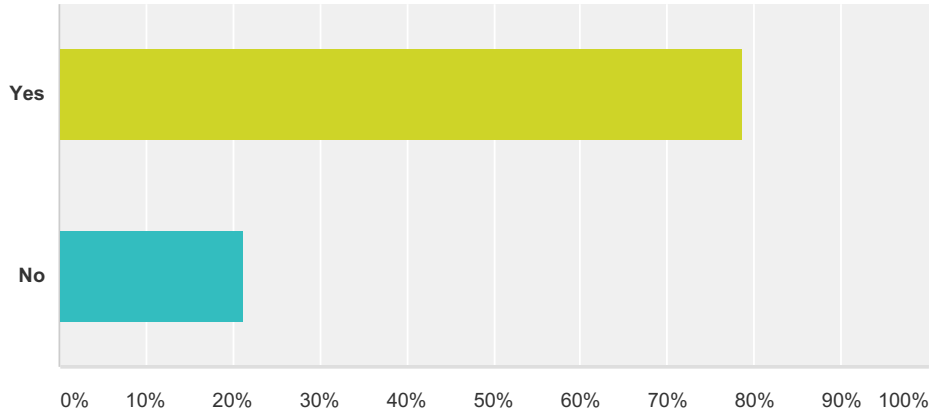
Answered: 329 Skipped: 9



Answer Choices	Responses	
Person with a disability	**44.07%**	145
Family member of a person with a disability	**21.88%**	72
Professional that serves those with disabilities	**44.38%**	146
Total Respondents: 329		

Q2 Have you searched for housing on HousingLink in the past year?

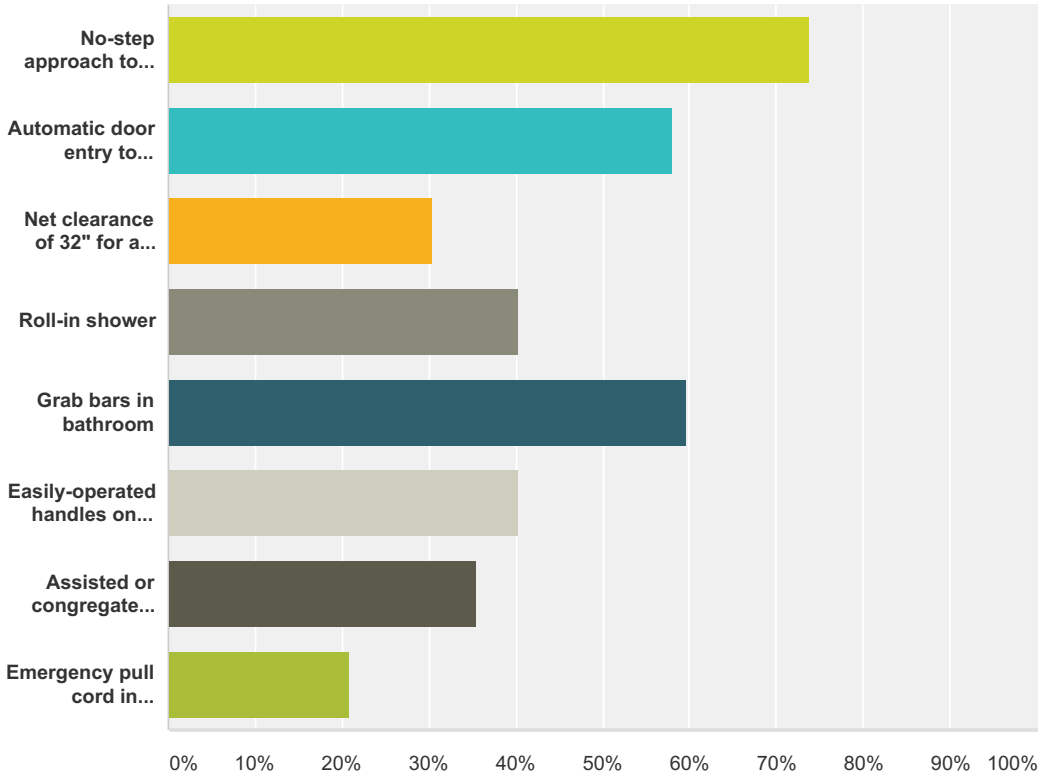
Answered: 338 Skipped: 0



Answer Choices	Responses	
Yes	**78.70%**	266
No	**21.30%**	72
Total		**338**

Q3 Which accessible housing features are most helpful to know in your housing search? (select all that apply)

Answered: 291 Skipped: 47



Answer Choices	Responses	
No-step approach to building and unit	**73.88%**	215
Automatic door entry to building for disability access	**58.08%**	169
Net clearance of 32" for all building/unit passageways	**30.58%**	89
Roll-in shower	**40.21%**	117
Grab bars in bathroom	**59.79%**	174
Easily-operated handles on doors (levers/loops)	**40.21%**	117
Assisted or congregate living	**35.40%**	103
Emergency pull cord in bathroom	**20.96%**	61
Total Respondents: 291		

Q4 What other accessibility features would you like to see when searching for housing?

Answered: 192 Skipped: 146

Q5 For those with a mental illness, what do you most need to know about a place when renting?

Answered: 192 Skipped: 146

Listening Feedback Session Summary Recommendations

The following were common themes identified during the 18 listening feedback sessions that are driving key changes HousingLink will make to the hList housing search application and website.

1. Allow renters to search/filter by individual accessibility features
2. Allow renters to search/filter by individual property and unit amenities.
3. Allow renters to search/filter by which pets are allowed at a property.
4. Allow renters to search/filter by specific subsidized housing programs (Project Based Section 8, Public Housing, Section 42, etc)
5. Add “Elevator” as an accessibility feature and make it searchable
6. Change “Grab Bar” to two options: Grab bar near toilet, Grab bar near shower
7. Add “Lowered Kitchen Cabinets” as an accessibility feature and make it searchable
8. Make sure all education content in PDFs is also in text on a webpage so the site impaired can access it through a screen reader.
9. Add more education related to accessibility, reasonable accommodation, companion animals, and more.
10. Make it easier to increase the font size on the website.
11. Make it easier to access educational content on the site through dropdown navigation.

EXHIBIT 5-11: SS 2G – REPORT ON OTHER SEGREGATED SETTINGS

Report on Other Segregated Settings
Submitted and accepted by Subcabinet: December 15, 2014
To be Reviewed and Approved: February 9, 2015

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Minnesota Olmstead Plan: Demographic Analysis, Segregated Settings Counts, Targets and Timelines

Continuing Care Administration

Children and Family Services Administration

September 30, 2014

For more information contact:

Minnesota Department of Human Services
Disability Services Division
St. Paul, MN 55101
651-431-4262

This information is available in accessible formats to individuals with disabilities by calling 651-431-4262,
Or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

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Contents

Tables of Figures

Olmstead Plan Language

Housing section

Action One: Identify people with disabilities who desire to move to more integrated housing, the barriers involved, and the resources needed to increase the use of effective best practices

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

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 50.

Supports and Services section

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

For individuals in other[1] segregated settings:

- *By September 30, 2014 DHS will identify a list of other segregated settings, how many people are served in those settings, and how many people can be supported in more integrated settings.*
- *By September 30, 2014 DHS will review this data and other states[2] plans for developing most integrated settings for where people work and live. Based on this review DHS will establish measurable goals related to demonstrating benefits to the individuals intended to be served and timelines for moving those individuals to the most integrated settings.*

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 64.

Introduction

Minnesota's Olmstead Plan goal is to ensure that Minnesota is a place where people with disabilities live, learn, work and enjoy life in the most integrated setting. Services and supports that enable people to exercise their right of self-determination, to live in the most-integrated settings and to be able to freely participate in their communities will be appropriate to their needs and of their choosing.

To achieve this, the Olmstead Plan sets goals and identifies strategic actions in the following areas: employment, housing, transportation, supports and services, lifelong learning and education, healthcare and health living, and community engagement.

[1] In the Olmstead Plan, immediately preceding this quoted section, is a list of actions and measures related to certain segregated settings: Intermediate Care Facilities for Persons with Developmental Disabilities, nursing facilities (specifically for people under 65 who are there more than 90 days), Anoka Metro Regional Treatment Center, Minnesota Security Hospital and Minnesota Specialty Health System-Cambridge. The term used here, "other segregated settings", refers to places other than these previously listed five settings.

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

This report focuses on moving people on increasing the number of people living in the most integrated settings and decreasing the number of people living unnecessarily in segregated settings.

The State must better align the design and provision of supports and services with these outcomes. The culture surrounding the delivery of supports and services will be based on a holistic approach to supporting people. Many factors influencing quality of life will have to come together, such as expectations and aspirations, skills developed over a lifetime, personal supports, location of one's home and transportation options.

Increasing flexibility and options in all of these areas will require collaboration among divisions within state agencies, across state agencies, with providers, businesses, community organizations and, of course, people with disabilities and their families.

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

- Increase in the number of people living in most integrated settings
- Decrease in people living unnecessarily in segregated settings
- Increase in the quality of life as reported by people with disabilities, using indicators described in the Quality Assurance section of the plan
- People will have timely transitions back to their community from hospital care or short-term institutional care

Background Information

People with disabilities in Minnesota receive long-term supports and services either in what we consider an institutional setting or through home and community based services. Home and community based services include home care and personal care assistant services covered through the Medicaid state plan, the Alternative Care program, the Elderly Waiver and the disability waivers.

In state fiscal year 2013, 93 percent of people with disabilities and 68 percent of older adults received their long-term supports and services through home and community based services (83 percent across both populations combined). Of those, 73 percent of people with disabilities and 76 percent of older adults received those services in their own homes.

Related Olmstead actions

This report was produced in conjunction with the Olmstead Plan actions cited on page one. There are several other closely related Olmstead Plan actions. This report includes demographic and baseline data about people receiving services in potentially segregated settings and lays out targets and timelines for moving people to more integrated settings. The related actions are what the state is planning to do, or currently implementing, to achieve those goals.

The plan lays out several actions to promote person-centered practices which identify people who would like to move to a more integrated setting, and those who would not be opposed to such a move. The plan includes actions to support people in more integrated settings and improve the quality of life of people with disabilities.

The plan includes developing and implementing transition protocols to support successful transitions. There are specific, measurable targets for transitioning individuals from Intermediate Care Facilities for

Developmental Disabilities (ICF-DDs), nursing facilities, the Minnesota Specialty Health System facility in Cambridge, the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital.

There are several actions in the plan that will identify people with disabilities who are exiting state correctional facilities, including youth who are leaving juvenile facilities, and connect them with appropriate services and supports upon release.

There are several actions in the plan related to increasing the use of positive practices. The plan also includes actions to increase planning in order to reduce crises and to respond quickly and effectively when crises do occur.

The plan directs the state to change the way prioritization for accessing limited services (waiver wait list) so that those who want to move to a more integrated setting will be able to access the necessary home and community-based supports in a reasonable amount of time.

The plan includes actions to increase flexibility of and access to certain services and supports.

The state has developed plans to provide training and technical assistance to services providers who have business models structured around segregated and non-competitive employment to transition their service delivery model to integrated, competitive employment models.

There are several Olmstead Plan actions related to housing that will facilitate meeting the state's targets and timelines for transitioning people from segregated to more integrated settings. One strategic action is to increase housing options that promote choice and access to integrated settings by reforming the Group Residential Housing (GRH) and Minnesota Supplemental Aid (MSA) Housing Assistance programs. The goal of the reform is to allow income supplement programs that typically pay for room and board in congregate settings to be more easily used in non-congregate settings. It is expected that this change would result in more people with disabilities transitioning from the potentially segregated settings identified in this report to more independent housing.

The plan also calls for increasing the availability of affordable housing. Another is to increase access to information about housing options. And, the plan includes actions to promote counties, tribes and other providers to use best-practices and person-centered strategies related to housing.

HCBS Settings Rule

Simultaneous to Minnesota's Olmstead Plan implementation, the Centers for Medicare and Medicaid Services (CMS) published a rule, effective March 17, 2014, outlining new requirements for states' Medicaid home and community-based services.

The intent of the rule is to ensure that individuals receiving long-term services and supports through home and community-based services programs have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate to meet the needs of the individual. The rule is designed to enhance the quality of home and community-based services and provide protections for people who use those services. The rule defines, describes and aligns requirements across the home and community-based services programs. It defines person-centered planning requirements for persons in home and community-based settings.

States have until March 17, 2019, to bring existing programs into compliance with the rule and must submit a plan to transition their existing home and community-based services waiver programs services

by that date. In Minnesota, this impacts the Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Individuals with Disabilities (CADI), Developmental Disabilities (DD), and Elderly Waiver (EW) programs. New programs under 1915(i), 1915(k) and any new 1915(c) will be required to be in full compliance from the date of implementation. In Minnesota, the new Community First Services and Supports (CFSS) program must meet this requirement.

The new federal HCBS rules require that individuals be afforded a real choice between settings in which they receive services. Minnesota's implementation of these rules will further the state's progress in implementing its Olmstead goals.

Process

Internal work groups

Two groups were convened to work on this project, one to develop the data set for measuring people in potentially segregated settings and another to analyze the data from a policy perspective and set the targets and timelines. The groups included data and policy experts from the Minnesota Department of Human Services Adult Mental Health, Children's Mental Health, Economic Assistance and Employment Support, Disability Services Division, Compliance Monitoring, and Chemical Health Divisions. The Department of Health and the Department of Employment and Economic Development also participated. This work has a direct link to the Olmstead Plan action to develop additional affordable housing and, therefore, included participation by the Minnesota Housing Finance Agency.

How people with disabilities were/will be involved in planning for community integration

Individuals can have significant impact on realizing their personal goals when their preferences as well as their needs are incorporated into assessment and service planning . Minnesota is currently rolling out MnCHOICES, which continues and enhances Minnesota's person-centered approach tailoring services to individual's strengths, preferences and needs. This major reform has been underway for several years and is now in the final stages of its staged roll-out.

People with disabilities also have the opportunity to participate as advocates and planning partners in shaping the future of Minnesota's HCBS system. A series of meetings and input sessions around the state were held as part of the preliminary planning for the HCBS settings rule implementation. Meetings specifically targeted for self-advocates were held to seek input in addition to other forums.

DHS also engaged stakeholders in providing input to the GRH/MSA reform efforts. This effort focused on receiving feedback regarding current housing options and barriers and comments on proposed future directions for this program. For this effort, six listening sessions were held throughout the state with over 450 participants, including people with disabilities and their families.

The Minnesota Department of Human Services conducts a biennial process to gather information about the current capacity and gaps in services and housing needs to support people with long-term care needs in Minnesota. The gaps analysis was originally focused on the needs of older persons but in 2011 the needs of children and adults with disabilities and/or mental illness were added to the study. As part of this process, people with disabilities, people with mental illness, older people and their families participated in focus groups to provide insights about long-term services and supports, based upon their personal experience. For the 2012/2013 study, focus groups were held in 16 communities across the state, with 260 individuals taking part. There were 110 people who participated by completing a short

on-line survey. Twenty-three percent of survey respondents identified as having a disability and 23 percent as parents and caregivers.

As part of the six-year Pathways to Employment initiative, the Department of Human Services, in conjunction with other state agencies, engaged people with disabilities and other stakeholders in a public process to identify what it will take to increase the employment of people with disabilities in Minnesota. Pathways supported three summits which brought together people with disabilities and other stakeholders with one focus—how to make employment the first and preferred choice of youth and adults with disabilities. Pathways also supported a series of events around the state, conversations with various disabilities sub-populations, that yielded nine policy briefs in the following areas: brain injury, mental health, Deaf-blindness, Deaf and hard of hearing, blindness, Autism Spectrum Disorder, intellectual/developmental disabilities, and physical disabilities.

Review of other state's plans (Olmstead Plan item SS 2G.2)

The policy work group that developed targets and timelines reviewed initiatives to reform state employment and day support services in Massachusetts, Oregon and Rhode Island. A chart showing their analysis of those plans is included in Appendix A.

The strategies that are being used by other states informed the development of Minnesota's implementation plans for increasing competitive employment and those plans informed the process for setting targets for competitive employment. The effort to support people to be competitively employed intersects with the targets to support people receiving day services in more integrated settings.

The strategies that Minnesota are pursuing include:

- Adopting an Employment First Policy
- Training and technical assistance to support day service providers to convert their service models from congregate and segregated, "sheltered workshop" day services to more individualized, person-centered approaches of community supports and competitive employment services
- Interagency collaboration to promote promising practices and coordinate services for transition-age youth
- Increasing expectations and work experiences
- Improved data system for tracking employment outcomes for students and adults with disabilities
- Documenting informed choice to enable tracking individuals' decisions and potential barriers to employment
- Service enhancements for people who are seeking competitive employment at minimum wages or higher
- Expanding self-advocacy and peer networks

Minnesota is using earned monthly income ≥$600/month as an indicator of competitive employment.

Our data base contains information about individuals' income, including what is earned income and what is the amount and type of unearned income. We recognize that many people have earned income, but would not necessarily be employed in what we consider "competitive employment"—that is, employment that is part of the regular workforce, not in a segregated setting, and which is compensated at a market rate. Minnesota is setting a relatively high threshold of monthly earned income to separate

those who have jobs that pay sub-minimum wages (more likely to be in segregated settings) from those who have jobs that pay at least a minimum wage.

This is an important distinction to keep in mind, particularly when comparing Minnesota to other states which may be using another benchmark, such as having *any* earned income as an indicator of employment. To illustrate this point, in 2013, 15.8 percent of people on a disability waiver have earned income over $250/month. (This is not the exact same population as used for the rest of our measures, but a number we've been tracking since 2007, and used here just for illustrative purposes).

Methodology

Available data sources

That data that is available comes from existing data systems that were designed for specific purposes. Therefore, there are many shortcomings with the data we have to inform and track our Olmstead implementation.

- Some data can only partially get at some questions
- Some data available for some of the people in the system but not for everyone
- Data fields that could be used, but which aren't reliably used or updated by the people who populate the data base.
- No data available to address some questions or track certain outcomes

MAXIS
MAXIS is a computer system used by state and county workers to determine eligibility for public assistance and health care. For cash assistance and food support programs, MAXIS also determines the appropriate benefit level and issues benefits.

For the purposes of this report, data from MAXIS were used to identify people with disabilities who receive benefits through the Group Residential Housing (GRH) program. This program pays for room and board costs related to living in a licensed or registered setting, as well as services for some people. GRH recipients were included in this report if they reside in one of the following settings: adult foster care, boarding care, board and lodge, board and lodge with special services, homeless shelter, housing with services establishment, or supervised living facility. For settings other than adult foster care, the individual had to be on the program for at least 90 days to be counted. This control sorted out people who are more likely to be living in a segregated setting, rather than passing through one on a temporary basis.

MMIS
Health care providers throughout the state – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in a Minnesota Health Care Program. These programs provide health care services to low-income families and children, low-income elderly people and individuals who have physical and/or developmental disabilities, mental illness or who are chronically ill.

For the purposes of this report, data from MMIS were used to identify people with disabilities who received long-term supports and services typically provided in licensed, and potentially segregated, settings.

Data limitations specific to this project

1. Olmstead Plan does not have measureable definitions or criteria to identify segregated settings
2. Current data bases have limited information regarding the type of settings in which people receive services
3. Current databases do not identify people who want to move to a more integrated setting
4. Current databases lack information required to indicate the type of setting in which the individual is being served (e.g., day/employment services settings). Therefore, it is also difficult, if not impossible, to track movement between settings with current databases.
5. Setting types, as recorded in DHS data systems, represent a wide variety of actual places where people live, and do not necessarily indicate how "integrated" a person in any particular setting is. For example, a person may receive customized living services in an assisted living residence which is comprised entirely of older adults, being in this residence may give the individual more access to community life than the person may have had in their own home.
6. Providers have up to 12 months through MMIS to submit a claim so the claims data for fiscal year 2014 is subject to change through June 30, 2015
7. There is different data kept for people depending on the program they use. For example, people who apply for a Developmental Disabilities waiver will have extensive assessment information in their records. People who are in a nursing facility also have assessment data, but from a different assessment tool with different data points. People who are in the Group Residential Housing program may not have any assessment data.

Data development plan

Because of the data which is currently available does not fully answer questions that could guide us in the process of assisting people move to the most integrate setting, we need to develop additional ways to get information. MMIS and MAXIS are large data bases that are central to the state's operations in administering public programs. The demands upon them are great and changes are not easily made. It is not practical to build additional statewide data systems so we need to work with our existing systems. MnCHOICES is a new assessment system, currently being rolled out, which will provide much more person-centered data in the future.

We are taking short-term and long-term approaches to improving our data. The HCBS segregated settings transition plan will provide the basis for most of the short-term improvements.

1. Develop criteria for measuring a setting's degree of segregation/integration.
2. HCBS waiver providers in potentially segregated settings will complete a self-assessment.
3. Develop a method for rating site-specific "integration-based" criteria using data from provider assessments.
4. Create short-term system for tracking numbers of people who make a move to more integrated setting.
5. Build long-term systems solution for identifying, verifying, collecting and sharing information about degree of integration/segregation.
6. Create long-term system for tracking numbers of people who move from to or from less integrated settings.

Data pull

The baseline and demographic data were compiled using the following process.

1. Data used came from fiscal year 2014 (July 1, 2013 – June 30, 2014).
2. Data included all people, irrespective of age.
3. MMIS data was queried using claim codes of services that are delivered in a potentially segregated setting. Individuals were included in the counts if there was at least one claim meeting criteria within fiscal year 2014. This list included specific waiver services and services commonly accessed by people with serious mental illness or serious and persistent mental illness.
4. Data from MMIS does not include data about Group Residential Housing (GRH). GRH recipients must meet disability criteria to qualify for this program. Therefore, data was pulled from MAXIS to capture people receiving GRH.
5. Some people are only on GRH for a short stay in a temporary setting and therefore would not be considered someone living in a segregated setting. To control for that, we narrowed the MAXIS group, for every setting except adult foster care, to only include people who were in the setting for at least 90 days.
6. We combined the MAXIS group and the MMIS group to arrive at the people that we consider to have been in potentially segregated settings in fiscal year 2014.

List of potentially segregated settings (requires further analysis)

Criteria

There is nothing in current state statute, policy or rule that defines what constitutes a segregated setting in Minnesota. The Olmstead Plan provides the following definition of 'segregated setting', taken from the *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.*[3]

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

This definition needs to be broken down into measurable criteria, e.g., what constitutes "lack of privacy or autonomy."

The state will develop ways to measure these qualities. In the meantime, we identified settings that are *potentially segregating.* It is important to note that, in addition to developing measurable criteria, data, over and above that currently available to the State, will required in order to identify segregated settings. Additionally, our current data systems do not necessarily identify the setting in which a person receives a service.

In light of these limitations, this is where we are starting the task of identifying people in segregated settings, recognizing that this work will need further analysis, including possibly looking at other settings that weren't included in this first analysis.

[3] www.ada.gov/olmstead/q&a_olmstead.htm

The group divided settings into residential settings and day/employment services settings. The logic is that strategies for transitioning people to more integrated settings will be similar within those categories and different outside those categories. In other words, a strategy to help people change residence will likely be useful across residential settings but not necessarily in helping people change their day/employment services settings. Likewise, strategies to make day service settings more integrated will likely work across day/employment services but not necessarily with transition out of residential settings.

We included people who are homeless in the count of people living in segregated settings for two reasons. First, according to the U.S. Department of Housing and Urban Development, over 40 percent of America's homeless population is people with disabilities[4]. Second, we consider our goal to be not only decreasing the number of people living unnecessarily in segregated settings but also increasing the number of people living in the most integrated settings. From a quality of life perspective, the people who are homeless have fewer opportunities to participate in community life. Therefore, we chose to look for indicators of homelessness and include people who are likely to be homeless in the counts of being in potentially segregated settings.

The group then developed criteria to use to identify if settings and services in each group will be considered potentially segregated.

Residential – potentially segregated/not integrated criteria

- The setting is controlled by the service provider
  - The exception to this criterion is private family settings (i.e., family foster care)
- There are no limits to length of stay
- A person who is likely to be homeless is considered not well-integrated in their community

Day/employment services settings – potentially segregated criteria

- Services which are often delivered in a provider-controlled setting
- Services which are often delivered in settings with a predominance of other people with disabilities

List of potentially segregated settings

Figure 1: List of potentially segregated settings and services (See Appendix B for definitions)

Residential settings/services delivered in potentially segregated settings	Day/employment services delivered in potentially segregated settings
Adult foster care	Adult day services
Assisted living residence (customized living service)	Day training and habilitation center
Board and lodge (includes homeless shelters)	Family adult day services
Board and lodge with special services	Pre-vocational service
Boarding care	Structured day program
Child foster care	Supported employment services
Children's residential care (children's residential facilities- Rule 5)	
Crisis respite (foster care)	

[4] U.S. Department of Housing and Urban Development, 2013 Continuum of Care Homeless Populations and Subpopulations Report (See www.hudexchange.info/reports/CoC_PopSub_NatlTerrDC_2013.pdf).

Residential settings/services delivered in potentially segregated settings	Day/employment services delivered in potentially segregated settings
Housing with services establishment	
Supervised living facilities	
Supported living services	

Data analysis

Residential services/settings

Figure 2: Residential settings by age and gender, fiscal year 2014

	Setting	Recipient	Age Group 0-13	Age Group 14-18	Age Group 19-26	Age Group 27-35	Age Group 36-64	Age Group 65+	Gender Female	Gender Male
MAXIS	Adult Foster Care	873	-	30	198	161	444	40	413	460
	Boarding Care	521	-	4	63	67	368	19	231	290
	Board and Lodge	3,070	-	36	616	758	1,627	33	765	2,305
	Board and Lodge w/ Special Serv	5,003	-	76	817	1,021	3,017	72	1,207	3,796
	Homeless Shelter	4,715	-	79	890	1,034	2,683	29	1,308	3,407
	Housing w/ Services Establ	2,690	-	21	340	401	1,832	96	920	1,770
	Supervised Living Facility	1,046	-	17	257	257	508	7	371	675
	Unduplicated	**10,562**	**-**	**152**	**1,804**	**2,079**	**6,281**	**246**	**3,132**	**7,430**
Claims	Adult Foster Care	5,318	-	97	910	813	2,821	677	2,255	3,063
	Assisted Living	2,610	-	-	38	62	945	1,565	1,685	925
	Assisted Living w/ 24 Hr Care	8,282	-	-	43	98	1,264	6,877	6,017	2,265
	Child Foster Care	187	55	124	8	-	-	-	62	125
	Crisis Respite	188	34	30	64	25	33	2	56	132
	Children's Residential Care	462	221	241	-	-	-	-	174	288
	Supported Living Services	10,470	45	225	1,510	2,079	5,657	954	4,468	6,002
	Unduplicated	**27,517**	**355**	**717**	**2,573**	**3,077**	**10,720**	**10,075**	**14,717**	**12,800**
Total Unduplicated		**38,079**	**355**	**869**	**4,377**	**5,156**	**17,001**	**10,321**	**17,849**	**20,230**

- A total of 38,079 individuals resided in other potentially segregated setting at some point during fiscal year 2014.
    - Of the GRH-only recipients, the largest group (47 percent) was in Board and Lodge with Special Services facilities. Of those with MA claims, the largest group (30 percent) was in Assisted Living with 24 hour care.
- Of the total, 72 percent were over the age of 35.
- Of the total number in all settings combined, nearly 47 percent were female; however, among the GRH-only recipients 70 percent were male.

Figure 3: Residential settings by race/ethnicity, fiscal year 2014

	Setting	Recipient	Race White	Race Black	Race Am Indian	Race Asian	Race Pac Island	Race Hispanic	Race 2+	Race Unknown
MAXIS	Adult Foster Care	873	697	89	29	25	2	15	6	10
	Boarding Care	521	391	82	12	11	1	14	4	6
	Board and Lodge	3,070	1,858	805	153	45	4	84	50	71
	Board and Lodge w/ Special Serv	5,003	3,048	1,256	324	60	2	133	77	103
	Homeless Shelter	4,715	2,375	1,653	322	51	4	129	90	91
	Housing w/ Services Establ	2,690	1,196	1,207	147	18	1	66	27	28
	Supervised Living Facility	1,046	666	228	59	15	4	27	22	25
	Unduplicated	**10,562**	**6,300**	**2,895**	**599**	**141**	**11**	**271**	**147**	**198**
Claims	Adult Foster Care	5,318	4,533	344	137	91	6	91	38	78
	Assisted Living	2,610	2,263	173	38	59	-	26	6	45
	Assisted Living w/ 24 Hr Care	8,282	7,458	308	69	91	2	54	13	287
	Child Foster Care	187	116	24	13	1	-	14	12	7
	Crisis Respite	188	126	32	5	9	-	7	4	5
	Children's Residential Care	462	278	54	53	2	-	29	31	15
	Supported Living Services	10,470	9,528	424	181	123	1	109	26	78
	Unduplicated	**27,517**	**24,302**	**1,359**	**496**	**376**	**9**	**330**	**130**	**515**
Total Unduplicated		**38,079**	**30,602**	**4,254**	**1,095**	**517**	**20**	**601**	**277**	**713**

- Of individuals residing in other potentially segregated setting, blacks were overrepresented (11 percent versus 6 percent of Minnesota's entire population). This disparity increased in the GRH-only group, where 27 percent were black.
- American Indians were overrepresented among those residing in Children's Residential Care and Board and Lodge with Special Services (11 percent and 6 percent, respectively, versus 1 percent of Minnesota's entire population).

Figure 4: Residential settings by diagnosis, fiscal year 2014

	Setting	Recipient	Acquired Cognitive Disability	Austism Spectrum Disorder	Blind	IDD	Deaf	Hard of Hearing	Mental Illness	SMI	SPMI	Substance Abuse
MAXIS	Adult Foster Care	873	611	111	11	365	5	243	808	245	204	469
	Boarding Care	521	387	14	1	77	1	127	517	190	142	449
	Board and Lodge	3,070	2,017	64	3	157	3	544	2,695	633	447	2,736
	Board and Lodge w/ Special Serv	5,003	3,500	95	11	265	-	979	4,563	944	660	4,540
	Homeless Shelter	4,715	3,286	79	8	191	-	916	4,238	778	493	4,260
	Housing w/ Services Establ	2,690	1,928	41	6	147	-	596	2,432	260	158	2,310
	Supervised Living Facility	1,046	845	52	2	86	-	260	1,037	575	490	967
	Unduplicated	**10,562**	**7,304**	**298**	**28**	**914**	**9**	**2,177**	**9,534**	**1,958**	**1,418**	**9,053**
Claims	Adult Foster Care	5,318	4,675	918	124	2,814	25	2,163	5,180	1,538	1,148	3,164
	Assisted Living	2,610	2,203	77	57	518	13	1,006	2,112	282	193	1,026
	Assisted Living w/ 24 Hr Care	8,282	7,280	119	179	966	17	2,665	6,511	408	277	2,100
	Child Foster Care	187	146	85	6	109	-	79	187	116	93	29
	Crisis Respite	188	134	125	1	186	2	85	181	30	6	24
	Children's Residential Care	462	309	119	1	78	-	165	459	424	414	155
	Supported Living Services	10,470	8,049	3,452	311	10,417	123	5,899	9,762	604	45	1,417
	Unduplicated	**27,517**	**22,796**	**4,895**	**679**	**15,088**	**180**	**12,062**	**24,392**	**3,402**	**2,176**	**7,915**
Total Unduplicated		**38,079**	**30,100**	**5,193**	**707**	**16,002**	**189**	**14,239**	**33,926**	**5,360**	**3,594**	**16,968**

- Individuals with an Intellectual/Developmental Disability were more likely to have an MA claim than were GRH-only recipients (55 percent versus 9 percent).
- Individuals with substance abuse issues were more likely to be GRH-only recipients (86 percent versus 28 percent of those with MA claims).
- Nearly all of the GRH-only recipients living in a Boarding Care facility had some history of mental illness, and 21 percent had a serious mental illness.

Figure 5: Residential settings by mobility, fiscal year 2014

	Setting	Recipient	No Impairment	Walks Aided (i.e. walker)	Uses Wheelchair	Not Mobile	Unknown
MAXIS	Adult Foster Care	873	369	81	30	13	380
	Boarding Care	521	291	15	2	-	213
	Board and Lodge	3,070	362	59	28	7	2,614
	Board and Lodge w/ Special Serv	5,003	655	117	23	5	4,203
	Homeless Shelter	4,715	433	98	20	6	4,158
	Housing w/ Services Establ	2,690	307	117	17	7	2,242
	Supervised Living Facility	1,046	285	30	6	1	724
	Unduplicated	**10,562**	**1,791**	**353**	**88**	**26**	**8,304**
Claims	Adult Foster Care	5,318	3,520	723	576	498	1
	Assisted Living	2,610	833	1,286	327	164	-
	Assisted Living w/ 24 Hr Care	8,282	1,849	3,500	2,137	796	-
	Child Foster Care	187	170	1	15	1	-
	Crisis Respite	188	113	70	4	-	1
	Children's Residential Care	462	81	1	1	-	379
	Supported Living Services	10,470	5,868	3,861	624	110	7
	Unduplicated	**27,517**	**12,434**	**9,442**	**3,684**	**1,569**	**388**
Total Unduplicated		**38,079**	**14,225**	**9,795**	**3,772**	**1,595**	**8,692**

- 40 percent of individuals residing in other potentially segregated setting were assessed to have some sort of mobility impairment (15,162 individuals), indicating a *potential* need for a physically accessible unit.
- Nearly half of the individuals receiving assisted living services were assessed to need assistance with walking.

Figure 6: Residential settings by income source, fiscal year 2014

	Setting	Recipient	Earned Income	Unearned Income	Earned or Unearned Income	Income Unknown	Unearned Subgroup: RSDI	Unearned Subgroup: SSI	Unearned Subgroup: RSDI or SSI	Unearned Subgroup: Other
MAXIS	Adult Foster Care	873	384	614	728	145	421	284	601	50
	Boarding Care	521	87	369	421	100	269	157	366	19
	Board and Lodge	3,070	842	733	1,495	1,575	407	380	656	200
	Board and Lodge w/ Special Serv	5,003	1,075	1,368	2,378	2,625	797	726	1,278	299
	Homeless Shelter	4,715	1,046	995	2,045	2,670	469	600	900	286
	Housing w/ Services Establ	2,690	345	784	1,095	1,595	380	481	700	135
	Supervised Living Facility	1,046	262	479	681	365	272	289	462	65
	Unduplicated	**10,562**	**2,426**	**3,524**	**5,491**	**5,071**	**2,082**	**1,867**	**3,297**	**607**
Claims	Adult Foster Care	5,318	2,197	4,966	5,238	80	3,707	2,049	4,959	229
	Assisted Living	2,610	209	2,503	2,598	12	2,214	598	2,501	93
	Assisted Living w/ 24 Hr Care	8,282	317	7,917	8,256	26	7,478	1,125	7,915	333
	Child Foster Care	187	16	86	119	68	23	73	86	28
	Crisis Respite	188	64	156	170	18	64	117	156	14
	Children's Residential Care	462	12	184	280	182	84	124	184	92
	Supported Living Services	10,470	7,626	10,043	10,430	40	8,025	3,834	10,030	342
	Unduplicated	**27,517**	**10,441**	**25,855**	**27,091**	**426**	**21,595**	**7,920**	**25,831**	**1,131**
Total Unduplicated		**38,079**	**12,867**	**29,379**	**32,582**	**5,497**	**23,677**	**9,787**	**29,128**	**1,738**

- Around one-third of individuals residing in other potentially segregated setting reported some amount of earned income.
- 26 percent (9,787 individuals) reported only receiving income from SSI. The maximum monthly benefit for SSI is $721; hence, people who receive SSI are likely to have limited ability to afford housing in the community.
- An additional 20 percent (10,968 individuals) were General Assistance recipients. This group has even less income. The General Assistance benefit for individuals living in the community is $203 per month.

Figure 7: Residence by region, fiscal year 2014

	Setting	Recipient	1 North West	2 Head-waters	3 Arrow-head	4 West Central	5 North Central	6 South West Central	7 East Central	8 South West	9 South Central	10 South East	11 Twin Cities	Unkn	Frontier
MAXIS	Adult Foster Care	873	2	14	56	18	15	10	241	8	45	133	318	13	4
	Boarding Care	521	3	1	9	4	5	4	70	1	1	25	396	2	3
	Board and Lodge	3,070	4	7	142	65	90	46	159	39	75	336	2,076	31	7
	Board and Lodge w/ Special Serv	5,003	20	19	615	111	129	51	278	54	108	246	3,338	34	29
	Homeless Shelter	4,715	8	18	326	76	44	28	166	13	39	229	3,707	61	9
	Housing w/ Services Establ	2,690	3	9	111	14	39	4	37	1	58	41	2,363	10	1
	Supervised Living Facility	1,046	11	14	68	19	7	29	67	30	32	35	722	12	9
	Unduplicated	**10,562**	**37**	**54**	**833**	**191**	**204**	**100**	**676**	**87**	**258**	**669**	**7,361**	**92**	**44**
Claims	Adult Foster Care	5,318	107	134	470	469	199	231	637	135	261	505	2,166	4	56
	Assisted Living	2,610	105	64	268	230	146	142	170	49	151	234	1,046	5	37
	Assisted Living w/ 24 Hr Care	8,282	134	141	1,162	404	317	235	829	148	489	920	3,499	4	71
	Child Foster Care	187	6	1	26	14	8	8	27	9	14	11	62	1	6
	Crisis Respite	188	1	1	6	8	2	3	18	-	-	7	142	-	-
	Children's Residential Care	462	9	26	103	27	13	24	59	11	41	28	120	1	4
	Supported Living Services	10,470	286	163	920	520	338	505	856	396	587	1,253	4,643	3	174
	Unduplicated	**27,517**	**648**	**530**	**2,955**	**1,672**	**1,023**	**1,148**	**2,596**	**748**	**1,543**	**2,958**	**11,678**	**18**	**348**
Total Unduplicated		**38,079**	**685**	**584**	**3,788**	**1,863**	**1,227**	**1,248**	**3,272**	**835**	**1,801**	**3,627**	**19,039**	**110**	**392**

- Half (50 percent) of individuals residing in other potentially segregated setting were in the Twin Cities Metro Area.
- Of GRH-only recipients, however, nearly three-quarters (70 percent) were in the Twin Cities Metro Area.

Figure 8: Unduplicated provider count by setting/service type (residential), fiscal year 2014

Residential setting/service	Unduplicated provider count
Adult Foster Care (MMIS)	1,074
Adult Foster Care (MAXIS)	491
Assisted living Residence (customized living service)	664
Assisted living Residence (24-hour customized living service)	1,047
Board and Lodge	173
Board and Lodge w/ Special Services	167
Boarding Care	18
Child Foster Care	91
Children's Residential Care (Children's Residential Facilities-Rule 5)	69
Crisis Respite (Foster Care)	18
Housing w/ Services Establishment	992
Supervised Living Facility (SLF)	31
Supported Living Services	708

Day/employment services

Figure 9: Service utilization by age, fiscal year 2014

	Setting	Recipient	Age Group 0-13	Age Group 14-18	Age Group 19-26	Age Group 27-35	Age Group 36-64	Age Group 65+
Day	Adult Day Center	5,782	0	6	119	140	1271	4246
	Day Training & Habilitation	10,135	0	34	1940	2383	5134	644
	Family Adult Day Servcies	46	0	0	2	0	6	38
	Prevocational Services	2,556	0	23	539	461	1464	69
	Structured Day Program	182	0	0	13	39	123	7
	Supported Employment Services	2,827	0	15	719	721	1324	48
	Unduplicated	20,055	0	70	3033	3411	8557	4984

- The data pull included people of all ages and therefore included older Minnesotans using long-term supports and services whose need for those services may have resulted from conditions acquired as they aged and/or conditions that were disabling, independent of their aging.

Figure 10: Service utilization by diagnosis, fiscal year 2014

	Setting	Recipient	Acquired Cognitive Disability	Austism Spectrum Disorder	Blind	IDD	Deaf	Hard of Hearing	Mental Illness	SMI	SPMI	Substance Abuse
Day	Adult Day Center	5,782	4,780	232	129	1,338	32	2,724	5,043	261	160	1,230
	Day Training & Habilitation	10,135	7,302	3,363	287	10,135	124	5,352	9,095	394	13	963
	Family Adult Day Servcies	46	39	-	-	6	-	18	44	3	2	10
	Prevocational Services	2,556	2,175	557	66	1,733	34	1,104	2,449	596	400	1,261
	Structured Day Program	182	181	28	1	121	1	65	177	13	6	100
	Supported Employment Services	2,827	2,195	826	39	2,242	12	1,182	2,645	455	284	1,115
	Unduplicated	20,055	15,461	4,634	497	14,467	194	9,788	18,066	1,466	698	4,084

- Individuals may have more than one diagnosis so these are not unduplicated counts. The service called day training and habilitation is only covered under the Developmental Disabilities waiver, so everyone receiving that service had that diagnosis. Individuals may have had additional diagnoses, as well.

Figure 11: Service utilization by source of income, fiscal year 2014

	Setting	Recipient	Earned Income	Unearned Income	Earned or Unearned Income	Income Unknown	Unearned Subgroup: RSDI	Unearned Subgroup: SSI	Unearned Subgroup: RSDI or SSI	Unearned Subgroup: Other
Day	Adult Day Center	5,782	427	4944	5663	119	2036	3371	4933	717
	Day Training & Habilitation	10,135	8079	9794	10127	8	7395	4165	9785	300
	Family Adult Day Servcies	46	6	42	44	2	19	26	42	2
	Prevocational Services	2,556	2229	2445	2550	6	1839	956	2443	80
	Structured Day Program	182	121	175	182	0	139	65	175	7
	Supported Employment Services	2,827	2483	2669	2824	3	2122	925	2665	94
	Unduplicated	20,055	12008	18666	19919	136	12437	9022	18641	1156

- The chart shows only the source of income, not the amount of income. The 'earned income' category does not distinguish between competitive employment and earnings at sub-minimum wages.
- Individuals could have multiple sources of income so counts are not unduplicated, unless specified.

Figure 12: Service utilization by living arrangement, fiscal year 2014

	Setting	Recipient	Home	Family Foster Care	Corp Foster Care	ICF-DD	NF	Board and Lodge	Housing with Services	Corr Facility	Hospital	Unknown
Day	Adult Day Center	5,782	4,656	119	597	3	80	116	185	-	9	17
	Day Training & Habilitation	10,135	2,879	582	6,549	29	32	2	-	-	-	62
	Family Adult Day Servcies	46	36	-	5	-	1	4	-	-	-	-
	Prevocational Services	2,556	1,022	153	1,147	1	29	92	80	1	10	21
	Structured Day Program	182	36	4	118	-	3	12	9	-	-	-
	Supported Employment Services	2,827	1,423	155	1,090	1	23	53	43	-	6	33
	Unduplicated	20,055	9,427	937	8,814	34	158	248	291	1	25	120

Figure 13: Unduplicated provider count by service type (day/employment), fiscal year 2014

Day/employment services	Unduplicated provider count
Adult day services center (EW) & Adult Day Care	229
Family adult day services setting	14
Structured Day Program	57
Day Training and Habilitation center	246
Pre-Vocational Service	177
Supported Employment Services (SES)	187

Targets and timelines

There are initiatives across the state agencies to support people moving to more integrated settings. While some are smaller in scale and targeted, others are larger and geared to systems-level changes. The systems changes take longer to implement and longer to see results, and will ultimately have a larger impact. The smaller projects will impact the lives of individuals quickly.

The targets given here set a base, but do not limit the number of people that can move. As strategies outlined in the Olmstead Plan, and reforms by DHS are implemented, such as those to promote community living and employment options, shift provider business models, peer mentoring to share their stories of moving to homes of their own or working, manage waiver resources differently, and support experiential learning of options to inform choice, momentum will build, needed community capacity and infrastructure will expand, and increasingly more people every year will seek and obtain community living and employment options.

The ability to transition people to more integrated settings will be affected by the availability of resources to support this work. The DHS will assess progress annually and will adjust targets as necessary to incent movement to the most integrated community living and employment.

These are targets for the settings identified in this report, and do not reflect targets that have been set elsewhere for Anoka Metro Regional Treatment Center, the Minnesota Security Hospital in St. Peter, Intermediate Care Facilities for Developmental Disabilities and nursing facilities.

These are some of the strategies the state is pursuing to reduce the number of people in segregated settings.

Residential interventions

- Continuing moratoriums on development of new ICF-DDs and corporate adult foster care beds
- Reforms to the Group Residential Housing (GRH) and Minnesota Supplemental Assistance (MSA) programs
- Expansion of Housing Access Services
- Technology grants to assist people in developing ways to use technology to support them in the homes and to otherwise meet their needs and goals
- Local planning grants to counties to develop alternatives to corporate foster care
- Providing technical assistance to service providers
- Quality improvement processes
- Transition protocols
- New and modified services
- Changes in payment for services
- HCBS transition plan

Day services interventions

- Working with school districts (Minnesota Department of Education to lead effort)
- Continue to develop and promote the use of Disability Benefits 101 (DB101), a benefits and work planning tool
- Provide technical assistance to providers
- Family outreach

- Develop opportunities for youth work experiences
- New and modified services
- Changes in payment for services
- HCBS transition plan
- Developing standards and managing capacity for day services

Figure 14: Targets and timelines for "other segregated settings"

RESIDENTIAL SETTINGS TARGETS	DAY SETTINGS TARGETS
In SFY 2015 Without additional resources: 50	In SFY 2015 Without additional resources: 50
In SFY 2016 Without additional resources: 125	In SFY 2016 Without additional resources: 150
In SFY 2017 Without additional resources: 300	In SFY 2017 Without additional resources: 200
In SFY 2018 Without additional resources: 350	In SFY 2018 Without additional resources: 500
In SFY 2019 Without additional resources: 400	In SFY 2019 Without additional resources: 500

Appendix A: Analysis of State Plans from Massachusetts, Oregon and Rhode Island

KEY ELEMENTS LEADING TO COMPETITIVE, COMMUNITY SUPPORTED EMPLOYMENT and COMMUNITY-BASED DAY SUPPORT SERVICES:

A Summary of Rhode Island, Oregon and Massachusetts State Reform Initiatives

KEY ELEMENTS LEADING TO COMPETITIVE, COMMUNITY SUPPORTED EMPLOYMENT and DAY SUPPORT SERVICES REFORM	RI Settlement Agreement	OR Governors Executive Order *(Lawsuit Pending)*	MASS Blue Print For Success
Response to U.S.D.O.J. litigation of Title II-ADA, Olmstead.	Y (reactive)	Y (preemptive)	Y (proactive)
Response to CMS' HCBS Final Rule Regulation and Requirements.	Y (reactive)	N	Y (proactive)
Parties Involved in the Plan.	Human Services, VR & Education	ODHS-ODDS, ODE & ODVR	MADDS, MASS ARC MA Provider Org.
Develop and conduct a comprehensive, statewide educational outreach campaign directed at state and local government agencies, providers, schools, people with disabilities and their families.	Y	Y	Y
Close new referrals to congregate, segregated sheltered workshops and facility-based day service programs providers.	Y	Y	Y
Discontinue the purchase of congregate, segregated sheltered workshop services and facility-based day services.	Y	N	Y (within 5 years)
Require providers to convert from congregate, segregated sheltered workshop programs and facility-based day service providers to community-based, competitive employment service providers and day support service providers.	Y	N	Y
Provide comprehensive training, business consultation, strategic planning and technical assistance support to providers on redesigning services and restructuring organizations to convert from congregate, segregated sheltered workshop programs and facility-based day service providers into individualized, community-integrated employment service providers and individualized, community-integrated day support service providers.	Y	Y	Y
Adopt Employment First Policy, and align all provider service and support practices with Employment First Policy.	Y	Y	Y
Create a financial system or service rate structure that incentivizes integrated, community-based, competitive employment services, supports and outcomes.	Y	Y	Y
Develop transition or action plans for people to move from congregate, segregated sheltered workshops and facility-based day service programs to individualized, community-based, competitive employment services and supports or individualized, community-based day services and supports.	Y	Y	Y
Design and implement a community-based, competitive employment services and support plan that gradually phases out special/subminimum wage work and increases minimum wage or higher jobs for people.	Y (Variances are allowable)	N	Y
Construct a comprehensive, compendium of community-based services and supports that produce an individualized employment plan for assessing, exploring, acquiring and maintaining community-based, competitive employment.	Y	Y	Y
Construct a set of community-based services and supports that assist people in other supportive activities such as transportation training, learning independent living skills, teaching personally-effective social skills, recreation and leisure assistance.	Y	N	Y
Identify and implement services and supports for transition age school students and young adults that produce individualized employment plans for assessing, exploring, acquiring and maintaining community-based, competitive employment as well as other supportive activities that assist with life skills instruction.	Y	Y	N
Build a comprehensive employment database system to track community-based, competitive employment and progress on system reforms.	Y	Y	Y

Establish and finance oversight positions that monitor outcomes and quality.	Y	Y	Y
Fund system transformation by converting existing funding, which supports congregate, segregated sheltered workshops programs and facility-based day service, to support individualized, community-based employment service and individualized, community-integrated day support services.	Y	Y	Y
Fund system reform and transformation initiatives with increased state dollars to possibly receive matched by federal financial participation money.	Y	N	Y

RHODE ISLAND

RHODE ISLAND SETTLEMENT

(Rhode Island Consent Decree)

BACKGROUND

On January 14, 2013, the United States Department of Justice initiated an investigation into whether the State has violated Title II of the Americans with Disabilities Act and Olmstead v. L.C. through its administration and operation of its day activity services system, including employment, vocational, and sheltered workshop day services for individuals with intellectual and developmental disabilities.

FINDINGS

1.) Approximately 80 percent of the people with I/DD (about 2,700 individuals)receiving state services are placed in segregated, sheltered workshops or congregate, facility-based, day service programs.
2.) Only about 12 percent (approximately 385 people) participate in individualized, community-integrated employment.
3.) Only about five percent of students with disabilities transitioned into jobs in community-integrated settings.
4.) Placement in segregated settings is frequently permanent:

A.) nearly half (46.2 percent) of the individuals in sheltered workshops have been in that setting for ten years or more, and
B.) over one-third (34.2 percent) have been there for fifteen years or more.

5.) Individuals with I/DD in sheltered workshops reportedly earn an average of about $2.21 per hour.

AGREEMENTS and ACTIONS

1.) Permanently stop placements and funding into sheltered workshops and facility-based, day service programs.
2.) On a scheduled basis, conduct supported employment placements of about 2,000 individuals between January 2015 and January 2024, including:

A.) at least 700 people currently in sheltered workshops;
B.) at least 950 people currently in facility-based non-work programs; and
C.) approximately 300-350 students leaving high school.

3.) Adults transitioning to supported employment services (SES) will receive:

A.) Person-centered career planning process that includes asset-based vocational assessments such as discovery, situational assessments and time-limited, trial work exploration experiences;
B.) Supports Intensity Scale ("SIS") assessment;
C.) Benefits analysis and planning;
D.) Medicaid Buy-In program information and counseling; and an
E.) array of other vocational services and supports to ensure that they have meaningful opportunities to live and work in the community (***Appendix # 1, item # 1***).

4.) School youth in transition (ages 14 – 21 years old), approximately 1,250 students, will receive:

A.) Person-centered, individual learning plans;
B.) Person-centered, school-to-work transition career plans;
C.) Integrated vocational and situational assessments including discovery, vocational assessment, situational assessment and time-limited trial work exploration experiences; and an
D.) array of other transitional services and supports to ensure that they have meaningful opportunities to live and work in the community after they exit school (***Appendix # 1, item # 2***).

5.) SES placement in community integrated employment settings must:

A.) pay at least minimum wage;
B.) allow the person to work the maximum number of hours consistent with their abilities and preferences;

C.) allow the person interact with peers without disabilities to the fullest extent possible;
D.) average 20 hours of work per week in integrated employment settings;
E.) allow access to community-integrated work and non-work day services and supports for a total of 40 hours per week; and
F.) receive transportation and other direct (face-to-face) and indirect (not-face-to-face) employment services and supports.

6.) Supported employment placements cannot be in group job enclaves, mobile work crews and time-limited work experiences.
7.) No vocational or situational assessments shall be conducted in segregated, sheltered workshops and congregate day service program settings.
8.) Employer-sponsored training or provider-subsidized trial work exploration experiences can only occur for 4 – 8 weeks prior to job placement.
9.) Work compensated by any other entity than the employer of record will not qualify as a job placement.
10.) Community-integrated, (non-work) day services and supports shall not be services provided as part of a sheltered workshop, day services facility, group home, or residential program service provider.
11.) Develop an informational outreach campaign for schools and the general public that educates about the benefits of supported employment, and addresses families' concerns about supported employment.
12.) Create an employment first advocacy task force of local stakeholders, advocacy organizations, business networks, individuals with I/DD and family representatives for oversight and monitoring.
13.) Develop Interagency MOU Collaboration Agreements among human services, VR and education.
14.) Adopt an Employment First Policies and presumptions that all people with disabilities can competitively work at jobs in the community given proper services and support.
15.) Variances to SES placements can occur if the eligible person:

A.) makes a voluntary, informed choice for placement in a group work arrangement (e.g., enclaves, crews, etc.), segregated sheltered workshop facility, congregate day services program;
B.) receives one vocational or situational assessment;
C.) receives one trial work exploration experience, except when a documented medical condition poses an immediate and serious threat to their health or safety, or the health or safety of others;
D.) receives outreach educational information and counseling about SES;
E.) receives benefits planning;
F.) annual re-assessment for SES; and
G.) elects an integrated day supports-only placement in lieu of a SES placement.

FUNDING and FINANCING PROJECT INITIATIVES

1.) Establish a Sheltered Workshop Conversion Institute and Trust Fund ($800,000) to assist providers of sheltered workshop services to convert to SES.
2.) Pursue and fund a contract for training and technical assistance vendors to provide leadership, competency and value based training and TA to state staff, employment, sheltered workshop and day service providers.
3.) Reallocate financial resources now spent on segregated sheltered workshop and congregate day service programs to instead fund SE and/or community-integrated day services. Allow funding to follow the person without an increase in cost (maintaining budget neutrality).
4.) Develop and implement performance-based contracts for SES providers to meet goals and objectives.
5.) Provide ongoing funding sources to sufficiently support a competent and qualified system of providers with the capacity to deliver effective SES and Integrated Day Services.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

1.) Identify information and data elements to measure and collect for the U.S. DOJ and the court monitor:

A.) number of individuals in segregated sheltered workshop programs, congregate day services facilities, group job enclaves, mobile work crews and time-limited trial work exploration experiences

B.) number of completed career development plans

C.) number of individuals referred to and receiving SES

D.) number of transition youth exiting or graduating from school with career planning goals, and where they are transitioning to following their graduation or exit from school

E.) number and client capacity of supported employment providers

F.) number of qualified and trained SES professionals

G.) number of qualified and trained vocational counselors and assessment professionals

H.) number of hours worked per week, hourly wages paid, and job tenure in a community integrated employment setting

I.) number and reason(s) for lost jobs and/or terminations from employment along with plans for re-employment

J.) number and client capacity, hours per week, and tenure within community integrated day services providers, including the number of individuals participating in Integrated Day-Only Services

K.) number of variances granted

L.) number of outreach educational information campaign efforts performed

2.) Public reports to the U.S. DOJ and the selected court monitor on identified information and data elements also include:

A.) findings and results of regularly conducted on-site reviews of converting sheltered workshops and day service programs;

B.) identified program service provider deficiencies and required corrective action plans;

C.) employment service and support outcomes and recommendations; and

D.) compliance with the consent decree

Appendix # 1: Services and Supports

1. Vocational services and supports

job discovery and development, job-finding, job carving, job coaching, job training, job shadowing, co-worker and peer supports, reemployment supports, benefits planning and counseling, transportation services, environmental modifications and accessibility adaptations, behavioral supports, personal care services, case management services, assistive technology, social skills training, self-exploration, career exploration, career planning and management, job customization, time management training, self-employment opportunities and supports, adaptive behavior and daily living skills training.

2. Transitional services and supports

career instruction, employment preparation training, school-based preparatory job experiences, integrated work-based learning experiences, business site visits, job shadowing, work skill development, internships, part-time employment, summer employment, youth leadership, self-advocacy, peer and adult mentoring, living skills training, teaching community services, post-secondary school educational opportunities, transportation instruction, benefits planning, and assistive technology.

Appendix # 2: Supported Employment and Integrated Day Services Placements Schedule

Rhode Island Sheltered Workshop and Rhode Island Youth Exit Target Populations

a. By January 1, 2015, the State will provide Supported Employment Placements to at least 50 individuals in the Rhode Island Youth Exit Target Population who left during the 2013-2014 school year.

b. By July 1, 2015, the State will provide Supported Employment Placements to all remaining individuals in the Rhode Island Youth Exit Target Population who left, or will leave, school during the 2013-2014 and 2014-2015.

c. By January 1, 2016, the State will provide Supported Employment Placements to at least 50 individuals in the Rhode Island Sheltered Workshop Target Population.

d. By July 1, 2016, the State will provide Supported Employment Placements to all individuals in the Rhode Island Youth Exit Target Population who left school during the 2015-2016 school year.

e. By January 1, 2017, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.

f. By January 1, 2018, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.

g. By January 1, 2019, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.

h. By January 1, 2020, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

i. By January 1, 2021, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

j. By January 1, 2022, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

k. By January 1, 2023, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

l. By January 1, 2024, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

Rhode Island Day Target Population

a. By January 1, 2016, the State will provide Supported Employment Placements to at least 25 individuals in the Rhode Island Day Target Population.

b. By January 1, 2017, the State will provide Supported Employment Placements to at least an additional 25 individuals in the Rhode Island Day Target Population.

c. By January 1, 2018, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Day Target Population.

d. By January 1, 2019, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Day Target Population.

e. By January 1, 2020, the State will provide Supported Employment Placements to at least an additional 75 individuals in the Rhode Island Day Target Population.

f. By January 1, 2021, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Day Target Population.

g. By January 1, 2022, the State will provide Supported Employment Placements to at least an additional 200 individuals in the Rhode Island Day Target Population.

h. By January 1, 2023, the State will provide Supported Employment Placements to at least an additional 200 individuals in the Rhode Island Day Target Population.

i. By January 1, 2024, the State will provide Supported Employment Placements to at least an additional 225 individuals in the Rhode Island Day Target Population.

OREGON

OREGON EXECUTIVE ORDER

(Oregon Executive Order)

BACKGROUND

On January 25, 2012, the first class action lawsuit case in the nation that challenges sheltered workshops as a violation of the integration mandates in Title II of the Americans with Disabilities Act and Olmstead v. L.C was filed. The case, ***Lane v. Kitzhaber***, was filed on behalf of eight named plaintiffs who are:

1.) stuck in sheltered workshops;
2.) spending years, and often decades in these congregate, segregated settings;
3.) qualified and prefer to work at real jobs in the community; and
4.) often paid less than a $1.00/hour for their labor in the workshops.

The class action lawsuit case is brought on behalf of thousands of similarly situated and qualified persons with disabilities placed in Oregon's sheltered workshop system. The class action lawsuit case seeks an injunction to require the State of Oregon, and its' Department of Human Services, to end the segregation of persons with intellectual and development disabilities, and to assist them in obtaining integrated employment opportunities with supported employment services. The case is pending and proceeding to court, unless a settlement can be reached.

FINDINGS

1.) In October 2011, the United States Department of Justice concluded via a lengthy investigation that the State of Oregon has violated Title II of the Americans with Disabilities Act and Olmstead v. L.C. by funding, structuring, and administering its disability employment services system in a manner that segregates persons with intellectual and developmental disabilities in sheltered workshops.

2.) The U.S. DOJ determined that segregated workshops constitute an ADA violation and a Rehabilitation Act violation, and that the state's employment service system must be reformed in order to expand integrated employment opportunities.

3.) The DOJ claims that Oregon's disability employment service system perpetuates segregation of individuals with disabilities by unduly relying upon sheltered workshops rather than providing employment services in integrated settings, thus causing the unnecessary segregation of individuals who are capable of, and not opposed to, working at jobs in the community.

4.) 2,691 persons receive employment and vocational services. 1,642 – 61% – received at least some of those services in sheltered workshops. By contrast, only 422, or less than 16%, of these persons received services at any time in individual supported employment settings.

5.) The average hourly wage for sheltered workshop participants is currently $3.72. Over 52% of participants earn less than $3.00 per hour. By contrast, the overwhelming majority of persons with disabilities in individual supported employment earn Oregon's minimum wage of $8.80 or above.

6.) The DOJ recommended that Oregon implement certain remedial measures, including the development of sufficient supported employment services to enable those individuals who are unnecessarily segregated, or at risk of unnecessary segregation, in sheltered workshops to receive services in individualized, integrated employment settings in the community.

7.) The DOJ determined that voluntary compliance was not possible after months of negotiations to reach a settlement and avoid litigation.

OREGON GOVERNOR'S EXECUTIVE ORDER (July 1,2013) – AN UNSUCCESSFUL REMEDY

1.) The Oregon Department of Human Services (ODHS) and the Oregon Department of Education (ODE) shall work together to further improve Oregon's systems of designing and delivering employment services to those with intellectual and developmental disabilities.

2.) Oregon will make significant reductions in state support for sheltered work over time.
3.) Oregon will make increased investments in employment services and supports for people with disabilities.
4.) Employment services will be provided immediately to working age people with I/DD who receive sheltered workshop services. Employment services shall be individualized and evidence-based or recognized as effective practices.
5.) Employment services will be provided immediately to transition age young adults (@ 16 – 23). Employment services shall be individualized and evidence-based or recognized as effective practices.
6.) Individualized employment Services shall be based on an individual's capabilities, choices, and strengths.
7.) ODDS and OVRS will provide Employment Services to at least 2000 individuals in the ODDS/OVRS Target Population, in accordance with a schedule (please refer to Appendix 1).
8.) ODDS shall adopt and implement policies and procedures for developing individualized career development plans. The policies will include a presumption that all individuals in the ODDS/OVRS are capable of working in an integrated employment setting. The primary purpose of all vocational assessments shall be to determine an individual's interests, strengths, and abilities, in order to identify a suitable match between the person and an integrated employment setting.
9.) By January 1, 2014, ODDS and OVRS will establish competencies for the provision of Employment Services, and will adopt and implement competency-based training standards for career development plans, job creation, job development, job coaching, and coordination of those services.
10.) By July 1,2016, ODDS and OVRS will purchase Employment Services for people with I/DD only from agencies or individual providers that are licensed, certified, credentialed or otherwise qualified as required by Oregon Administrative Rule. Such requirements for the provision of Employment Services will be competency-based and may include national credentialing programs as the APSE Certified Employment Support Professional exam or a substantial equivalent.
11.) By January 1, 2014, ODDS and OVRS will develop an outreach informational education campaign for all people receiving services from ODDS/OVRS that explains the benefits of employment, addresses family and perceived obstacle concerns to participating in employment services.
12.) Through a developed MOU agreement, ODE will partner with OVRS and ODDS to establish and implement a Statewide Transition Technical Assistance Network to assist high schools in providing Transition Services.

FUNDING and FINANCING PROJECT INITIATIVES

1.) By July 1, 2014, Oregon will no longer purchase or fund vocational assessments for individuals with I/DD that occur in sheltered workshop settings.
2.) By July 1, 2015, Oregon will no longer purchase or fund ***NEW*** sheltered workshop placements.
3.) State agencies will make good faith efforts, within available budgetary resources, to ensure that there are a sufficient number of qualified employment providers to deliver the services and supports necessary for individuals in the ODDS/OVRS system to receive competent employment services.
4.) By January 1, 2014, DHS will financially support new or existing technical assistance provider(s) or use other available training resources to provide leadership, training and technical assistance to counties, employment service providers, support service providers, and vocational rehabilitation staff.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

1.) By July 1, 2014, DHS will develop and implement a quality improvement initiative that is designed to promote Employment Services and to evaluate the quality of Employment Services provided to persons with I/DD.
2.) Starting January 1, 2014, an appointed State Employment Coordinator (as of 10/2013) and a newly formed Policy Review Committee (as of 07/2013) will monitor progress semi-annually through data

collection, data analysis, quality improvement activities and make annual recommendations to the Governor and legislature for performance improvements.
3.) Starting January 1, 2014, and semi-annually thereafter, ODDS and OVRS shall collect data and report to the Employment Coordinator and the Policy Review Committee data for working age individuals that will include:

a. The number of individuals receiving Employment Services;

b. The number of persons working in the following settings: individual integrated employment, self-employment, sheltered employment, and group;

c. The number of individuals working in an integrated employment setting;

d. The number of hours worked per week and hourly wages paid to those persons;

e. The choices made by individuals between integrated work, sheltered work, and not working;

f. Problems or barriers to placement and retaining employment in community-integrated settings;

g. Service gaps;

f. Complaints and grievances.

Appendix # 1: Services and Supports

a. By July 1, 2014, ODDS and/or OVRS will provide Employment Services to at least 50 individuals.

b. By July 1, 2015, ODDS and/or OVRS will provide Employment Services to at least an additional 100 individuals.

c. By July 1, 2016, ODDS and/or OVRS will provide Employment Services to at least an additional 200 individuals.

d. By July 1, 2017, ODDS and/or OVRS will provide Employment Services to at least an additional 275 individuals.

e. By July 1, 2018, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

f. By July 1, 2019, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

g. By July 1, 2020, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

h. By July 1, 2021, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

i. By July 1, 2022, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

Massachusetts

MASS. - Blueprint for Success: Employing Individuals with Intellectual Disabilities in Massachusetts

BACKGROUND

In response to recent United States Department of Justice (DOJ) litigation regarding Title II of the Americans with Disabilities Act and Olmstead v. L.C. , and CMS' "HCBS Final Rule" requirements regulating size and settings of non-residential service settings; a group of Massachusetts (MA) disability service providers, advocates, and the Department of Developmental Services (DDS) examined day and employment support service programs for adults with intellectual disabilities (ID). As a result of their analysis, the Massachusetts Association of Developmental Disabilities (ADDP), the Arc of Massachusetts, and the Massachusetts Department of Developmental Services (DDS) entered into a proactive plan to increase community-integrated competitive employment opportunities for people with intellectual disabilities (ID). The plan emphasizes the importance and benefits of having a job and contributing to community businesses through work.

ACTION STEPS

1.) Inform providers that purchasing sheltered workshop services will discontinue within five years.
2.) Require providers to submit business plans on how they are going to increase community-integrated, competitive employment and phase out sheltered workshop services.
3.) Require providers to make concerted efforts to assist people to enter into community-based, supported employment (individual or group), and re-structure their programs into employment services.
4.) Define and align all provider service practices with Employment First Policy.
5.) Develop, establish and implement a new standardized services rate structure that incentivizes integrated, community-based, supported employment (individual or group) services and outcomes (please refer to Appendix 2).
6.) Close new referrals to sheltered workshop programs as of January 1, 2014 as a first step to phase out by June 30, 2015.
7.) During fiscal year 2015, individuals currently in sheltered workshop programs will gradually transition into individual supported employment, group supported employment, and/or community-based day services (CBDS) programs (please refer to Appendix 1). Facility-based, day training and habilitation will only be a service option when it has been determined the most appropriate service option for the person.
8.) Increase the number of people who participate in community integrated individual and group supported employment that pays minimum wage or higher in fiscal years 2016, 2017 and 2018. Gradually phase out group employment settings that pay less than minimum wage.
9.) Expand the scope of CBDS programs to include service options with a career exploration/planning component to serve as a pathway to employment through use of a variety of different volunteer, internships (e.g., Project Search), situational assessments/discovery opportunities, skills training or other community-based experiences. Continue to transition individuals from CBDS into community-integrated work opportunities that pay minimum wage or higher. The CBDS model will also be used to provide complementary supports for individuals who work part-time and need and want to be engaged in structured, program services for the remainder of the work week.
10.) Develop and implement a common framework for a planning and assessment process that allows informed choice as an integral part of the development of a person-centered career plan.
11.) Recruit and fund state advocacy organizations to develop and conduct a comprehensive, statewide educational outreach campaign directed at people with disabilities and their families that includes informational resources, regional forums, family-to-family connection groups and peer support groups.
12.) Create via appointment an Employment First review council to facilitate implementation and monitor ongoing progress of the transition plan.

TRAINING AND SYSTEM DEVELOPMENT

1.) Engage in business consultation, strategic planning and technical assistance to providers on redesigning services and restructuring organizations to convert from congregate and segregated, sheltered workshops into individualized, community-integrated employment services and support provider, including Community-Based Day Services (CBDS).

2.) Develop comprehensive training for employment specialists/job developers with curriculum and field work experiences that are aligned with credentialing //certification entities for employment specialist professionals.

3.) Design educational material and resources for benefits analysis, planning and work incentives.

4.) Produce training on (a) career exploration and discovery approaches; (b) customized job development; (c) systematic instruction techniques, (d) working with specific populations; (e) technology on the job, and (f) other relevant topic areas to be identified.

5.) Create communities of practice that provide in-service learning courses.

6.) Conduct Peer-to-Peer learning sessions for providers to work together on common issues.

7.) Build and fund a coalition of regional employment collaboratives across the state to maximize resources, share best practices, share lessons learned, conduct macro-level job development and provide opportunities for partnership among state agencies, employment service provider organizations and employers. Central Massachusetts Employment Collaborative uncovered over 248 employment opportunities and 136 individuals with disabilities were hired at minimum wage or higher by businesses in the community.

8.) Draft a comprehensive MOU agreement that cooperatively collaborates and coordinates inter-agency responsibilities, resources, services and funding to achieve a unified effort toward getting youth and adults competitively employed in the community.

9.) UMass-Boston ICI will establish a consultant pool consisting of individuals and/or qualified organizations as subject matter experts and technical advisors.

FUNDING and FISCAL STRATEGY (please refer to Appendix #2)

1.)* A total investment of $26.7 million over four fiscal years, from 2015 through 2018 is projected.

2.) Cost analyses are based on the number of people who are receiving facility-based, sheltered workshop services on a full-time basis or part-time basis as of July 1, 2013. The total number of individuals participating in sheltered workshop services is 2,608: 1,251 attend sheltered workshops full-time (typically 30 hours/week) and 1,357 attend part-time (52%).

3.) An investment of new funding is needed to provide resources and opportunities for people to move from sheltered workshop services (rate = $8.42/hour) to individual (rate = $47.96/hour) or group (rate = $13.80/hour) supported employment, and/or CBDS programs (rate = average $12.92/hour). These services have higher rates due to service design and staffing ratio requirements. The incremental infusion of new funding provides a "bridge" to new service options for individuals currently receiving sheltered workshop services.

Important Note: The net cost to the state would only be approximately $13 million dollars due to Medicaid HCBS waiver reimbursement via federal financial participation at almost 50%. for these services.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

With UMass – Boston ICI, continue to develop and implement an employment outcome data collection system that:

1.) effectively records and reports relevant information and data on new job placements and movement within the service system in order to track and document progress; and

2.) informs the planning processes and transformation initiatives.

Appendix # 1: Services Descriptions

Center-Based Work Services (activity code 3169)
Center-based work services ("sheltered workshops") are essentially work preparatory services that are delivered in segregated settings and that provide supports leading to the acquisition, improvement, and retention of skills and abilities that prepare an individual for work and community participation. Services are not predominantly job-task oriented, but are intended to address underlying generalized habilitative goals, such as increasing a participants attention span and completing assigned tasks, goals that are associated with the successful performance of compensated work. It is intended that the service should be time-limited to assist individuals to move into supported employment options. This service must be provided in compliance with Department of Labor (DOL) requirements for compensation.

Individual Supported Employment (activity code 3168)
An individual receives assistance from a provider to obtain a job based on identified needs and interests. Individuals may receive supports at a job in the community or in a self-employed business. Regular or periodic assistance, training and support are provided for the purpose of developing, maintaining and/or improving job skills, and fostering career advancement opportunities. Natural supports are developed by the provider to help increase inclusion and independence of the individual within the community setting. Employees should have regular contact with co-workers, customers, supervisors and individuals without disabilities and have the same opportunities as their non-disabled co-workers. Individuals are generally paid by the employer, but in some circumstances may be paid by the provider agency.

Group Supported Employment (activity code 3181)
A small group of individuals, (typically 2 to 8), working in the community under the supervision of a provider agency. Emphasis is on work in an integrated environment, with the opportunity for individuals to have contact with co-workers, customers, supervisors, and others without disabilities. Group Supported Employment may include small groups in industry (enclave); provider businesses/small business model; mobile work crews which allow for integration, and temporary services which may assist in securing an individual position within a business. Most often, the individuals are considered employees of the provider agency and are paid and receive benefits from that agency.

Community-Based Day Supports (activity code 3163)
This program of supports is designed to enable an individual to enrich his or her life and enjoy a full range of community activities by providing opportunities for developing, enhancing, and maintaining competency in personal, social and community activities. Services include, but are not limited to, the following service options: career exploration, including assessing interests through volunteer experiences or situational assessments; community integration experiences to support fuller participation in community life; skill development and training; development of activities of daily living and independent living skills; socialization experiences and support to enhance interpersonal skills; and pursuit of personal interests and hobbies. This service is intended for individuals of working-age who may be on a "pathway" to employment; as a supplemental service for individuals who are employed part-time and need a structured and supervised program of services during the day when they are not working, which may include opportunities for socialization and peer support; and individuals who are of retirement-age and who need and want to participate in a structured and supervised program of services in a group setting.

Appendix # 2: Funding and Fiscal Strategy

FY 2014: This is an important planning year to conduct assessments and develop plans with individuals in sheltered workshop programs to determine which alternative service option(s) will best meet their needs.

FY 2015: The largest investment is needed this year to facilitate transition to individual or group supported employment, and/or to CBDS programs for **all** participants in center-based/sheltered workshops. It is expected a majority of individuals will initially move to CBDS programs, which will provide opportunities to explore work-related possibilities. This will enable DDS to reach the goal of phasing out sheltered workshop services and removing the concern of sub-minimum wage payments related to sheltered work programs by June 30, 2015. (Proposed investment: $11.1 million; Net state cost: 5.55 million).

FY 2016: It is expected that a larger number of individuals will move to individual or group supported employment options this year from CBDS programs. In addition, funding will provide participation in CBDS for individuals who work part-time. (Proposed investment: $6.3 million; Net state cost: $3.15 million).

FY 2017: There will be continued movement of individuals from CBDS programs to individual and/or group supported employment services to provide integrated employment opportunities for all individuals who had previously been participating in sheltered workshop programs. (Proposed investment: $8.3 million; Net state cost: $4.15 million).

FY 2018: The final year of investment is used to solidify gains made in integrated employment services for individuals in CBDS and also facilitate movement of individuals to group supported employment earning above minimum wage. (Proposed investment: $1 million; Net state cost: $500,000).

Results

- Ends the purchasing of sheltered workshop services and successfully transition individuals into other employment or service options by the end of fiscal year 2015.
- Eliminates sub-minimum wage payments used by sheltered workshops.
- This funding investment would support individuals to:
    (a) obtain community-integrated, competitive jobs through individualized supported employment services, and
    (b) facilitate movement of individuals in group supported employment to earning minimum wages or higher.
- Develops an employment services provider network and system of supports that are more responsive in meeting the needs of people with ID.
- Establishes a system of inclusive employment and day service options that support people with disabilities in competitive, community employment and life pursuits.

Appendix B: Service and settings definitions

Residential Setting/Service	Description
Adult foster care	Licensed, living arrangement that provides food, lodging, supervision, and household services. They may also provide personal care and medication assistance. Adult foster care providers may be licensed to serve up to four adults or five adults if all foster care residents are age 55 or older, have no serious or persistent mental illness, nor any developmental disability. There are two types of adult foster care: Family Adult Foster Care is an adult foster care home licensed by the Minnesota Department of Human Services. It is the home of the license holder and the license holder is the primary caregiver. Non-Family Adult Foster Care (Corporate Adult Foster Care) is an adult foster care home licensed by the Minnesota Department of Human Services that does not meet the definition of Family Adult Foster Care because the license holder does not live in the home and is not the primary caregiver. Instead, trained and hired staff generally provide services. The same foster care license requirements apply to both family and non-family homes. BI, CAC and CADI waiver recipients may use waiver services of adult foster care when the scope of services assessed and identified in the service plan exceeds the scope of services provided through the foster care payment rate paid from the person's assessed resources and the Group Residential Housing rate.
Assisted living residence	Assisted Living residences generally combine housing, support services, and some kind of health care. Individuals who choose assisted living can customize the services they receive to meet their individual needs. To be considered an assisted living residence, the facility must provide or make available, at a minimum, specified health-related and supportive services. Examples include: assistance with self-administration of medication or administration of medication, supervised by a registered nurse; two meals daily; daily check system; weekly housekeeping and laundry services; assistance with three or more activities of daily living (dressing, grooming, bathing, eating, transferring, continence care, and toileting); and assistance in arranging transportation and accessing community and social resources. Every assisted living facility must have a license from the Minnesota Department of Health in order to operate
Board and lodge	Board and Lodge vary greatly in size, some resemble small homes and others are more like apartment buildings. They are licensed by the Minnesota Department of Health (or local health department). Board and lodges provide sleeping accommodations and meals to five or more adults for a period of one week or more. They offer private or shared rooms with a private or attached bathroom. Substance abuse - Board and Lodge can provide housing for up to six months for clients who need stable supportive housing, and strives to provide its residents with additional support services, including Peer Support Services, yet many of these additional services are not currently reimbursable. Often, the client will reside in a "Sober House" while at the same time receive outpatient services from another provider. Homeless shelters are a subset of board and lodge facilities.
Board and lodge with special services	Many Board and Lodge facilities offer a variety of supportive services (housekeeping or laundry) or home care services (assistance with bathing or medication administration) to residents
Boarding care	Boarding Care homes are licensed by the Minnesota Department of Health and are homes for persons needing minimal nursing care. They provide personal or custodial care and related services for five or more older adults or people with disabilities. They have private or shared rooms with a private or attached bathroom. There are common areas for dining and for other activities.
Child foster care	Children under the age of 18 - BI, CAC and CADI waiver recipients may use the waiver service of child foster care when the scope of services assessed and identified in the service plan exceeds both the scope of services provided in the Out of Home Placement Plan and the payment rate that the lead agency is required to cover.
Children's residential care (Children's residential facilities – Rule 5)	Children's residential facilities standards (Minnesota Rules, Chapter 2960) govern the licensing of providers of residential care and treatment or detention or foster care services for children in out-of-home placement. These standards contain the licensing requirements for residential facilities and foster care and program certification requirements for program services offered in the licensed facilities. Statutory language defines "certification" as meaning the commissioner's written authorization for a license holder licensed by the Commissioner of Human Services or the Commissioner of Corrections to serve children in a residential program and provide specialized services based on certification standards in Minnesota Rules. The term "certification" and its

	derivatives have the same meaning and may be substituted for the term "licensure" and its derivatives.
Crisis respite (foster care)	Short-term care and intervention strategies to an individual for both medical and behavioral needs that support the caregiver and/or protect the person or others living with that person. Crisis respite services may be provided: • In-home or • Out-of-home in a specialized licensed foster care facility developed for the
Housing with services establishment	Generally apartment building settings with individual units. Family adult day services must meet standards in Minn. Stat. §245A.143 or Minn. R. 9555, parts 5105 to 6265. If you hold a license as an adult foster care provider and meet the family adult day services standards, DHS does not require you to obtain a separate family adult day services license.
Supervised living facilities	Group home setting serving five or more people with disabilities. SLF provides supervision, lodging, meals, counseling, developmental habilitation or rehabilitation services under a Minnesota Department of Health license to five or more adults who have a developmental disability, chemical dependency, mental illness, or a physical disability.
Supported living services	Developmental disability waiver services provided in a foster care setting are called Supported Living Services (SLS) under Residential Habilitation. Residential Habilitation: Services provided to a person who cannot live in his or her home without such services or who need outside support to remain in his or her home. Habilitation services are provided in the person's residence and in the community, and should be directed toward increasing and maintaining the person's physical, intellectual, emotional and social functioning.
Employment/Day Service/Setting	
Adult day services/Adult day care	Adult day services /Adult day care: Services provided to persons who are 18 years of age or older that are designed to meet the health and social needs of the person. The plan identifies the needs of the person and is directed toward the achievement of specific outcomes.
Family adult day services	A family adult day service program is a program that operates fewer than 24 hours per day and provides functionally impaired adults, none of which is under age 55, have serious or persistent mental illness or people with developmental disabilities or a related condition, with an individualized and coordinated set of services including health services, social services and nutritional services that are directed at maintaining or improving the participants' capabilities for self-care. A family adult day services license is only issued when the services are provided in the license holder's primary residence, and the license holder is the primary provider of care. The license holder may not serve more than eight adults at one time, including residents, if any, served under an adult foster care license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.
Structured day program	Service designed for persons who may benefit from continued rehabilitation and community integration directed at the development and maintenance of community living skills. (Only available through the Brain Injury waiver.)
Day training & habilitation	Licensed supports to provide persons with help to develop and maintain life skills, participate in community life and engage in proactive and satisfying activities of their own choosing.
Pre-vocational service	Services designed to prepare persons for paid or unpaid employment, as reflected in the plan of care.
Supported employment services	Services for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, needs intensive ongoing support to perform in a work setting. The person receiving services must be in a paid employment situation.

EXHIBIT 5-12: SS 4B – WAIT LIST REPORT - SEPTEMBER 2014

Olmstead HCBS Waiver Wait List Report
Submitted and Accepted by Subcabinet: September 29, 2014
To be Reviewed and Approved: February 9, 2015

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Olmstead HCBS Waiver Wait List Report

Continuing Care Administration

September 2014

For more information contact:

Minnesota Department of Human Services
Disability Services Division
St. Paul, MN 55101
651-431-4262

This information is available in accessible formats to individuals with disabilities by calling 651-431-4262,

Or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

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Contents

Olmstead Plan Language

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

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014) Page 68.

Introduction

Supports and services provided through Minnesota's Home and Community-Based Service (HCBS) waivers provide desired assistance for people with disabilities to live in integrated settings and fully participate in the community. Access to waiver services may be critical to some for successful community living. Ensuring access to waiver services for those with the most urgent need allows services to be used appropriately to divert services that are more restrictive.

Language in Minnesota's Olmstead Plan requires that this report include recommendations on improving the process related to the waiting list for Minnesota's HCBS waivers. As dictated in the Olmstead Plan language, the report addresses the definition of urgency, how to track urgency and those waiting for waiver services and how adopting the recommended practices in the following sections will result in improving the waiting list process.

Background Information

Historically, the state has provided waiver waiting list information through the DHS public website. This tool allows the public to examine the waiting list by a number of different factors including county, age, service, and more. As of July 8, 2014, the date data was last available for this report, there were 1,393 people waiting for services under the Community Alternative for Disabled Individuals (CADI) waiver. Statewide, there were 3,507 people waiting for services under the Developmental Disabilities (DD) waiver.

Minnesota Statute 256B.092, subdivision 1f directs county agencies to maintain waiting lists for individuals needing and qualifying for HCBS waiver services, but who cannot receive waiver services at that time. Minnesota Statutes 256B.092, subdivision 12 and 256B.49, subdivision 11a establish statewide priorities for individuals on a waiver waiting list. Section (c) of each of these statutes also grants the commissioner the power to transfer waiver funds between lead agencies to accommodate these statewide

priorities, while accounting for a necessary base level reserve amount for each lead agency.

These statutes list criteria for establishing which people would have priority for moving into services, but they do not address the factor of urgency. While several individuals may meet one or more of the criteria, some individuals are in a more urgent need of service than others. Creating categories of urgency that inform prioritization of the waiting list should give lead agencies guidance for consistent management of the waiting list.

Categorizing urgency must account for other complications that arise when managing a waiting list. These complications include:

- Individuals can receive non-waiver services that meet most of their needs while they are on a waiting list. For example, currently 66 percent of people on DD and 62 percent of people on CADI waiver waiting lists receive some other non-waiver service. These statistics also do not account for informal or other supports, such as schools, that meet individuals' needs.

Research Process

Three meetings with stakeholders, facilitators from the Management Analysis & Development (MAD) division of Minnesota Management & Budget, and DHS staff preceded the creation of this report. Stakeholders included county representatives and professional advocates from the disability community. After DHS staff completed the report, they held a fourth meeting for stakeholders to provide feedback.

Stakeholders recognized that Minnesota lacked a consistent process for prioritizing urgency in waiver services. Stakeholder and DHS identified this issue as the mandate for the workgroup in the Olmstead plan. When identifying best practices for prioritizing urgency, DHS raised the idea of using the Prioritization of Urgency of Needs for Services (PUNS) system. Tony Records, a consultant specializing in Olmstead, identified this system in an earlier presentation to DHS. Workgroup members identified the PUNS system as a method to base a Minnesota prioritization system on. An example of the PUNS form is located on the Pennsylvania Department of Public welfare website.

Defining Urgent

Pennsylvania and Illinois use the PUNS system to define urgency while on a waiting list for waiver services. The PUNS system uses 30 Yes/No questions to determine a category of need and a level of urgency for each person. At first, stakeholders did not

recommend that Minnesota should begin using the PUNS system; however, they found helpful the broad categories the system uses to create levels of urgency.

After reviewing the PUNS system, stakeholders do not support use of the PUNS system in its entirety because it would add another rigid layer to an already large assessment structure. Representatives also expressed a belief that urgency criteria should take into consideration factors such as those listed in M.S. 256B.092, subd. 11a and M.S. 256B.49, subd. 12, as well as criteria adapted from the PUNS system. Given the subjective nature of these factors, county representatives expressed a strong desire to retain flexibility in decision-making about these factors.

Recommendation: Using Four Categories to Define Urgency

The workgroup recommends that DHS consider using a PUNS approach to categorize an individual's level of urgency respective to receiving waiver services. The following structure could build on the assessment process and provide guidelines to lead agencies to categorize an individual's level of urgency:

Urgency Category	**Description**
Institutional Exit	Individuals in this subcategory have an immediate need due to exiting an institutional setting. Waiver planning must start within 90 days.
Immediate Need	Individuals in this category have an immediate need and must receive waiver services within 90 days.
Serious Need	Individuals in this category have assessed needs that may develop into an immediate need, and monitoring will occur to watch if this happens. If a county has waiver funds available, and all individuals in the "Immediate" and "Institutional Exit" categories are served, those in this category may begin waiver services.
Planned Need	Individuals in this category may have a need for waiver services at a point in the future. Until that point, they may use non-waiver disability services or other supports.

Potential recipients who are exiting institutions will begin waiver services at a reasonable pace, defined as no more than 90 days. If the lead agency, in consultation with the individual, determines 90 days will be too little time to have services and housing ready for someone exiting an institution, the planning process for this individual must begin within 90 days of the assessment. Those determined to have an "Immediate Need" for waiver services will also begin services within 90 days. This proposed

categorization system establishes a statewide structure while retaining the professional decision-making flexibility desired by county representatives.

Conversations with county representatives have shown that, currently, the judgment of those conducting assessments has informed the level of prioritization for individuals in need of services. To inform prioritization, DHS will establish criteria that incorporate statutory priorities and measures adapted from the PUNS system. When assessing a person's level of urgency, lead agencies will consider the criteria established in M.S. 256B.092, subd. 11a for the DD waiver and M.S. 256B.49, subd. 12 for the CAC, CADI, and BI waivers, as well as guidance DHS delivers related to an individual's assessed needs, a caregiver's ability to provide support, and an individual's environmental issues. Lead agencies may consult with DHS staff to ensure consistency in professional judgment. DHS will provide lead agencies with further information on the criteria on prioritizing urgency of need.

Tracking Urgency and Those Waiting for Services

Implementing the above categorization system would standardize data collection on a statewide basis, and is needed to make sure those with the most urgent needs, including individuals in segregated settings, receive waiver services at a reasonable pace. After the categorization system has been implemented and DHS collects this data, the state may understand whether individuals remain in non-integrated settings because of a lack of access to waiver services.

One workgroup suggestion is to use an electronic record system created by DHS for use across all waivers for capture of the individual's assessed level of urgency.

This new adaptation would allow lead agencies and the state to pull and view urgency data to create a complete picture of how many individuals enter the waiting list at different levels of urgency. It will be necessary to establish a consistent record system across all of the waivers.

DHS would also recommend tracking of the number of days individuals are on the waiting list. This will ensure that those placed in the "Institutional Exit" and "Immediate Need" categories begin receiving waiver services at a reasonable pace. DHS staff will monitor whether lead agencies are moving at a reasonable pace. DHS staff and system reminders will help counties understand how long someone in the "Institutional Exit" or "Immediate Need" categories has been waiting for services.

If lead agencies do not comply with the reasonable pace requirement, DHS will undertake steps to learn why, and take appropriate action. Actions may include reallocation of resources if a county is unable to service individuals with urgent needs within their county waiver budget, providing technical assistance to the county to

establish services and managing priorities within the resources available to them, and as necessary, documenting when the demand for services exceeds statewide resources. Those assessed to have a Serious or Planned Need will be tracked using the electronic record system to monitor how long they are on a waiting list. Lead Agencies are expected to begin waiver services for Serious Need individuals as funding and services are available.

Improving the Waiting List Process

Implementing the recommendations mentioned above will improve the waiting list process because it will provide transparency and statewide consistency in prioritizing access to waiver services. In conjunction with using professional judgment, guided by statute, to determine the urgency of a person's need, lead agency staff will also be able to apply a uniform categorization process across the state. Additionally, individuals on the waiting list will have a greater understanding of the prioritization process, and their status on the waiting list. DHS will also make summary data available to the public on an annual basis through its public website.

DHS is in the process of transitioning to a new assessment process. Therefore, a multi-tiered approach to collecting waiting list data is required. In the immediate-term, the temporary electronic record system will allow DHS to collect waiting list information while the assessment transition occurs. Once the transition is complete, DHS may move to an electronic record system that interacts with the new assessment. This process allows DHS to collect and monitor data without delay.

Additional Issues Affecting Waiver Services

Some discussion in the Olmstead Wait List Workgroup meetings surrounded the level of "county reserves." County reserves are the difference between what counties have been allocated in their waiver budgets, and what they authorize and spend. Currently, lead agencies are not using all of their allocated budgets. Waiting lists would be reduced if reserves were lowered to a reasonable and necessary level and funds used to provide service to more individuals. All workgroup attendees recognized the need for additional attention, understanding and discussion of the county reserve issue. Within three months, DHS will convene a group of county and disability stakeholders to discuss what options exist to maximize the benefit of waiver funds.

There are three indicators to monitor when managing the waiver funding. The first is the funding granted to a county through an allocation process of dollars that are to be used for waiver services. Counties must manage the number of individuals and the amount of services authorized, not only for new individuals, but also for the changing needs of those already on the program within this waiver allocation. The second factor is the amount of dollars authorized for individuals for their services and is the maximum a

provider can deliver and bill. The third is the reimbursement level, which is the actual level of spending in the program. The Medical Assistance forecast is based on the reimbursement level.

Based on historical averages, county reserve levels could be lowered. For the CAC, CADI and BI waivers the average statewide reserve from Fiscal Year 2012 to 2014 was 8.65 percent. For the DD waiver the average statewide reserve from Calendar Year 2011 to 2013 was 6.99 percent. The central issue surrounding county reserves is how to maximize dollars to serve as many individuals with the appropriate level of service as possible within county waiver budgets.

As mentioned above, the commissioner already has statutory authority to transfer funds between lead agencies to accommodate statewide priorities. There has not yet been a situation where this has been necessary. DHS will develop and publish a protocol for transferring funds between lead agencies for greater transparency.

Recommendations Summary

In summary, DHS will take the following administrative actions based on the recommendations of the Olmstead Wait List Workgroup members:

- Within three months of this report's presentation, DHS will convene a group of county and disability stakeholders to discuss further action on maximizing the benefit of waiver funds. This was completed on September 5, 2014.
- By December 31, 2014, DHS will:
    - Establish four levels of urgency (Institutional Exit, Immediate Need, Serious Need and Planned Need) for individuals requesting waiver services. Lead agencies will prioritize individuals applying for waiver services on their assessed level of urgency.
    - Develop and distribute criteria based on statute and the PUNS system that will be used to determine urgency of need.
    - Establish and publish a training curriculum on using the temporary electronic record system. This system will collect data on urgency of need categorizations.
    - Offer support to lead agencies prior to implementation of the electronic record system.
    - Create a temporary electronic record system to track the urgency of need categories across the DD, CAC, CADI and BI waivers.
- By February 1, 2015, DHS will develop and publish a protocol for implementing the provisions of M.S. 256B.092, subd. 12 and M.S. 256B.49, subd. 11a, granting the commissioner the power to transfer waiver funds between lead agencies to accommodate statewide priorities.

- Beginning February 1, 2015, DHS will:
    - Require that individuals with the “Institutional Exit” categorization begin service planning within 90 days of an assessment. DHS will require that individuals with the “Immediate” categorization receive services within 90 days to the extent that statewide resources are available to support them. This may be accomplished through DHS technical assistance or transferring waiver funds between lead agencies. Categorization of individuals will be completed on a rolling basis, as they are assessed and reassessed. Information about the number of days an individual has been on the waiting list will be available to DHS through the temporary electronic record system.
    - Provide technical assistance to lead agencies that do not comply with the reasonable pace requirement.
- By July 1, 2015, DHS will provide technical assistance to lead agencies on their ability to access a second year to control excess spending as per M.S. 256B.0916, subdivision 11.
- Beginning February 1, 2016, DHS will provide summary data about waiting list urgency categories to the public on an annual basis.
- By February 2017, DHS will create a final electronic record system that may work with the state’s electronic assessment system to track the urgency of need categories across the DD, CAC, CADI and BI waivers. Corresponding training and support will be offered to lead agencies before this date. This system will replace the temporary electronic record system.
- DHS will participate in upcoming discussion on waiver waiting lists, hosted by the National Association of State Directors of Developmental Disabilities Services.

Appendix A: Olmstead Wait List Workgroup Participants

Stakeholders:

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Sandra Foy, Ramsey County
Cindy Grosklags, Renville County
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Management Analysis & Development:

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Appendix B: Waiver Reserve Group Participants

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EXHIBIT 5-13: HC 2I – HEALTH CARE TRANSITION PLANNING FOR YOUTH

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Olmstead Benchmark Report

October 8, 2014

Submitted by Barb Lundeen RN, PHN, MA Children and Youth with Special Health Needs

Action # HC 2I

Definitions:

Children and youth with special health needs (CYSHN) are those who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. (Maternal and Child Health Bureau)

Transition has been defined as "the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult-oriented health care systems.

Background:

Health care transition planning for youth with disabilities, including those with chronic conditions, came to the forefront in 1989 when former Surgeon General Dr. C. Everett Koop convened a conference of family members and health professionals to focus on the health needs of youth as they transition from school to work and from home to independent living. In 2002 the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physician coauthored a consensus statement; "The goal of transition in health care for young adults with special health care needs is to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood." This process can be challenging, particularly for CYSHN. Currently one of the six core objectives of the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB) is that "all youth with special health care needs will receive the services necessary to make appropriate transitions to adult health care, work, and independence."

All youth need to be connected to programs, services, activities, and supports that prepare them to manage their physical, mental and emotional well-being and develop life skills to make informed choices. This is especially true for youth with chronic health conditions. The benefits of purposeful transition care are that it provides youth with ongoing access to primary care and subspecialist care, promotes competence of disease management, fosters independence, social and emotional development through teaching self-advocacy and communication skills, and allows for a sense of security for support of long-term health care planning and life goals. The employment rate for youth with special health needs is historically below the national average for youth and young adults of similar ages without disabilities. The ability to manage one's health is critical to going to school and transitioning into employment.

The information and quotes found in this report are from the following group meetings:

- Community Transition Interagency Committee in Grand Rapids on April 10, Carlton May 7, and Minneapolis on September 10, 2014
- "Let's Talk About Transition" ARC sponsored meeting for professionals and parents in St. Cloud September 18, 2014
- South west Maternal Child Health Meeting in Olivia on September 22, 2014
- Governor's Council on Developmental Disabilities on October 1, 2014
- Minnesota Transition Community of Practice on October 3, 2014
- Youth Board meeting on October 6, 2014
- Care Coordination-Mapping the Current State for CYSHN on October 8, 2014
- Transitions grant quarterly reports from Family Voices of Minnesota. Meeting of the clinics in the grant project on May 1, 2014

Gap

A. Intentional Health Care Planning for Transitioning of Care. Youth with special health needs are not all receiving needed preparation from their health care providers about transition from pediatric to adult health care. According to the National Survey of Children with Special Health Care Needs only 52% on Minnesota youth with special health needs receive the services necessary to make appropriate transitions to adult health care, work and independence.

The role of parents may change when their son or daughter transitions to adult medicine. They may not be involved in all decision making. Many parents voice frustration and fear with their children leaving their pediatric provider. "I beg my pediatric specialists not to let my 18 year old go" said one parent. "Transition to adult services: It is a disaster. Like being shoved off a cliff." Another parent said "My son has 13 specialists." Youth, too are concerned about leaving their pediatric provider and finding a new clinician. "I don't know how to find a doctor that gets me and my mental health" said one youth. One hundred percent of youth from the PACER Advisory Board (ages 14-18) said that no physician has talked to them about transition. All of the youth agreed that they are most concerned with dealing with the pharmacy and refilling medications.

The MDH CYSHN Transition in Health Care eighteen month grant with Family Voices of Minnesota began August 2013. Family Voices of Minnesota is working with four clinics (Health Care Homes) in both rural and metro areas of Minnesota to incorporate the following National Health Care Transition Center's six core elements:

1. Transition policy-develop a practice health care transition policy and share with providers, staff, youth and families
2. Transition age youth registry-identifying transitioning youth (current/future) and enroll in a transition registry
3. Transition preparation –Assess and track all readiness for adult health care activities with youth and families.

4. Transition planning – address all health care transition needs/gaps setting goals together with youth and family.
5. Transition and transfer of care-transfer from pediatric to adult care.
6. Transition completion – transition/transfer is declared complete.

Got Transition, a cooperative agreement between the Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health, released The Six Core Elements of Health Care Transition, which define the components of transition support and are based on the AAP transitions clinical report. Three tool packages are available for practices, including one focused on youth transitioning out of pediatric care. Each package, available in English and Spanish, includes sample tools, feedback surveys, and measurement tools that are customizable and available for download. "There are transition tools available but we need to get them to the right providers." Family Voices of Minnesota

Parents who are in the transition project through this grant voiced positive experiences. "The adult practitioner came to the pediatric clinic four times and worked with the pediatrician, care coordinator and my family before my daughter was transitioned to adult medicine." She continued to say that "the care plan also transferred to adult medicine." Another parent from CentraCare said "the transition process has gone so easy." Parents voiced appreciating the transition tools. One St. Cloud parent said "there were things on the check list I never would have thought of discussing with my child."

A deliverable of the grant is to develop strategies to address special needs of the patient population including racial and ethnic disparities. A care coordinator reported concern that there is "another layer of parents who have English as a second language." Hennepin County Medical Center's (HCMC) transition model has successfully addressed the needs of families from diverse and linguistic groups by using community health workers.

Strategy:

- Each of the clinics will be expected to test tools from Got Transition and develop strategies to engage youth with special health needs and their families in transition programs and policies that can be spread to other clinics in Minnesota in the future.
- A tool kit that physicians can utilize will be available by December of 2014.
- A transition session including the tool kit will be presented to health care homes at the May 2015 HCH/ State Innovation Model (SIM) Learning Collaborative in St. Cloud.
- HCMC will report to the Learning Collaborative on their success with community health workers.
- Develop educational information and resources particularly for multicultural families. Present to parents at charter school and evaluate impact by parent satisfaction.
- Education and outreach for youth, families, and other caring adults. Underscore the interdependence between health and wellness, and employment through education and outreach.
- Provide training for youth and families regarding transition to adult health care systems.

B. **Local Public Health Partnerships**

Local public health nurses are not typically involved with families who have transition age children. They are, though, and integral part of the health care system. Staff from CYSHN has talked to public health nurses in the NE and SW portions of Minnesota. Another meeting is set for Oct. 23 in Bemidji to educate nurses on transition in health care and also on Olmstead.

Strategy:

- Continue to encourage local partnerships by attending local maternal child health meetings throughout Minnesota.
- Present at local Community Transition Interagency Committees and the Transition Community of Practice on the role of public health in youth transitioning.
- Encourage transition discussions to begin by age twelve.

C. **Access to continuous and uninterrupted health insurance coverage.** Despite the intent behind the Social Security Systems' employment support provisions such as Ticket to Work, the potential of losing financial benefits, and most important, health insurance discourages youth with disabilities from seeking employment. Failure to connect to the workforce in early adulthood has been linked to lower earnings and lower levels of employment in later life. Perceptions of the system contribute to keeping health care transitions and post-school transitions separate. Work and health are inextricably linked.

Strategy:

- Professional development for health care professionals that incorporate employment transition related outcomes.
- Provide health-care providers and other youth service professional development opportunities to gain the knowledge, skills and abilities needed to guide through a coordinated self-determined, cross discipline transition planning process.

EXHIBIT 5-14: SS 3C, 3D, 3E – STATEWIDE PLAN FOR POSITIVE PRACTICES AND SUPPORTS

Minnesota's Statewide Plan
Submitted to OIO: October 22, 2014
Submitted to and Accepted by Subcabinet: December 15, 2014
To be Reviewed and Approved: February 9, 2015

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Minnesota Departments of Human Services and Education

Minnesota's State-wide Plan

Building Effective Systems for Implementing Positive Practices and Supports

Department of Human Services
10/22/14

Publication Date: 2014

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Executive Summary

This report was completed by state leaders from the Minnesota Departments of Human Services and Education (e.g. DHS and MDE respectively) in collaboration with the Institute on Community Integration at the University of Minnesota. The purpose of this report is to summarize progress made on assigned objectives that are associated with Minnesota's Olmstead Plan. All of the efforts reflected in this report are driven by a vision to improve the lives of all people living in Minnesota. This report provides a framework for organizing policies, technical assistance, and resources to ensure people receiving services, are treated with respect, and receive the support they need to live independent, self-determined and meaningful lives in their home communities. Real change occurs when one's vision for a better life is not merely a set of words that are referred to in written form. *When a vision that is articulated by a group of people is made a part of everyday actions taken within an organization, county, region, and state-wide, significant and meaningful work can be achieved* (Fullan, 2005).

The state plan described in this report will be successful by a) designing and implementing a technical assistance plan that involves teaching organizations to embed the values and vision outlined in the Minnesota Olmstead plan into the everyday actions taken by individuals providing services, and b) working collaboratively to implement the plan with stakeholders who represent people receiving services across the lifespan, family members, caregivers, advocates, practitioners and community members. For this reason, the report represents a first step in the state-wide planning process. Four major activities that are being used to make the vision outlined in the Olmstead Plan a reality are included in this report. These activities are described in this summary and with a locator table (see Table 1) to align the work being completed with the objectives listed in Action 3 of the Olmstead Plan.

Inventory of Minnesota Policies and Best Practices. DHS and MDE initiated a system for the inventory and analysis of both restrictive procedures and positive practices currently used across agencies. The results from the first dissemination of an online survey is available in Appendix A. Responses from the survey and earlier work from various team members was used to gather the initial identification of policies and practices from 25 different statutory citations. Once inventory data for DHS and MDE are finalized, the inventory review process will be expanded to other agencies. A subset of staff members from a state-wide planning team are continuing to meet regularly to complete the DHS and MDE inventory by January, 2015.

Unified Cross-agency Definition of Key Terms. The first step in aligning definitions across agencies is to evaluate the extent to which these terms currently vary starting with DHS and MDE. Key terms were identified for common reporting purposes. The inventory survey included questions used to gather more information about terms used within each agency. A grid compiling the definitions for any terms that were submitted as part of the survey is being compiled but has not yet been finalized due to the need for further information (see Appendix B). The same workgroup assigned to finalizing the inventory will continue working on the definitions first identified in this activity.

Best Practice in Positive Supports. The state recommends that teams use a collaborative data-based decision making framework to support people and adopts the

broader term *positive supports* to reflect practices that are person-centered, encourage self-determined behavior, build on social and emotional skills, and take a person's physical, social, and mental health into consideration. Positive behavior support provides a larger framework for implementing systems change. This implementation framework will be used to guide technical assistance efforts with the assumption that technical assistance efforts reflected in this state-wide plan will include a number of positive practices for preventing problem behavior. However, person-centered planning and positive behavior support are recommended whenever a person would clearly benefit from these practices and/or when other positive supports have not been effective.

Minnesota's State-wide Plan for Implementing Positive Supports. The state-wide team recommends using research findings summarized by Fixsen and his colleagues (2005) to create a state-wide communication and technical assistance framework for coordinating efforts to decrease the use of restrictive procedures and increase implementation of positive supports across agencies. This infrastructure will be used to ensure the following six implementation goals are implemented: 1) establishing a technical assistance infrastructure across agencies, 2) designing and implementing strategies for data-based decision making and evaluation, 3) creating a marketing plan for increasing awareness of positive supports across the state, 4) expanding preservice and aligning inservice training systems state-wide, 5) developing and maintaining an inventory of policies related to restrictive practices and positive supports, and 6) expanding interagency crisis prevention planning. A logic model was developed by the team to summarize the expected outcomes related to positive support implementation (see Figure 3 and the Appendix D for more details). The first steps taken by the state-wide team is to recruit workgroup chairs and initial team members for each of six major implementation tasks. Initial meetings (one or more) within each workgroup will occur on or before January, 15, 2015. Quarterly state-wide team meetings will be scheduled for November, 2014 January, 2015 April, 2015, and July, 2015.

Table 1. Locator Table with Page Numbers Related to Action 3 of the Olmstead Plan.

Activities (Pages 65-67)	*** Olmstead Activities from Action 3**	**Timeline**	**Page Numbers**
Action 1 [SS 3A]	The state will implement the new Minnesota Statute §245D standards.	1-1-14	
Action 2 [SS 3B]	A Rule with operational details that replaces Minnesota Rules, parts 9525.2700 to 9525.2810 (also known as Rule 40) will be promulgated. [SS 3B]	7-1-15	
Action 3 [SS 3C]	The state will create an inventory and analysis of policies and best practices across state agencies related to positive practices and use of restraint, seclusion or other practices which may cause physical, emotional, or psychological pain or distress.	7-1-14	5-6 10-12 26, 27 Appendix A
Action 4 [SS 3D]	A report outlining recommendations for a state-wide plan to increase positive practices and eliminate use of restraint or seclusion will be delivered to the Olmstead Subcabinet or their designee by an assigned team of representatives from Olmstead Subcabinet agencies.	7-1-14	5-6 15-30 Appendix D
Activity 5 [SS 3E]	The state will develop, across state agencies, a common definition of incidents, including emergency use of manual restraint, that are to be reported, and create common data collection and incident reporting processes.	8-1-14	5-6 12-13 22-24 Appendix B
Action 6 [SS 3F]	State-wide implementation of common incident reporting will begin.	7-1-15	22-23 26-27 Appendix D
Action 7 [SS3G.1-3G.4]	Quarterly summaries of incidents of emergency use of manual restraint or other types of restraint, seclusion or other practices that may cause physical, emotional, or psychological pain or distress will be reported to an assigned team of representatives from each state agency for review and to inform recommendations to reduce the incidents.	10-1-15	15-24 25 Appendix D
Action 8 [SS H.1, 3H.2]	Annually thereafter, the team will provide recommendations to the Olmstead Subcabinet to reduce emergency use of restraints, or other practices that may cause physical, emotional, or psychological pain or distress, and to increase positive practices.	7-1-15	26 Appendix D
Action 10	A coordinated triage and "hand-off" process for crisis	8-1-14	26-27

[SS 3I]	intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation. Report will be delivered to the Olmstead Subcabinet.		Appendix D
Action 11 [SS 3J]	An assigned team of representatives from state agencies, community organizations, community corrections and people with disabilities who have used the crisis system will: identify best practices, including use of technology; set service standards; and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions (e.g. person-centered planning, positive practices, available resources). Progress toward goal will be reported to the Olmstead Subcabinet or their designee.	12-1-14	26-27 Appendix D
Action 12 [SS 3J.1]	DHS will have completed the necessary analysis and planning to expand crisis services, diversion, and early intervention services to persons at risk of experiencing a crisis situation. The expansion plan will include projected start dates for implementation of the services.	1-15-15	22-23 25,27 Appendix D
Action 13 [SS 3J.1]	Crisis services, including diversion and early intervention services, will be made available to any person in need of these supports and at risk of experiencing a crisis situation. The purposes of this intervention include stabilizing the person's situation or avoiding the use of civil commitment.	7-1-15	26-27 Appendix D
Action 14 [SS 3K]	Develop measurements to better understand and track crisis episodes across service systems; create a data collection plan and mechanisms; establish baseline data and set targets (e.g., number of crisis calls made, reason for the call, response given, follow-up information.) Baseline data and targets will be delivered to the Olmstead Subcabinet or their designee.	7-1-15	26, 27 Appendix D

** While not the Direct Focus of the Report, the Actions Indicated in Light Grey are Addressed as Part of State-wide Planning and Future Targeted Timelines*

Minnesota's State-wide Plan: Building Effective Systems for Implementing Positive Practices and Supports

Purpose and Introduction

This report was completed by state leaders from the Minnesota Departments of Human Services and Education (e.g. DHS and MDE respectively) in collaboration with the Institute on Community Integration at the University of Minnesota. The purpose of this report is to summarize progress made on objectives that are associated with Minnesota's Olmstead Plan including the actions related to an inventory of policies, creating common definitions for reporting purposes, best practice technical assistance in the implementation of positive supports, and state-wide planning. All of the efforts reflected in this report are driven by the vision that seeks to improve the lives of all people living in Minnesota as outlined in the Olmstead Plan report (pages ten and eleven). The actions taken by the state-wide team will help to articulate how services will be delivered in a manner that will ensure all people are treated with respect and receive the support they need to live independent, self-determined and meaningful lives in their home communities.

Research in systems change indicates that it is not sufficient to create a vision and mission statement that is referenced in written reports or placed on posters that are hung on the wall. Significant and meaningful change occurs when one's vision for a better life is not merely a set of words that are referred to in a passive manner; a vision and mission must be made a part of the actions taken within an organization and that drive decisions on an every day basis (Fullan, 2005). The goal of implementing positive and proactive interventions and decreasing the use of restrictive procedures across the state of Minnesota will become a reality when the vision that has been articulated in the Olmstead Plan has been embedded within the state system and within organizations providing services across the state. To make this vision a reality, it is important to align and improve policies at state and organizational levels, disseminate ongoing and coordinated training and technical assistance, and recognize, reward, and empower leaders who demonstrate to others how people across the lifespan can be empowered and supported using person-centered services and supports.

Furthermore, the state planning described in this report will only be successful if all of the stakeholders across the state of Minnesota are actively involved in making decisions and guiding all implementation efforts. Team-based collaboration is necessary to achieve these changes with participants representing people receiving services across the lifespan, family members, caregivers, advocates, practitioners, and community members. For this reason, the state-wide plan described in this report is considered a first draft that will be expanded and modified based on feedback from stakeholders who are assisting the state in these systems change efforts. This planning process presumes that the changes that are implemented will occur across and within state systems including Direct Care and Treatment and services provided under Disability Services Division (DSD) as well other divisions (mental health, aging education, etc.).

The report will describe four major activities that will assist the state in making the vision outlined in the Olmstead Plan a reality. These tasks include:

- Creating an inventory of policies that refer to limiting the use of restraint,

seclusion or other practices and establishing best practices across state agencies related to positive support practices;
- Developing a common definition of incidents that will lead to (including emergency use of manual restraint), common data collection and incident reporting processes;
- Identifying best practices, setting service standards, and developing and delivering training and technical assistance in order to respond to a request for assistance with least intrusive service/actions; and
- Outlining recommendations for a state-wide plan to increase positive practices and eliminate use of restraint or seclusion.

The locator table (see Table 1) provides information regarding how the report addresses objectives listed in Action 3 of the Olmstead Plan. Timelines for actions in the report are aligned with the objectives listed on pages 65-67 of the Olmstead Plan report. Each section of this report describes important elements related to the four objectives including: a) the process used to establish an inventory of policies related to restrictive practices and positive strategies for increasing person-centered prevention-based interventions, b) steps taken to define key terms associated with incidents of problem behavior and positive strategies for supporting people, c) best practices in positive behavior support for large-scale technical assistance, d) a first draft of a state-wide plan to decrease the use of restrictive practices and increase person-centered prevention-based supports, e) an evaluation plan for measuring the impact of the state's implementation efforts, and f) next steps for moving forward.

Inventory of Policies and Practices

The Minnesota Department of Human Services initiated a process for creating an inventory and analysis of both restrictive procedures and positive practices across state agencies. To accomplish this task, a plan was developed to complete the inventory and analysis with input from state leads. The Minnesota Department of Human Services (DHS) (including Disability Services Division, Adult Mental Health, Aging, Alcohol and Drug Abuse Division, Children's Mental Health etc.), and the Department of Education (MDE) were identified as the first two state agencies to complete the inventory survey. The following state agencies are identified for next phase of inventory include the Department of Health (MDH), Department of Employment and Economic Development (DEED), Department of Corrections, Department of Human Rights and other state agencies identified during the inventory process. Key deliverables of the plan included:

- Identifying inventory categories,
- Creating an online inventory survey using a format accessible to state agency staff,
- Recruiting key staff to complete inventory survey,
- Launching the online survey,
- Reviewing and analyzing inventory results, and
- Identifying next steps for finalizing what will become an annual inventory assessment process.

An online inventory survey was created by the University of Minnesota ICI using Qualtrics Survey platform to collect information about current policies and practices across state agencies. Key DHS and MDE staff with policy-related expertise were recruited to assist in designing the cross-agency inventory. Staff members from DHS representing Disability Services Division, Adult Mental Health, Alcohol and Drug Abuse Division, Children's Mental Health were then recruited to participate in completing the initial survey inventory. Lead staff members from MDE were also sent a request to complete the inventory. MDE representation included key staff from Compliance and Assistance Division.

A draft of a survey that would be used to gather information for the inventory was reviewed on Oct. 3, 2014 and revisions were made to this survey on Oct 8, 2014. The inventory survey was activated on Oct. 10, 2014 and sent to identified staff who were asked to complete the survey on or before October 15, 2014. The online survey, available in Appendix A of this report, asked respondents to identify: a) policies and practices that restrict, limit, define the use of non-positive supports including approaches that are prohibited; and /or b) best practices/promising practices that support prevention of problem behavior through positive, self-directed support to people at risk. Survey details to be completed by respondents included:

- State agency and division,
- Identification of policies related to restrictive practices and promote positive, proactive strategies for preventing problem behavior,
- Identification of best practices/evidence-based practices used to address restrictive/restricted or prohibited practice and promote positive, proactive strategies for preventing problem behavior,
- Source of document including hyperlink, when applicable;
- Publication date of document and whether it's in process of being revised or updated including status;
- Identification of type of document (policy, procedure, statute/law, rule/regulation, practices manual etc.);
- Citation of state or federal regulation, statute, rule or policy, if applicable;
- Names of related documents and numbers, where applicable;
- Application of policy or practice for personnel requirements related to practices or programs;
- Definition of incidents requiring reporting and documentation;
- Information about data collection systems (how information is recorded and summarized);
- Identification of who is intended audience for policy or practice; and
- Contact information for the staff completing the inventory survey.

The result of the first dissemination of the survey is available in the Appendix A Responses from the survey and earlier work from various team members produced the initial identification of policies and practices from 25 different statutory citations; 13 rule citations; five (5) trainings and six (6) policy and practice citations. Those policies and practices identified through the inventory survey include five (5) responses identifying the policy as best practice/evidence based practice for positive supports, ten (10)

responses identifying that the policy restricts, limits, defines the use of non-positive supports such as restrictive procedures, seclusion, restraint, prohibited procedures etc. Additionally, eight (8) of the survey responses indicated that the policy or practice contained a definition of incidents that must be reported. The next step in gathering inventory information will be to reach out to state staff who can provide information about the areas of the inventory that are not completed. After the complete inventory process is finalized across DHS and MDE, the process will be expanded to other agencies.

A subset of staff members from the state-wide planning team are continuing to meet regularly to complete the inventory of DHS and MDE policies and to analyze the final results. The inventory of policies for DHS and MDE will be completed by January, 2015 and timelines for expanding the inventory to other agencies will also be reported at that time. The subset of staff working on this task will be reaching out to stakeholders to share the inventory results and the finalized inventory of policies will available online for public use. The inventory survey included questions about the definitions that are used by DHS and MDE to record significant problem behaviors. Of particular interest is how incident reports and office discipline-related terms are used to document problem behavior occurring in educational contexts, and within residential and community settings.

Unified Cross-agency Definition of Key Terms

The state team identified a list of common terms that are used across DHS and MDE in common reporting systems while the inventory survey was being completed. Clear and consistent definitions are important for establishing the data collection systems that will be used by the state but are also essential for creating a common language of prevention across the state. The following were identified by the team as examples of terms that need to be formally defined:

- reportable incidents,
- restrictive procedures/restricted procedures,
- crisis,
- emergency,
- positive supports,
- positive behavior support,
- person-centered planning,
- evidence-base practices, and
- best practices.

The first step in aligning definitions across agencies is to evaluate the extent to which these terms currently vary across DHS and MDE contexts. A grid outlining the definitions of key terms that were submitted as part of the online survey cannot be summarized until the inventory of policies are completed. However, Appendix B provides the initial organizational structure that will be used to complete this task. The same workgroup assigned to complete the inventory will continue working on the definitions in collaboration with state information technology (IT) staff and state personnel involved in incident report data collection systems. Lead staff across each

agency and representatives of stakeholder groups will be asked to provide feedback and gain consensus on the definitions as a part of a consensus-building process. Since the definitions in question will be used for evaluation and data-based decision making at the local, regional, agency-wide, and state-wide levels, the state is proceeding systematically to ensure the data collected will align with technical assistance efforts. Part of the technical assistance efforts that are implemented related to positive supports will include teaching organization-wide teams to use data to implement interventions, engage in progress monitoring, and to report decreases in incidents, crises, use of restraints and other responses associated with problem behavior. A number of important terms that will help make the vision and mission of the Olmstead plan a reality are addressed in the next section of this report including: evidence-based practices, positive behavior support, and positive support strategies, a broader term that describes a broader array of value and prevention-based practices.

Evidence-based Practices

The term, evidence-based practice, is now widely used at the federal and state levels and across many fields of study. Most of these definitions share similar features across different fields (for example, please see Table 2 and http://nrepp.samhsa.gov/AboutNREPP.aspx).

Table 2. Definitions of Evidence-based Practice Across Different Fields.

American Psychological Society	"Evidence-based practice in positive behavior support is defined as the integration of rigorous science-based knowledge with applied expertise driven by stakeholder preferences, values, and goals within natural communities of support."
Institute for Medicine	"...the integration of best research evidence with clinical expertise and patient values".
Association for Positive Behavior Support	"Evidence-based practice in positive behavior support is defined as the integration of rigorous science-based knowledge with applied expertise driven by stakeholder preferences, values, and goals within natural communities of support."

Not all current practices have fully completed the rigorous large-scale research studies necessary to be considered an evidence-based practice. Practices that are evidence-based must establish the efficacy of the approach and its applicability across the diversity of today's settings, people, and contexts. Many practices across different fields of study are still in the process of acquiring this evidence and are not yet recognized as a formally approved evidence-based practice. For this reason, the need for individual data-based decision making is essential for people and their teams to ensure that each person's services are evaluated closely.

Positive Supports as a Broader State Term for Prevention

During early discussions with state team members and other stakeholders, the importance of honoring all positive prevention-based practices used across agencies was described as an essential consideration. Person-centered planning, dialectical behavior therapy, cognitive behavior therapy, positive behavior support, trauma informed therapy, and many other practices were identified as strategies for preventing problem behavior. This conversation led to the identification of a broader term, *positive supports*. *The state-wide team recommends the use of positive supports as a more inclusive term referring to all practices that include the following characteristics: 1) person-centered interventions, 2) prevention of problem behavior, 3) skill-building, independence, and self-determination, and 4) interventions that focus on changing the social, emotional, and physical environment around a person (sensitivity training for staff members, increasing predictability, stability, etc.).*

Team-based action planning requires interagency teams to work together to empower an individual and his/her family in identifying the practices that will help the person achieve self-determination, independence and a high quality of life. Interventions and practices are selected to fit the unique skills, communication preferences, mental health status, and physiological and health needs of each person receiving support. The state recommends that teams evaluate practices and use data-based decision making to improve outcomes for people receiving services. One approach that naturally encourages interagency collaboration within a team-based data-based decision-making framework is positive behavior support.

National experts define positive behavior support as a set of tools and strategies incorporating: 1) valued outcomes (plans must improve the quality of a person's life and fit cultural views, skills, and resources of people implementing the plan), 2) research based on the principals of behavior, mental health and biomedical sciences, 3) validated procedures that are proven to be effective, and 4) systems change strategies to ensure supports are both effective and sustainable over time. Positive behavior support includes an assessment process that is used to identify the reason, or function, maintaining problem behavior. Once the function of the problem behavior is identified, interventions for teaching new social, emotional, and communication skills are used to prevent problem behavior. Changes in the social and physical environment are made, mental health and wellness strategies implemented, and biomedical and physiologically-base interventions are put in place to improve quality of life and decrease problem behavior.

Positive behavior support is an approach that places great importance on interagency collaboration as an essential feature necessary for effective planning and supports. Each positive behavior support plan is based on a trans-disciplinary team including the people receiving services, family members and caregivers, community representation, and professionals representing key areas of expertise who provide services across wide variety and type of services including but not limited to disabilities, mental health, education, juvenile justice, foster care and family preservation, and aging. Each professional involved in assisting a person in need of support brings a wealth of knowledge about important prevention-based practices that are complementary in nature with positive behavior support. The goal is to empower the individual and his/her family in identifying the unique supports and services needed to improve quality of life, ensure self-determination, and assist people in living meaningful lives in their own communities.

However, positive behavior support is not always necessary in all situations and settings. For instance, person-centered planning can result in significant decreases in problem behavior making a positive behavior support plan unnecessary. A person and his/her team will select the practices that are the best fit while providing evaluation data showing evidence that these practices are successful. For this reason, the state recommends that person-centered planning be implemented prior to positive behavior support. Furthermore, both person-centered planning and positive behavior support are recommended in situations where people who engage in problem behavior would benefit from applied behavior analysis, physiological and biomedical interventions, data-based evaluation, and evidence of improved quality of life outcomes. If other positive support strategies that have been implemented do not prove to be successful as a stand-alone intervention, positive behavior support should be added to a person's planning process.

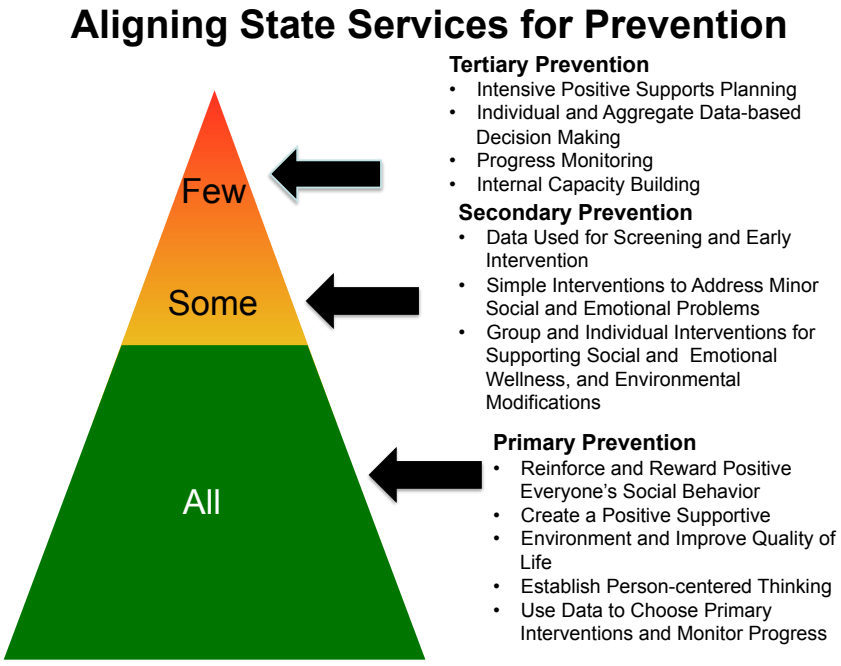
Creating a Framework for Large-scale Implementation

A unique feature of positive behavior support is its emphasis on systems change and strategies for larger scaling up implementation efforts. An interagency synthesis of research on systems change conducted by Dean Fixsen and his colleagues 2005) provides a framework for implementing large-scale technical assistance and training. Positive behavior support efforts are underway across the nation and in a growing number of countries using the information outlined by Fixsen and his colleagues. Large-scale, state-wide implementation of positive behavior support using a three-tiered prevention model is now implemented in the disability field, juvenile justice, early childhood, education, and mental health. A growing number of states are working on strategies for improving interagency communication at the state-wide level as different agencies move forward implementing technical assistance in positive behavior support.

Three-tiered Prevention of Problem Behavior. Key elements of these systems-change efforts include establishing a framework or infrastructure that will assist state teams in training, supporting, and monitoring schools and organizations involved in the implementation of three different levels of systems change (See Figure 1). The three tiered model described in this section was adopted by the World Health Organization (2004) and adapted to address the prevention of problem behavior (Gordon, 1983). The three prevention levels are described as universal or *primary prevention interventions* including practices for promoting person-centered environments and encouraging positive social communication among staff members and people receiving services. At the primary prevention level, teams use data to guide decision making and monitor progress. S*econdary prevention strategies* involve the use of data for early identification and intervention to support people who are at risk for engaging in more serious problem behavior. *Tertiary prevention systems* provide intensive and individualized person-centered planning, positive behavior support, and other practices that will assist people who do not respond to primary and secondary interventions. An important element of positive behavior support at each prevention level is the use of data for decision making. Trainers using a three-tiered model for preventing problem behavior teach organization-wide teams to use data on a regular basis to change inservice and preservice training, improve management, increase or modify supervision, and tailor services and supports for people receiving services. *The state-wide team recommends the use of the implementation framework used to implement positive behavior support but will broaden*

the goals of this infrastructure by using it as a vehicle for implementing the broader array of positive support practices that are identified within state-wide planning processes.

Figure 1. Aligning State Services with a Three-tiered Prevention Model.



Organization-wide Team-based Planning. The goal of positive behavior support at an organizational level is to teach people receiving services, staff members, administrators, and family and community members to work together to solve problems (for example, how do we improve staff training, increase positive reinforcement, become more sensitive to past trauma, accommodate mental health issues, etc.). Consensus building and buy-in increases when all individuals within a setting contribute to important decisions that are made. This empowering message combined with data for progress monitoring, commitment to continuous improvement, troubleshooting, and celebration of success provides a powerful model for building community. Organization-wide teams choose to participate in positive behavior support knowing it requires a long-term commitment. Administrator leadership and direct participation is essential to the change process. Buy–in and consensus-building processes using a team approach and all individuals (people receiving services, staff, management, family members, etc.) within a particular setting increases the likelihood of effective implementation. Regular team meeting processes employ the use of data to drive action planning over time. Positive reinforcement systems are used to acknowledge and recognize staff members' efforts in improving a person's quality of life, encouraging independence, and facilitating meaningful friendships with others. In some organizations, people receiving services actively reinforce staff members they observe engaging in positive person-centered actions.

Agency-wide Coordination. Figure 2 shows how state-wide agency teams are organized to produce large-scale coordination of positive behavior support. The purpose of the agency-wide team is to provide oversight and coordination of technical assistance to organizations learning to make fact-based, data-based decisions for improving outcomes for the people they serve. The data collected by these organizations are summarized at the agency-wide team with an emphasis on using these data in a manner that is dedicated to the ethical principles associated with continuous services and personal improvement. State-wide leadership teams coordinating the implementation of positive behavior support within one service area (e.g. education, mental health, etc.) ensure open communication and transparent processes are established by recruiting people who represent important stakeholders. Examples of stakeholders include people receiving services, family members, administrators, managers, professionals, community members, higher education, and anyone else who represents an important stakeholder associated with services within a particular agency context. Figure 2 describes the important roles of the leadership team. Teams meet on a regular basis to ensure funding is available for technical assistance efforts, there is visibility and awareness of the positive behavior support efforts taking place (website, newsletters, board presentations, community outreach), technical assistance content is in place, and policies are aligned with best practices. Interagency systems are established to improve coordination of services and communication.

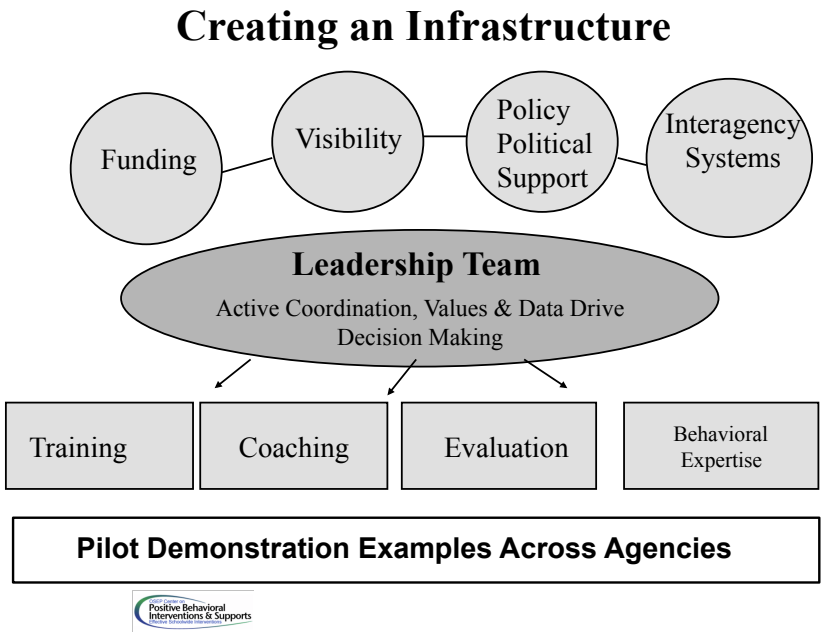
The leadership team establishes the curriculum needed for technical assistance with an agency-wide coordinator taking on the role of ensuring training events are organized, handling logistics related to state-wide meetings, and prompting organizations to collect and submit data for reporting purposes. The coordinator supports and monitors coaches who work within each organization to ensure that organization-wide teams are meeting, action plans are moving forward, and data are being collected and submitted. The evaluation process is monitored through the agency-wide team with the coordinator working with coaches to collect data regularly and to assist in problem solving when issues arise.

An immediate consideration for most organizations is the need to train professionals who will facilitate positive behavior support plans as well as other positive support strategies and who will, over time, take on the role of inservice and preservice preparation within the organization. It takes time for people to become confident facilitating positive behavior support. For this reason, organizations are encouraged to start training professionals to facilitate positive behavior support immediately, plan for unexpected staff attrition, and provide staff incentives for participating in intensive positive behavior support facilitator training.

Internal Organizational Capacity for Positive Support. The state team recommends that an investment of intensive positive support facilitator training should occur with evaluation methods put in place and monitored over time to provide evidence that outcomes are improving for people receiving services. The team is now discussing intensive training needs for a number of positive supports and identifying the types of instruction that will be needed to build capacity across the state. Positive behavior support and person-centered planning facilitator training will be selected as practices that will be used to pilot the first implementation efforts. Evidence provided by person-centered positive behavior support facilitators include: direct observation data collected

across baseline, intervention, and follow-up phases for problem behavior as well as for social behavior intended to help an individual achieve a self-determined lifestyle, evidence of improved quality of life, and survey data that show that the plan meets the needs of family members, caregivers, and other people who implement the positive behavior support plan.

Figure 2. Establishing Technical Assistance Systems to Ensure Effective Sustainable Implementation.



Adapted From: Sugai, G., Horner, R., Sailor, W., Dunlap, G., Eber, L., Lewis, T., Kincaid, D., Scott, T., Barrett, S., Algozzine, B., Putnam, B., Massanari, C., & Nelson, M. (2005). *School-wide positive behavior support: Implementers' blueprint and self-assessment.* T echnical Assistance Center on P ositive Beha v-ioral Interventions and Supports.

Reinforcement and Recognition. An important role of the agency-wide team is to consider strategies for reinforcing organization-wide efforts that are successful implementing positive behavior support and can show evidence that incident reports and the use of restrictive procedures are decreasing while positive support strategies are increasing over time. Currently, many individuals associate sharing of data with punishment. This can occur when systems focus more on remediation rather than on encouraging the use of positive supports by the organization. Teaching organizations to use data to monitor and celebrate progress can increase the perceived value of data. Nationally, agency-wide teams have established benchmarks for organizations to reach by providing data summaries with incentives tied to key accomplishments. In some states, organizations receiving these "bronze, silver, and gold" awards create friendly competition with other organizations and are a cause for celebration. Creating opportunities for organizations to meet annually to report successes, celebrate progress, problem solve together, and share resources provides another type of reinforcement that can bolster implementation efforts. Annual conferences or meetings that allow organization-wide teams, coaches, and mentors to come together in this manner is an

important way in which to establish a positive culture of innovation and changes the way in which people perceive the use of data. Sending champions, mentors, and coaches to annual positive support-related conferences for ongoing learning is yet another example of how some states have considered reinforcement systems at a state-wide level. While punishment for organizational misbehavior is necessary at times, the use of reinforcement and recognition for positive implementation efforts can increase motivation and morale.

State-wide Coordination. States with more than one agency implementing scaling up methods for positive behavior support often form an overall state-wide interagency team including coordinators representing state agencies that are implementing positive behavior support, state leaders, professionals representing major prevention efforts (e.g. positive supports), people receiving services, family members, higher education professionals, state policy professionals, non-profit community leaders, and any other representation that will further the team's action planning efforts. The goal of the interagency team is to establish a common language for prevention efforts, leverage limited state resources, align state-wide technical assistance, and summarize evaluation data for policy, funding, and state reporting issues. A number of states currently maintain interagency state-wide teams. However, since state systems are unique, these teams vary in vision, mission, and overall action planning efforts.

Minnesota's State-wide Implementation Plan

The best practice information described in this report was used to establish a state-wide action plan for implementing positive supports. *This report will refer to positive behavior support when discussing the infrastructure for establishing technical assistance systems and data collection processes but will consider the broader term positive supports when discussing all content and practices that will be disseminated via the technical assistance efforts that take place.* The information in this report sets the stage for future legislative requests that will drive technical assistance efforts. The state will re-allocate existing funds working smarter not harder to implement the action plan. The information in this report will be used to guide implementation efforts and to move forward using funds that are available. The scale, progress, timeline, and impact of these efforts across the state will determined by the ability of the state-wide team to acquire the funds necessary for moving forward.

An initial interagency team was formed to begin state-wide planning with the understanding that more individuals representing different stakeholder groups will be recruited once the October 22, 2014 report is complete. The team that met to create the initial state-wide report included state personnel at the Department of Human Services' Disability Services Division, the Adult Mental Health Division, the Alcohol and Drug Abuse Division and the Division of Direct Care and Treatment at the Department of Human Services as well as Positive Behavior Support professionals from the Minnesota Department of Education. The goal of this team was to report on the actions already taken by the state across the four main tasks outlined in the introduction (inventory, definitions, best practice, and state-wide report) and to design a communication infrastructure and implementation plan that would allow for systematic growth of positive supports across agencies in Minnesota.

Figure 2 shows a second part of the overall infrastructure. Regional, agency-wide, county-wide, and the interagency state-wide teams will use the leadership model

described in Figure 2 as a way to guide implementation efforts. At the bottom of Figure 2, pilot demonstration exemplars are considered a helpful feature for launching positive behavior support. The state's efforts to implement positive supports will be more successful when there are organization-wide teams sharing success stories and providing examples of exemplary implementation using data to evaluate progress. Agencies involved in the first implementation efforts, aging, disabilities, mental health, and education will begin action planning at county-wide and region-wide levels. Each agency will have a unique plan with targeted positive supports that will be implemented. The agency-wide teams will establish exemplary organization-wide demonstrations and create a plan for taking these efforts to scale across the state.

Development of Roles and Responsibilities. The state is already implementing technical assistance across a number of positive support practices. These technical assistance efforts use terms to describe the implementation process with clear roles and responsibilities and terms used for types of trainers. The term "coach" and "mentor," for instance, are used within the training person-centered planning. The state-wide team will work with already existing implementation efforts like person-centered planning to establish the overall technical assistance infrastructure and to define key terms within the overall infrastructure including:

- Organization-wide, county-wide, region-wide, and state-wide teams,
- Coordinators who guide meetings, provide oversight at regional, agency-wide, and state levels, and assist in gathering and summarizing data,
- Coaches who assist individuals within their organizations to implement positive supports, and
- Mentors who provide training to individuals within organizations.

Consistent use of terms such as coaches, mentors, etc. will improve consistency of communication across state training efforts and streamline communication at organization-wide, county-wide, region-wide, and state-wide levels.

Regional Teams and Facilitation. Regional teams are recommended as an addition to the Minnesota technical assistance system. This regional team model will encourage interagency collaboration and improve communication across agencies. The regional teams will include broader goals for improving service coordination and communication. Regional Coordinators will be added to the Minnesota state-wide infrastructure with the role of facilitating regional action plans, assisting in oversight of training systems, and gathering data for regional decision making. The number and types of organizations in each region will vary depending on the number and type of organizations that choose to participate each year.

Since Minnesota school-wide PBS is already in progress, implementation efforts in education will be tailored to meet the unique needs of each region. In some regions, exemplary school coaches and teams will be able to assist in regional training and supports. For example, in some states, new coaches from outside agencies will visit with school coaches spending time observing how similar tools and procedures are used in education. This helps coaches from the different agency learn more about the universal elements of the training and contributes to cross-agency awareness. Coaches then return to their own trainer/mentors and learn how to use similar types of tools in mental health

settings, nursing homes, residential settings or employment contexts. Taking advantage of the strengths of the current positive behavior support implementation in education is an opportunity unique to Minnesota's state-wide planning efforts. This strength-based approach to organization-wide training will help model the importance as it is applied to each field.

Establishing Communities of Practice. The state-wide team will use communities of practice across many levels of the infrastructure for Minnesota's technical assistance efforts. The goal of the large-scale technical assistance efforts will be to ensure that organization-wide teams can identify the unique needs within local and regional contexts. This information is used to initiate, organize and facilitate local communities of practice events. Examples of community of practice events include self-advocate led learning opportunities, meetings for families interested in learning more about positive supports, or interagency meetings held to share information about positive support resources available within the community. Each coaching level within the Minnesota technical assistance efforts (state agency coordinators, regional coaches, organization-wide coaches) will form a community of practice with events scheduled to encourage ongoing learning, troubleshoot together, and share ideas about implementation efforts. Individuals who learn to facilitate specific positive support strategies will form another type of community of practice. Individuals who participate in facilitator-level communities of practice continue learning about the new research strategies, systems change approaches, and other information that can be used to continuously improve services for people across the state.

Gradual Expansion of Agency-wide Coaching. State coordinators who will oversee implementation in mental health, DSD, and aging will be recruited as a first step in building an infrastructure for positive behavior support implementation. Training and supports will be provided to new state coordinators as initial implementation steps are taken within their agency. State-wide coordinators will learn to communicate regularly with regional coaches, facilitate agency-wide action planning to gradually expand the number of organizations participating, and assist in summarizing data for state-wide action planning purposes. Early training steps will include inviting the current state-wide school-wide positive behavior support coordinator to present to new agency coordinators. Training systems will be created in each agency starting positive support implementation. Each agency will have the opportunity to ensure that the tools and larger positive supports curriculum needed are organized for implementation. By August, 2015, action plans for implementation will be established for aging, mental health, and DSD and a tailored expansion plan will be in place for education as it continues its implementation efforts. Each organization recruited will be asked to prepare for training by identifying a coach, establishing a team, and completing a readiness assessment that includes clear administrator buy in and support for implementation of positive behavior support. Prior to August, 2015, the agency coordinators will work with the interagency state-wide team to recruit organizations within five regional teams as a first step in the implementation process.

Mentors and Local Champions. Mentors are also considered an important element within the Minnesota State-wide plan. Although similar, coaches and mentors have different roles within the implementation process. Coaches prompt organization-wide teams to schedule and record meetings, work with the team to collect and submit

data, and communicate with agency-wide team coordinators. Mentors provide training to coaches and organization-wide teams with guidance provided on an ongoing basis throughout the implementation process. Mentors will be identified and recruited over time through a variety of methods to ensure that ongoing technical assistance and training will continue in a sustainable manner at the local level. For instance, professionals who complete intensive positive behavior support facilitator training, coaches who show extraordinary skills supporting people who are learning new skills, regional professionals who might take on an autonomous role in facilitating regional team meetings are all examples of future mentors within the overall state-wide plan. The role of the state-wide team is to actively seek out and enroll individuals to champion state-wide efforts and to monitor the growing number of professionals who are assisting in overall state-wide efforts. *As mentioned earlier, the terms used to refer to individuals who provide training and mentoring in different contexts will be aligned with current terms that are used in technical assistance efforts.*

Data-based Decision Making. Data will be collected at the organizational level using the state's incident reporting system as a key mechanism for gathering and sharing data. Incident report data will include information about the events occurring including average incidents per day per month, types of problem behavior, time of problem behavior, the person for whom the incident was written, other people involved in incidents, and location of problem behavior. Other data will be included such as restraints used, police or legal contacts, and contextually relevant terms such as in and out of school suspension, acute care short-term stays, or emergency room visits. Organization-wide teams will also learn to collect other types of data to guide decision making including staff attrition, and climate surveys for staff members and people receiving services. A statistical measure that will assist the state in making comparisons will be identified. For instance, office referral data are often organized using "incident reports by 100 students". This allows for comparisons to be made across larger and smaller organizations across the state. The state-wide interagency team will work with IT staff to establish summaries of incident report data for teams at the organization-wide, regional, agency-wide, and state-wide levels. Table 3 describes the types of data that will be used by different teams for decision-making purposes. The next section of this report describes how the state-wide plan will be organized and evaluated using a logic model to describe the details related to implementation efforts.

Aligning State Services to a Three-tiered Prevention Model. In addition to establishing a system for implementing technical assistance in positive supports across agencies, the state-wide team will assess how funds, services, training and technical assistance, and other resources are used to address primary, secondary, and tertiary prevention systems. The team will complete the prevention triangle for each agency with assistance from representative stakeholders, identify gaps in the types of prevention-based services that exist, and closing them by changing policy.

Table 3. Types of Data Used by Teams for Decision Making.

Teams Implementing Action Plans	**Types of Data Summarized**
Organization-wide Teams (Examples Include Schools, Districts, Residential Support, Supported Employment, Mental Health Centers)	• Action Planning Evaluation (What the Organization Achieved) • Incident Reports • Restraints and Crisis Events • Injuries, Emergency Room Visits • Acute Care/ Restrictive Settings • Climate Data Related to People Receiving Services and Staff • Fidelity of Implementation • Individual Support Plans Evaluated and Aggregated Attrition, Workers Compensation
County Teams	• Action Planning Evaluation (What the County Teams Achieved) • Number and Type of Organizations within County • Growth Patterns for Organizations by County • Summary of Implementation Outcomes and Fidelity of Implementation *Across County Agencies* • Individual Support Plans Evaluated and Aggregated
Regional Teams (Interagency Regional Teams)	• Action Planning Evaluation (What the Regional Teams Achieved) • Number and Type of Organizations per Region • Growth Patterns for Organizations by Agency • Summary of Implementation Outcomes and Fidelity of Implementation *Across Agencies* • Individual Support Plans Evaluated and Aggregated
Agency-wide Teams (Mental Health, Aging, DSD, Education)	• Action Plan Evaluation (What the Agency Teams Achieved) • Number of Organizations implementing Within Each Agency • Growth Patterns for Organizations *by Region* • Summary of Implementation Outcomes and Fidelity of Implementation *Across Organizations and Regions* • Individual Support Plans Evaluated and Aggregated *by Organization and Region*
State-wide Interagency Team (Responsible for Oversight of Entire System)	• Action Plan Evaluation (What the State-wide Team Achieved) • Growth Patterns for Organizations *Across Agencies and Regions* • Summary of Implementation Outcomes and Fidelity of Implementation *Across Agencies* • State-wide Summary of Implementation Outcomes and Fidelity of Implementation • Individual Support Plans Evaluated and Aggregated *by Organization, Region, State*

The goal will be to assess whether additional waiver services, training systems, data collection and progress monitoring systems, or other resources are needed to ensure that each agency provides services addressing primary, secondary, and tertiary prevention. Actions will be taken to ensure that each agency has outlined a three-tiered prevention model with positive support practices addressing each prevention level.

The meetings that takes place to gather this information will provide state personnel with an opportunity to gather information from key stakeholders about: the overall state-wide plan, progress made on developing an inventory of policies, thoughts related to building common definitions for key terms, as well as the types of positive support practices that are unique to each particular agency. Strategies for continuing to disseminate information across each agency will be discussed as well. The information that is gathered will be brought back to the state-wide team and a plan for continuing to reach out via various marketing and awareness strategies will be established. In the next section of this report, the way in which the state-wide team will implement the overall state-wide planning goals and objectives are described.

Logic Model and Outcome Measures

The state-wide team met during the month of October, 2014 to outline the draft of a state-wide plan. Special attention was given to how this state-wide plan would be organized and linked to the infrastructure for technical assistance and to the alignment of services across a three-tiered prevention model. The first step taken was to create a logic model to summarize the major elements associated with implementation and evaluation of the state-wide plan.

Description of Logic Model. A logic model provides a helpful framework for implementing positive supports (see Figure 3). This particular logic model in Figure 3 summarizes the major details while Appendix D contains a more detailed description of state-wide planning. The word "Context" is written in a vertical band on the left hand side of this visual. Due to page/figure size constraints, details related to important contextual elements of Minnesota's state-wide planning are summarized in this report. In program development and evaluation terms, "Context" refers to the political, fiscal, social, and organizational settings and situations that, collectively, constitute the broader cultural environments ("Contexts") in which programs operate (i.e., the historical, contemporary and future influences that are expected to support or hinder the anticipated inputs, implementation, reach, and/or outcomes for Minnesota's state-wide plan). The first main column of the logic model starting on the far left hand side of Figure 3 describes how and to what extent a state-wide team uses and/or allocates its resources, described as "Inputs" in the first main column. The goals that will be put into place are listed in the second column called "Implementation". The third column describes the people the state-wide plan intends to impact, referred to as "Reach". The "immediate", "intermediate", and "longer-term" outcomes are then listed as they relate to the implementation goals listed in column two.

"Impacts," refer to the broader changes that occur due to implementation of a project. Contextual features can influence these potentially larger-scale "Impacts" of a program in ways which can affect larger-scale quality well beyond that of program participants. In order to draw meaningful conclusions or make judgments about the efficiency, fidelity of implementation, and/or effectiveness of Minnesota's state-wide

planning efforts, it is first necessary to understand the contextual features that have influenced its conception, development, implementation, and outcomes. The next section of the report provides a summary of each of the elements of the logic model starting with context.

Context. The Olmstead plan and efforts to decrease the use of restrictive procedures is an important contextual feature influencing the state-wide plan for implementing positive supports. The pressure to implement key action-planning goals by specific timelines already guide the state's efforts to decrease restrictive practices and increase proactive and prevention-based efforts. The emphasis on the development interagency and common policy and procedures is an important contextual feature to state-wide planning and works well with what is known about improving outcomes for people in need of positive supports. Focusing on interagency systems and a common language for prevention can be seen as a contextual strength for implementation. Currently, there are not enough professionals who have experience facilitating positive supports such as person-centered planning, trauma informed thinking, positive behavior support, and other important practices. This contextual feature must be considered within the planning process. The other issue discussed by some state-wide team members was that it would be important to ensure that within agency contextual issues would be addressed to ensure that communication and collaboration would occur *within* agencies as well as *across* the different state agencies.

Inputs. The Minnesota state-wide team benefits from a number of resources that can be used within the action planning process. There are a number of stakeholders who can participate in and contribute to the planning process. These stakeholders represent people across the lifespan who receive one or more services from the state. Family and community members, state professionals across agencies, university and college professionals, practitioners and providers, and individuals with a background in positive supports. A variety of funds can be leveraged or added to state-wide planning efforts. For instance, the State-wide School-wide Positive Behavior Support team has funding for current implementation efforts and provides a helpful model for other agencies moving forward. State-wide FTE dedicated to issues related to behavioral support can be helpful when thinking how to "work smarter, not harder" with existing funds. There are also state-wide and national resources that can be used to assist in the implementation of positive supports. Several universities are moving forward with training and technical assistance related to positive supports and online resources are available to providers across the state. The International Association for Positive Behavior Support encourages members to share ideas, tools, and resources with individual networks often collaborating in different ways on state-wide planning related tasks.

Implementation. Six implementation goals were identified and outlined in Figure 3. These goals include:

1) Establishing Technical Assistance Infrastructure Across Agencies,
2) Designing and Implementing Strategies for Data-based Decision Making and Evaluation,
3) Creating a Marketing Plan for Increasing Awareness of Positive Supports Across the State,

4) Expanding Preservice and Align Inservice Training Systems State-wide,

5) Developing and Maintaining an Inventory of Policies Related to Restrictive Practices and Positive Supports, and

6) Expanding Interagency Crisis Prevention Planning.

Each implementation goal is broken down into further objectives with strands of immediate, intermediate, and long-term goals documented to show how the timeline and impact of action planning over a five year period of time. Appendix D provides more detailed information about outcomes that are targeted for implementation based on funding allocated for these tasks.

Reach. The individuals and organizations that the state-wide team will reach out to are listed in the third column of Figure 3. A number of agencies will start the implementation and planning process first. These agencies include: aging, education, disabilities, and mental health. Once the framework for implementing positive supports technical assistance is established and large-scale implementation is initiated, additional agencies will be added to the technical assistance efforts. The agencies that will follow the "First Step" agencies as part of the "Expansion of Reach" includes: Department of Corrections, DEED, Department of Health, Human Rights, the Courts, and ombudsman. The variety of stakeholders that will be involved in the planning process includes people receiving services across the lifespan, family and members, practitioners across services, legal professionals (judges, police, attorneys, etc.), and higher education.

Immediate Intermediate, and Long-term Outcomes. Figure 3 is also organized so that the immediate, intermediate, and long-term outcomes are considered across pathways associated with the main implementation goals. For instance, the technical assistance planning occurring with the first step agencies (aging, disabilities, education, and mental health) is in place within the first six months. By the first few years, pilot demonstrations that provide evidence of the effectiveness of the state's efforts are provided at the organizational level and with individual positive behavior support plans within those organizations. This means that the people receiving services (living, working, and learning) within those settings are reporting that they are happier, that they have more opportunities for making choices, engaging in self-determined actions that are meaningful to them, and that their quality of life has been impacted due to the implementation efforts taking place. Individual PBS plan summaries would provide evidence that restrictive procedures are decreasing and that the lives of people who have experienced challenges within their settings are improving over time.

The state-wide team will form workgroups to ensure that the implementation details outlining immediate, intermediate, and long-term goals and objectives (see the Appendix D for more information) for all six of the main implementation efforts are achieved. Workgroups will be assigned a state staff person to take on the role of Chairperson although Co-chairs also may represent other stakeholder groups. Teams will include representation across diverse stakeholder groups and anyone who learns about the planning process and is interested in joining a workgroup will be encouraged to contact the state-wide team coordinator. The coordinator will make sure that each workgroup has an adequate number of team members.

Figure 3. Minnesota's State-wide Planning Logic Model.

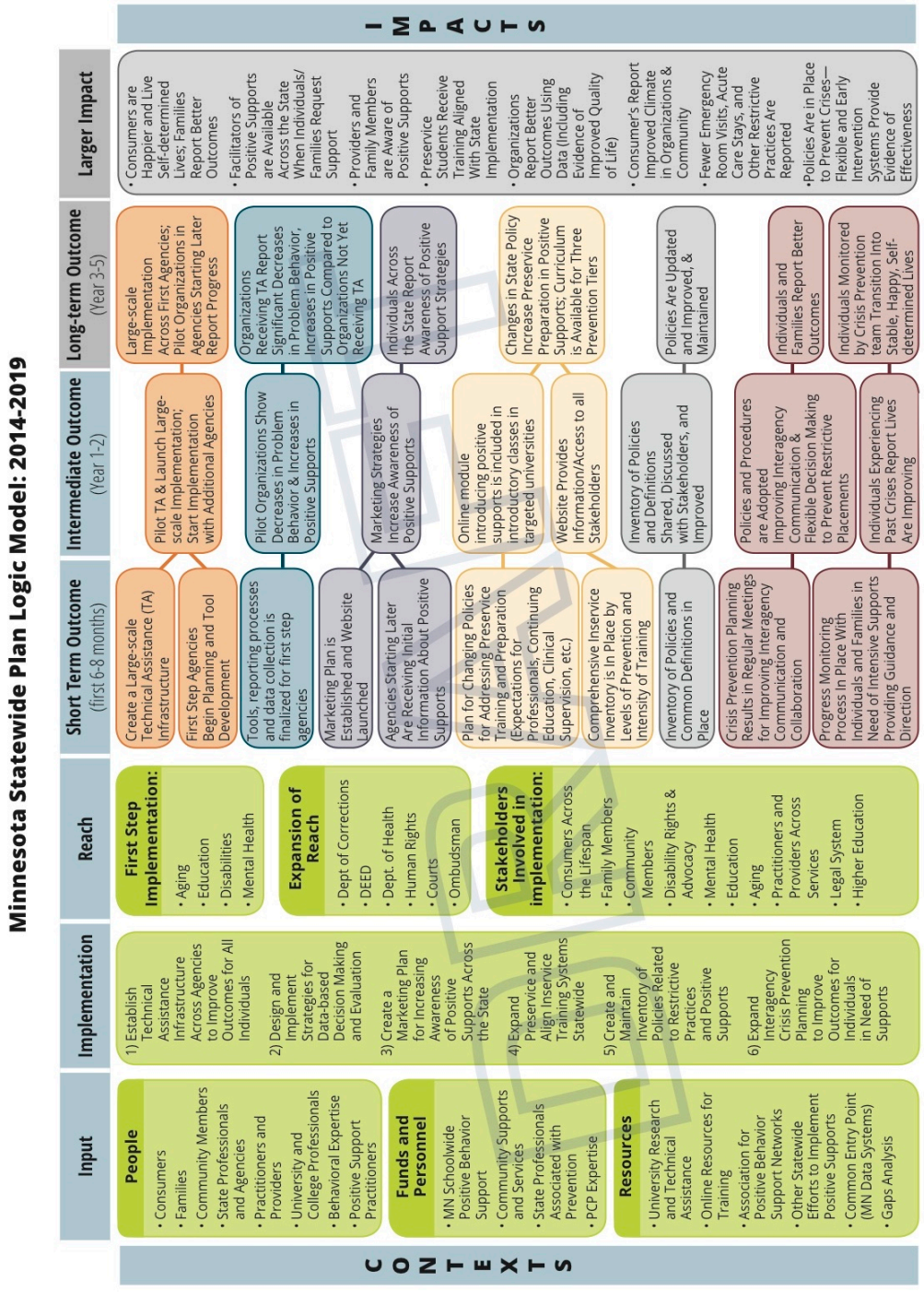
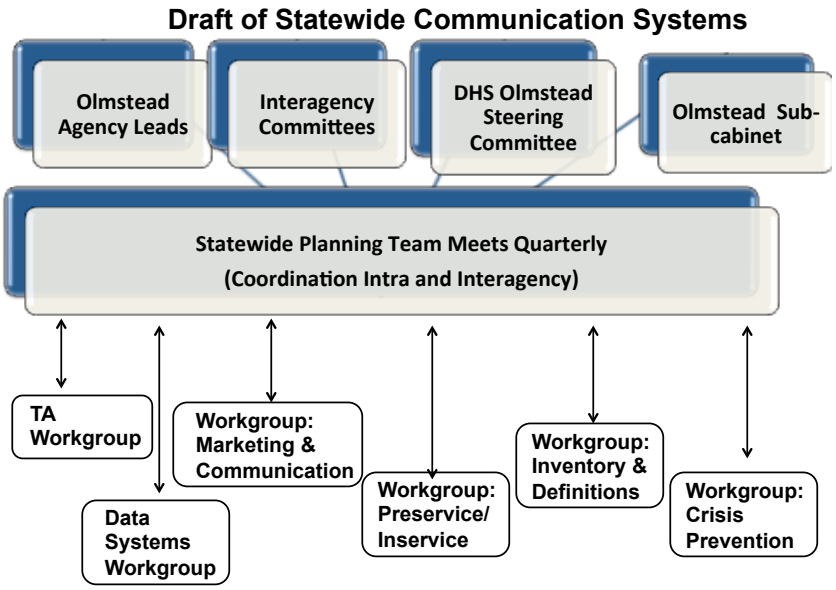


Figure 4 describes the communication infrastructure that will be used to monitor the state-wide plan and to ensure data are used for decision making. There are a four groups meeting at the state level related to implementing the Olmstead plan: DHS Olmstead Steering Committee, Olmstead Agency Leads, Interagency Committees (addressing topics including, for example, the Employment Interagency Leadership Panel), and Olmstead Sub-cabinet. Figure 3 demonstrates how the Interagency State-wide Team will form a hub of communication with information coming from each of the six workgroups and from the Minnesota Olmstead Planning teams. The state-wide team will meet quarterly with workgroups meeting schedules meeting more frequently in order to report progress on the action plan outlined in the Appendix D at the quarterly state-wide meetings. The coordinator of the state-wide meeting will share information with the three Olmstead committees and will ensure that information is shared with the state-wide team and each of the workgroups.

Figure 4. Communication and Feedback Systems for Interagency State-wide Positive Supports Planning



The workgroup associated with data collection systems will work closely with the technical assistance workgroup to ensure that the data entered into the state monitoring system can be summarized and shared at the organizational, regional, agency, and state-wide levels. In addition to quantitative data gathered using the state's data collection systems, qualitative information will gathered to ensure that people receiving services and their families or caregivers will be able to communicate their perspectives on an ongoing basis. The state has a number of surveys and quality of life measures that are already in the planning stage. The workgoup responsible for data collection will gather information about the various activities already planned and ensure that all elements of

the state-wide planning process will include opportunities to gather information from people receiving services and other stakeholders. This information will be used to ensure that the state-wide planning, technical assistance and training, marketing and communication, preservice training, crisis management systems will be guided by people receiving services across the state of Minnesota.

Impacts. This essential element of the logic model is referred to as "Impacts" and is visible in Figure 3 as a vertical band on the right hand side of the logic model. Impacts are the results of a project that goes well beyond long-term outcomes and reflect the larger shifts that may occur as a result of the implementation efforts. The impacts of programs can be positive, whether planned or unplanned, or impacts can be well intended, but ultimately counter- productive ("iatrogenic") in nature. The challenge of the state-wide team is to ensure that all elements of the implementation efforts described here encourage people to participate in the implementation of positive supports and seek strategies to decrease restrictive practices. As Fullan (1993) stated most eloquently, "You can't mandate what matters... the more complex a change effort is, the less likely you can force individuals to become involved in the process" (p. 21). For this reason, the state will work diligently to establish positive and proactive strategies for encouraging participation, collaboration, and consensus-building strategies throughout all elements of the implementation process. Systems change research highlights the need to establish champions at all levels within systems. This means that everyone is important and plays an essential role in systems change. The state will seek out champions of positive supports across the state of Minnesota and encourage these individuals to become leaders within their region of the state. Strategies for rewarding organizations and individuals who champion the positive supports efforts will be considered as an essential part of the state-wide planning process. Individuals who are recruited to participate in intensive person-centered planning or positive support training will be recognized and rewarded for participating in these certification processes and the state-wide team will seek out ways to ensure these trainings are considered essential requirements for organizations. In summary, the goal will be to model the behaviors that are expected by the same practices recommended in positive prevention-focused efforts with the people we expect to change their behaviors as part of the implementation process. Practitioners, administrators, and community members respond to the same respectful, positive and proactive approaches we demand are used with all people who receive services.

Next Steps

Many of the tasks reflected in this state-wide plan are already being implemented by professionals representing state, university, and other stakeholders. The goal of this state-wide plan is to create a communication infrastructure to ensure that information is shared systematically and action-planning efforts are streamlined. The first steps taken by the state-wide team is to recruit workgroup chairs and initial team members for each of the six major implementation tasks. Some of these workgroups are already operational even though a full workgroup with stakeholder representation has not yet been achieved. For instance, the group involved in policy inventory and definition of common terms have completed the initial assessment and are conducting further work to establish a system for refining and maintaining the inventory of polices. While some workgroups are already moving forward, the goal is to launch all workgroups and achieve one or more

meetings within each workgroup before January, 15, 2015. Quarterly state-wide team meetings will be scheduled for November, 2014 January, 2015 April, 2015, and July, 2015. The first full meeting with a more representative stakeholder group will occur by January, 2015. A plan for sharing information about this state-wide plan, the work mentioned earlier related to establishing common terms, and details about the policy inventory will also be in place by January, 2015

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Appendix A

Progress Defining Common Terms

The following statutes, rules, policy and practices was identified by DHS staff to be included in inventory survey.

Identified For Inventory

Statutes:

Minnesota Statute 245D Home and Community Based Services Standards
- Protection Standards 245D.06
- Emergency Use of Manual Restraint 245D.061
- Service Planning and Delivery; Intensive Supports 245D.071

Minnesota Statute 245.8261 Restrictive Procedures Planning and Reporting (Mental health services for children)
Minnesota Statute 125A.094 Standards for Restrictive Procedures (Schools)
Minnesota Statute 125A.0941 Standards for Restrictive Procedures (Definitions)
Minnesota Statute 125A.0942 Standards for Restrictive Procedures (Standards)
Minnesota Statute 121A Students Rights, Responsibilities and Behavior
- Exclusion and expulsion of pupils with a disability 121A.43
- Corporal Punishment - Banned 121A.58
- Student Discipline; Reasonable Force 121.582
- Discipline and Removal of Students from Class 121A.61
- Removal by Peace Officer – Specifically for Students with IEP's 121A.67

Minnesota Statute 245.461 Minnesota Comprehensive Adult Mental Health Act; Policy and Citation
Minnesota Statute 245.487 Minnesota Comprehensive Children's Mental Health Act Citation; Declaration of Policy; Mission
Minnesota Statute 245A.66 Requirements; maltreatment of minors
Minnesota Statute 252A.111 Powers and Duties of Public Guardian or Conservator
Minnesota Statute 253B Civil Commitment
Minnesota Statute 256B Medical Assistance for Needy Persons
Minnesota Statute 524.5-101 to 524.5-502 Uniform Guardianship and Protective Proceedings Act
Minnesota Statute 6090.255 False Imprisonment
Minnesota Statute 626.566 Reporting of Maltreatment of Minors
Minnesota Statute 626.557 Reporting of Maltreatment of Vulnerable Adults
- Definitions 626.5572

Rules:

Minn. R. 9525.2700 to 9525.2810 (formerly known as Rule 40)
Proposed Minn. R. 9544.000-9544.0160 (Positive Supports)
Minn. R. 3525.0850 (State Policy to encourage use of positive approaches in schools)
Minn. R. 3525.2810 (Behavioral Interventions and Supports in schools)
Minn. R. 9555 Social Services for Adults
Minn. R. 9502 Licensing of Day Care Facilities
Minn. R. 9520 Mental Health Services

Minn. R. 9503 Child Care Center Licensing
Minn. R. 2960 Licensure and Certification of Programs for Children

Policy & Practice:
Behavior Intervention Reporting Form – Form 5148
Positive Support Transition Plan – Form 6810
Positive Support Transition Plan Review – Form 6810A
Instructions for Completing Positive Support Transition Plan – Form 6810B
Sample Policies and Forms for Basic Supports and Services
Sample Policies and Forms for Intensive Supports and Services

Incidents
Emergency Use of Manual Restraint Policy
Behavior Intervention Reporting Form – Form 5148
Positive Support Transition Plan – Form 6810
Positive Support Transition Plan Review – Form 6810A
Instructions for Completing Positive Support Transition Plan – Form 6810B

Initial Report of Survey Results

Initial Report 10.19

Last Modified: 10/19/2014

1. Is this a policy or a practice? Check all that apply

#	Answer		Response	%
1	Policy		11	50%
2	Practice		0	0%
3	Other, please specify		11	50%

Other, please specify
State Statute
Statute
Statute
Rule and Variance
case law
Training
Training
Training
Training
Training
Training

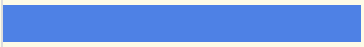
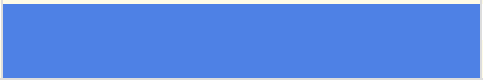
Statistic	Value
Min Value	1
Max Value	3
Total Responses	22

2. Which best describes this policy or practice? Check all that apply

#	Answer		Response	%
1	A. This policy or practice is best practice/evidence based practice for positive supports		5	36%
2	B. This policy or practice restricts, limits, defines the use of non-positive supports such as restrictive procedures, seclusion, restraint, prohibited procedures etc.		10	71%
3	C This policy or practice is a prohibited practice		2	14%
4	Other, please specify		0	0%

Other, please specify Statistic	Value
Min Value	1
Max Value	3
Total Responses	14

3. Which of the following does this policy or practice that restricts, limits and or defines the use of non-positive supports influence or guide? Check all that apply

#	Answer		Response	%
1	Personnel requirements such as licensure, certification or professional development		9	75%
2	Practice		12	100%
3	Programs		12	100%

Statistic	Value
Min Value	1
Max Value	3
Total Responses	12

4. Does this policy or practice contain a definition of incidents that must be reported?

#	Answer		Response	%
1	Yes		8	67%
2	No		4	33%
	Total		12	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.33
Variance	0.24
Standard Deviation	0.49
Total Responses	12

5. If you responded yes to question above, what data must be collected for reportable incidents?

Text Response
Annual report stating number and types of restrictive procedures performed.
each use of protective procedure is documented in the client record;
use of restraint and seclusion
"Subdivision 1.Incident response and reporting. (a) The license holder must respond to incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person... h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b) within 24 hours of the occurrence. The license holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061."
Subd. 5.Reporting emergency use of manual restraint incident. (a) Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the designated coordinator the following information about the emergency use:

Statistic	Value
Total Responses	5

6. What happens to incident report data once collected?

Text Response
This has been an unfunded mandate that the department does not collect.
there is a quarterly administrative review required by the rule
administrative review

Statistic	Value
Total Responses	3

7. State Agency Select one

#	Answer		Response	%
1	Department of Human Services (DHS)		16	89%
2	Depart of Education (MDE)		2	11%
3	Department of Health (MDH)		0	0%
4	Department of Employment & Economic Development (DEED)		0	0%
5	Department of Corrections (DOC)		0	0%
6	Department of Human Rights		0	0%
7	Other, please specify		0	0%
	Total		18	100%

Other, please specify

Statistic	Value
Min Value	1
Max Value	2
Mean	1.11
Variance	0.10
Standard Deviation	0.32
Total Responses	18

8. Division
Text Response
Children's Mental Health
Alcohol and drug abuse
Alcohol and Drug Abuse Division
Alcohol and Drug Abuse Division
Adult Mental Health
Disability Services
DSD
Compliance and Assistance
DSD
Compliance and Assistance
DSD

Statistic	Value
Total Responses	11

9. Document Name and Number, where applicable
Text Response
RESTRICTIVE PROCEDURES PLANNING AND REPORTING
Chemical Dependency Licensed Treatment Facilities (Rule 31): Behavioral Emergency Procedures
Detoxification Programs: Protective Procedures
Integrated Dual Diagnosis Treatment: Policies, Procedures, and protocols
Civil Commitment; temporary confinement; emergency admission; authority to detain and transport a missing patient
Chapter 2960 Licensure and certificatio of programs for children
Vulnerable Adult Act and Maltreatment of Minors Act
Civil Commitment Act
Rule 36 and the IRTS Variance to Rule 36
the Jarvis decision and the Price Sheppard decision
Home & Community Based Standards-Protection Standards
Emergency Use of Manual Restraint
Standards for Restrictive Procedures
Positive Behavior Support – SOS0000830
Intro-Positive Behavior Supports in Mental Health – SOS0001397
MN Positive Behavior Support Initiative – SOS0001488
Positive Behavior Supports on the Job – SOS0001558
CDS: PBS – Understanding Positive Approaches – SOS0001734
Intro to Function Based Positive Behavior Supports – SOS0001770
Service Planning and Delivery; Intensive Supports
Standards for Restrictive Procedures
Administrative Rule-Formerly known as Rule 40

Statistic	Value
Total Responses	22

10. Citation of State or Federal Regulation, Statute, Rule or Policy, if applicable

Text Response
Minnesota Statutes 245.8261.
Rule 9530.6475
Rule 9530.6535
9530.0050 Subp. 3 Behavioral emergency procedures
Chapter 253B; 253B.045; 253B.05; 253B.141
2960.0710
Minnesota Statutes 626.557 and 626.5572, 626.556
253b
Caselaw
Minn. Stat. 245D.06
Minn. Stat. 245D.061
Minn. Stat. 125A.094
Minn. Stat. 245D.071
Minn. Stat. 125A.0941
Minn. R. 9525.2700 to 9525.2810

Statistic	Value
Total Responses	15

11. Document SourceInclude hyperlink to on-line location when applicable

Text Response
https://www.revisor.mn.gov/statutes/?id=245.8261
https://www.revisor.leg.state.mn.us/rules/?id=9530.6475
https://www.revisor.leg.state.mn.us/rules/?id=9530.6535
https://www.revisor.leg.state.mn.us/rules/?id=9533.0050
https://www.revisor.leg.state.mn.us/statutes/?id=253B
https://www.revisor.leg.state.mn.us/rules/?id=2960.0710
https://www.revisor.leg.state.mn.us/statutes/?id=245D.06
https://www.revisor.leg.state.mn.us/statutes/?id=245D.061
https://www.revisor.leg.state.mn.us/statutes/?id=125A.094
https://www.revisor.leg.state.mn.us/statutes/?id=245D.071
https://www.revisor.leg.state.mn.us/statutes/?id=125A.0941
https://www.revisor.leg.state.mn.us/rules/?id=9525.2700

Statistic	Value
Total Responses	12

12. Publication Date of Document

Text Response
2011
10/15/2013
10/15/2013
11/12/2013
08/05/2008
Ongoing
Ongoing
Ongoing
Ongoing
2013- Amended in 2014
2013
2013
2013
October 16, 2013

Statistic	Value
Total Responses	14

13. Type of Document/Publication.Check all that apply.

#	Answer		Response	%
1	Policy		0	0%
2	Procedure		0	0%
3	Practices Manual		0	0%
4	Statute/Law		9	41%
5	Rule/Regulation		6	27%
6	Interpretative Guideline		0	0%
7	Bulletin		0	0%
8	Form		0	0%
9	Case Law		1	5%
10	Training (State funded)		6	27%
11	Technical Assistance Guide/Manual		0	0%
12	Other, please specify		1	5%

Other, please specify
Variance

Statistic	Value
Min Value	4
Max Value	12
Total Responses	22

14. Who is the intended audience for this policy or practice? Check all that apply

#	Answer	Response	%
1	Policymakers	13	81%
2	Organization Leaders	12	75%
3	Regulators/Licensors	12	75%
4	Lead agencies, counties, tribes	13	81%
5	Service Providers-Management	14	88%
6	Service Providers-Supervisory	12	75%
7	Service Providers-Direct Support Professionals	12	75%
8	Educators - K-12	3	19%
9	Educator - Post Secondary	1	6%
10	Clinicians	9	56%
11	Family members	6	38%
12	Self-advocates	5	31%
13	People being supported with services	10	63%
14	Guardians	6	38%
15	Other, please specify	0	0%

Other, please specify

Statistic	Value
Min Value	1
Max Value	14
Total Responses	16

15. Is this policy or practice currently being revised or updated?

#	Answer	Response	%
1	Yes	2	18%
2	No	9	82%
	Total	11	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.82
Variance	0.16
Standard Deviation	0.40
Total Responses	11

16. If responded yes, what is status of the revision or update?	
Text Response	
draft proposals are being vetted with stakeholders; DHS commissioner working on a plan to include detoxifcation services as a medical assistance benefit	
Statistic	Value
Total Responses	1

17. Name	
Text Response	
Jill Johnson	
Brian Zirbes	
Brian Zirbes	
Brian Zirbes	
Brian Zirbes	
Brian Zirbes	
Faye Bernstein	
Faye Bernstein	
faye bernstein	
faye bernstein	
ICI Staff	
ICI Staff	
Robyn Widley by ICI Staff	
Stacy Danov	
Stacy Danov	
Stacy Danov	
Stacy Danov	
Stacy Danov	
Stacy Danov	
ICI Staff Entry	
Robyn Widley	
ICI Staff for Charles Young	
Statistic	Value
Total Responses	22

18. Title
Text Response
Children's Mental Health Consultant
Planner Principal State
Planner Principal State
Planner Pricipal State
Planner Principal State
Planner Principal State
Mental Health Program Consultat
Program Consultant
mental health program consultant
mental health program consultant
ICI Staff
ICI Staff
Community Capacity Building Clinical Coordinator

Statistic	Value
Total Responses	13

19. Email
Text Response
jelaine.johnson@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
ICI Staff
ICI Staff
Stacy.e.danov@state.mn.us

Statistic	Value
Total Responses	13

Appendix B

Sample Crosswalk for Definition of Incident across state agencies:

State Agency	DHS	MDE	MDH	DOC	DEED
Definition					
Reporting Requirements					

Inventory Survey Results for Policies and Practices that include a definition of incidents that must be reported.

Incidents

Last Modified: 10/19/2014

Filter By: Report Subgroup

1. Is this a policy or a practice? Check all that apply

#	Answer		Response	%
1	Policy		5	63%
2	Practice		0	0%
3	Other, please specify		3	38%

Other, please specify
State Statute
statute
Rule and Variance

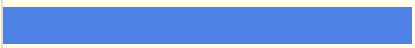
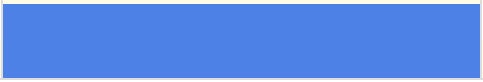
Statistic	Value
Min Value	1
Max Value	3
Total Responses	8

2. Which best describes this policy or practice? Check all that apply

#	Answer		Response	%
1	A. This policy or practice is best practice/evidence based practice for positive supports		1	14%
2	B. This policy or practice restricts, limits, defines the use of non-positive supports such as restrictive procedures, seclusion, restraint, prohibited procedures etc.		7	100%
3	C This policy or practice is a prohibited practice		1	14%
4	Other, please specify		0	0%

Other, please specify Statistic	Value
Min Value	1
Max Value	3
Total Responses	7

3. Which of the following does this policy or practice that restricts, limits and or defines the use of non-positive supports influence or guide? Check all that apply

#	Answer		Response	%
1	Personnel requirements such as licensure, certification or professional development		6	86%
2	Practice		7	100%
3	Programs		7	100%

Statistic	Value
Min Value	1
Max Value	3
Total Responses	7

4. Does this policy or practice contain a definition of incidents that must be reported?

#	Answer		Response	%
1	Yes		8	100%
2	No		0	0%
	Total		8	100%

Statistic	Value
Min Value	1
Max Value	1
Mean	1.00
Variance	0.00
Standard Deviation	0.00
Total Responses	8

5. If you responded yes to question above, what data must be collected for reportable incidents?

Text Response
Annual report stating number and types of restrictive procedures performed.
each use of protective procedure is documented in the client record;
use of restraint and seclusion
"Subdivision 1.Incident response and reporting. (a) The license holder must respond to incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person... h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b) within 24 hours of the occurrence. The license holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061."
Subd. 5.Reporting emergency use of manual restraint incident. (a) Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the designated coordinator the following information about the emergency use:

Statistic	Value
Total Responses	5

6. What happens to incident report data once collected?

Text Response
This has been an unfunded mandate that the department does not collect.
there is a quarterly administrative review required by the rule
administrative review

Statistic	Value
Total Responses	3

7. State Agency Select one

#	Answer		Response	%
1	Department of Human Services (DHS)		7	100%
2	Depart of Education (MDE)		0	0%
3	Department of Health (MDH)		0	0%
4	Department of Employment & Economic Development (DEED)		0	0%
5	Department of Corrections (DOC)		0	0%
6	Department of Human Rights		0	0%
7	Other, please specify		0	0%
	Total		7	100%

Other, please specify

Statistic	Value
Min Value	1
Max Value	1
Mean	1.00
Variance	0.00
Standard Deviation	0.00
Total Responses	7

8. Division
Text Response
Children's Mental Health
Alcohol and Drug Abuse Division
Adult Mental Health
Disability Services
DSD
DSD

Statistic	Value
Total Responses	6

9. Document Name and Number, where applicable
Text Response
RESTRICTIVE PROCEDURES PLANNING AND REPORTING
Detoxification Programs: Protective Procedures
Chapter 2960 Licensure and certificatio of programs for children
Vulnerable Adult Act and Maltreatment of Minors Act
Rule 36 and the IRTS Variance to Rule 36
Home & Community Based Standards-Protection Standards
Emergency Use of Manual Restraint
Administrative Rule-Formerly known as Rule 40

Statistic	Value
Total Responses	8

10. Citation of State or Federal Regulation, Statute, Rule or Policy, if applicable
Text Response
Minnesota Statutes 245.8261.
Rule 9530.6535
2960.0710
Minnesota Statutes 626.557 and 626.5572, 626.556
Minn. Stat. 245D.06
Minn. Stat. 245D.061
Minn. R. 9525.2700 to 9525.2810

Statistic	Value
Total Responses	7

11. Document SourceInclude hyperlink to on-line location when applicable
Text Response
https://www.revisor.mn.gov/statutes/?id=245.8261
https://www.revisor.leg.state.mn.us/rules/?id=9530.6535
https://www.revisor.leg.state.mn.us/rules/?id=2960.0710
https://www.revisor.leg.state.mn.us/statutes/?id=245D.06
https://www.revisor.leg.state.mn.us/statutes/?id=245D.061
https://www.revisor.leg.state.mn.us/rules/?id=9525.2700

Statistic	Value
Total Responses	6

12. Publication Date of Document
Text Response
2011
10/15/2013
08/05/2008
Ongoing
Ongoing
2013- Amended in 2014
2013
October 16, 2013

Statistic	Value
Total Responses	8

13. Type of Document/Publication.Check all that apply.

#	Answer		Response	%
1	Policy		0	0%
2	Procedure		0	0%
3	Practices Manual		0	0%
4	Statute/Law		4	50%
5	Rule/Regulation		4	50%
6	Interpretative Guideline		0	0%
7	Bulletin		0	0%
8	Form		0	0%
9	Case Law		0	0%
10	Training (State funded)		0	0%
11	Technical Assistance Guide/Manual		0	0%
12	Other, please specify		1	13%

Other, please specify
Variance

Statistic	Value
Min Value	4
Max Value	12
Total Responses	8

14. Who is the intended audience for this policy or practice? Check all that apply

#	Answer	Response	%
1	Policymakers	7	88%
2	Organization Leaders	7	88%
3	Regulators/Licensors	8	100%
4	Lead agencies, counties, tribes	8	100%
5	Service Providers-Management	8	100%
6	Service Providers-Supervisory	7	88%
7	Service Providers-Direct Support Professionals	7	88%
8	Educators - K-12	1	13%
9	Educator - Post Secondary	1	13%
10	Clinicians	4	50%
11	Family members	3	38%
12	Self-advocates	2	25%
13	People being supported with services	5	63%
14	Guardians	3	38%
15	Other, please specify	0	0%

Other, please specify

Statistic	Value
Min Value	1
Max Value	14
Total Responses	8

15. Is this policy or practice currently being revised or updated?

#	Answer	Response	%
1	Yes	2	33%
2	No	4	67%
	Total	6	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.67
Variance	0.27
Standard Deviation	0.52
Total Responses	6

16. If responded yes, what is status of the revision or update?
Text Response
draft proposals are being vetted with stakeholders; DHS commissioner working on a plan to include detoxification services as a medical assistance benefit

Statistic	Value
Total Responses	1

17. Name
Text Response
Jill Johnson
Brian Zirbes
Brian Zirbes
Faye Bernstein
faye Bernstein
ICI Staff
ICI Staff
ICI Staff for Charles Young

Statistic	Value
Total Responses	8

18. Title
Text Response
Children's Mental Health Consultant
Planner Principal State
Planner Principal State
Mental Health Program Consultat
mental health program consultant
ICI Staff
ICI Staff

Statistic	Value
Total Responses	7

19. Email
Text Response
jelaine.johnson@state.mn.us
brian.zirbes@state.mn.us
brian.zirbes@state.mn.us
faye.bernstein@state.mn.us
faye.bernstein@state.mn.us
ICI Staff
ICI Staff

Statistic	Value
Total Responses	7

APPENDIX C

Vision and Goals of the Minnesota Olmstead Plan (Pages 10-11)

The Olmstead Subcabinet adopted a vision statement at one of its first meetings:

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

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

Olmstead Plan Goals

To move the state forward, towards greater integration and inclusion for people with disabilities, the state has set an overall goal. If Minnesota's Olmstead Plan is successful, Minnesota will be a place where:

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

To achieve this overall goal, Minnesota's Olmstead Plan addresses goals related to broad topic areas:

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

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

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

Supports and Services: People with disabilities of all ages will experience meaningful, inclusive, and integrated lives in their communities, supported by an array of services and supports appropriate to their needs and that they choose.

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

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

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

Action Three: ***Build effective systems for use of positive practices, early intervention, crisis reduction and return to stability after a crisis*** **(pages 65-67)**

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

- Person-centered planning that includes a balance of what is important *for* the person with what is important *to* the person;
- Individual plans for services that reflect principles of the most integrated setting, consistent with Minnesota's Olmstead Plan;
- Types and use of positive and social behavioral supports;
- Prohibitions on use of restraints and seclusion; and,
- Requirement that care is appropriately informed by a recognition and understanding of past trauma experienced by an individual. People will be able to move to and remain in integrated settings when plans and supports are in place to avoid crises and timely and appropriate crisis intervention is available. The term 'crisis' covers a range of situations, such as behaviors that present potential harm, the loss of a caregiver, or a significant change in a medical or health condition that compromises the ability of a person to manage their symptoms.

Timeline:

- By January 1, 2014 the state will implement the new Minnesota Statute §245D standards,[SS 3A], and by July 1, 2015 a Rule with operational details that replaces Minnesota Rules, parts 9525.2700 to 9525.2810 (also known as Rule 40) will be promulgated. [SS 3B]

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

- By July 1, 2014 the state will create an inventory and analysis of policies and best practices across state agencies related to positive practices and use of restraint, seclusion or other practices which may cause physical, emotional, or psychological pain or distress. [SS 3C]
- By July 1, 2014 a report outlining recommendations for a state-wide plan to increase positive practices and eliminate use of restraint or seclusion will be delivered to the Olmstead Subcabinet or their designee by an assigned team of representatives from Olmstead Subcabinet agencies. [SS 3D]
  Responsibility: The Olmstead Subcabinet will designate a responsible person.
- By August 1, 2014 the state will develop, across state agencies, a common definition of incidents, including emergency use of manual restraint, that are to be reported, and create common data collection and incident reporting processes. [SS 3E] By July 1, 2015, state-wide implementation of common incident reporting will begin. [SS 3F] Beginning October 1, 2015, quarterly summaries of incidents of emergency use of manual restraint or other types of restraint, seclusion or other practices that may cause physical, emotional, or psychological pain or distress will be reported to an assigned team of representatives from each state agency for review and to inform recommendations to reduce the incidents. [SS 3G.1 – 3G.4] By July 1, 2015 and annually thereafter, the team will provide recommendations to the Olmstead Subcabinet to reduce emergency use of restraints, or other practices that may cause physical, emotional, or psychological pain or distress, and to increase positive practices. [SS 3H.1, 3H.2] **Responsibility:** The Olmstead Subcabinet will designate a responsible person.
- By August 1, 2014 a coordinated triage and "hand-off" process for crisis intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation. Report will be delivered to the Olmstead Subcabinet. [SS 3I] **Responsibility:** The Commissioner of DHS will designate a responsible person.
- By December 1, 2014 an assigned team of representatives from state agencies, community organizations, community corrections and people with disabilities who have used the crisis system will: identify best practices, including use of technology; set service standards; and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions (e.g. person-centered planning, positive practices, available resources). Progress toward goal will be reported to the Olmstead Subcabinet or their designee. [SS 3J] **Responsibility:** The Olmstead Subcabinet will designate a responsible person.
- By January 15, 2015 DHS will have completed the necessary analysis and planning to expand crisis services, diversion, and early intervention services to persons at risk of experiencing a crisis situation. The expansion plan will include projected start dates for implementation of the services. **Responsibility:** The Commissioner of DHS will designate a responsible person.
- By July 1, 2015 crisis services, including diversion and early intervention

services, will be made available to any person in need of these supports and at risk of experiencing a crisis situation. The purposes of this intervention include stabilizing the person's situation or avoiding the use of civil commitment. [SS 3K] **Responsibility:** The Commissioner of DHS will designate a responsible person.

- By July 1, 2015 develop measurements to better understand and track crisis episodes across service systems; create a data collection plan and mechanisms; establish baseline data and set targets (e.g., number of crisis calls made, reason for the call, response given, follow-up information.) Baseline data and targets will be delivered to the Olmstead Subcabinet or their designee. [SS 3L] **Responsibility:** The Commissioner of DHS will designate a responsible person.

APPENDIX D

Minnesota's State-wide Plan

Work Group Name: Establishing Infrastructure for Technical Assistance and Data Systems

Date: _____ Committee/Work Group Members:_____

Implementation Goal #1: Establishing Infrastructure for Technical Assistance and Data Systems

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Establish Interagency State-wide Organizational Chart to Show Communication System	Organizational Chart	• Establish Workgroup • Draft of Organizational Chart • Gather Feedback From All Relevant Stakeholders	Creates the Communication and Feedback Systems Necessary for Achieving Goal	To Be Finalized in First Six Months (April, 2015)
Identify Facilitator of the Interagency State-wide Team	FTE Assigned to Facilitator Meeting Minutes	• Recruit Individual • Provide Mentoring to New Coordinator	Assigns a Person Who Will Schedule Meetings, Reserve Rooms, Send Communication, Address Logistics, etc.	To Be Finalized in First Six Months (April 2015)
Workgroup creates plan to address training for each of the agencies in first step implementation with timeline for steps involved	A document showing the timeline for implementation of technical assistance with be established and progress will be documented within the state's annual interagency evaluation report	• Timeline for Implementation Established: Aging Disabilities Mental Heal *Education Ombudsman • Timeline for Agencies Implementing Later: DEED Dept. of Corrections Dept. of Health Human Rights Courts	A System for Implementing positive supports is necessary to ensure organizations receive effective technical assistance (TA)	Timeline for Implementation Available With First Six Months (April 2015)

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Curriculum is developed for each agency	Curriculum and TA Systems Described as Training Manual Online at Designated Time for Each Agency Implementing	Each Agency That Begins Implementation Will 1. Form an Agency Oversight Team 2. The Team Will Assign an Agency-wide Coordinator 3. Team will meet regularly to establish training and data collection systems 4. Agency will report to Interagency state-wide team quarterly and provide annual summary of progress	Agency representation must be involved in the creation of the content to establish buy in, ensure content meets the need of the agency, and that professionals will be prepared to participate in training when it is implemented	Timeline will be dictated by when agencies start implementing
State and regional coaching systems will be established for the TA system	State-wide Team will document assessment and action plan for using state FTE to organize efforts – annual report will document decisions made State Coordinators, Regional Coaches, and Organization-wide (local) coaches roster will be available Meetings scheduled regularly for training and to monitor implementation	State Coordinators will be recruited based on timelines for agencies to start process State coordinators recruited for agencies starting as part of the legislative ask proposal Regional Coordinators recruited as part of the legislative ask proposal Organization-wide coaches will be recruited from organizations participating in	Coordinators and coaches are "positive nags" who ensure dates for meetings are set, agendas are ready, meeting minutes are sent, and data are being completed at local, regional, and state-wide levels These individuals communicate via the interagency state-wide communication system when problems are encountered or	Identification of State-wide Coordinators starting the TA: (April 2015) Regional Coaches: prior to legislative ask implementation (August, 2015) Coaches will be identified once implementation is organized (September,-October, 2015)

		legislative ask proposal Curriculum and training for coordinators and coaches will be prepared prior to the legislative ask implementation timeline	assistance is needed	
Workgroup meets with IT to ensure training is set up for local and regional decision making and that data are available for decision making	Meeting minutes indicating IT and workgroup are meeting Curriculum for all providers describing new incident reporting system	Webinars, website information, and local awareness presentations give to providers. Documentation of organizations who have received training within each agency area shows expansion of training across the state State requires all providers to complete simple online training explaining how to complete incident report and IT are available to support and answer questions	The accuracy of data collection is important to ensure information is accurate Organizations receiving additional TA in positive supports will learn how to collect additional data for decision making The goal is to show that TA is an effective way in which to decrease problem behavior, crises, etc.	

* School-wide PBS is already being implemented; SWPBS goals address expansion plan

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Agencies participating in TA process later are involved in curriculum and tool development DEED Dept. of Corrections Dept. of Health Human Rights Courts	Meeting minutes from state-wide and agency wide teams Agency workgroups formed to work on tasks Tools and curriculum available	As per plan described in immediate steps, agencies targeted to move forward will: • Establish an agency coordinator • Develop curriculum and training system • Work with regional coaches to recruit organizations to participate in TA	Training systems for moving forward systematically with agencies will ensure organizations receive what they need to be successful	October, 2015-October 2016
Infrastructure for interagency state will move from initial implementation to full implementation of TA systems	Org chart will be finalized Annual report will describe changes made to improve feedback and communication systems, data collection, etc.	State-wide team will meet with regional coaches, local coaches, and other stakeholders to share how systems can be improved Team will review surveys of satisfaction from participants in TA for organizations and Cohort training	The implementation process requires modifications and improvements to ensure effectiveness and sustainability	August, 2015-October, 2016 Annual Reports for each year
Curriculum for agencies starting the process will move from initial implementation to full operation	Meeting minutes from agency-wide team Curriculum Annual report will describe changes made	Agency-wide teams will meet regularly to discuss what worked well, what needs to be modified Team will review surveys of satisfaction from	The implementation process requires modifications and improvements to ensure effectiveness and sustainability	August, 2015-October, 2016 Annual Reports for each year

		participants		
Annual report and quarterly report systems will be move from initial formats to a more formalized system	State-wide team's meeting minutes Annual reports at different levels will be simple but include key updates • Agency-wide summary • State-wide summary • Regional summary • Organization-wide summary	State-wide team will meet with key participants to review the initial reporting system and make improvements based on feedback	Data summaries at different levels of the system are important for communication systems	Annual Reports for each year
Champions will be identified across the state from coach roles, cohort training, leadership, people receiving services, etc. These individuals will be recruited to assist in state-wide efforts	Number of stakeholders participating in state-wide planning processes Diversity of stakeholders participating in process Annual report will document progress in this area	Encourage individuals to assist in state-wide planning efforts Identify and recruit individuals during trainings, awareness presentations, webinars, local events, etc. Create incentives for champions to ensure there are positive outcomes associated with participation	Buy in and consensus will increase when individuals from different stakeholder groups are advocating, teaching, and sharing successes	October 16 should show significant listing of "champions" participating in state-wide planning in different ways (providing awareness trainings, attending meetings, testimonials and quotes, case studies, etc.)

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Agencies show that organizations receiving TA have higher levels of positive support implementation, lower problem behaviors, and fewer restrictive interventions	**Outcome data that include:** Organization-wide Data • Fidelity of implementation • Incident reports • Restrictive interventions • Emergency room visits • Acute care events • Staff attrition, injury • Workers comp **Individual Plan Data** • Fidelity of Implementation • Baseline intervention data showing decreases in problem behavior, increases in positive social behavior • Quality of life data • Goodness of fit (how plan fits family, caregivers) **Qualitative Data** • Focus Groups • Interviews • Surveys **Pre-post Conceptual Knowledge** • Staff in organizations participate in survey before and after TA is	• Implementation of training for TA in positive supports, • Training for all providers in collecting effective incident report form data • IT systems are in place to gather and report data at local, regional, agency, and state-wide levels	This long-term objective will show that the state's efforts to provide training and support has been effective	Annual report of progress August 15, 2015 (first organizations participating in TA) August 15, 2016 (evaluation data for organizations in first training efforts) August 15, 2017 (evaluation data for first organizations and organizations starting in next implementation year)

	provided • Regional teams ask all organizations in catchment area to complete survey (organizations not yet participating) with incentive			
State-wide infrastructure moves from full operation to innovation with examples of improvements and changes made based on mature implementation efforts	Qualitative review of meeting minutes, focus group and interviews with key participants, Review Annual report -- describe changes made to improve feedback and communication systems, data collection, etc.	Data workgroup summarizes results of qualitative efforts to evaluate effectiveness of infrastructure Data workgroup presents information via the interagency state-wide team for discussion Quantitative and qualitative data are used to create new and innovative changes to systems	Moving to innovation stages of implementation requires data-based decision making	Annually 2016, 2017, 2018
Expansion of leaders and champions in the system lead to larger impact level changes across the state	Qualitative and Quantitative data will show that the numbers of people receiving support is growing faster compared to previous years as measured by • Aggregate data on individual plans • Organizations reporting data • Champions available to assist the state • State-wide incident report and data overall	State-wide interagency team uses workgroups to • Evaluate progress over time • Create incentives for people interested in becoming champions • Establish a tracking system to monitor evidence of expansion	State will reach a "critical mass" when there the number of people who implement positive supports will market the implementation efforts beyond the state-wide team's efforts	Evidence is available within the 2018-2019 annual report

Work Group Name: __Design Qualitative and Quantitative Systems for State-wide Data-based Decision Making

Date: _____ Committee/Work Group Members_____

Implementation Goal #2: Design Qualitative and Quantitative Systems for State-wide Data-based Decision Making

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Incident report system collect key data used for local, regional, agency, and state decision making—List of key data included in recording will be clearly outlined	New system is beta tested with participants indicating successful data collection via simple survey and report	Create templates for incident report forms and plan for beta test implemented Feedback from beta test used for last edits Plans to analyze local, regional, and state-wide data are in draft including how regional and local coaches will access the data regularly	Data will be a key outcome for state-wide planning	
Data workgroup will work with the infrastructure workgroup to ensure that training systems are in place for providers who will use the incident reporting system	Meeting minutes Documented plan for training Curriculum	Infrastructure and data workgroups will meet to outline training curriculum and system	Accurate data collection will be essential for state-wide planning	
Tools for fidelity of implementation at the organization-wide and individual level are in draft for first participating agencies	Fidelity documents are available for first participating organizations	Representatives from first participating organizations learn how MN SW data are collected at state-wide meeting	It is important to show that positive supports are actually being implemented	June, 2015

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Workgroup will provide a list of data that will be collected via local, regional, agency, and state-wide levels for first step agencies	Document listing all data not included in incident report that will be part of the decision making process – this will be completed in collaboration with the infrastructure workgroup	Infrastructure and data workgroups will meet to outline the key data collection procedures	An important key to success will be the training systems for providers to ensure accurate data	
Plan for qualitative data collection is in place	Documented plan is available describing how data will be gathered, analyzed, and used	Workgroup identifies key professionals who will gather data State team identifies all qualitative data already being collected Plan is written describing how different sources of qualitative information will be used	Qualitative data will provide rich information about how the state-wide planning is impacting the lives of people receiving services and providers	August 2015

* School-wide PBS is already being implemented; SWPBS goals address expansion plan

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Tools for fidelity of implementation at the organization-wide and individual level are in draft for agencies expanding later in the timeline	Fidelity documents are available for participating organizations expanding later in timeline	Representatives from participating organizations learn how MN SWPBS data are collected at state-wide meeting Agency team meets regularly to establish data that will be used to evaluate organizational and individual planning progress Tool will be created in draft form and circulated to gather feedback	It is important to show that positive supports are actually being implemented	August, 2016
Summaries of incident report data are available for annual report purposes a the local, regional, agency, and state levels	Annual report will include data at each level	Infrastructure workgroup and data workgroup will ensure data are gathered and reported for report	Content and IT professionals are needed to create the most effective summaries of data	August 2016
Qualitative workgroup team analyzes first year of data and provides a summary for the annual report	Qualitative transcripts analyzed, themes established, and summary of results are included in annual report	From August 2015-April, 15, 2015 data collection occurs, transcribing completed, and themes identified April, 2015-August, 2016 Written summary organized and presented to state-wide team for report	Quotes and stories that can be used for marketing, awareness, etc will come from this type of evaluation Information about changes in quality of life for people receiving services and providers will be available in descriptive form	September, 2016

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Pre-post conceptual knowledge about positive supports will be conducted prior to organizations participating in TA and a plan for systematically surveying organizations not yet started will be in place	Survey data gathered August-September, 2015 and again during August-September, 2016 will be available for review	Workgroup will work with infrastructure workgroup to establish survey draft Survey will be shared with key content professionals across the state and nationally A system for gathering data from participating organizations and nonparticipating organizations will be approved by the state-wide team Data will be gathered and analyzed for annual report	Pre post data provides some evidence that the TA process is contributing to increased awareness and knowledge of key positive support terms	August-September, 2015 August-September, 2016 Annual Report for 2016-2017
State-wide team provides evidence that efforts to implement TA after first year of implementation outlining in detail successful pilot/exemplary implementation sites	Case studies of pilot/exemplary case examples of implementation based on TA support for marketing purposes	Data workgroup and marketing workgroup will use the case studies gathered for awareness trainings, newsletters, website, etc.	The goal is to show how data can be used to celebrate and reinforce people; Marketing by stakeholders to stakeholders is more effective than by state or university professionals alone	

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
State-wide team provides evidence that efforts to implement TA on a wide-scale basis is effective in decreasing problem behavior, incident reports, emergency room visits, acute care stays, restrictive procedures, etc.	Interagency Annual report data Interagency Annual Report for 2017-2018 Interagency Annual Report for 2018-2019	Data are gathered from infrastructure system at the local level; Regional coordinators summarize data and share with agency teams; Agency teams share progress across regions with state-wide team State-wide team will review the MN SWPBS annual report and discuss as a first step discussion for agency-level reporting Responsibility for gathering and summarizing data occurs at each level of the system: • Local Coach • Regional Coordinator • Agency Coordinator • State-wide Coordinator State-wide coordinator works with interagency team to design and finalize interagency report format	Creating a system for summarizing data allows for a distribution of work related to preparing the final report	First Draft of an Interagency Report occurs September, 2016 September 2017 September, 2018

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Qualitative evaluation data show that people receiving services, family members, and provider lives are improving over time	Annual report – section dedicated to qualitative analysis	Qualitative team provides summary of progress each year; Changes in themes are captured as implementation occurs over time across regions Team reports if any changes are occurring in organizations that have implemented positive supports over 2-3 years	Perspectives of stakeholders are an important consideration in state-wide evaluation	August 2017 Annual Report August 2018 Annual Report August 2019 Annual Report
Pre-post conceptual knowledge about positive supports will show that organizations not yet participating in intensive training is showing increases in key terms via simple awareness and marketing (comparison with outcomes from prior years with nonparticipating organizations---but also showing slightly lower scores compared to organizations participating in intensive training)	Survey data gathered August-September, 2017 and again during August-September, 2018 will be available for review for organizations in later expansion Survey data will continue to be gathered for agencies expanding number of organizations participating August-September, 2017 and again during August-September, 2018	Workgroup will work with infrastructure workgroup to establish survey draft for agencies in later expansion Survey will be shared with key content professionals across the state and nationally A system for gathering data from participating organizations and nonparticipating organizations will be approved by the state-wide team Data will be gathered and analyzed for annual report	Pre post data provides some evidence that the TA process is contributing to increased awareness and knowledge of key positive support terms	August-September, 2017 August-September, 2018 August – September, 2019 Annual Report for 2017-2018 Annual Report for 2018-2019

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Cost Benefit Analysis Evaluation is conducted to evaluate: Costs of TA, costs related to crises (state costs) Decreases in Costs related to Problem behavior at the organizational level (workers comp, staff attrition	Annual report for 201- 1019	Recruit professional who can consult with state on cost effectiveness/cost benefit related issues Create a plan to evaluate costs involved in training and gather data related to costs incurred by state and by organizations related to problem behavior	It is important to evaluate the costs involved in large-scale implementation efforts and to establish sustainable and affordable strategies while maintaining prevention-focused state-wide planning	August, 2018

Work Group Name: __Establishing a Marketing Plan to Increase Awareness of Positive Supports_____

Date: _____ Committee/Work Group Members: _____

Implementation Goal #3: Establish a Marketing Plan to Increase Awareness of Positive Supports

Immediate Term Objectives *(To Be Achieved Within Next 6-8 Months)*

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Create a plan for marketing positive supports strategies across the state	Document summarized for annual report documenting plan for expanding awareness	Create a list of stakeholders that will be targeted for marketing purposes Establish timeline for posting website; Identify a team representing the TA efforts, cohort training, IT, etc.	It is important to make sure people know how to access information and join training and TA efforts	May, 2015

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Share state-wide plan with representative stakeholders across the state via onsite meetings and webinars; use feedback to modify and improve plan for final formalized document	Feedback documentation; evidence of modifications made to plan	Meet with interagency team to present recommendations from the workgroup that includes: • Number of webinars • Placement of state-wide plan on public website for access • Number of presentations • Locations of onsite presentations	It is important to increase awareness of the state-wide plan, and to build buy in and consensus by the direct involvement of stakeholders; this process may help to identify possible champions and participants	To Be Finalized in First Six Months (April, 2015)
Create a website that will be used as an entry point for awareness, a place to learn more about data collection, and the site of all training materials including: • Awareness • Skill building materials • Cohort training in PBS, PC thinking/PCP, Trauma informed thinking/Therapy, positive psychology, etc.) • Trainer/Champion Level (How to become a trainer in positive supports)	Website Pages Launched Website Stats	Create a first draft of the website Identify an easy to remember URL Find a website stats program to monitor visitors, unique visitors, downloads, etc. Create a password system to allow for champion/leader communication systems Pilot website and gather feedback via online survey Launch fully functional website in time for TA from legislative		May, 2015

		ask		
What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Monitor Website Statistics, Awareness trainings, cohort trainings, etc. and provide annual summaries of progress	Quarterly and Annual Website Data Reports	Work with Data team to set up website statistics and set up quarterly access to data Review data in workgroup meetings and at interagency state-wide meeting once a year	Website statistics are used to increase awareness and usage over time	August 15, 2015-August 15, 2016 August 2016-August, 2017 August 2018-August 2019
Market awareness materials to agencies involved in later expansion	Presentation materials and dates of events Documentation of awareness materials	Establish plan and timeline Recruit individuals to participate in tool development with infrastructure and data workgroups	It is important to prepare stakeholders and increase awareness--- this helps with later recruitment and increases buy in	August, 2016
Create newsletters, brochures, and other materials for expanding awareness; Use case studies, quotes, and other information from TA efforts and qualitative evaluation	Presentation materials and dates of events Documentation of awareness materials	Establish actions dedicated to expanding awareness of positive supports to DEED Dept. of Corrections Dept. of Health Human Rights Courts	Increase awareness of positive supports and how to participate in training opportunities	First plan by April, 2015 Annually each year
The workgroup will use state-wide plan to submit petition to the Association for PBS to become a network; Five APBS members are needed in this first petition	Petition documentation Email confirmation from APBS	Obtain petition documentation Finalize state-wide planning document (logic model, annual report document, action plan tool example) Identify lead network person and submit petition	Becoming an APBS network provides the state with access to other state networks interested in sharing resources	January, 2015

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Create main sections of website to meet the needs of state-wide planning including: • Entry to training materials (Organization-wide positive supports, person-centered thinking, person-centered planning, trauma informed care, etc.) • Resources for stakeholder groups • Awareneness materials • Information about state-wide planning • Communication site for implementers • Place for Champions to access information • Reinforcement for • Evaluation data summaries	Online surveys evaluating site, feedback from agency-wide teams, feedback from professionals participating in training events, website statistics	Agency-wide planning teams work with the marketing workgroup to place content related to positive practices and to ensure pages address context	Information for marketing, easy to located training materials, and communication are key contributions of the website	**August 15, 2015**
Ensure events are scheduled that allow individuals to share implementation success and for the state to recognize exemplary practice (award ceremonies, certificates of completed trainings, etc.)	Conference evaluation surveys, number of individuals in attendance	Assess the events already scheduled that could be reorganized to address reinforcement, sharing of positive supports, etc.	Stakeholders will be more likely to implement new practices when their colleagues are recommending it; Buy in increases when leadership occurs from implementation levels	Annually starting in 2016 (Date to be identified in a manner that meets the needs of interagency stakeholders)

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Materials developed for marketing purposes become a part of every presentation, webinar, training, and event (e.g. postcards, business cards, newsletters, case study stories, etc.)	Materials available in marketing portfolio both in hard copy and online	Workgroup uses marketing plan to create timeline for creating materials for distribution and infrastructure workgroup assists by distributing within training and TA Evaluation of marketing materials occurs annually to ensure all agencies are represented starting with first step agencies Workgroup places all marketing materials in a portfolio that can be used by all state professionals Agency-wide teams review portfolio and makes recommendations to improve representation of all stakeholders	Representation of case studies and information must reach all stakeholders using context, language, and stories that fit unique people served	Portfolio created by April, 2016 Evaluation of portfolio annually starting in 2016

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Qualitative and Quantitative Data indicate that stakeholders know what positive supports are and how to receive assistances	Evidence: pre post conceptual knowledge, qualitative evaluation, number of people impacted via presentation, google search shows MN-PBS website in first 10 links, website stats show visitors from MN increase every year, etc.	Collaborates with state-wide team to make sure that evidence evaluating marketing plan is in place	The first step in systems change is awareness of a new practice	August, 2017 Annual Report August 2018 Annual Report
Awareness presentations are given across the state by MN Champions (individuals trained and recruited to assist in implementation)	Number of presentations, types of trainings, or other interactions with stakeholders implemented by individuals who are not part of initial training and TA	Work with state-wide team to ensure that a plan for tracking volunteer behavior is in place Incentive system is established to encourage individuals across the state to assist in marketing, presentations, and training Infrastructure workgroup trains champions to complete task they volunteer to complete	The implementation of positive supports will occur when stakeholders are advocating for its use	August, 2017 Annual Report August 2018 Annual Report
Website stats show that the state's website is known both within the state and nationally as an important interagency resource	Evidence of prominence includes visitors, unique visitors, downloads, visits from the state,	Promote website in all trainings and presentations (in and out of state)	It is important to create a site that is easy to find when people need assistance, that	August, 2017 Annual Report August 2018 Annual Report

	visits from other states/countries (indirect evidence of strong content), types of google search strings used, MN website shows up using regular search engines like google in first 10 links offered	Create brochures, flyers, etc. Recognize exemplary implementers in case studies Work with IT to ensure website can be found on search engines	offers problem solving ideas, assists MN providers in reaching out to others, and creates a place where individuals know they can access best practice training materials	

Work Group Name: __Design Comprehensive Preservice and Inservice Training Systems for Three-tiered Positive Support

Date: _____ Committee/Work Group Members:_____

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Implementation Goal #4: Design Comprensive Preservice and Inservice Training Systems for Three-tiered Positive Support

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Evaluate the extent to which the state can influence policy and supervisory systems to encourage universities to include specific training resources for preservice purposes (legislative requirements for education, clinical supervision, continuing education, etc.	Annual report, 2016 and annually thereafter will include section that addresses the expansion of preservice training in positive supports	Make a list of the universities and colleges in MN already providing positive supports education at bachelors and masters level Prioritize types of departments that workgroup will start contacting Use list of state-level actions to begin communicating with universities and colleges in the prioritized list	Professionals need to be prepared to implement positive supports and need to be exposed to practicum and supervisory experiences that will prepare them for success	Initial discussion, assessment, and prioritization occurs by March, 2015 Annual report 2016 summarized first actions taken and evaluates effectiveness

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Workgroup assesses all training materials related to inservice training across agencies and creates a summary of content-plan for comprehensive cross-agency inservice training systems is established (e.g. SWPBS, trauma informed care, cognitive behavior therapy, person-centered planning, cohort PBS training, etc.)	Section of annual report includes details regarding training materials and systems related to positive supports and where this training can be accessed	State-wide team discusses how to move forward with assessment process (e.g. SWPBS team presents training and evaluation tools, mental health presents information on trauma informed care, etc.) Workgroup organizes inventory of training materials and provides a way that individuals can access these materials	It can be helpful for professionals involved in implementation to gain access to the training materials used by, for instance, SWPBS teams to make comparisons and learn more about systems used to monitor progress	August, 2015

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Changes in state expectations leads to examples of policies and supervisory systems that are adapted and evidence that universities and colleges have responded will be provided	Policy documentation Meeting minutes and documented conversations Number of universities impacted	Based on initial assessment, state professionals change policies related to preparing professionals in different service areas—starting with content related to prioritized departments Work with one or two universities to establish new clinical supervision systems Evaluate the effectiveness of these efforts	Preparing individuals to provide effective services is a proactive strategy for changing behavior	Annual report 2016
Create short online introduction to the state's implementation of positive supports that can be included in introductory classes	Online training documentation	Based on conversations with universities and colleges, create a simple online training that can be included as an activity in a class that introduces students to education, psychology, special education, etc.	Awareness of positive supports must start in different ways including with the university professional	Online module available by summer, 2017

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Map out curriculum needed for preservice and inservice related to positive supports across the three-tiered model with curriculum that addresses • Universal prevention (wellness, person-centered strategies, data based decision making) • Secondary prevention (group interventions for social skills, counseling, communication) • Tertiary prevention (individualized behavioral support, cognitive behavior therapy, etc.)	Annual report, 2016 includes an inventory of training systems and curriculum addressing three tiers and plans for adding curriculum that may not be available (for instance, secondary prevention group instruction in sexuality education, friendship building, etc.)	Work with agency leads to establish initial inventory of training systems and materials Present to state-wide team and discuss need for curriculum to be developed Create a plan for continuing to build on curriculum and to add into infrastructure training	The infrastructure workgroup needs assistance in developing resources that can be used by organizations implementing positive supports	Inventory included in Annual Report 2016
Map out curriculum need for preservice and inservice training related to levels of intensity needed in positive supports training including: Awareness Skill building in positive supports Facilitation of positive supports Trainer-level preparing facilitators	Annual report, 2016 includes an inventory of levels of training intensity in positive supports	Work with infrastructure and marketing workgroups and agency leads to establish initial inventory of training systems and materials Present to state-wide team and discuss need for curriculum to be developed Create a plan for continuing to build on curriculum and to add into infrastructure	Although awareness level training materials have been targeted within the marketing workgroup, a comprehensive assessment will be helpful outlining the types of training material by level of intensity across positive supports (for instance, trauma informed	Inventory included in Annual Report 2016

		training	therapy vs. trauma informed thinking)	

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the long-term objective be evaluated?**	**What are steps to achieve the long-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
State positions include application and hiring procedures that require individuals to have experience in positive supports	Documentation of state application, hiring, and related documents	Agency-wide teams take the lead by creating policy and documentation indicating all state positions strongly prefer professionals who have received training in positive supports in preservice or inservice settings	State professionals who are already aware of positive supports are better able to support implementation	2017 Annual Report includes progress made in this area
Curriculum is in place across three prevention tiers and across levels of intensity for positive supports; website provides a way in which individuals can learn more about accessing these layers of curriculum	Annual report 2017 described final steps in initial curriculum development Website describes layers of curriculum to individuals interested; access to training materials is available via the website	State-wide team works through immediate and intermediate steps to finalize this goal Workgroups responsible continue to refine and innovate curriculum over time	Data are used to improve training systems each year and website provides transparent and easy access to training for systems change purposes	2018 Annual Report
Departments in prioritized list across universities are providing preservice training and working with state professionals to prepare individuals for implementing positive supports	Annual report 2018 provides list of accomplishments including universities and departments that responded to requests Policy describing changes in personnel preparation via bachelor's degree,	State-wide team works through immediate and intermediate steps to finalize this goal State finalized documentation necessary to support changes in policy	Policy level changes helps to ensure sustainable practice	2018 Annual Report 2019 Annual Report

	master's degree, continuing education, and clinical supervision and practicum experiences to align with need for training in positive supports			

Committee/Work Group Name: Create and Maintain an Inventory of Policies

Date: _____ Committee/Work Group Members:_____

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Implementation Goal #5: Create and Maintain an Inventory of Policies

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
An inventory of policies across agencies related to restrictive practices and positive supports is conducted	Documentation (inventory)	Create excel file Send out online survey to gather information	The state is reviewing consistency of policies across agencies to improve practices	October 22, 2014
Team analyzes inventory and identifies strengths and areas of need	Annual report 2014 including summary of strengths, needs, and actions taken	State-wide team members review inventory and creates a summary to be shared with state-wide team	The analysis assists the state in moving forward with consistency and best practice	October 22, 2014
Inventory is placed on Sharepoint internally within the state for initial sharing of information	Sharepoint contains information	DHS will take the lead in posting materials	Transparency and communication is important in the state-wide planning process	November, 2014
A list of common terms that will be evaluated to ensure information is consistent across agencies	Documentation for annual report, 2015	Team is listing common terms based on overall inventory	Communication and consistency is an important goal in state-wide planning	October, 22, 2014

What Actions Are Needed to Meet This Goal?	How will the success of the immediate-term objective be evaluated?	What are steps to achieve the immediate-term objective?	How is this immediate-term objective relevant to the long-term objective?	What is the time frame for achieving the immediate-term objective?
A grid with definitions occurring across agencies for the common terms will be established	For October 22, 2014 report	Terms are gathered across agencies along with the inventory of policies	First steps in establishing common definitions is to assess similarities	October, 22, 2014
Action plan for continuing to link definitions to incident reporting system for data-based decision making is in place	For October 22, 2014 report	Definitions to increase commonality across specific terms (e.g. restraint, crisis, etc.) will be presented across stakeholder groups, placed online for common via online survey, and modified based on definitions that fit across agencies	Communication and consistency is an important goal in state-wide planning	October, 22, 2014 through July, 2015 as incident report system is finalized

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Inventory of terms are placed on the MN PBS website for all stakeholders	Website Documentation	Work with marketing workgroup to establish website Place content in section that is easy to access Monitor access to inventory via downloads	Communication and consistency is an important goal in state-wide planning	August 2015

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Training materials and incident report form information is available on MN PBS website	Website Documentation	Work with marketing workgroup to establish website Place content in section that is easy to access Monitor access to inventory via downloads	Communication and consistency is an important goal in state-wide planning	August 2015
Once inventory is stable and definitions confirmed with stakeholders, the state-wide team will organize a webinar and invite APBS network members from other states to participate in discussion	Webinar materials for presentation	Establish lead presenter Set up logistics (date, platform for sharing materials, etc.) Invite individuals using the apbs.org members site to identify individuals who may be interested	Sharing information with others may provide new ideas and ways to proceed forward	October, 2015

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	How will the success of the long-term objective be evaluated?	What are steps to achieve the long-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Inventory is refined and maintained online over time reflecting evolution of MN Positive Supports	Meeting minutes Inventory documentation Annual reports	State-wide team adds inventory to agenda each year and reviews whether changes are necessary	State-wide planning will move from initial implementation to innovation over time	Updates to inventory reported in Annual Reports 2016-2019
Definitions are reviewed and modifications made to data systems	Meeting minutes Grid with definitions	State-wide team adds inventory to agenda each year and reviews whether changes are necessary	State-wide planning will move from initial implementation to innovation over time	Updates to inventory reported in Annual Reports 2016-2019

Committee/Work Group Name: __Establish an Interagency Crisis Management Team to Monitor and Support Individuals Needing Intensive Plans

Date: _____ Committee/Work Group Members:_____

Implementation Goal #6: Establish an Interagency Crisis Management Team to Monitor and Support People Needing Intensive Plans

Immediate Term Objectives ***(To Be Achieved Within Next 6-8 Months)***

What Actions Are Needed to Meet This Goal?	**How will the success of the immediate-term objective be evaluated?**	**What are steps to achieve the immediate-term objective?**	**How is this immediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the immediate-term objective?**
Form an interagency crisis prevention team	Meeting minutes List of participants for public meeting List of sub team members to monitor people regularly	State-wide team makes a list of crisis systems teams, and state professionals; Other related stakeholders are invited (people receiving services, advocates, etc.) Part of meeting is public (2x a year for larger discussions) State sub team members will identify specific people who engage in serious problem behavior and have experienced multiple "crises"	Crisis prevention is part of Tier 3 services provided by the state	November, 2014
Identify an initial small number of people to follow and monitor progress Establish whether individualized plans are in place to support individual	Meeting minutes	Use information about a small group of people needing more intensive supports to: • Streamline communication across agencies • Improve flexibility of services for people • Establish	Providing a way to monitor people with a history of experiencing crisis can provide important information that is used to improve services	November, 2014

		strategies for improving positive supports • Brainstorm ways to increase behavioral expertise and supports		
Explore national crisis models and identify ways to improve outcomes and increase behavioral expertise for crises	Presentations by invited professionals	Invite presenters representing major crisis management systems	Learning about best practice in crisis management systems provides new information as new systems are reported over time	January, 2015 through July, 2015

Intermediate Term Objectives ***(To Be Achieved Within Next 1-2 Years)***

What Actions Are Needed to Meet This Goal?	**How will the success of the intermediate-term objective be evaluated?**	**What are steps to achieve the intermediate-term objective?**	**How is this intermediate-term objective relevant to the long-term objective?**	**What is the time frame for achieving the Intermediate-term objective?**
Outline lessons learned by crisis prevention team and create a report that outlines policies and procedures to improve crisis prevention	Annual report includes section on crisis prevention planning	Use information gathered from public discussions and private progress monitoring to make recommendations Workgroup shares recommendations with state-wide team Policies and procedural suggestions are made formally to state system	The crisis workgroup will provide details necessary to consider innovative strategies for prevention	Annual report 2015

What Actions Are Needed to Meet This Goal?	How will the success of the intermediate-term objective be evaluated?	What are steps to achieve the intermediate-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
Create a plan to provide incentives to exemplary organizations who choose to work with people who have a history of challenging behavior since these systems are better able to prevent challenging behavior	Annual report provides this information based on workgroup recommendations	Crisis workgroup continues gathering information from public group and progress monitoring Recommendations are proposed to the state-wide team Information is shared via a proposal for new policy and supports	Use growing evidence and data from implementation to show why policies are needed	Annual report 2015 Policy documents 2016

Long Term Objectives ***(To Be Achieved Within Next 3-5 Years)***

What Actions Are Needed to Meet This Goal?	How will the success of the long-term objective be evaluated?	What are steps to achieve the long-term objective?	How is this intermediate-term objective relevant to the long-term objective?	What is the time frame for achieving the Intermediate-term objective?
New policies and procedures are approved and legislative support in place to improve crisis prevention system	Policies and procedures approved Evidence of legislative proposals	Workgroup completes immediate and intermediate actions to accomplish this task	New ideas driven by workgroup experience improves interagency communication and service provision	Annual report 2016 and 2017 describes progress made
Data from state-wide planning show that organizations receiving TA have lower numbers of crises over time compared with organizations that have not yet started implementing	Data from local, regional, agency-wide and state-wide reports	Work with state-wide team to monitor data related to crises, injury, emergency room visits, acute care stays, etc. via the crisis management workgroup	Using data for decision making should occur at all levels of state-wide planning	Annual reports 2017, 2018, 2019 highlights evidence regarding long term implementation of positive supports
Incentives are in place for exemplary organizations to manage more	Policy documents finalized and approved	Plan for sharing information via organizations participating in	Transition planning occurs for people who are not well	Annual reports 2017, 2018

challenging cases since these systems are better able to support people with challenging behavior		TA Place information on the website Workgroup identifies people who would excel in certain conditions and assists in transition planning	suited for current living situations Organizations serving individuals choose to participate in TA training in order to improve services for individual the group is monitoring	