

**UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA**

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

Civil No. 09-1775 (DWF/FLN)

Plaintiffs,

v.

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

Defendants.

Minnesota Olmstead Subcabinet Report to the Court

STATUS UPDATE

November 1, 2014 – December 31, 2014

Report Number 6

ADDENDUM

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I. PURPOSE

A special Olmstead Subcabinet meeting was scheduled for March 10, 2015 to complete the review of remaining actions for the reporting period of November and December 2014 and any outstanding items needing approval by the subcabinet.

This addendum to bimonthly report number 6 provides status updates on Olmstead Plan action items due in November and December 2014 and items specifically found non-compliant by the Court Monitor in his December 31, 2014 report to the Court. The exhibit numbering continues from Report 6.

Proposed Modifications to the Olmstead Plan

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

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

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

On January 9, 2015, the Court provisionally approved the November 10, 2014 proposed revisions, subject to the Court's review of the State's modifications and any submissions by Plaintiff's Counsel. The court stated that the State shall file a revised Olmstead Plan by March 20, 2015. The Subcabinet reviewed the proposed modifications to the Plan at the March 10, 2015 special meeting.

II. OLMSTEAD PLAN IMPACT ON LIVES OF INDIVIDUALS

The next report on this section will be in the April 2015 Bimonthly report.

III. OLMSTEAD PLAN ACTION ITEMS STATUS UPDATE

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

Item	Deadline	Brief Description	On Time	Late – Complete	Late – In process
OV 1A	12/31/14	Individual planning service		X	
OV 3A	12/31/14	Leadership opportunities		X	
QA 2A	6/30/14	Dispute resolution process		X	
QA 4A	9/30/14	Quality Improvement Plan			X
EM 3A	8/31/14	Person centered planning employment first		X	
EM 3D	9/30/14	Motivational interviewing training		X	
HS 2A	12/31/14	Affordable housing baselines/targets	X		
TR 1B	9/30/14	Review of administrative practices			X
SS 3I	8/1/14	Crisis triage and hand-off process		X	
SS 3J	12/1/14	Technical assistance on positive practices	X		
SS 4B	9/30/14	Improvements to the waiting list	X		
SS 4C	12/31/14	Expand use of assistive technology			X
ED 1D	11/30/14	Stakeholder input on prohibition of prone restraint in schools	X		
HC 1C	12/31/14	Framework for behavior health home	X		
HC 2G	12/31/14	Baseline data for current care	X		
HC 2I	9/30/14	Barriers in healthcare transitions for youth		X	
HC 2J.1	12/31/14	50% of youth transition to adult health care	X		
CE 1A	12/31/14	Increase opportunities in policy making		X	
CE 1B	12/31/14	Peer support and self-advocacy programs		X	
CE 2A	12/31/14	Involvement in public planning processes		X	

- On Time = verified as completed on the due date
- Late/Complete = 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.

ITEMS FOR REVIEW AT MARCH SUBCABINET MEETING

The subcabinet scheduled a special meeting on March 10, 2015 to complete the review of remaining action items for the reporting period (November 1, 2014 through December 31, 2014) and any outstanding items needing approval by the subcabinet.

OVERARCHING STRATEGIC ACTIONS

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

Status: The deadline was not met. The State has adopted the broad principles of person-centered planning as defined in the Olmstead Plan. This will allow flexibility for individuals to choose the tool that best meets their needs and conforms to the core principles of person-centered planning.

[Exhibit 6-17](#) shows that the person-centered planning services are funded for a certain portion of the population, but more work needs to be done to acquire funding to allow for further expansion. It is being recommended that the subcabinet reassign the responsibility of this action item to DHS, DEED, and MDE.

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

Status: The December 31, 2014 deadline was not met. The action item is included on page 27 of the Community Engagement Plan which is included as [Exhibit 6-29](#). The plan sets forth three ways to increase leadership opportunities: active engagement with Governor appointed councils, groups and boards; increased participation of self-advocates in Tuesdays at the Capitol; and increased state agency employment (as set forth in Executive Order 14-14). Goals and timelines were established for each of the three areas.

QUALITY ASSURANCE AND ACCOUNTABILITY

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

Status: The deadline was not met. The Olmstead Implementation Office has established a process for the referral of individuals with disputes to one of the several existing dispute resolution bodies within state agencies. [Exhibit 6-18](#) includes the Dispute Resolution Process Work Plan which describes the current process and preliminary findings. The workplan includes a recommendation to establish a workgroup with specific responsibilities to complete an assessment of agency dispute resolution processes, address problem areas identified in the early implementation of the plan, define effective ways to educate the public about the various dispute resolution processes, and develop a plan to disseminate the report to the public.

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

Status: The deadline was not met. The proposed Quality Improvement Plan creates the expectation of improving timely completion of action items as reported in the Bimonthly status reports from the baseline of 48% to 73% by December 2015. Additionally, the OIO will create a standard report to be submitted to the subcabinet bimonthly. The report will cover the seven components identified in the Plan action item. The subcabinet will use these reports to monitor overall performance in these specific areas and to identify areas that need additional attention or corrective action. The Quality Improvement Plan is included as [Exhibit 6-19](#).

EMPLOYMENT

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

Status: The deadline was not met. “Make Work Part of the Plan” modules are provided during the Person Centered Planning (PCP) training. Individuals who previously completed PCP training are being notified that the training is available on the “Set the Stage for Change” page of the [DB101 website](#). Additionally the contracted entity that provides the PCP training is incorporating the Make Work Part of the Plan modules into their community of practice training. The training is also targeting an expanded audience by including it in the College of Direct Supports. Training completion will be tracked through the Train Link system.

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

Status: The deadline was not met. Motivational Interview training will be done at a statewide conference hosted by CommUnity a Mental Health Initiative from Central Minnesota to occur in 2015. DHS has provided funding to this Mental Health Initiative to develop the statewide training for: Mental Health practitioners, Mental Health Clinical Directors and Program Managers, VRS Rehabilitation Area Managers, VRS Counselors serving Individual Placement and Support (IPS) Projects and Community Rehabilitation Program (CRP) Placement Professionals and Program Managers supporting IPS projects.

It is anticipated that most key members of statewide IPS projects will attend because there is a great deal of interest to develop best practices in supporting individuals with serious mental illness (SMI) in obtaining and maintaining employment. Conference attendance and registration will be tracked to ensure the target audience is reached. Following the statewide IPS conference training on Motivational Interviewing/Engagement Training, IPS Project will be provided a trainer list of MINT’s (Motivational Interviewing Network of Trainers) to further develop Motivational Interviewing of new and veteran IPS Team members. An overview of training concepts that will be covered is included as [Exhibit 6-20](#).

HOUSING

- **HS 2A** - By December 31, 2014 a baseline will be established and targets for future years determined addressing: The number of new affordable housing opportunities created compared to the previous 5 years' average; the number of people with disabilities accessing affordable housing opportunities in the community; the number of people with disabilities with their own lease; and for people who move to more integrated settings, track measures related to housing stability such as duration of residence and transitional moves within the system.

Status: The deadline was met. Measurable goals were submitted to the Court Monitor on December 31, 2014. These goals are impacted by the Governor's Budget and updates are being provided to the Monitor.

TRANSPORTATION

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

Status: The deadline was not met. The report has been delayed. A draft copy will be going out for public comment on March 9, 2015. It will be finalized on March 24, 2015 and ready for subcabinet review and approval at the April 13, 2015 meeting.

SUPPORTS AND SERVICES

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

Status: The deadline was not met. The "*Crisis Triage and Hand-Off Process*" report summarizes the crisis services currently available through community-based mental health services, home and community-based services, and state operated facilities. The report identifies current barriers that exist in access, available services, and follow-up for people in crisis. The barriers are addressed in a three pronged approach to improve crisis responses which includes improving crisis triage and handoff; use of positive supports and person-centered planning; and mental health system reform. The report includes measurable goals that would result from efforts to improve the crisis system. These goals are dependent on funding requests currently under consideration in the 2015 legislative session. Crisis Triage and Hand-Off Process Report is included in [Exhibit 6-21](#).

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

Status: The deadline was met. This action item is imbedded in “*Minnesota’s Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports*” which was approved by the Subcabinet as **Exhibit 6-14** in February 2015. [Exhibit 6-22](#) includes an overview of the requirements in this action item.

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

Status: The deadline was met. An initial draft of the Wait List report was submitted to the subcabinet on September 29, 2014. The revised report is included as [Exhibit 6-23](#). “*Home and Community-Based Supports and Services Waiver Waiting List Report*” specifies a structure based upon urgency of need by the individual that will allow individuals to move from the wait list at a reasonable pace. Additionally the report specifies actions to enhance data collection and analysis to improve monitoring and transparency of the process. The report also calls for comprehensive technical assistance, training and monitoring for compliance.

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

Status: The deadline was not met. Key agencies with responsibility for funding and the provision of assistive technologies have begun meeting. It is being recommended that the subcabinet designate a state agency with responsibility and expertise in assistive technology to lead the workgroup. The workgroup will present a work plan for accomplishing this action item at the April subcabinet meeting.

LIFELONG LEARNING AND EDUCATION

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

Status: The deadline was met. The 2014 Restrictive Procedure (RP) stakeholder group began meeting in 2014 to review the 2013 statewide plan. A summary of the activities completed by the group is included in Appendix A of the “[Report on Districts’ Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools](#)” 2015 Report to the Legislature. The report is included in [Exhibit 6-24](#).

The Governor's Budget for FY 16-17 recommends additional support at 2.3 million dollars per year to accelerate the implementation of school wide Positive Behavioral Intervention and Supports (PBIS) in schools and districts throughout Minnesota. This funding would build on legislative priorities around the reduction in the use of restrictive procedures and actions in the Olmstead plan.

HEALTHCARE AND HEALTHY LIVING

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

Status: The deadline was met. The Department of Human Services (DHS) is working to implement behavioral health homes (BHH) as a first step in the 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).

The BHH work group has contracted with an external entity to conduct consumer focus groups; determine service eligibility; design the service definitions and structure; determine the team make-up, qualifications and responsibilities; develop provider standards and preliminary certification process; develop a legislative proposal for submission in the Governor's budget; and develop a State Plan Amendment that will be submitted to CMS for review and approval. [Exhibit 6-25](#) includes a full implementation report for items due by December 31, 2014.

The original timeline in the Plan had Minnesota implementing BHH services on July 1, 2015. Implementation requires additional funding. The Governor's 2015 budget proposal includes funding for this project. If adopted the start time of BHH services would need to move from July 1, 2015 to January 1, 2016. This would require a request for modification to the Court Monitor.

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

Status: The deadline was met. In accordance with the action item, baseline data was established for current care of people with disabilities and is included as [Exhibit 6-26](#). Additionally a plan was defined to monitor the system performance against the baseline. This information will be used for the analysis and identification of policy, practice, and program changes necessary to improve access as required in action item HC 2H which is due August 1, 2015.

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

Status: The deadline was not met. A report summarizing the system analysis describing barriers that need resolution for transitioning youth with special health care needs to adult health care is included in [Exhibit 6-27](#). The report also includes a plan for addressing those barriers.

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

Status: The deadline was met. The baseline was established. There are 76,735 children aged 12-17 in Minnesota with special health needs. Of those youth, 36,065 or 47.1% receive the services necessary to make transitions to adult health care. Measurable goals were established and submitted to the Court Monitor on December 31, 2014 and are included in [Exhibit 6-28](#).

The goals are:

- By December 31, 2014, the number of Minnesota’s transition age youth with disabilities who receive the services necessary to make transitions to adult health care will increase to 38,368 (50%).
- By December 30, 2016, the number of Minnesota’s transition age youth with disabilities who receive the services necessary to make transitions to adult health care will increase to 42,204 (55%).
- By December 30, 2018, the number of Minnesota’s transition age youth with disabilities who receive the services necessary to make transitions to adult health care will increase to by 46,041 (60%).

COMMUNITY ENGAGEMENT

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

Status: The deadline was not met. This item is on page 22 of the Community Engagement Plan which is included as [Exhibit 6-29](#). Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The measurement processes within the Plan will be used to assess engagement of people with disabilities and the level of meaningfulness of that engagement process. The OIO will provide technical assistance and training related to the engagement plan to ensure understanding. Measurable goals for this item are identified in the plan.

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

Status: The deadline was not met. The item is on page 23 of the Community Engagement Plan which is included as [Exhibit 6-29](#). The Olmstead Implementation Office reviewed literature regarding self-advocacy and peer supports and consulted with people with disabilities, family members, community groups and state agencies in order to assess the size and scope of programs in Minnesota. Goals and timelines are included.

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

Status: The deadline was not met. This item is on page 18 of the Community Engagement Plan which is included as [Exhibit 6-29](#). The OIO is working with the State Treasury and Bonding Office and Minnesota Management and Budget to determine appropriate data sources for the creation of a baseline measurement of publicly funded action items at the state level. This information will be the first step toward ensuring that people with disabilities are included and engaged in action items that are publicly funded and that their input is used in meaningful ways.

This baseline measure will be established by June 30, 2015. In addition to the baseline measurement and goals to be set related to publicly funded projects cities, counties and other local governments will be provided with this community engagement plan and toolbox to aid them in engaging people with disabilities in their projects. The Olmstead Implementation Office will offer education sessions to train county and other local government staff at least two times per year on the Olmstead Community Engagement Plan. The purpose of these sessions will be to familiarize staff with the plan and its requirements as well as teach them to train others on the same material.

PREVIEW OF ITEMS DUE IN NEXT FOUR MONTHS

There are no updates to this section of the report since the February 20, 2015 report.

IV. ACTIONS TAKEN BY SUBCABINET

1. The subcabinet took the following actions on the Plan action items below:

Item	Deadline	Brief Description	Action(s) Taken
OV 1A	12/31/14	Individual planning service	Approved plan with minor edit Reassigned from OIO to DHS, DEED, MDE
OV 3A	12/31/14	Leadership opportunities	Approved Community Engagement Plan Approved measurable goals
QA 2A	6/30/14	Dispute resolution process	Adopted plan Established workgroup
QA 4A	9/30/14	Quality Improvement Plan	Requested edits to the plan Moved review to April
EM 3A	8/31/14	Person centered planning employment first	Approved plan
EM 3D	9/30/14	Motivational interviewing training	Approved plan
HS 2A	12/31/14	Affordable housing baselines/targets	No action needed – Baseline already submitted to Court Monitor
TR 1B	9/30/14	Review of administrative practices	Report to be finalized on March 24 th Moved review to April
SS 3I	8/1/14	Crisis triage and hand-off process	Approve report with minor edit
SS 3J	12/1/14	Technical assistance on positive practices	Approved report
SS 4B	9/30/14	Improvements to the waiting list	Approved report with minor edit
SS 4C	12/31/14	Expand use of assistive technology	Reassigned from OIO to Dept. of Admin. Moved review of workplan to April
ED 1D	11/30/14	Stakeholder input on prohibition of prone restraint in schools	Approved report
HC 1C	12/31/14	Framework for behavior health home	Approved report
HC 2G	12/31/14	Baseline data for current care	Approve report with minor edit
HC 2I	9/30/14	Barriers in healthcare transitions for youth	Approved report
HC 2J.1	12/31/14	50% of youth transition to adult health care	Approved report
CE 1A	12/31/14	Increase opportunities in policy making	Approved Community Engagement Plan Approved measurable goals
CE 1B	12/31/14	Peer support and self-advocacy programs	Approved Community Engagement Plan Approved measurable goals
CE 2A	12/31/14	Involvement in public planning processes	Approved Community Engagement Plan Approved measurable goals

2. The subcabinet approved the February Bimonthly report 6 addendum.
3. The subcabinet approved reassigned OV 1B, OV 1C and SS 1B from OIO to DHS, DEED, and MDE.
4. The subcabinet approved the Subcabinet Procedures ([Exhibit 6-30](#)).
5. The subcabinet appointed DEED as the third member of the Subcabinet Executive Committee.
6. The subcabinet authorized the Subcabinet Executive Committee to approve the final response to the January 9, 2015 Court Order.

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Exhibit 6-29	CE 1A, 1B, 2A AND OV 3A – Community Engagement Plan
Exhibit 6-30	Olmstead Subcabinet Procedures

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EXHIBIT 6-17: OV 1A – INDIVIDUAL PLANNING SERVICE

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Olmstead Plan Report

Action Item OV 1A – Individual Planning Service

Introduction: Begin with the individual.

The Olmstead Plan’s first overarching strategic action is to “begin with the individual.” This means, “listen to individuals to ascertain their preferences for services and their views about quality of life, ensure that their rights are recognized, and incorporate this perspective through all phases (assessment, planning, service delivery, and evaluation).” (*Id.*)

Olmstead Plan action items.

The Plan requires the state to take two actions by December 31, 2014 to carry out “beginning with the individual:”

1. “Define an individual planning service that is available to people with disabilities to assist them in expressing their needs and preferences about quality of life. (This service may be an expansion of an existing practice or development of new practices).
2. Make funds available for this purpose.” (Olmstead Plan, OV 1A)

This report will explain what the state has done toward these two action items. In addition to these two items, the Plan requires the state to “develop a plan to initiate this service” during the first quarter of 2015. (Olmstead Plan, OV 1B) A report will be provided to the subcabinet on that item at the June 2015 meeting.

Responsible Agency.

The subcabinet assigned the Olmstead Implementation Office (OIO) to complete these action items. As work progressed, however, the Department of Human Services (DHS) took the laboring oar because of their expertise. Accordingly, the OIO and DHS jointly recommend that the Subcabinet reassign the responsibility for OV 1A and OV 1B to DHS, DEED and MDE.

Status Report.

1. DHS prepared a proposal for an individual planning service to assist people with disabilities in expressing their needs and preferences about quality of life. Specifically, DHS sought funding for a new individual planning service through the Medical Assistance (MA) state plan and through grant funding for those not eligible for Medical Assistance.
2. In the budget request, DHS identified that the individual planning service must conduct person-centered planning according to the definition in the Olmstead Plan.

3. New funding will not be available for the proposed service at this time.
4. However, person-centered planning is funded for people with disabilities who receive waived services. In November, 2014, DHS distributed information about these services to lead county agencies and other entities that subscribe to the Home and Community-Based Services (HCBS) list-serve.
5. In addition, DHS has incorporated person-centered planning principles into lead county agencies' annual assessments of individuals with disabilities.
6. Person centered principles as identified in the CMS regulations¹ are incorporated into the transitions planning and monitoring required in the Olmstead Plan to support people in moving to the most integrated setting (See Plan, Supports and Services section – action one). DHS is participating in the National Core Indicators for people with intellectual and developmental disabilities, older adults and people with disabilities to obtain information about the outcomes of services using person centered principles to assess our state performance and establish benchmarks for longitudinal improvement.
7. Also, the Employment First policy adopts person-centered planning principles for persons with disabilities when explaining options and obtaining informed choice about employment. Standards from the CMS regulations and new federal WIOA² on person centered planning, and informed choice will be used by state agencies when implementing the Employment First Policy.
8. Moreover, DHS and the Department of Education (MDE) use person-centered planning as the foundation in their Statewide Person Centered Positive Support Plan.

¹ Federal Register/Vol.79, No. 11/ Thursday, January 16, 2014/Rules and Regulations page 336. §441.725 Person-centered service plan.

² In spring 2015, the Departments of Labor and Education plan to concurrently publish five Notices of Proposed Rulemaking (NPRMs) to implement *WIOA*. One of these will be a joint NPRM involving jointly administered activities including unified and combined state plans, performance, and aspects of the one- stop system. Another NPRM will implement the remaining provisions of Title I and Title III that are administered by the Department of Labor. Three additional NPRMs involve Department of Education programs, including one implementing Title II Adult Education and Literacy and two implementing the Title IV Amendments to the *Rehabilitation Act of 1973* of *WIOA*. These five NPRMs will be published in the *Federal Register* and posted on www.regulations.gov, where public comments can be submitted following publication. The Departments of Labor and Education will analyze these public comments, and anticipate issuing Final Rules implementing *WIOA* in early 2016. Because many provisions of *WIOA* go into effect July 1, 2015, the Department of Labor's Employment and Training Administration (*ETA*) also will issue operating guidance in spring 2015 to support implementation. In addition, *ETA* intends to issue targeted guidance documents in the spring, accompanied by technical assistance activities. Once issued, the guidance can be accessed at www.doleta.gov/wioa/.

EXHIBIT 6-18: QA 2A – DISPUTE RESOLUTION PROCESS WORK PLAN

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Olmstead Dispute Resolution Process Work Plan

*Author: Olmstead Implementation Office in collaboration with Department of
Human Rights for QA 2A*

Date submitted to Subcabinet: / / Date Approved by Subcabinet: / / Date submitted to
Court: / /

2/24/2015

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Introduction

The Olmstead Implementation Office (OIO) has been working to assist individuals to access existing dispute resolution processes among the agencies that comprise the Olmstead subcabinet.

This document provides an overview of the activities undertaken thus far, activities recommended to occur in the near future, and a proposed 2015 work plan for review by the subcabinet to provide guidance for activities going forward.

Current Plan

The current dispute resolution process includes the following components:

- The process currently operates out of the Olmstead Implementation Office (OIO) under the direction of the Olmstead subcabinet.
- The OIO team receives complaints, discusses the issues with the individual and works informally with them to resolve the complaint.
- The OIO team works with various agencies to establish working relationships for purpose of obtaining appropriate resources and finding resolutions to identified complaints.
- The majority of the complaints have been referred and resolved through the agencies' informal efforts.
- The OIO had several instances of complaints elevated to the Compliance/Legal Office of the respective agency or referred to outside referral sources.
- The OIO tracks and documents all complaints in a spreadsheet.
- The Olmstead Implementation Office will provide a summary report to the subcabinet.

Future Plan

The Minnesota Olmstead Plan (Plan) envisions individuals who believe that they have not received services or supports in accordance with the principles set forth in *Olmstead v. L.C.* will have a way to raise their concerns and address the problem.

Preliminary Feedback

In the course of implementing the current process above, the following issues of concern were identified:

- Existing dispute resolution processes were reported as ineffective in resolving Olmstead related concerns
- There is need for a comprehensive list of existing dispute resolution processes within agencies
- Individuals with Olmstead related concerns reported a need for consumer advocacy services
- The dispute resolution processes vary widely within the agencies in several areas including: timeframes for filing complaints, formality of the process, and impact on the individual to seek other legal relief
- It is unclear to individuals which dispute resolution process is the most appropriate for their situation

Recommendations

It is recommended that the subcabinet adopt the following actions:

- By March 31, 2015, establish a workgroup including the OIO and the Minnesota Department of Human Rights (MDHR) and other stakeholders as appropriate
- The workgroup will review the concerns identified and make recommendations to modify the dispute resolution process to address these areas.
- This may include contracting with a third party to develop and conduct a survey of all subcabinet agencies to outline existing processes, types of complaints, length of time to resolution, and complainant satisfaction.
- The workgroup will examine effective ways to educate the public about the various dispute resolution processes, ways to access those processes, and recommend a continuous improvement process
- The workgroup will include a plan to disseminate the report to the public, advocacy organizations and agencies.
- By December 31, 2015 the workgroup will report findings and recommendations for improving the dispute resolution process to the Subcabinet

Timetable

Activity	Time Frame	Responsible
Continue current dispute resolution plan	Present	OIO
Report lessons learned from dispute resolution plan	3/2015	OIO
Establish workgroup to develop report	3/2015	OIO/MDHR
Submit dispute resolution report	12/2015	OIO/MDHR
Convene public events on dispute resolution practices	2016	OIO/MDHR

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EXHIBIT 6-19: QA 4A – QUALITY IMPROVEMENT PLAN

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Olmstead Quality Improvement Plan

Author: Olmstead Implementation Office for QA 4A

Date submitted to Subcabinet: / / Date Approved by Subcabinet: / / Date submitted to
Court: / /

2/26/2015

Olmstead Quality Improvement Plan

Introduction

The Quality Improvement Plan will be an evolving and expanding process to address the changing needs for implementing the plan and making sure that the plan is working for individuals. The Jensen Settlement Agreement and the subsequent court orders make it clear that the state of Minnesota is expected to demonstrate that the plan is being monitored and is effectively implemented. The Quality Improvement Plan incorporates the processes and structures to make sure this happens and is the foundational framework for quality assurance and accountability.

The purpose of the Quality Improvement Plan is to document and assemble statewide quality structures that measures performance; provides transparency and assures accountability. The state will utilize these structures to monitor performance and initiate necessary changes. The structures will provide people with disabilities, their families and their advocates the necessary and sufficient information on outcomes to hold the state and other public entities accountable for implementation and when necessary recommend modification of the plan. (Olmstead Plan, Page 33)

Quality Improvement is only one of the four main strategic actions to ensure quality and accountability. *The four strategic actions include:*

- 1) *Quality of Life measurement*
- 2) *Dispute resolution process for individuals with disabilities*
- 3) *Oversight and monitoring implementation of the plan*
- 4) *Quality improvement (Olmstead Plan, page 33)*

Quality Improvement Plan

The Plan states that the subcabinet will adopt an Olmstead Quality Improvement Plan to be administered by the Olmstead Implementation Office. (QA 4A, page 37) To meet this requirement the Olmstead Implementation Office will provide a standard report at the subcabinet meetings on progress in the areas identified below. The subcabinet will use these reports to monitor overall performance in these specific areas and to identify areas that need additional attention or corrective action.

- *Engagement methods of Governor's Appointed Councils and Advisory Committees*
- *Policies and procedures that establish best practice in the prevention of abuse and/or neglect of persons with disabilities.*
- *Methods to conduct ongoing quality of life measurement, quality improvement structures, and needs assessment.*
- *Description of the availability of self-advocates; peer support specialists or similar peer delivered services that promote self-determination and greater independence in life choices.*

- *Methods to monitor all legislative proposals that may impact the rights of persons with disabilities in accordance with the Olmstead Decision and ADA.*
- *A description of how people with disabilities and their families are involved in monitoring and reviewing the community services and support, and how they serve in leadership roles in modifying the services and supports over time.*
- *Coordinated data system and established process to measure and analyze existing data from abuse, neglect, exploitation, injuries, and deaths reporting systems. Establishing uniform definitions, standards and protocols, assuring transparency to the consumer, tracking trends, identifying problem areas; and aiding in the development of interventions using state of the art technology. (Olmstead Plan, page 36)*

Performance Improvement Project:

The Olmstead Implementation Office will initiate a performance improvement project to improve the timely completion of action items as reported in the Bimonthly Status Reports.

The current baseline is:

- 48% (35 of 73) action items were completed on time. This includes items included in Bimonthly Status Reports 4, 5 and 6 (October 2014 through March 2015)

The goal is:

- For items due during 2015, increase the action items completed on time by 25%.

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EXHIBIT 6-20: EM 3D – MOTIVATIONAL INTERVIEWING TRAINING OVERVIEW

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Motivational Interviewing

Vocational Rehabilitation Services The Minnesota Experience

What is Motivational Interviewing (MI)?

MI is a person centered counseling style for addressing the common problems of ambivalence about change.

- Purposeful conversation directed at a particular change goal (target behavior)
- Pays careful attention to what consumers say
- Aims to elicit a consumer's own desire & reasons for change (intrinsic motives)
- Involves competence in a well-defined set of skills (OARS)
- MI is done **for** or **with** someone, not **on** them or **to** them.

Developed by William Miller in 1983 in work with substance abusing clients. Through extensive research, MI has been shown to:

- increase consumer engagement in the change process
- reinforce consumer self-motivation
- improve consumer completion rates
- contribute to better consumer outcomes

MI is an evidence-based practice in the fields of substance abuse treatment, mental health, and corrections. It has been translated into over 39 languages, and disseminated in training and practice all over the world. For more information, see www.motivationalinterview.org

Key Concepts in Motivational Interviewing

The Spirit of Motivational Interviewing

What do you believe about consumers and their ability to change? MI works best when you believe that consumers really want to change, and they are just stuck, ambivalent, or don't know how to change.

The underlying spirit of MI is characterized by:

- **Partnership:** Establishing a partnership with the consumer to work together to change
- **Acceptance** includes demonstrating:
 1. Absolute worth of the individual
 2. Accurate empathy
 3. Autonomy support
 4. Affirmation
- **Compassion:** actively promoting the other's welfare, giving priority to the other's needs
- **Evocation:** Do more asking than telling; do more listening than talking

Four Key Processes

- **Engaging:** Establishing a helpful connection and working relationship
- **Focusing:** Developing and maintaining a specific direction in the conversation about change
- **Evoking:** Eliciting the client's own motivations for change
- **Planning:** Developing commitment to change and formulating a concrete plan of action

Micro Skills which increase motivation for change

- Open-ended questions
- Reflections
- Affirmations
- Summaries
- Advice with Permission

Change Talk

Recognizing and responding to consumer comments about change will lead to change. Talking about changing can predict success and leads to commitment and taking steps to change.

MI practitioners selectively attend to elements of client statements, and elicit and reinforce client statements in favor of change (“change talk”) while diffusing talk that sustains the status quo.

MI practitioners listen closely for:

- **Desires** to change
- **Abilities** to change
- **Reasons** for change
- **Need** to change
- **Commitment** to change

Responding effectively to “sustain talk” (consumer comments that favor the status quo) and “discord” (signals of disharmony or dissonance in the working alliance) is a key to successful progress toward change.

Sustaining the Spirit and Practice of Motivational Interviewing

A great deal has been learned about effective ways to implement and sustain evidence-based practices and other innovations. The components of effective implementation and sustainability of a new practice can be thought of as three legs of a three-legged stool. As such, all three legs are needed to successfully make the stool stand on its' own.



Staff Competence

Organizational supports

Leadership

Staff Competence: includes selection, training, and coaching of staff to perform the Evidence-based Practice with fidelity to the way it was intended to be delivered (Fixsen & Blasé, 2007).

Organizational Supports: includes systems intervention toward changing the work culture as a result of the innovation, facilitative and supportive administration to implement the innovation, decision and evaluation data to support the innovation (Fixsen & Blasé, 2007).

Leadership which is adaptive to change and has technical expertise relative to the new innovation is the third vital leg to implement and sustain an evidence-based practice. (Fixsen & Blasé, 2007).

The challenges faced by the Implementation Team include where to begin? Some practical questions for the Implementation Team:

1. **Who in the group/agency/program will continue to sustain and infuse MI into practice?**
("Champions", Implementation Committee)
2. **How will you continue to implement and infuse MI into the "practice" of the agency?**
(Work with clients/participants? Practice exercises, Clinical Case Consultations, Assessment and or intake process, taping and coding of interviews)
3. **How to support and sustain MI into the work culture of the agency/program?**
(New Staff onboarding, job descriptions & hiring practices, Administrative support, staff meetings)
4. **What resources do you need to do this?**
(List of training exercises, bibliography of references, websites)

EXHIBIT 6-21: SS 3I – CRISIS TRIAGE AND HAND-OFF PROCESS

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Crisis Triage and Hand-off Process

Minnesota Department of Human Services
Community Supports Administration
February 2015



For more information contact:

Minnesota Department of Human Services
Adult Mental Health Division
St. Paul, MN 55101
651-431-2225

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

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

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Olmstead Plan Language

Supports and Services section

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

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

-Minnesota’s Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 66.

Introduction

Crisis is defined as a condition of instability or danger that constitutes a turning point in a person’s life. Crises occur where people live and work, in big cities and wide-open spaces, when people are alone or in community, during office hours and in the dead of night. The requirements for reliability across all support systems, ensuring that there is early crisis planning and immediate crisis response, as well as the gravity of the consequences if the response is not provided, demands extraordinary levels of systems coordination, integration, and synthesis.

The overarching goal of crisis services is to provide timely and appropriate support to people who are experiencing significant instability in their lives or are facing eminent danger. The term “crisis” covers a range of situations, such as those prompted by the loss of a caregiver or a significant change in a medical or health condition, that compromise the ability of a person or that person’s support system to manage their symptoms or behaviors to such an extent that there is potential for serious harm to the person or others.

A response that is activated only when physical safety of the person or others is compromised is often “too little, too late” or “no help at all” in addressing the root of the crisis.”¹ Effective crisis services, therefore, constitute an interconnected network of supports before, during, and after a crisis episode, during which appropriate responses must also meaningfully address the issues underlying the crisis.

Minnesota currently offers crisis services to people with disabilities through different service systems—community-based mental health services, home and community-based services, and state operated facilities. These three systems have different definitions of and responses to “crises.” These differences are part of the underlying issues that lead to gaps in the crisis response system.

¹ [Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.](#)

Background Information

Current services

A number of existing efforts and planned initiatives are underway to serve people in crisis. There are themes around which these efforts and initiatives can be grouped, as follows:

Case Management: Related services include Community Support Services Crisis Teams; Metro Crisis Coordination Program in the seven county Twin Cities metro area; adult mental health crisis response teams, who routinely see clients in rural hospital emergency departments or jails; and an array of children's mental health services. Crisis response teams are expected to develop regional collaborations with law enforcement, probation officers, schools, case management, and emergency departments for referrals and to know when and how to access crisis services. Case managers are encouraged to develop crisis/relapse prevention plans as part of the individual's Community Support Plans. Crisis plans become part of a person-centered plan that seeks to proactively address both positive as well as challenging behaviors in the community. With the recipient's consent, these plans are shared with the mental health crisis response teams. Adult protective services is a 24/7 county-based common entry point for reporting suspected maltreatment of a vulnerable adult screening for immediate need for protective services or law enforcement, and referral to lead agency to investigate the alleged maltreatment. Additionally, there is a 2015 legislative proposal for enhanced crisis wrap-around services for persons with Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI), and Development Disability (DD) waiver services that had two or more behavioral-related hospitalizations in the previous calendar year.

Mobile Crisis Response Services: The mental health services system includes mobile crisis response teams in 79 counties and one tribe.

Training for Community Capacity: Mental health crisis teams provide community intervention with families and other affected persons; children's mental health services include families and guardians in service design and evaluation; Community Support Services provides training, mentoring, and coaching to clients and others, technical assistance to divert commitments and address crises; and the Minnesota Family Investment Program is developing short- and long-term crisis planning for families with children with mental illness.

Short-term Residential Crisis Stabilization and Respite Capacity: Crisis stabilization beds are available for short-term crisis services for adults; Minnesota Intensive Therapeutic Homes (MITH) Respite offers 30-day crisis return to forensic transitions to prevent revocation of provisional discharge; residential crisis stabilization facilities (licensed as either Intensive Residential Treatment Services or Adult Foster Care) provide structured living for adults who are fragile or are experiencing a crisis; the state-operated Life Bridge program provides housing and support during transitions; currently there are 16 crisis respite beds (≤90 day stay) available statewide for persons with developmental disabilities. There is also in-home crisis respite service available for persons who are on the Developmental Disabilities waiver.

Sustainable and Flexible Funding: A number of services are paid through federal waivers. In addition, services are funded through third-party payer billing, grant funding, county funding, state funding, medical assistance, and the Medicaid State Plan.

Technology-Assisted Consultations: Telepresence is implemented in 18 southwestern counties for Assertive Community Treatment teams, emergency rooms, and psychiatrists for consult; mental health crisis teams are beginning to use telepresence to assist mental health practitioners; Community Support Services Crisis consultation and telepresence is under expansion in the Southern Cities Clinic; and the Phase II Telepresence Option is being planned.

First Episode of Psychosis: A cross-divisional workgroup designed a proposal to strengthen the state's capacity to provide early identification and intensive intervention services for children and adults who have a first episode of psychosis.

Understandable and Accessible Information: The MNhelp.info Network provides objective information to individuals to help them make decisions about services; culturally-specific grants are available to help with outreach to diverse communities. There are recommendations in place for reforming case management to make services more accessible and less duplicative.

Help People Retain Housing: The Crisis Housing Fund provides temporary rental, mortgage, and utility assistance for persons with serious and persistent mental illness while they receive mental health treatment.

Provider Training: Positive support strategies and guidelines on emergency use of manual restraints, and a legislative proposal to provide training between Community Support Services teams, Metro Crisis Coordination Program, and Assertive Community Treatment teams to enhance competency of treating individuals with complex comorbid conditions.

Long-Term Monitoring: Community Support Services Extended Supports provides long-term monitoring for up to 75 individuals with clinical complexity and intellectual disabilities.

Post-Discharge Psychiatric Consultation: Consultation for individuals recently discharged from St. Peter Security Hospital, Anoka Metro Regional Center, and from community behavioral health hospitals where the discharge planning team determines that ongoing post discharge monitoring provided by psychiatrists and psychologists would be essential to successful community placement.

Crisis-related barriers to achieving integration

Although there are a number of crisis-related services, there are a number of barriers that currently exist in access, available services, and follow-up for people in crisis. The examples below help to illustrate the issues that are not yet adequately addressed.

Layering Effect: People with co-occurring conditions, such as those with both mental illness and developmental disabilities, may be treated and stabilized in crisis but end up back in the system because of the complexity of treating the co-occurring conditions. Or, in times of crisis they may not be able to

connect in a timely fashion with providers who have the necessary skills to support them, resulting in what may have been avoidable moves back to more restrictive settings. For example, at times the underlying mental health needs are not adequately addressed by providers of developmental disability services. Similarly, mental health providers may use talk-based therapies that are not well-targeted to the needs of people with developmental disabilities. If the mental health needs of people with developmental disabilities or brain injury are not met as they emerge, there can be further complications such as drug use, homelessness, and chronic physical disease. Another example is, when people are using services from different systems, there can be confusion about where to turn in a crisis. This can be particularly true for people who have recently transitioned from a more controlled setting to a more integrated setting.

Housing for Persons with Behavioral Issues: People with mental illnesses, dementia, developmental disabilities, or other disabilities who have experienced crisis may be admitted to psychiatric inpatient hospital units or other institutional settings without community options for re-establishing housing, or their options for future housing may be limited to sites far from their home communities when they can no longer stay in their former domiciles because of behavioral issues. There may be barriers to reestablishing housing, such as those found when subsidized housing sites screen out individuals with a history of violence or other behavioral issues.

Lack of Experienced, Trained Staff: Direct support workers may not have adequate training, experience, or assistance available to deal with crisis situations. When crisis situations arise, these staff may not be able to address the situation themselves, and also may not have access to someone in their organization with the appropriate skills. Providers may not be aware of the range of services that are available to help them with crisis incidents, and may not be knowledgeable about trauma-informed care, which can help providers identify the triggers of behavior that cause a life crisis.

Crises outside the Home: Crises may occur in the community, such as school, a day service program, or a vocation setting. Most interventions are focused on supporting the person in their home or residential setting.

Measurable Goals

Following are measurable goals that will result from Minnesota's efforts to improve the crisis system for people with disabilities. **These goals are dependent on funding requests currently under consideration in the 2015 legislative session.** *Note: Goal below builds to an increase of 500 people.*

In 2015

- Baseline of 7,045 people will receive crisis services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention.
- Expand DHS data reporting system to include elements for tracking this goal.
- Metro Crisis Coordination Program (MCCP) will begin providing specialty telephone consultation 24 hours a day to mobile mental health crisis teams who are serving people with traumatic brain injury or intellectual disability who are experiencing a mental health crisis.

In 2016

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,170 metro-wide - 125 people over the baseline of 7,045).
- Of the additional 125 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation. (*Note: this is our baseline year. The number will be adjusted as needed.*)
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 38 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2017

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,295 metro-wide - 250 people over the baseline of 7,045).
- Of the additional 250 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 63 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2018

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,420 metro-wide - 375 people over the baseline of 7,045).
- Of the additional 375 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 94 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2019

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,545 metro-wide - 500 people over the baseline of 7,045).
- Of the additional 500 people who will receive a crisis response service, half (250) people will receive immediate face-to-face services and half (250) people will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as safely possible give the traffic and weather.
- 125 people who receive face-to-face services will be able to remain in the community rather than be admitted to a hospital.

Process to Develop Strategic Approach

Community participation

Community members, particularly those who use public services, their families, advocates, service providers, and community partners, such as counties and tribes, all play a critical role in helping shape how public services are designed and delivered.

Within the last couple of years, as the Olmstead Plan was written and implementation began, there have been numerous ways in which the public engaged in processes that contributed to the development of the framework described in this report. The following list highlights some of this work.

- The Department of Human Services conducted numerous focus groups with people who use services, such as those organized through the National Alliance on Mental Illness Minnesota in planning the Minnesota Behavioral Health Homes.
- People who use mental health services and their families meet (typically) monthly to discuss adult mental health initiatives.
- The State Advisory Council on Mental Health consists of stakeholders representing all facets of the mental health system. The Local Advisory Workgroup, a subset of the Council, is made up of individuals with a lived experience of a mental illness, family members, and a county provider. The Subcommittee on Children’s Mental Health provides recommendations to the Council. It is comprised of parents, people who presently or formerly used adolescent mental health services, and other stakeholders.
- Certified Peer Specialists quarterly networking
- Offenders with Mental Illness Workgroup
- Mental Health Improvement Workgroup
- ADAD Tribal and Citizen Advisory Council
- Community First Services and Supports and Money Follows the Person Implementation Council
- State Quality Council
- Traumatic Brain Injury Advisory Committee
- Autism Spectrum Disorder Advisory Council
- Home and Community Based Services Settings Rule forums
- Autism public meetings and other input opportunities
- Tribal listening session on people with brain injury and releases from correctional facilities
- Gaps analysis surveys and focus groups
- Olmstead Plan development process, including Olmstead Plan Committee, public meetings, and public comment period

State work groups

State-led work groups contributed to the development of the plan presented here and included people from a broad array of perspectives, including from the following:

- Adult mental health
- Children’s mental health
- Disability services
- State-operated services
- County crisis services
- Youth services
- Minnesota Department of Health
- Minnesota Department of Education

In addition to participation in work groups, community subject matter experts contributed feedback and advice.

Strategic Approach to Crisis System

Minnesota is undertaking transformative systems change to achieve the goal of having people with disabilities living in the most integrated settings, being fully engaged in the community of their choice, and pursuing their own life goals and interests. This transformation will take years to fully realize, and our wide-reaching, cross-sector approach needs to be strategic to be feasible and successful. The crisis triage and hand-off concept, which is the focus of this report, fits within a broader strategic approach to crisis response and intervention. And, in turn, the crisis strategic approach interlocks with other key strategic focuses, such as building a person-centered culture, effective transitions, increased access to housing, and competitive employment. The barriers identified in the earlier section are addressed in various ways across these strategic focuses as well as in the crisis area.

The three-pronged approach to improving crisis response and intervention services includes: 1) improving crisis triage and hand-off; 2) use of positive supports and person-centered planning; and 3) mental health system reform.

Crisis triage and hand-off

The intent of the statewide crisis triage and hand-off system is to efficiently get people to the best service for them in times of crisis, and to ensure that the hand-off between providers is effective. To do this, the state must develop a statewide, integrated, crisis information, intake, referral, and assessment network model. The intent is to have a centralized point of entry, that people in crisis contact in a crisis, regardless of their diagnosis or what type of services they provide (e.g., community-based mental health services, state-operated services, waiver services).

This is envisioned as a single statewide phone number. The people staffing the phone/portal will provide an immediate response to requests for crisis services statewide with appropriate triage and coordination among crisis services. They will be skilled in crisis assessment and determine both the urgency of the need intervention, and the most appropriate provider for that intervention. They will be well-versed in the services that are available across the state and who they serve.

The access, intake, and processes for service delivery determination and authorization will be seamless to the person. Having a single point of entry, staffed by skilled providers, will decrease confusion, duplication of effort and gaps, resulting in callers getting to the right service in a timely manner. This is crucial as timely, appropriate intervention is the best way to stabilize crisis situations.

In addition to getting the person to necessary services, the intent of the centralized triage system is to ensure that crisis services are delivered in the least restrictive setting possible.

Another key feature of the centralized system is that the triage providers will follow-up with the callers to see if the person actually connected with and received the appropriate service in a timely manner. If there are problems identified, the triage system can work to resolve them, if that is possible, or, at a minimum, record the system failure.

One of the benefits of a centralized system will be the opportunity to track meaningful data that will be used to help us measure the success of the system, identify gaps, and continuously improve the state triage system.

For example, the system will be designed to track data, such as:

- Response times
- Crisis resolutions
 - Resolutions that result in the person remaining in their home, returning home from a medical facility, i.e. ER/urgent care, etc.
- Outcome comparisons by access route, geographic location, population, etc.
- Crisis interventions initiated in psychiatric hospitals, other hospitals and other facilities despite the individual not meeting requirements for those levels of care

While the current system is fragmented, it does have strengths upon which the model can be built. The state will strategically develop this network in phases, using the opportunities and strengths that are available.

Developments in technology in recent years are a great boon to this kind of effort.² Some parts of the crisis response system are already beginning to make use of tele-presence technology.³ Another existing strength is that Minnesota already has pieces of a ‘centralized’ system for crisis response. Specifically, within the Twin Cities metropolitan area, mental health services are already using a central point of access and triage protocols.

² For example, Minnesota operates technologically integrated systems (i.e., MNhelp.info Network and its Senior Linkage Line, Disability Linkage Line, and Veterans Linkage Line) that support people, help them navigate complex service systems, connect policy and service professionals in ‘real time’, follow-up with them, and track/measure the effectiveness in achieving meaningful outcomes for people.

³ Community Support Services (CSS) Crisis Teams, Southern Cities Clinic use telepresence and 18 counties in southwestern Minnesota also telepresence for consultation between Assertive Community Treatment (ACT) teams, emergency rooms, and psychiatrists.

The first phase of developing a statewide triage system is currently underway and expected to last through June 2015. This work centers on defining the roles and responsibilities within the state-operated services and county and provider system of waiver services. These two systems are administered by the Department of Human Services Direct Care and Treatment Administration and the Disability Services Division of the Community Supports Administration, respectively. They support many people with co-occurring conditions, people who are moving from segregated settings to more integrated settings and people who are at high risk of experiencing crises and returning to segregated settings.

Building upon the first phase, also in 2015, the second phase will involve building the statewide triage and hand-off system. This work will center on adding mental health services that are administered through the Adult and Children's Mental Health Divisions of the Community Supports Administration into the project. This phase will include planning and initial implementation. Implementation will begin with realigning currently available resources and continue as resources and opportunities become available.

Also in 2015, there is proposed legislation to build a single statewide number for all mental health crisis services. If this is enacted, it will provide a significant platform upon which to build the single triage system for all disability-related crises (i.e., mental health and/or behavior-related crises).

Positive supports and person-centered planning

Promoting statewide use of positive supports is one of the three-prongs of Minnesota's crisis strategy. The term *positive supports* refer to practices that are person-centered, encourage self-determined behavior, build on social and emotional skills, and take a person's physical, social and mental health into consideration. Positive supports include strategies that teach people productive ways to deal with stress. These supports are essential to eliminate the use of prohibited procedures, avoid emergency use of manual restraints, and prevent physical harm to the individual and others.

The use of positive supports has been proven to be effective in preventing problem behavior and helping a person gain new skills or alternative behaviors to participate effectively in community life. Problem behavior can trigger a crisis situation; the use of positive supports, therefore, is a strategy for avoiding crises.

Person-centered planning is the foundation for positive support practices. Pro-active person-centered planning and assessment anticipates, prevents, and/or responds in a timely way to potential or actual crisis situations, in a way that promotes maintaining individuals in the community, particularly for people with co-occurring conditions.

In October 2014, the Minnesota Departments of Human Services and Education produced a report entitled *Minnesota's Statewide Plan: Building Effective Systems for Implementing Positive Practices and Supports*. The report provides a framework for organizing policies, technical assistance, and resources to ensure people receiving services, are treated with respect, and receive the support they need to live independent, self-determined, and meaningful lives in their home communities. The plan described in

the report will be successful by a) designing and implementing technical assistance that involves teaching organizations to embed the values and vision outlined in the Minnesota Olmstead plan into the everyday actions taken by individuals providing services, and b) working collaboratively with stakeholders who represent people receiving services across the lifespan, family members, caregivers, advocates, practitioners, and community members. The report represents a first step in the state-wide planning process. The plan itself will continue to be refined and updated as it is implemented.

The plan identifies six implementation goals: 1) establishing a technical assistance infrastructure across agencies, 2) designing and implementing strategies for data-based decision making and evaluation, 3) creating a marketing plan for increasing awareness of positive supports across the state, 4) expanding pre-service and aligning in-service training systems state-wide, 5) developing and maintaining an inventory of policies related to restrictive practices and positive supports, and 6) expanding interagency crisis prevention planning. A graphic illustration of the logic model for the plan appears in Appendix A.

Mental health system reform

Minnesota's mental health infrastructure is insufficient with many gaps, poor measurement, and insufficient service availability. Gaps in the system can mean that opportunities for early intervention are missed and crisis situations arise. Gaps in the system can mean that when there is a crisis situation the intervention takes place in a more restrictive setting than is necessary. Sometimes people in crisis go into a segregated setting and, once there, encounter barriers to moving back into integrated settings.

Minnesota has a package of mental health reforms before the Legislature in 2015 that address several of the gaps listed on page 3 in this report. More information about these reforms is in Appendix B.

Prevention and early intervention

- Offer training and consultation for staff at 250 child care centers. Provide assessments and treatment for 1,250-2,500 children with mental health concerns.
- Pilot a new model to help schools support students with mental health and substance use disorders in order to reduce arrests, expulsions and suspensions, while increasing referrals for treatment and services.
- Strengthen the state's capacity to serve youth (16-26) with early signs of psychosis and bridge gaps between children's and adult mental health services.
- Increase availability of mental health crisis services, moving toward a goal of 24 hours statewide coverage for both children and adults.
- Establish one statewide number for all mental health crisis services.
- Improve consistency and quality of crisis services.
- Expand children's mental health respite care grants to serve 500-1,000 additional children and their families.
- Provide training on Adverse Childhood Experiences to 5,000 community partners, parents, and providers. Support local efforts to provide earlier intervention.

Reform and enhance Minnesota's mental health treatment system

- Analyze the state's payment structure for mental health services and develop reforms to stabilize the state's financially fragile mental health system.
- Provide grant funding to stabilize intensive mental health services infrastructure (IRTS/RCS/ACT).
- Provide an immediate rate increase for mobile crisis services to retain current services and promote expansion.
- Enhance the state's community mental health centers, which are the foundation of the public mental health safety net.
- Apply for Federal demonstration project to implement improvements and receive 90 percent federal financial match.
- Implement Behavioral Health Homes to provide integrated psychical and mental health care.

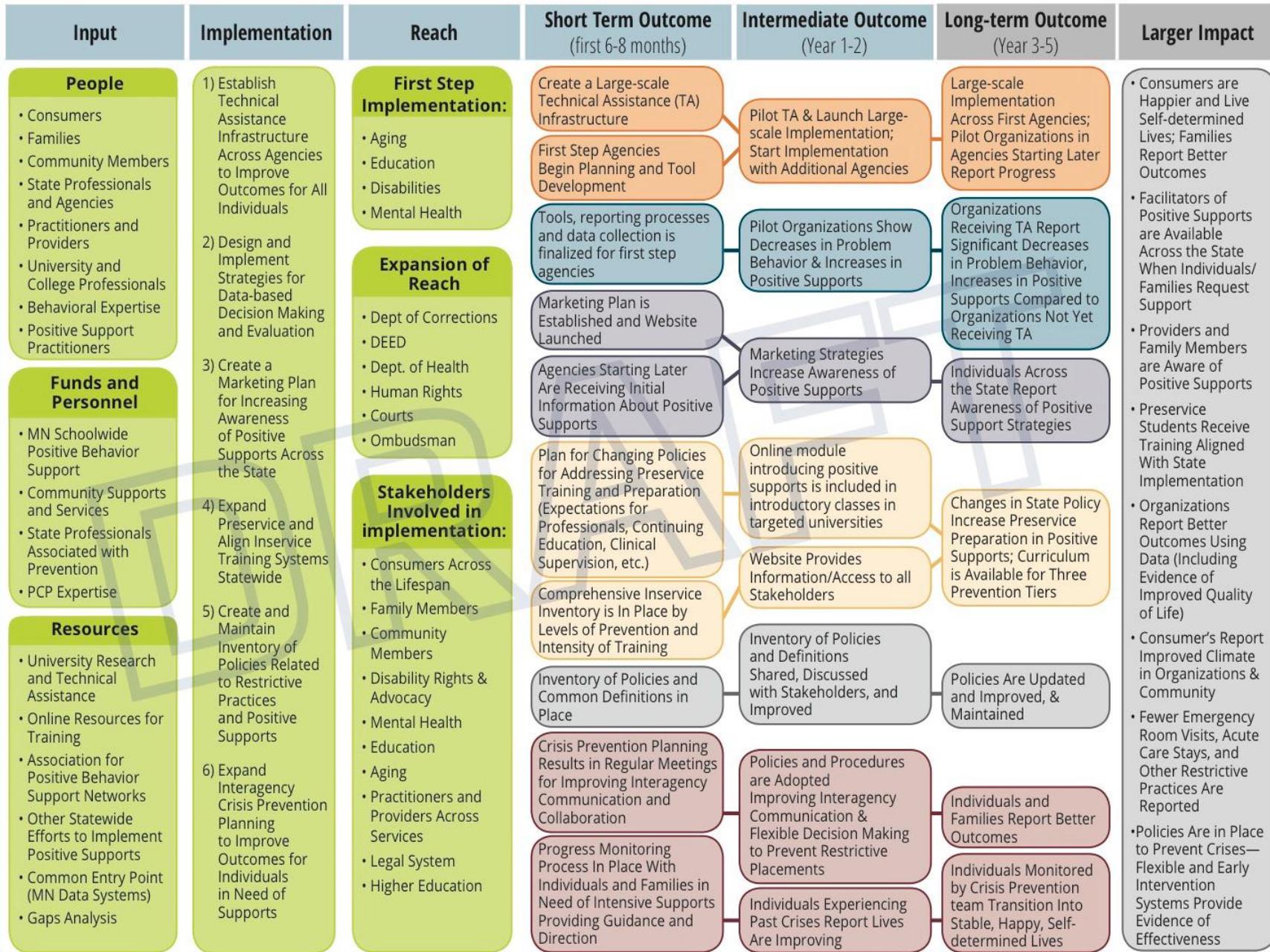
Expand capacity to care for children and adults with complex needs

- Establish Psychiatric Residential Treatment Facilities (PRTF) to support children with very serious mental illnesses who are going unserved.
- Establish extended-stay hospital psychiatric beds, on a contract basis, for youth in need of intensive services on a longer term basis, including those currently served at the Child and Adolescent Behavioral Health Services (CABHS) program.
- Create three new Intensive Residential Treatment Service (IRTS) programs for people transitioning from Anoka-Metro Regional Treatment Center.
- Sustain improvements at MSH including more clinical services, strengthened treatment teams, and increased programming opportunities for patients.
- Create a public psychiatry track in the University of Minnesota's residency program.

Promote and support recovery

- Expand housing with supports grants to serve 1,260 adults with serious mental illness in permanent supportive housing.
- Enhance the quality of current Assertive Community Treatment services.
- Expand high quality Assertive Community Treatment services across Minnesota.
- Develop a Forensic Assertive Community Treatment Team to serve people involved with the criminal justice system.
- Allow greater flexibility to use current funding to help more people exit institutional settings and return to the community.

Appendix A: Positive Supports Implementation Plan Logic Model

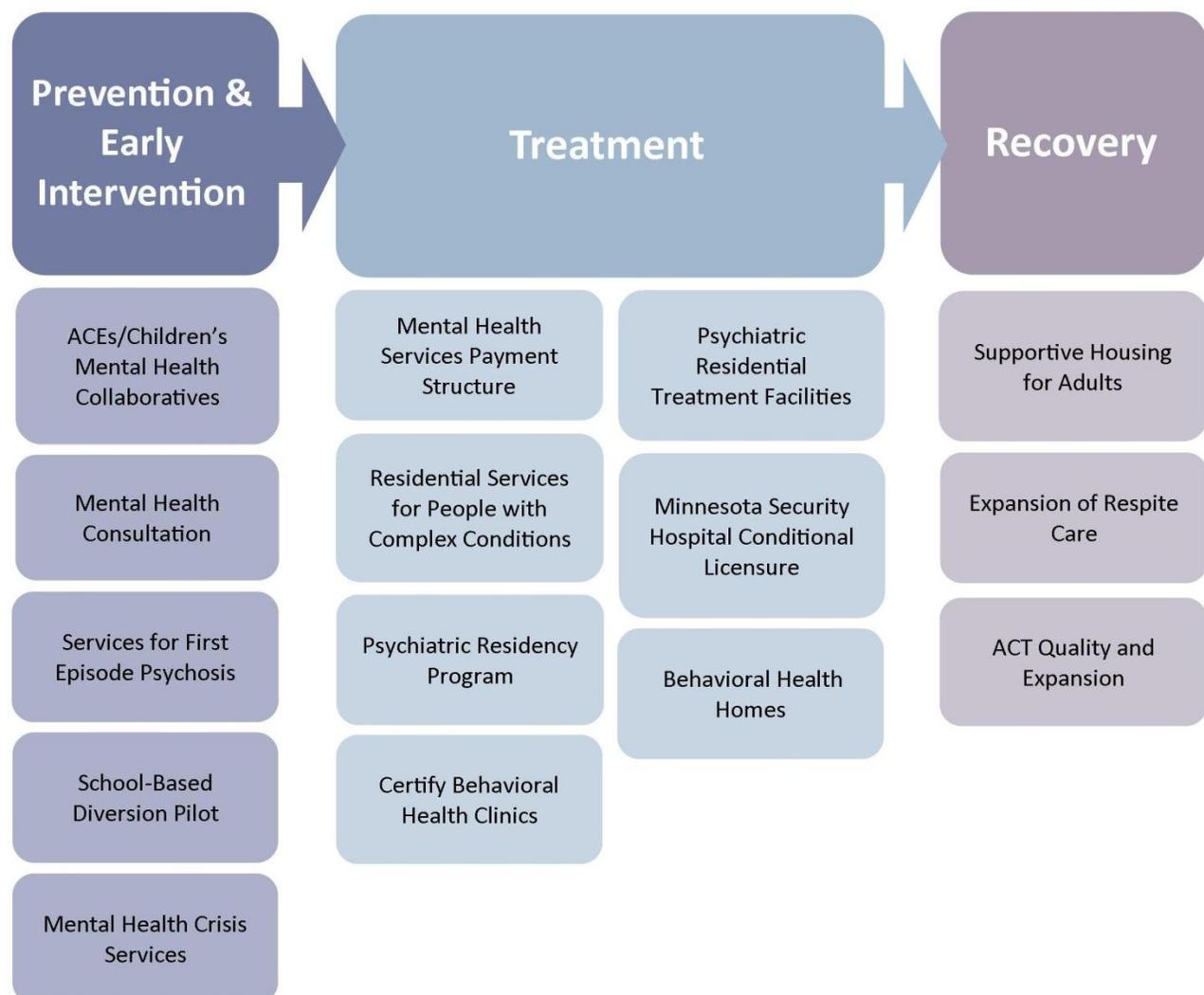


Appendix B: Mental Health System Reform Proposals

2015 Mental Health Reform

The Problem	The Solution	The Impact
Minnesota's mental health infrastructure is insufficient with too many gaps, poor measurement, and insufficient service availability.	A continuum of care that includes: <ul style="list-style-type: none"> • Mental health promotion and mental illness prevention • Clinical service stability and quality • Community supports 	More than 230,000 adults and 75,000 children with mental illness and their families will have the services available they need.

Building a continuum of mental health care for all Minnesotans



Current opportunities

Problem:

Minnesota's Mental Health System is Fragile:

- Residential services are in demand but capacity is shrinking. The Woodlands Center Intensive Mental Health Service (IRTS) closed earlier this year and others are in financially precarious positions.
 - Community mental health services are vulnerable. Riverwood Community Mental Health Center, which served some 3,000 clients, closed suddenly in 2014.
-

Problem:

Existing Community Capacity Does Not Meet Needs:

- Minnesota lacks community-based services for adults, especially those with the greatest needs. Anoka Metro Regional Treatment Center has a waiting list of over 75.
 - Intensive children's services are not available in Minnesota. There are between 300-400 children each year with aggressive or self-injurious behaviors whose needs cannot be met.
 - Prevention resources are limited. Focus has been on treatment and interventions, leaving prevention and early interventions behind.
 - Minnesota has a severe mental health workforce shortage. Most of Minnesota is designated as a Mental Health Professional Shortage Area.
 - Employment supports need to be expanded. People with serious mental illnesses in Minnesota have an 80 percent unemployment rate.
-

Problem:

Housing services are insufficient for those with multiple service needs

- Over 50 percent of children and adults in Minnesota who are homeless live with a mental illness.
- Residential reimbursement rates are inadequate. The average monthly room and board costs for Intensive Residential Treatment Services (IRTS) and residential crisis providers are \$1,210 per client. The current monthly group residential housing rate is \$876 per client.
- Capital improvements are not covered in current rate structure.
- Lack of treatment services for the most acute children and adults. The system does not have adequate resources for the most aggressive clients.
- Some children's services are not available in Minnesota. We have between 300-400 children each year who would be best served in Psychiatric Residential Treatment Facilities
- There is a workforce shortage. Most of Minnesota is designated as a Mental Health Professional Shortage Area.

2015 Reform Initiatives

Build a More Solid Foundation of Prevention and Early Intervention

Mental Health Consultation for Early Childhood Providers

- Offer training and consultation for staff at 250 child care centers. Provide assessments and treatment for 1,250-2,500 children with mental health concerns.

School-Based Diversion Pilot for Students w/Co-Occurring Disorders

- Pilot a new model to help schools support students with mental health and substance use disorders in order to reduce arrests, expulsions and suspensions, while increasing referrals for treatment and services.

Services and Supports for First Episode Psychosis

- Strengthen the state's capacity to serve youth (16-26) with early signs of psychosis and bridge gaps between children's and adult mental health services.

Mental Health Crisis Services

- Increase availability of mental health crisis services, moving toward a goal of 24 hours statewide coverage for both children and adults.
- Establish one statewide number for all crisis services.
- Improve consistency and quality of crisis services

Expansion of Respite Care

- Expand children's mental health respite care grants to serve 500-1,000 additional children and their families.

ACEs/Children's Mental Health & Family Services Collaboratives

- Provide training on Adverse Childhood Experiences to 5,000 community partners, parents, and providers. Support local efforts to provide earlier intervention.

Reform and Enhance Minnesota’s Mental Health Treatment System

Stabilize and Reform Mental Health Services Payment Structure

- Analyze the state’s payment structure for mental health services and develop reforms to stabilize the state’s financially fragile mental health system.
- Provide grant funding to stabilize intensive mental health services infrastructure (IRTS/RCS/ACT).
- Provide an immediate rate increase for mobile crisis services to retain current services and promote expansion.

Certify Behavioral Health Clinics

- Enhance the state’s community mental health centers, which are the foundation of the public mental health safety net.
- Apply for Federal demonstration project to implement improvements and receive 90 percent federal financial match.

Behavioral Health Homes

- Implement Behavioral Health Homes to provide integrated psychical and mental health care.

Expand Capacity to Care for Children and Adults with Complex Needs

Establish Psychiatric Residential Treatment Facilities

- Establish Psychiatric Residential Treatment Facilities (PRTF) to support children with very serious mental illnesses who are going unserved.
- Establish extended-stay hospital psychiatric beds, on a contract basis, for youth in need of intensive services on a longer term basis, including those currently served at the Child and Adolescent Behavioral Health Services (CABHS) program.

Residential Services for People with Complex Conditions

- Create three new Intensive Residential Treatment Service (IRTS) programs for people transitioning from Anoka-Metro Regional Treatment Center.

Minnesota Security Hospital (MSH) Conditional Licensure

- Sustain improvements at MSH including more clinical services, strengthened treatment teams, and increased programming opportunities for patients.

Psychiatric Residency Program

- Create a public psychiatry track in the University of Minnesota’s residency program.

Promote and Support Recovery

Supportive Housing for Adults with Serious Mental Illness

- Expand housing with supports grants to serve 1,260 adults with serious mental illness in permanent supportive housing.

Assertive Community Treatment (ACT) Quality and Expansion

- Enhance the quality of current ACT services.
- Expand high quality ACT services across Minnesota.
- Develop a Forensic ACT Team to serve people involved with the criminal justice system.

Increase Flexibility for Transitions to Community Initiative

- Allow greater flexibility to use current funding to help more people exit institutional settings and return to the community.

**EXHIBIT 6-22: SS 3J – ASSISTANCE WITH LEAST INTRUSIVE
SERVICE /ACTIONS**

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

Minnesota’s Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports

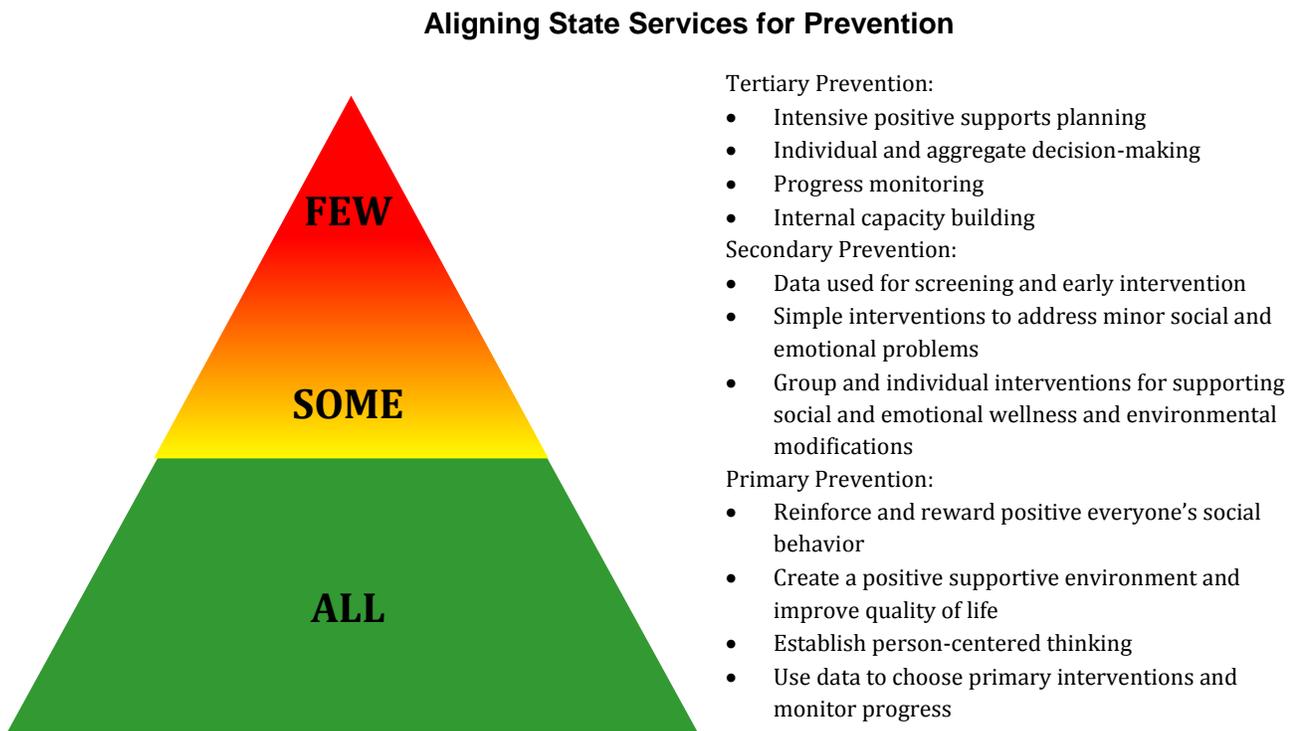
Minnesota’s Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports provides the framework for implementing positive practices throughout Minnesota. The *Statewide Plan* was delivered to the Olmstead Office, October 22, 2014 and was officially approved as a draft by the Olmstead Subcabinet on February 9, 2015.

The *Statewide Plan* identifies four major activities that will assist the state in making the *Olmstead Plan* vision a reality. It is clear to see how several Olmstead Plan action items, including SS 3J, are imbedded in therein. 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
- Outlining recommendations for a state-wide plan to increase positive practices and eliminate use of restraint or seclusion.

The State of Minnesota is promoting the use of positive supports and practices as its primary strategy for avoiding and responding to crisis situations. Figure 1 shows how positive practices are directly related to crisis prevention.

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



Page 27 of the *Statewide Plan* shows a logic model with the inputs, implementation, reach and short-, intermediate-, long-range outcomes and larger impact of plan. Each implementation action has a work group attached to it. There are six work groups being established:

- Technical assistance
- Marketing and communication
- Pre-service/In-service
- Inventory and definitions
- Crisis prevention
- Data systems

Work related to *Olmstead Plan* SS 3J will fall primarily to the inventory and definitions, crisis prevention, and technical assistance work groups.

Establish measurable goals and timelines

Appendix D of the *Statewide Plan* contains charts for each work group showing the actions needed to achieve the stated goals, how success will be measured, the steps to achieve the intermediate goals, and the timeframe for achieving the intermediate goals.

Person-level outcomes related to SS 3J are laid out in the crisis triage and hand-off report (SS 3I).

Identify best practices (including use of technology)

The Minnesota Department of Human Services (DHS) and the Minnesota Department of Education (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 are available in Appendix A of the *Statewide Plan*. Responses from the survey and earlier work from various team members were 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.

Set service standards

A workgroup has been developed to assess all training materials related to in-service training across agencies. The workgroup will begin meeting in March and is tasked to create a summary of a content plan for comprehensive cross-agency in-service trainings systems. These will include but are not limited to, school-wide positive behavior supports, trauma-informed care, cognitive behavior therapy, person-centered planning, and positive behavior support training.

The workgroup will evaluate how the state can influence policy and supervisory systems to encourage universities to include specific training resources for pre-service purposes. These may include clinical supervision requirements and further continuing education. The work group will identify Minnesota universities and colleges that are already providing positive supports education and foster communication and collaboration with these institutions.

Develop and deliver training and technical assistance

Another work group is developing training and technical assistance regarding positive supports. The work group will:

- Assess the training initiatives already in place across agencies
- Discuss the priorities that each agency has for technical assistance
- Describe the types of tools, curricula, and resources that will be needed in order for large-scale implementation to begin

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EXHIBIT 6-23: SS 4B – WAIVER WAITING LIST REPORT

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Home and Community-Based Supports and Services Waiver Waiting List Report

March 3, 2015

I. Executive Summary

A. Legal Requirements

Olmstead Plan. The Olmstead Plan requires the Department of Human Services to report to the subcabinet recommendations for improving the home and community-based services waiting list, including prioritizing based on urgency and need, and describing how these practices will result in the waiting list moving at a reasonable pace.(SS 4B, p. 68).

Olmstead v. L.C. The phrase “reasonable pace” comes from the U.S. Supreme Court’s decision in *Olmstead v. L.C.*, where the Court said that a state could meet its responsibility for providing home and community-based services “if, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated...”¹ The Court also said the state must have “leeway” to “maintain a range of facilities and to administer services with an even hand.” *Id.*

Jensen v. DHS. On January 9, 2015, the Court in *Jensen v. DHS* found Minnesota’s waiting list goals inadequate (specifically, the goal of prioritizing the waiting list and the goal of providing home and community-based services to 80 residents of intermediate care facilities for developmentally disabled persons). The Court stated, “This proposal does not adequately address the current baseline of 3,502 individuals who have requested a ‘Developmental Disabilities (DD) waiver’ and 1,450 individuals who have requested a ‘Community Alternatives for Disabled Individuals (CADI) waiver.’ If the State wishes to address existing services and support needs, the State must provide a deadline for completion of the waiting list.” *Jensen, et.al. v. DHS, et.al.*, (Minn. Dist.) 09-cv-01775 DWF-FLN, Doc. 378, p. 10.

B. Wait List Recommendations

DHS has four recommendations to ensure that individuals will receive the services they need in the community at a reasonable pace that allows the state “to maintain a range of facilities and to administer its services with an even hand.”²

Recommendation 1: Enhanced Assessment.

By December 1, 2015, DHS will require lead agencies to enhance their assessment of individual need through a person-centered planning process that includes planning for when the individual may need waiver services.

¹119 S.Ct. 2176, 2189; 527 U.S 581, 605-6 (1999).

² 119 S.Ct. at 2189; 527 U.S. at 605.

Recommendation 2: Wait list categorization.

DHS will divide the waiting list into four categories:

A. Institutional Exit: This category includes any person in an intermediate care facility for persons with developmental disabilities (ICF/DD) or nursing facility who does not oppose leaving the facility. For this category, service planning will begin within 45 days after a needs assessment or other indication shows the person is not opposed to leaving the facility.

Waivered services will begin as soon as practicable, but no later than 180 days after the indication that the person is not opposed to leaving the facility.

Once waiver services are authorized, the person will be removed from the wait list.

B. Immediate Need: This category includes any person in the community who meets at least one of the criteria listed in Minn. Stat. §256B.092, subd. 12(b) and Minn. Stat. §256B, subd. 11a(b) (has an unstable living situation due to age, incapacity, or sudden loss of caregivers; is moving from an institution due to bed closure; experiences a sudden closure of their current living arrangement; requires protection from confirmed abuse, neglect, or exploitation; experiences a sudden change in need that can no longer be met through state plan services or other funding resources alone; or meets other priorities established by the department).

Waivered services will begin as soon as practicable, but no later than 90 days after the person meets criteria in Minn. Stat. §256B.092, subd. 12(b) or Minn. Stat. §256B, subd. 11a(b).

Once waiver services are authorized, the person will be removed from the waiting list.

C. Defined Need: This category includes any person who is assessed as needing waiver services within a year from the date of assessment.

Waivered services will begin as soon as practicable, but no later than 365 days after the date of the assessment.

Once waiver services are authorized, the person will be removed from the wait list.

D. Future Need: This category includes any person who is assessed as needing waiver services more than a year after the assessment date.

The person is not placed on the wait list, but will be tracked on a “future interest” list.

The person will be assessed annually, and will be placed on the wait list upon meeting the definition of “defined need or “immediate need.”

Recommendation 3: Data capture and reporting.

The enhanced assessment will capture information we do not have now that will show how long it takes for authorization of a waiver in each category.

By December 1, 2015, DHS will require lead agencies to begin tracking the information captured by the enhanced assessment process. By June 1, 2016 DHS will report the first six months' of data to the Subcabinet. After we have a year of data, beginning December 31, 2016, DHS will report the information twice a year to the subcabinet.

DHS will require lead agencies to track:

- why individuals are on wait lists for services;
- how many individuals are in each urgency category;
- the time it takes for individuals to move off the wait list in each category;
- gaps in services and resources; and,
- any other important information about the pace at which people move off the wait list revealed by the enhanced assessment.

Recommendation 4: Oversight

Through training, technical assistance, outreach, and monitoring, DHS will work with lead agencies to implement the new waiting list process.

II. Discussion

A. What “waiver” means.

Minnesota provides home and community-based services funded by Medical Assistance to people who require the level of care that would otherwise be provided in institutional settings. Because the federal government waives some of the institutional requirements of Medical Assistance funding, these home and community-based services are called “waivers.” Minnesota has five home and community-based service waivers that provide community alternatives to nursing homes, intermediate care facilities for persons with developmental disabilities, and hospital settings. Of these five waivers, two currently have waiting lists: 1) the Developmental Disabilities (DD) Waiver; and 2) the Community Alternatives for Disabled Individuals (CADI) Waiver.

B. What causes a waiver waiting list?

Waiver services are not an entitlement, which means that states can set limits on the growth of these programs. In Minnesota, waiting lists occur because the budgets for the waivers are limited, both by: 1) the amount the federal government approves in the state

waiver plans; and, 2) the amount the legislature appropriates for the state share of the service costs. A wait list is created when people who cannot access the waiver.

C. How many people are on the waiting list?

As of January 3, 2015, there were 1,412 people on the waiting list for the CADI Waiver and 3,462 people on the waiting list for the DD waiver.

The CADI waiver waiting list, however, is likely to disappear in July 2015. This is because, under current law, as of July 1, 2015, there will be no growth limits for the CADI waiver, effectively eliminating this waiting list. In addition, the DD Waiver allows for greater growth than in the past.³

D. How long do people wait for waiver services?

1. Institutional settings:

CADI Waiver: Data for the last four years shows that individuals who resided in a nursing facility within 90 days of their most recent assessment started CADI waiver services between 224 and 322 days from the time of their initial assessment for services. See Appendix B, Table 4.

DD Waiver: Data for the last four years shows that individuals living in intermediate care facilities for persons with developmental disabilities (ICF/DD) who did not oppose moving to the community and requested to move within a year had a median wait time between 9 days and 84 days. See Appendix B, Table 3.

2. Non-institutional settings:

CADI Waiver: Data for the last four years shows that individuals who did not reside in a nursing facility within 90 days of the most recent assessment started services between a median of 59 days and 134 days from the initial assessment for services. See Appendix B, Table 6.

DD Waiver: Data for the last four years shows that individuals who were not living in an ICF/DD when starting DD Waiver services had a median wait time between 19 and 315 days after they were classified as having a need for services within one year. See Appendix B, Table 5.

³ Appendix A shows the average monthly enrollment limits for the CADI and DD waivers for the past five years.

E. Waiting list totals do not tell the whole story.

While we know how many people are on the waiting list and the median number of days some categories of individuals waited to receive services, these facts do not tell the whole story. Other important information includes:

1. Most people receive other MA-funded services and supports while on the waiver waiting list.

Being on a waiting list does not mean the person is not receiving any supports or services. People typically are eligible for one or more state plan services that are entitlements, such as home care services. Federal and state law requires that people access state plan services first and use waiver services only if the state plan services are insufficient to meet their needs. Minnesota has a robust set of state plan services. Almost all individuals on the DD Waiver waiting list receive some type of service, assessment, or case management. (See Appendix B, Table 7 showing types of state services).

Transition-age youth who have left school and are on a waiver waiting list may be able to access state or county funded services, in addition to Medical Assistance state plan services. As of January 3, 2015, 23.5% of individuals on the DD Waiver waiting list access county funded services, often day training and habilitation, 7.8% access the Family Support Grant and 5.0% access non-ICF/DD or nursing facility respite care. (Appendix B, Table 10).

2. Statute sets priorities for receipt of waiver services.

Where state-funded services are insufficient to meet needs, Minnesota law establishes priorities for waiver services, giving top priority to individuals who:

- (1) No longer require the intensity of services provided where they are currently living; or
- (2) Make a request to move from an institutional setting.⁴

Minn. Stat. §256B.092, subd. 12 (2014)(DD waiver).

The next priority is for individuals who:

- (1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;
- (2) are moving from an institution due to bed closures;
- (3) experience a sudden closure of their current living arrangement;

⁴ The language—“make a request to move” is different from the standard in the *Olmstead* decision, which requires states to provide community-based care when appropriate and “the affected persons do not oppose” it. 119 S.Ct. at 2190 527 U.S. at 607.

- (4) require protection from confirmed abuse, neglect, or exploitation;
- (5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or
- (6) meet other priorities established by the department.

Id.

3. Waiting list totals don't reveal whether people receive services when they need them.

The total number of people on the waiting lists only tells us the number of people eligible for but not yet receiving waiver-funded services. The wait list totals do not reveal:

- why an individual is waiting for services (e.g., whether it is availability of the waiver or another reason--such as development of the person-centered plan, recruitment of a provider, or completion of modification to housing);
- the urgency of an individual's need for waived services, and, if urgent, how many days have passed since the need became urgent;
- whether an individual does not desire waived services to begin at the time placed on the waiting list, but rather, at some future point, and when (e.g., a family with a child living at home planning for adulthood; a person meeting current needs with state plan services who anticipates a future need for waived services); and
- the extent to which an individual receives other supports and services.

The waiting list does not differentiate between people who have immediate needs and those who desire to reserve a spot for future access to services when the need arises. The data captured by the enhanced assessment process will help answer these questions.

F. Capacity

DHS has forecasted significant growth in the disability waivers during the next biennium (starting July 1, 2015). Enrollment limits on the CADI waiver will expire on that date and the DD waiver will have additional growth. DHS forecasts that nearly \$300 million additional dollars will be spent on disability waivers in the next biennium. This will allow more individuals to access waiver services.⁵

⁵ Appendix A shows the average monthly enrollment limits for the CADI and DD waivers for the past five years.

G. How we will ensure our wait lists move at a reasonable pace.

1. We will enhance our assessment of individual need.

In order to better serve the needs of individuals on the waiting list, we will implement a new, comprehensive needs assessment.

The needs assessment will use person-centered planning to help people make decisions about their goals and to identify which services can meet them. The enhanced needs assessment will connect people to the right services and supports when they are needed, which may include a waiver at the time of assessment or at some time in the future. Lead agencies will conduct the assessments and develop community support plans.

Enhanced assessment will answer why a person is on a waiver waiting list and whether there is an immediate need for waived services.

Lead agencies will begin using enhanced assessment by December 1, 2015.

2. We will divide the waiting list into four urgency categories.⁶

Urgency Category	Definition	Commencement of Services
1. Institutional Exit	Any person in an ICF/DD or nursing facility who does not oppose leaving the facility.	Service planning begins within 45 days after a needs assessment or other indication shows the person is not opposed to leaving the facility. Waivered services begin as soon as practicable, but no later than 180 days after the indication that the person is not opposed to leaving the facility. Once allocated the waiver, the person will be removed from the waiting list.

⁶ Stakeholders recommended this categorization during a series of three sessions held to gather suggestions for improving processes related to waiver waiting lists. Appendix C contains a list of workgroup members.

2. Immediate Need	A person who meets at least one of the criteria listed in Minn. Stat. §256B.092, subd. 12(b) or Minn. Stat. §256B.49, subd. 11a(b).	<p>Waivered services will begin as soon as practicable, but no later than 90 days after the person meets criteria in Minn. Stat. §256B.092, subd. 12(b) or Minn. Stat. §256B.49, subd. 11a(b).</p> <p>Once allocated waiver services, the person will be removed from the waiting list.</p>
3. Defined Need	A person who is assessed as needing waiver services within a year from the date of assessment.	<p>Waivered services will begin as soon as practicable, but no later than 365 days after the date of the assessment.</p> <p>Once allocated waiver services, the person will be removed from the wait list.</p>
4. Future Need	A person who is assessed as needing waiver services more than a year after the assessment date.	<p>The person is not placed on the waiting list, but will be tracked on a “future interest” list.</p> <p>The person will be assessed annually, and will be placed on the waiting list upon meeting the definition of “defined need Or “immediate need.”</p>

3. We will report what the enhanced assessment teaches us to the subcabinet.

The enhanced assessment will answer the questions we do not currently know. By December 31, 2016, we will have enough experience with the enhanced assessment to begin reporting twice each year to the subcabinet what we learn about:

- why individuals are on waiting lists for services;
- how many individuals are in each urgency category;
- the time it takes for individuals to move off the wait list in each category;
- gaps in services and resources; and,
- any other important information about the pace at which people move off the waiting list revealed by the enhanced assessment.

4. We will report available waiting list data to the subcabinet during the transition.

DHS will continue to provide bimonthly status reports to the subcabinet until data from the enhanced assessment is available. DHS will enhance these reports by including information similar to the data contained in this report.

5. We will provide waiting list data to lead agencies during the transition.

By July 1, 2015, DHS will provide waiting list information to lead agencies on a quarterly basis. Information will include a list of people on the lead agency's waiting list and the length of time that has passed since their initial assessment. Statewide summary data of this information will be provided to the subcabinet as described in number 4.

6. We will work to implement the new waiting list process.

Assuring effective implementation of these changes will require technical assistance, outreach and compliance monitoring and reporting. DHS will engage in the following quality implementation activities.

a. We will provide technical assistance to lead agencies.

To ensure individuals are placed in the appropriate waiting list categories and data is collected consistently, DHS will provide statewide technical assistance to lead agencies.

If lead agencies do not comply with timelines, DHS will undertake steps to learn why, and provide appropriate technical assistance. Additionally, DHS will consider reallocating resources if a county is unable to serve individuals with urgent needs within their county waiver budget.

b. We will reach out to individuals and families.

DHS will engage with its partners, including organizations such as Arc Minnesota and local Arc chapters, through July – December, 2015, to educate individuals and families about changes to waiver waiting lists.

c. We will monitor lead agencies' compliance with timelines.

In January 2016, DHS will begin monitoring lead agency compliance on a monthly basis. DHS already reviews county waiting lists and provides technical assistance

during its county waiver review. We will add a monthly compliance report which will include:

- Any assessed individuals who were not assigned an urgency category;
- An overall compliance score based upon assignment of urgency categories; and
- A list of individuals whose service start date is within 30 days of the report.

III. Recommendations Summary

DHS recommends that DHS commence the following actions by the following dates:

A. July 1, 2015:

1. For each lead agency, DHS will report on the number of individuals on disability waiver waiting lists and how long individuals have been on the lists.
 - a) DHS will report each lead agencies' data to each lead agency, and will report aggregate state-wide data to the subcabinet.
 - b) DHS will provide these reports on a quarterly basis until June 1, 2016, at which time DHS will begin reporting on the data specified in Recommendation 3 to the extent it is available.
2. DHS will engage with partners to educate individuals and families about changes to waiver waiting lists.

B. October 31, 2015:

1. Provide lead agencies with a mechanism to track the data specified in Recommendation 3 for all disability waivers;
2. Provide training and technical assistance, as needed, to lead agencies on enhanced assessment, classifying waiting list categories, and using the tracking mechanism.

C. December 1, 2015:

1. Require lead agencies to use the enhanced assessment;
2. Require lead agencies to track data according to the mechanism DHS provides;
3. Require lead agencies to authorize waiver services to individuals within the time periods specified herein;
4. Begin to track lead agencies' compliance and take steps to assist lead agencies with achieving compliance;
5. Collect the data specified in Recommendation 3.

- D. **June 1, 2016:** Report to the Subcabinet on the data collected since December 1, 2015.
- E. **January 15, 2016:** Report the waiting list data specified in Recommendation 3 to the subcabinet twice each year.

Appendix A: Historic Waiver Enrollment Limits

CADI Waiver Average Monthly Enrollment Limits (2010 – 2015)

Fiscal Year	Average Monthly Enrollment Limit
2010	95 people
2011	60 people
2012	60 people
2013	60 people
2014	85 people
2015 ⁷	Unlimited

DD Waiver Average Monthly Enrollment Limits (2010 – 2015)

Calendar Year	Average Monthly Enrollment Limit
2010	15 people
2011	6 people
2012	6 people
2013	6 people
2014	15 people
2015 ⁸	25 people

⁷ As of July 1, 2015

⁸ As of July 1, 2015

Appendix B: Data Analysis Results

Table 1 displays the total number of individuals who started DD Waiver services by calendar year.⁹

Table 1

Calendar Year	Number of Individuals
2011	657
2012	573
2013	631
2014	509
TOTAL	2,370

Table 2 displays the total number of individuals who started CADI Waiver services by calendar year.¹⁰

Table 2

Calendar Year	Number of Individuals
2011	2,958
2012	2,114
2013	2,823
2014	2,432
TOTAL	10,327

Table 3 reports the median number of days that passed between the date an individual indicated they needed waiver services within a year and the start of waiver services. This data is for individuals who resided in an ICF/DD within 90 days of their most recent assessment.

Table 3

Calendar Year	Median Number of Days from Waiver Need Index of "1" to Service Agreement Start
2011	84 days
2012	11 days
2013	19 days
2014	9 days

⁹ Waiver start numbers include all people, not just those starting from a waiting list.

¹⁰ Waiver start numbers include all people, not just those starting from a waiting list.

Table 4 displays the median number of days from the initial assessment to the start of CADI Waiver services for individuals who resided in a nursing facility within 90 days of the most recent assessment.

Table 4

Calendar Year	Median Number of Days from Initial Assessment to Service Agreement Start
2011	224 days
2012	265 days
2013	275 days
2014	322 days

Table 5 reports the median number of days that passed between the date an individual indicated they needed waiver services within a year and the start of waiver services. This data is for individuals who did not reside in an ICF/DD within 90 days of their most recent assessment.

Table 5

Calendar Year	Median Number of Days from Waiver Need Index of "1" to Service Agreement Start
2011	315 days
2012	15 days
2013	23 days
2014	19 days

Table 6 displays the median number of days from the initial assessment to the start of CADI Waiver services for individuals who did not reside in a nursing facility within 90 days of the most recent assessment.

Table 6

Calendar Year	Median Number of Years from Initial Assessment to Service Agreement Start
2011	59 days
2012	62 days
2013	130 days
2014	134 days

Table 7 displays non-waiver services individuals received the year before starting CADI or DD waiver services. These individuals did not reside in a nursing facility or ICF/DD at the time of the last assessment. This data displays totals between calendar year 2011 and 2014.

Table 7

Service	Number of Individuals Using this Service	Percentage of Individuals Using this Service
Mental Health Services	4,421	34.8%
Transportation Services: • Access Services • Transportation	3,839	30.2%
Home Care Services: • Consumer Directed Home Care • Home Health Services • Personal Care • Private Duty Nursing	3,415	26.9%
Assessments: • DD Screenings • Long-Term Care Consultation Pre-Admission Screening • Pre-Admission Screening and Resident Review	2,780	21.9%
Case Management Services: • Child Welfare Targeted Case Management • HIV Case Management • Home Care Targeted Case Management • Relocation Services Coordination • Vulnerable Adult Targeted Case Management	1,974	15.6%
School-Based Services: • IEP Nursing	1,120	8.8%
Nursing Facility Services	865	6.8%
Child & Teen Check-up Services: • Child and Teen Check-Up Outreach • Child and Teen Check-Up Services	324	2.6%
Chemical Dependency Services	286	2.3%
Administrative Services: • Buy-In • Collections, Miscellaneous • Financial Transactions • Premium Payments/Collections • Primary Care Utilization Review • Spenddown	280	2.2%
ICF/DD Services	173	1.4%
HCBS Services: • HCBS Waiver Conversion/Diversion • DT&H • Alternative Community Services • Moving Home Minnesota Waiver Services • Respite Care • Semi-Independent Living Services • Diversion	119	1.0%
Other Services: • Undetermined Services	116	0.9%

Table 8 displays the number and percentage of individuals living at home at the start of CADI or DD waiver services between 2011 and 2014.

Table 8

Calendar Year	Number of Individuals Living at Home at Start of Waiver Services	Percentage of Individuals Living at Home at Start of Waiver Services
2011	1,022	28.3%
2012	753	28.0%
2013	991	28.7%
2014	835	28.4%

Table 9 displays characteristics of individuals who are currently waiting to start CADI Waiver services. Service categories displayed indicate that an individual has received a service within the last year. For a description of what is included in service categories, see Table 7. These figures are current as of January 9, 2015.

Table 9

Total Number of Individuals on a CADI Waiver Waiting List	1,412 people
Percentage of Individuals on a CADI Waiver Waiting List who Reside at Home	21.3%
Average Age of Individual Currently Waiting for CADI Waiver	42.1 years old
Median Number of Days on CADI Waiver Waiting List Since Initial Assessment	829 days or 2.3 years
Number of People on a CADI Waiver Waiting list who have started the DD Waiver since September 2014	5 people
Number of Lead Agencies without anyone on a DD Waiver Waiting list	21
Percentage of Individuals Who Have Received Home Care Services	53.5%
Percentage of Individuals Who Have Received School-Based Services	28.4%
Percentage of Individuals Who Have Received Mental Health Services	25.4%
Percentage of Individuals Who Have Received Transportation Services	19.4%
Percentage of Individuals Who Have Received Case Management Services	19.0%
Percentage of Individuals Who Have Received Child & Teen Check-up Services	8.3%
Percentage of Individuals Who Have Received HCBS Services	5.7%
Percentage of Individuals Who Have Received Assessments	2.8%
Percentage of Individuals Who Have Received ICF/DD Services	1.9%
Percentage of Individuals Who Have Received Other Services	1.0%

Percentage of Individuals Who Have Received Administrative Services	0.9%
Percentage of Individuals Who Have Received Nursing Facility Services	0.6%
Percentage of Individuals Who Have Received Chemical Dependency Services	0.6%

Table 10 displays characteristics of individuals who are currently waiting to start DD Waiver services. Service categories displayed indicate that an individual has received a service within the last year. These figures are current as of January 3, 2015.

Table 10

Total Number of Individuals on a DD Waiver Waiting List	3,462 people
Percentage of Individuals on a DD Waiver Waiting List who Reside at Home	91.6%
Average Age of Individuals Currently Waiting for DD Waiver Services	15.4 years old
Median Number of Days on DD Waiver Waiting List Since Initial Assessment	2,012 days or 5.5 years
Number of People on DD Waiver Waiting List who have started the CADI Waiver since September 2014	8 people
Percentage of Individuals who have Received Case Management Services	99.2%
Percentage of Individuals who have Received School-Based Services	75.2%
Percentage of Individuals who have Received Home Care Services	34.1%
Percentage of Individuals who have Received County Funded Services	23.5%
Percentage of Individuals who have Received Family Support Grants	7.8%
Percentage of Individuals who have Received Respite Services (Not ICF/DD or NF)	5.0%
Percentage of Individuals who have Received CCB Waiver Services	3.0%
Percentage of Individuals who have Received Home Modifications or Equipment	2.6%
Percentage of Individuals who have Received ICF/DD Services	2.5%
Percentage of Individuals who have Received Jobs & Training Services	1.8%
Percentage of Individuals who have Received Other Services	0.5%
Percentage of Individuals who have Received Homemaker Services	0.3%
Percentage of Individuals who have Received Relocations	0.2%

Service Coordination	
Percentage of Individuals who have Received Adult Education Services	0.1%
Percentage of Individuals on DD Waiver Waiting List who have Received No Services	0.3%

Appendix C: Olmstead Wait List Workgroup Participants

Workgroup meetings held:

June 26, 2014

July 15, 2014

July 31, 2014

August 21, 2014

Stakeholders:

Sue Abderholden, National Alliance on Mental Illness – Minnesota

Rebecca Covington, Minnesota Consortium for Citizens with Disabilities

Andrew Ervin, Hennepin County

Sandra Foy, Ramsey County

Cindy Grosklags, Renville County

Carol Huot, Dakota County

Tim Jeffrey, Stearns County

Steve Larson, The Arc of Minnesota

Bud Rosenfield, Minnesota Disability Law Center

Bill Velte, Hennepin County

Minnesota Department of Human Services:

Alex Bartolic

Curtis Buhman

Patti Harris

Lorraine Pierce

Colin Stemper

Nan Stubenvoll

Management Analysis & Development:

Renee Raduenz

Barbara Tuckner

**EXHIBIT 6-24: ED 1D – REPORT ON PROGRESS IN REDUCING
USE OF RESTRICTIVE PROCEDURES IN SCHOOLS**

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**A Report on Districts' Progress in Reducing the Use of Restrictive
Procedures in Minnesota Schools**

Fiscal Year 2015

Report

To the

Legislature

As required by

Minnesota Statutes,

section 125A.0942

COMMISSIONER:
Brenda Cassellius, Ed. D.

February 1, 2015

FOR MORE INFORMATION CONTACT:

2015

Marikay Canaga Litzau, J.D.

Report to the Legislature

Division of Compliance and Assistance

651-582-8459

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As required by

Minnesota

Statutes

section

125A.0942

**A Report on Districts' Progress in
Reducing the Use of Restrictive
Procedures in Minnesota Schools**

Cost of Report Preparation

The total cost for the Minnesota Department of Education (MDE) to prepare this report was approximately \$20,000. Most of these costs involved staff time in compiling and analyzing data, staffing the stakeholder group, and preparing the written report. Incidental costs include paper, copying, and other office supplies.

Estimated costs are provided in accordance with Minnesota Statute, section 3.197, which requires that at the beginning of a report to the Legislature, the cost of preparing the report must be provided.

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INTRODUCTION

The Minnesota Legislature tasked MDE with developing a statewide plan “with specific and measurable implementation and outcome goals for reducing the use of restrictive procedures.”¹ MDE has submitted reports to the Legislature in 2012, 2013, and 2014, providing summary data of prone restraint and restrictive procedures along with its progress and recommendations for reducing the use of restrictive procedures and eliminating the use of prone restraints.

We commend the reporting school districts for their commitment and candor in their submission of the required data to MDE. For the 2013-14 school year, MDE received responses from all public school districts and charter schools. For the 2012-13 school year, MDE received responses from all but one traditional school district and five charter schools. Data collected for the 2012 and 2013 legislative reports was submitted in varying forms by districts until statutory changes required that districts/charter schools use a form developed by MDE. Thus, data collected and reported after July 1, 2012, represents a consistent reporting format.

2012-2013 Stakeholder Work Group

MDE convened a restrictive procedures work group (2012 stakeholder group) during the 2012-13 school year, as charged by the Minnesota Legislature. The 2012 stakeholder group included representatives from the following legislatively mandated participants: school districts, school boards, special education directors, intermediate school districts, and advocacy organizations. The 2012 stakeholder group met on five occasions between September 2012 and January 2013 to review restrictive procedures data and discuss areas of agreement about how to reduce the use of restrictive procedures.

The statewide plan generated by the 2012 stakeholder group is set forth in the 2013 legislative report available on MDE’s website.² The 2012 stakeholder group recommended 10 activities in the statewide plan and also recommended legislative changes to the restrictive procedure statutes. During the 2013 legislative session, most of the recommended changes, including extending the date for use of prone restraints to August 1, 2015, were passed by the Legislature. However, the Legislature did not authorize the requested appropriation funds targeted for use with students with disabilities experiencing the highest frequency of restrictive procedures, specifically prone restraints. “Prone restraint” means placing a child in a face down position.³ As described more fully below, the 2014 Legislature authorized \$250,000 in state funds targeted for use with those students.

Summary of Progress toward Implementing the 2012 Statewide Plan

During the 2013 legislative session, safe school levy funds were increased effective fiscal year 2015, and language was added to the levy fund statute to allow its use for co-locating and collaborating with mental health professionals who are not staff or contracted as staff. In

¹ Minn. Stat. § 125A.0942, subd. 3(b).

² See 2013 “The Use of Prone Restraint in Minnesota Schools,” *available at* <http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html>

³ Minn. Stat. § 125A.0941(e).

addition, the 2013 Omnibus Health and Human Services bill expanded the school-linked mental health grants program by \$4.5 million for the 2014 and 2015 biennium.

During the 2013-14 school year, MDE provided training throughout the state on the changes to the restrictive procedures statutes and updated the sample forms on the MDE website. MDE also continued to work across the agency to develop a process for and to provide targeted technical assistance. In addition, MDE conducted a survey of school districts and met with the Department of Human Services (DHS) to assist in the development of an expert list. The list was posted on MDE's website in July 2014. Further, MDE continued to coordinate the school-wide positive behavior interventions and supports (PBIS) trainings across the state.

2013-2014 Stakeholder Work Group

MDE reconvened the restrictive procedure work group (2013 stakeholder group) during the 2013-14 school year, as charged by the Legislature. This group was tasked with developing a statewide plan with "specific and measurable implementation and outcome goals for reducing the use of restrictive procedures..."⁴ The 2013 stakeholder group included representation from the following legislatively mandated participants: advocacy organizations, special education directors, teachers, intermediate school districts, school boards, day treatment providers, county social services, state human services department staff, mental health professionals, and autism experts.⁵

The 2013 stakeholder group met on four occasions between November 2013 and February 2014 to review the restrictive procedures data and discuss areas of agreement about how to reduce the use of restrictive procedures. The statewide plan that was generated by the 2013 stakeholder group contained eight goals and proposed amendments to Minnesota Statutes section 125A.0942.⁶ As set forth in the 2013 statewide plan, the 2013 stakeholder group believed there was a need to continue to meet on a quarterly basis to review prone restraint data, review the annual data for restrictive procedures, review progress in implementing the goals, and discuss any needed changes.

Summary of Progress toward Implementing the 2013 Statewide Plan

During the 2014 legislative session, the Legislature passed the recommended changes, including the requested \$250,000 in appropriation funds targeted for use with students with disabilities experiencing the highest frequency of restrictive procedures, specifically prone restraints.

During the summer of 2014, MDE began the process of developing a grant application targeted to seven districts who were using prone restraints and had students with disabilities experiencing the highest frequency of restrictive procedures; specifically prone restraint. Six districts submitted grant applications, and after a review and revision process, six grants totaling

⁴ Minn. Stat. § 125A.0942, subd. 3(b) (2013).

⁵ *Id.*

⁶ See Appendix A. of the 2014 legislative Report. available at <http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html>. (last visited Jan. 26, 2015).

\$150,000 were approved. Each district is to complete their work under the grant by June 30, 2015. The six districts developed work plans to focus on one or more of the following areas to reduce the use of all restrictive procedures and eliminate the use of prone restraint:

- Consistent training to develop common language and standards for reporting restrictive procedures and clarify expectations;
- Keeping law enforcement calls for service stable as restrictive procedures are reduced and prone restraint is eliminated;
- Building staff capacity in the area of proactive behavior interventions to provide resources and targeted interventions to students with disabilities who have significant behavior challenges and mental health needs who are experiencing a high usage of restrictive procedures and a high usage of prone restraint;
- Increasing capacity related to data collection, understanding student behavior, using preventative and de-escalation strategies more consistently, and implementing interventions with fidelity, and
- Providing crisis services in the school setting to reduce the need for 911 calls and subsequent student hospitalization.

In addition, MDE developed a request for proposal (RFP) for three online training modules to address the three subsets of students with disabilities who experience the highest rate of prone restraint, as set forth in Goal No. 2(c) in the 2013 statewide plan. The RFP application deadline was January 15, 2015, and the MDE review should be completed by January 30, 2015. If MDE approves a RFP application, the three online training modules are to be completed by June 30, 2015.

In July 2014, MDE completed and posted the restrictive procedure expert list, after obtaining input from DHS and special education directors. This was a goal in the 2012 statewide plan and is also a goal in the Revised Olmstead Plan⁷. The list will continue to be edited as additional experts are identified and requests submitted to MDE for inclusion. In accordance with Goal No. 4 of the 2013 statewide plan, MDE collaborated with school districts, advocacy groups, and DHS and facilitated two panel discussions on the reduction of restrictive procedures to provide targeted assistance to districts continuing to use prone restraint. The first panel was held at MDE and the second panel discussion was held at DHS and district staff participated both in person and through a live video stream.

MDE has continued to coordinate the school-wide PBIS trainings across the state and is on track to add a minimum of 40 additional schools by June 30, 2014, and each subsequent year thereafter. At this time, 24 percent of all public schools in Minnesota have completed the positive behavior interventions and supports (PBIS) training. This is in accordance with Goal 6 of the 2013 Work Plan and a similar goal in the Revised Olmstead Plan.

⁷http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_documents. (last visited Jan. 26, 2015).

In addition, MDE updated and posted the “Use of Restrictive Procedures District Summary Form” in accordance with Goal 1(a) and the 2014 legislative amendment to Minnesota Statute section 125A.0942 subdivision 6. Additional Forms were updated and posted and MDE added links to DHS resources on its website. More detail is provided in Appendix A.

2014-2015 Stakeholder Work Group

MDE reconvened the restrictive procedure work group (2014 stakeholder group) during the 2014-15 school year as charged by the Legislature. This group continued to be tasked with developing a statewide plan with “specific and measurable implementation and outcome goals for reducing the use of restrictive procedures...”⁸ The 2014 stakeholder group included representation from the following legislatively mandated participants: advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, state human services department staff, mental health professionals, and autism experts.⁹ The 2014 stakeholder group met in September 2014 to review the data from the annual summary report for the 2013-14 school year and the prone restraint data for the quarter ending June 30, 2014. The 2014 stakeholder group continues to meet quarterly with meetings scheduled through July 2015 to review the prone restraint data. The statewide plan generated by the 2014 stakeholder group contains nine goals and proposed amendments to Minnesota Statutes, section 125A.0942. The current statewide plan reflects the consensus among the 2014 stakeholder group.

Summary of the Decreased Use of Restrictive Procedures in Minnesota Schools

In reviewing the data school districts submitted to MDE over the last three reporting periods, there has been a decrease in: the number of districts using restrictive procedures (including prone restraint), the number of students with disabilities experiencing the use of restrictive procedures, and the number of total restrictive procedure incidents.

A comparison of the last two reporting periods¹⁰ demonstrates a reduction in the use of restrictive procedures during the 2013-14 school year, and a reduction in the use of prone restraint during the 2014 calendar year as follows:

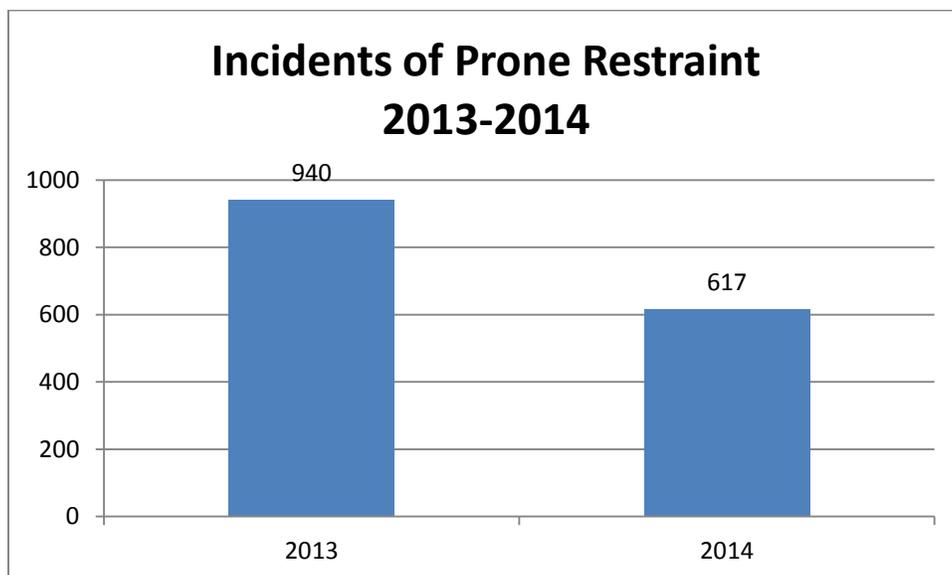
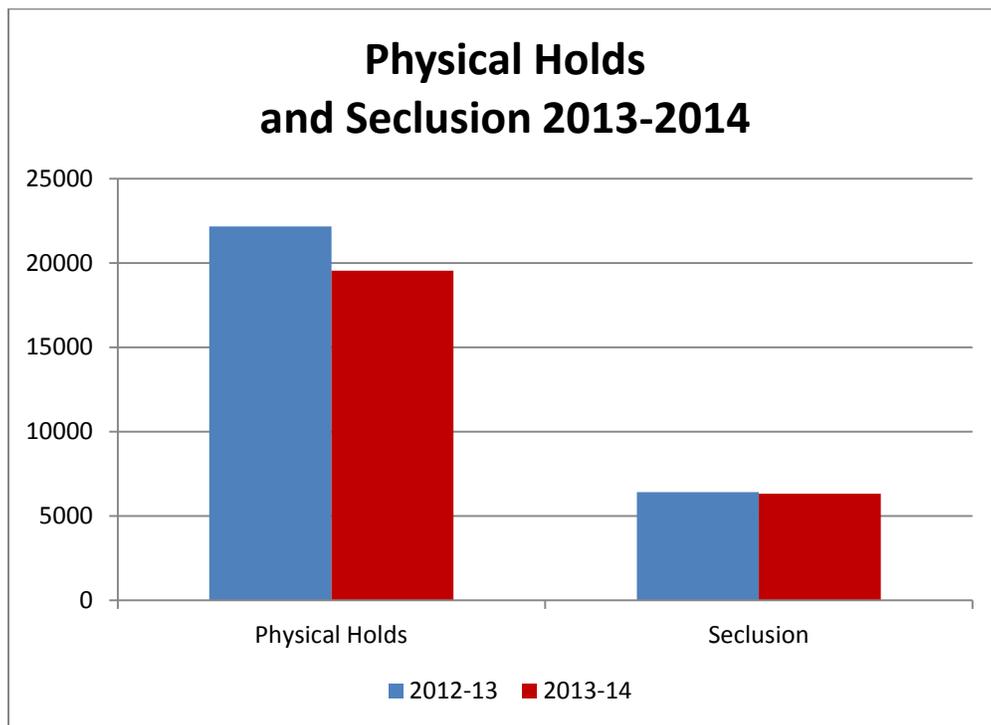
- 34 percent fewer incidents of prone restraint reported
- 12 percent fewer students with disabilities who experienced the use of prone restraint
- 19 percent fewer districts report the use of prone restraint
- 18 percent fewer Black students with disabilities experienced the use of prone restraint
- 9 percent fewer White students with disabilities experienced the use of prone restraint

⁸ Minn. Stat. § 125A.0942, subd. 3(b) (2014).

⁹ *Id.*

¹⁰ The reporting periods for restrictive procedures are 2012-13 and 2013-14. The reporting periods for prone restraint are the 2013 and 2014 calendar years.

- 16 percent fewer incidents of physical holding reported
- 2 percent fewer incidents of seclusion reported



HISTORY OF RESTRAINT IN MINNESOTA

There is an ongoing debate in Minnesota about the legality, morality, and efficacy of using seclusion¹¹ or restraint on individuals with disabilities. Some are concerned that these procedures are subject to misapplication and abuse, placing students at equal or greater risk than their problem behavior(s) pose to themselves or others.¹²

On February 1, 2012, MDE submitted a report to the Minnesota Legislature detailing the results of data on the use of prone restraint from August 1, 2011, through January 13, 2012.¹³ MDE made important disclaimers about the quality of the data presented, which included the short reporting window, the lack of information about the use of other non/prone physical holding and seclusion, and inconsistency in reporting forms, with recommendations for improvements both in data reporting and in clarification regarding the use of restrictive procedures.

During the 2012 legislative session, Minnesota Statutes, sections 125A.0941 and 125A.0942, were amended to include a definition of prone restraint¹⁴ and a revised definition of physical holding.¹⁵ The statute limited the use of prone restraint to “children age five or older,” but allowed its use until August 1, 2013,¹⁶ and required districts to report the use of prone restraint on an MDE form.¹⁷ Additionally, the Minnesota Legislature tasked MDE with developing a statewide plan “to reduce districts’ use of restrictive procedures.”¹⁸ As noted above, MDE continued to collect data on prone restraint, gathered restrictive procedure summary data from districts for the 2011-12 school year, and assembled a group of stakeholders to assist MDE with developing a statewide plan.¹⁹

In February 2013, MDE submitted a report to the Minnesota Legislature that detailed the results of data collected on the use of prone restraint from January 14, 2012 through December 31, 2012. The report provided summary data on the use of all reported restrictive procedures in Minnesota during the 2011-12 school year and also provided MDE’s progress and recommendations for reducing the use of restrictive procedures and eliminating the use of prone restraints.

¹¹ Minnesota’s restrictive procedures statute defines “seclusion” as “confining a child alone in a room from which egress is barred. Egress may be barred by an adult locking or closing the door in the room or preventing the child from leaving the room. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion.” Minn. Stat. § 125A.0941(g) (2014).

¹² U.S. Senate, Health, Education, Labor, and Pensions Committee, *Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficulty to Remedy: A Review of Ten Cases* (Majority Staff Report, issued February 12, 2014), Majority Committee Staff Report. Retrieved from <http://www.help.senate.gov/imo/media/doc/Seclusion%20and%20Restraints%20Final%20Report.pdf> (last visited Jan. 26, 2015).

¹³ For information related to the history of restraint in the educational setting prior to 2012, see 2012 and 2013 Legislative Reports, “The Use of Prone Restraint in Minnesota Schools,” available at <http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html>.

¹⁴ Minn. Stat. § 125A.0941(e) (2012).

¹⁵ Minn. Stat. § 125A.0941(c) (2012).

¹⁶ Minn. Stat. § 125A.0942, subd. 3(7) (2012).

¹⁷ Minn. Stat. § 125A.0942, subd. 3(a)(7)(iv). (2012)

¹⁸ Minn. Stat. § 125A.0942, subd. 3(b) (2012).

¹⁹ *Id.*

During the 2013 legislative session, Minnesota Statutes, sections 125A.0941 and 125A.0942 were amended to provide more content specificity for the oversight committee for a district's restrictive procedure plan, clarified requirements for when an individual education plan (IEP) team meeting must be held following the use of a restrictive procedure, clarified that restrictive procedures can only be used in an emergency and not for disciplinary reasons, extended the time period for use of prone restraint until August 1, 2015, tasked MDE with developing a statewide plan to reduce the use of restrictive procedures, included paraprofessionals under the training section, added to the training requirements to ensure school staff are aware of school side positive behavior strategies used by the school and procedures related to timely reporting of the use of restrictive procedures, and required MDE to develop and maintain a list of experts to help IEP teams reduce the use of restrictive procedures.

In February 2014, MDE submitted a report to the Minnesota Legislature that detailed the results of data collected on the use of prone restraint from January 1, 2013 through December 31, 2013. The report provided summary data on the use of all reported restrictive procedures in Minnesota during the 2012-13 school year and also provided MDE's progress and recommendations for reducing the use of restrictive procedures and eliminating the use of prone restraints.

Regulation of Restraint in DHS Facilities

In 2011, DHS entered into a settlement agreement enforced by the federal court in Minnesota, regarding the inappropriate use of aversive and deprivation procedures, including the improper use of seclusion and restraint techniques. As part of the 2011 "METO Settlement,"²⁰ DHS is currently undertaking a rulemaking process to amend Minnesota Rules, Parts 9525.2700 to 9525.2810 (commonly referred to as "Rule 40"), to reflect best practices regarding the use of aversive and deprivation procedures in facilities that serve persons with developmental disabilities, including through the use of positive behavioral approaches and the elimination of particular restraint practices. On December 24, 2014, DHS published proposed rules.²¹ A public hearing on the proposed rules is scheduled for February 23, 2015.

The Rule 40 Advisory Committee issued its final version of "Recommendations on Best Practices and Modernization of Rule 40" on July 2, 2013. To support the recommendations, DHS is holding Positive Supports Community of Practice meetings online on various training topics.²²

²⁰ METO Settlement, Case 0:09/cv/01775/DWF/FLN, Doc. 104/1, Attachment A, p. 5 (2011). Retrieved from http://www.dhs.state.mn.us/main/idcplg?ldcService=GET_DYNAMIC_CONVERSION&dID=137925. (last visited Jan. 26, 2015).

²¹ Proposed Rules Governing Positive Support Strategies, Person-Centered Planning, Limits on Use of Restrictive Interventions and Emergency Use of Manual Restraint, and Repeal of Rules Governing Aversive and Deprivation Procedures in *Minnesota Rules*, 9525.2700 to 9525.2810; Revisor's ID No. R-04213.

²² Minnesota Department of Human Services Positive Supports Community of Practice website, available at: <http://mn.gov/dhs/partners-and-providers/continuing-care/provider-information/positive-supports/positive-support-cop.jsp> (last visited Jan. 26, 2015).

As part of the 2011 Jensen stipulated class action settlement, the State of Minnesota agreed to develop an Olmstead Plan to move the state forward toward greater integration and inclusion for people with disabilities. The initial Olmstead Plan was submitted to Federal District Court (Court) on November 1, 2013. The State of Minnesota submitted Proposed Plan modifications to the Court, most recently on November 10, 2014 (Revised Olmstead Plan). On January 9, 2015, Justice Donovan Frank provisionally approved the State of Minnesota's Revised Olmstead Plan, subject to the Court's review of the State's modifications in accordance with the Order, which must be submitted by the State of Minnesota on March 20, 2015. As part of the Revised Olmstead Plan, MDE is responsible for two activities related to the elimination of the use of prone restraint in the public school setting by August 1, 2015, and reducing the use of restrictive procedures in the public school setting over the time period of June 30, 2015 to June 30, 2019.

23

REGULATORY DEVELOPMENTS

Recent Minnesota Developments

During the 2014 legislative session, Minnesota Statutes, sections 125A.0941 through 125A.0942 were amended to:

- Provide more content specificity for a district restrictive procedure plan, by including a description of how the school will provide training on de-escalation techniques, consistent with Minnesota Statutes, section 122A.09, subdivision 4, paragraph (k);²⁴
- Amend the date the legislative report is due and to make the workgroup ongoing; and
- Require districts to report the use of reasonable force, as defined in section 121A.582, which results in a physical hold as defined in section 125A.0941.25.

Federal Developments

The Keeping All Students Safe Act (H. 1893), legislation aimed at regulating restraint and seclusion on the federal level, was introduced in the United States House of Representatives by Representative George Miller on May 8, 2013, and the bill was referred to the Subcommittee on Early Childhood, Elementary, and Secondary Education.²⁶

At a news conference on February 12, 2014, Senator Tom Harkin, Chairman of the Senate Health, Education, Labor, and Pensions (HELP) Committee, released the findings of an investigation into the use of seclusion and restraints. The majority staff report is titled, "Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficult to Remedy: A Review of Ten Cases." The report highlighted cases in which restraint was used as

²³ http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_home. (last visited Jan. 26, 2015).

²⁴ 2014 Minn. Laws ch. 1X, art. 17, sec. 1.

²⁵ *Id.*

²⁶ U.S. Library of Congress website <http://beta.congress.gov/bill/113th-congress/house-bill/1893>. (last visited Jan. 26, 2015).

a form of punishment or control.²⁷ At the event, Harkin announced the Keeping All Students Safe Act, a bill to ensure the effective implementation of positive behavioral interventions in the education setting. On February 24, 2014, the bill was introduced in the Senate, read twice, and referred to the Committee on HELP.

Currently, 40 states and the District of Columbia have legislation and/or education agency regulations or policies that prohibit the use of prone restraints or restraints that impede a child's ability to breathe within the school setting. Fifteen states specifically prohibit the use of "prone" restraint in educational settings by state statute, rule, or policy.²⁸

Thirteen states specifically prohibit the use of prone restraint in educational settings by state statute, rule, or policy. In addition, 29 states have legislation and/or education agency regulations or policies that encompass all students, rather than only students with a disability. This is in accordance with Principle Four in the U.S. Department of Education, Office of Special Education and Rehabilitation Services (USDE OSERS) guidance document issued May 15, 2012, *Restraint and Seclusion: Resource Document*.²⁹

Only four states (Vermont, Massachusetts, Rhode Island, and Minnesota) prohibit the use of restraints that impede a child's ability to breathe and specifically allow the use of prone restraint in limited circumstances. Appendix B contains a citation to and a description of the provisions in place for each state addressing restrictive procedures.

MINNESOTA'S PRONE RESTRAINT DATA

Important Disclaimers Regarding the Data

Reporting Window. School districts have been statutorily required to report to MDE regarding their use of prone restraint since August 1, 2011. As described in the 2012 report, the initial data only covered prone restraint reports received over a five-month period (August 1, 2011 through January 13, 2012). The 2013 report included data from prone restraint reports received January 13, 2012, through December 31, 2012. For the 2014 and 2015 reports, the included data on the use of prone restraint is over a 12 month calendar period (January 1 through December 31), with relevant comparisons to previous years' data. Beginning in September 2012, Districts have been required to use the MDE form for reporting prone restraint and the data has been more consistent since that occurred.

Not the Whole Picture. We acknowledged in prior reports that the use of prone restraint is best evaluated within the context of the statewide use of all other types of restrictive procedures by

²⁷ U. S. Senate, Health, Education, Labor, and Pensions Committee, *Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficult to Remedy: A Review of Ten Cases*, Majority Committee Staff Report (Feb. 12, 2014), Retrieved at <http://www.help.senate.gov/imo/media/doc/Seclusion%20and%20Restraints%20Final%20Report.pdf>. (Last visited Jan. 26, 2015).

²⁸ Arkansas, District of Columbia, Georgia, Indiana, Iowa, Kansas, Kentucky, Michigan, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, West Virginia, Wyoming.

²⁹ U.S. Department of Education, Office of Special Education and Rehabilitation Services guidance document, *Restraint and Seclusion: Resource Document* (Issued May 15, 2012), Retrieved at <https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf>. (Last visited Jan. 26, 2015).

Minnesota school districts. Districts are required to maintain data on their use of restrictive procedures, including physical holding or seclusion,³⁰ and are required to report a summary of this data annually to MDE by June 30 of each year.³¹ As summary data, the restrictive procedures data has some limitations not present with the prone restraint data. The summary data necessarily lacks information about the range of numbers of physical holds and uses of seclusion per individual student. The data also lacks information about the length of time students were physically held and secluded and the types of restraints being used.

Limitations in the Restrictive Procedures Data

We received close to or a 100 percent response rate from all public school districts, including charter schools, for the last two school years (2012-13 and 2013-14). It is important to note that the number of restrictive procedure incidents that districts reported in the annual summary may not be aligned with MDE's definition of an "incident" of restrictive procedure, as discussed below. Therefore, incident level comparisons between restrictive procedures incidents and prone restraint report incidents are not likely to be valid. However, as a result of the summary data, we are able to provide policy makers with data to substantiate the percentage of students in the state that have been reported as restricted compared to the data specific to prone restraint.

Outliers. For the 2014 calendar year, one student accounted for 11 percent, or 53 of the 489 reports of prone restraint. Cumulatively, five students account for 24 percent, or 116 of the 489 reports, and 10 students accounted for 35 percent, or 173 of the 489 reports. The remaining 148 students accounted for 65 percent of the reports. These figures are similar to outliers for data collected in prior years.³²

Of those students who experienced the highest use of prone restraint during the 2014 calendar year, they were found eligible for special education services by meeting state criteria for Autism Spectrum Disorders (five), Emotional or Behavioral Disorders (two), Other Health Disabilities (two) and Developmental Cognitive Disability (one).

Including these unique situations in the overall data counts skews the appearance of the demographic data by incidents. However, this data is important for understanding the issues and potential solutions. The data illustrates that a relatively small number of students underlie the total number of reports and incidents. Though the specific students who make up this group change over time, intensive services targeted to these students are likely to have the greatest impact on diminishing the use of restrictive procedures.

Prone Restraint Data

Districts submitted written prone restraint reports to MDE through a secure website. Individual reports necessarily included personally identifying information related to specific students, and as such constitute non-releasable data under the Minnesota Government Data Practices Act.³³

³⁰ Minn. Stat. § 125A.0942, subd. 3(a).

³¹ Minn. Stat. § 125A.0942, subd. 3(b).

³² See prior Legislative Reports, available at <http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html>.

³³ Minn. Stat. § 13.02, subds. 5, 8a (2014).

MDE prepared and posted a summary of reported data by quarter on its Restrictive Procedures webpage.

Districts that Reported Use of Prone Restraint

District	2014 Reports	2013 Reports
Albert Lea (840)	1	0
Bemidji (31)	0	2
Benton-Stearns Ed. Dist. (6383)	57	72
Brainerd (181)	6	1
Buffalo-Hanover-Montrose (877)	0	2
Cambridge-Isanti (911)	1	0
Goodhue County Ed. Dist. (6051)	2	0
Hendricks (402)	0	2
Intermediate District 287	55	83
Intermediate District 917	137	218
Mankato (77)	23	36
Marshall (413)	0	12
Moorhead (152)	11	15
New London Spicer (345)	1	0
Northeast Metro 916	119	74
Pine City (578)	0	9
Southwest West Central (991)	74	85
Waterville-Elysian-Morristown (2143)	0	1
West Central Area (2342)	0	1
Willmar (347)	2	35
Total Prone Restraint Reports	489	647

Incidence of Prone Restraint by District

For the purposes of reporting, we consider prone restraint to begin when the child is placed in a prone position by one or more trained staff persons holding onto the child; it ends when the child is no longer being held. That cycle—a hold followed by the release of the hold—is one incident of prone restraint.

In more complex situations related to the same precipitating incident, this hold/release pattern was repeated a number of times before the child was returned to the classroom or other activity. Given that the statutory definition of a “physical hold” is based on the presence or absence of “body contact” or “physical contact,” we determined that this situation involved several incidents

of prone restraint, all of which were included on one written report. This explains the difference between the number of “incidents” that occurred (617) and the number of “reports” MDE received (489).

MDE received reports of 617 prone restraint incidents that occurred during the 2014 calendar year, a substantial decrease from the 940 prone restraint incidents reported for calendar year 2013. During the 2014 calendar year:

- 13 districts reported the use of prone restraint, a decrease of 19 percent from 16 during calendar year 2013.³⁴
- 158 students were restrained in a prone position by a staff member, a decrease of 12 percent from 180 students during calendar year 2013.

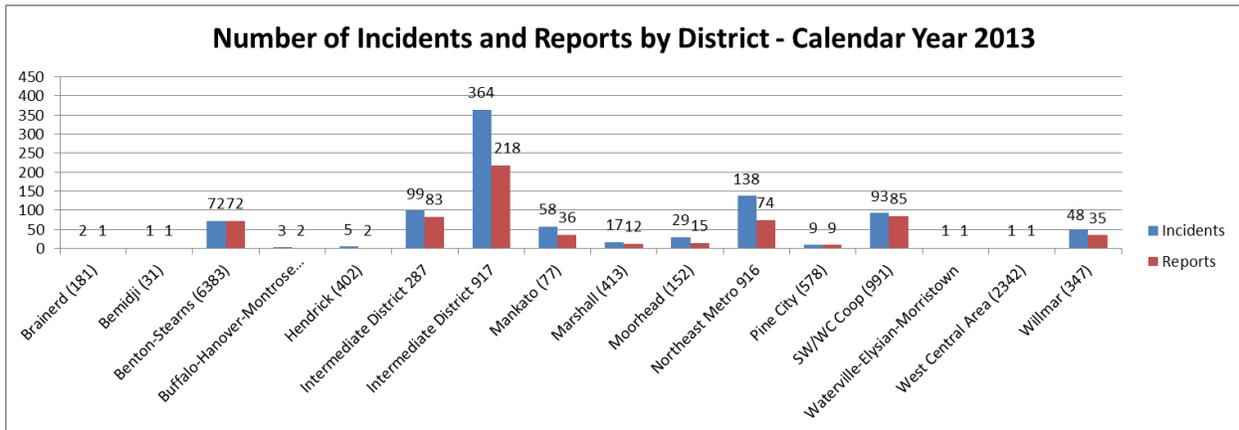
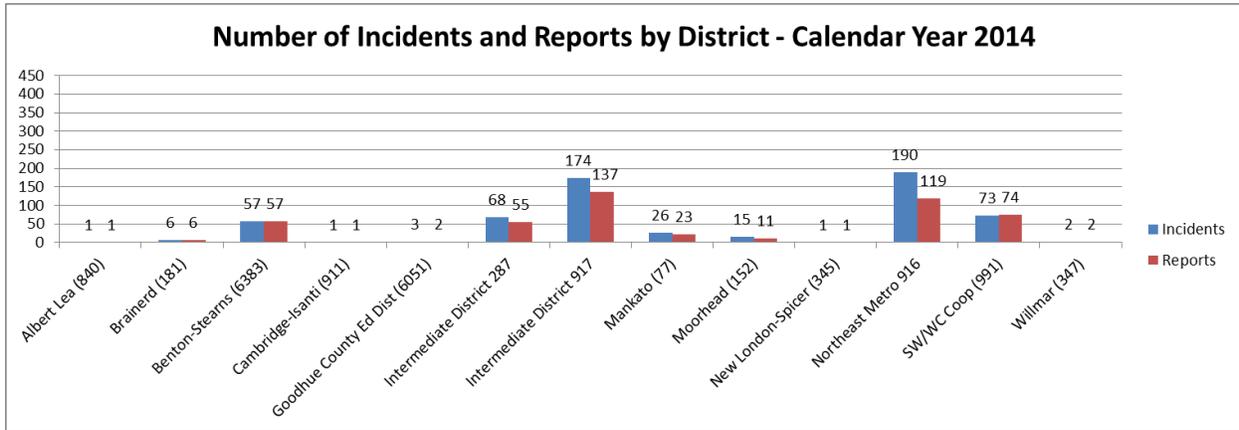
The majority of both prone restraint incidents and reports involved students at one of Minnesota’s three intermediate school districts. This is not surprising given that the intermediate districts provide, among other important services, a program of integrated services for special education students.³⁵ As a rule, the intermediate districts provide services to students with disabilities who have not experienced success at their original district, and a significant percentage of these students exhibit atypical behavioral challenges in a school setting. Two of the three intermediate districts continued to show a decrease in both the number of reports and incidents of prone restraint from the previous legislative report. One intermediate district showed a year-over-year increase, though it was still down substantially from the 2012 report. At the stakeholder meetings, the intermediate districts shared the efforts made to implement data-driven positive behavior strategies and to review the restrictive procedures data on an ongoing basis, as well as staffing and environmental changes.

With the exception of the intermediate district described above and one independent school district, all other districts with reported use of prone restraint in calendar year 2013 showed a year-over-year decrease, some to zero for calendar 2014. In addition, four districts reported use of prone restraint in calendar year 2014, though no use was reported in the prior year. The use of prone restraint in greater Minnesota continues to be mostly reported by special education programs at cooperatives or education districts and districts that are regional centers. In greater Minnesota, these programs and districts function similarly to the intermediate school districts in the Twin Cities metropolitan area, in part, by serving students with the most challenging behaviors.

The following two charts represent the distribution of both prone restraint incidents and reports for the last two annual reporting periods. Statewide, the number of reports submitted, incidents reported, and students involved, and the number of districts using prone restraint during the 2014 calendar year have all decreased compared to the 2013 data, though, on a district level, two districts reported increases.

³⁴ *Id.*

³⁵ Minn. Stat. § 136D.01 (2014).

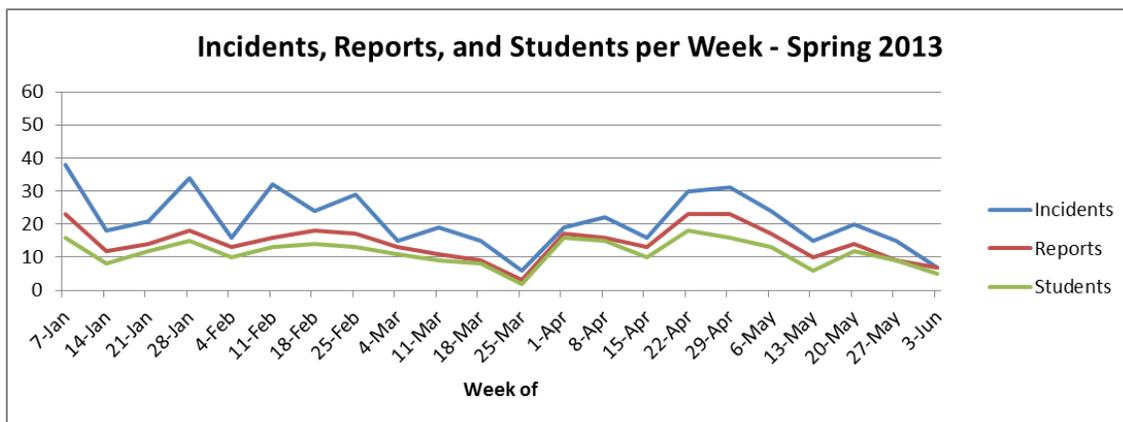
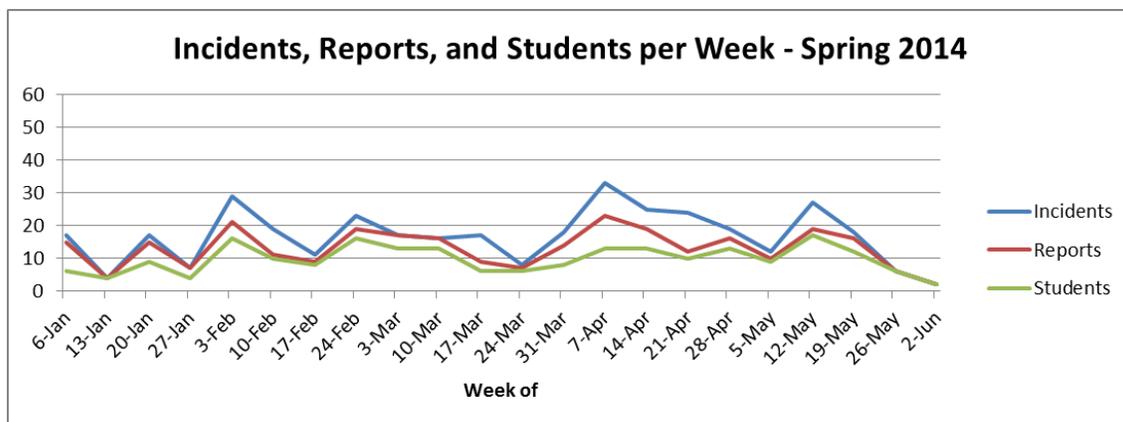
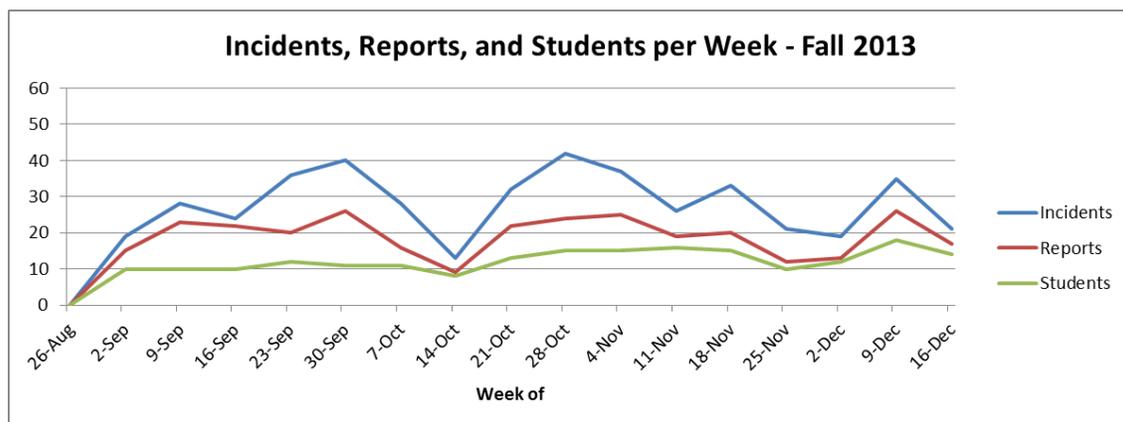
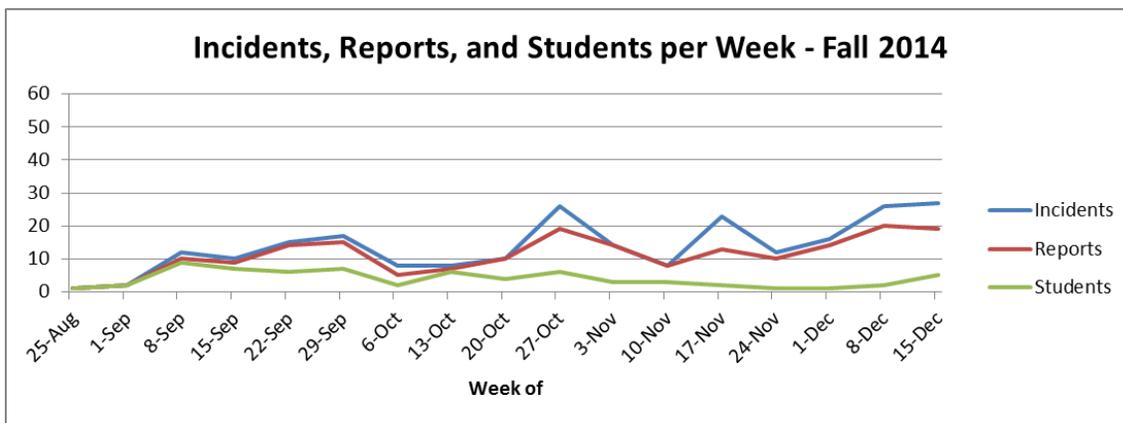


Number of Students in Prone Restraint

For the 2014 calendar year, districts reported that 158 students with disabilities were restrained using prone restraint one or more times. In comparing individual students who experienced prone restraint over multiple calendar years:

- 62 students experienced prone restraint during the 2013 and 2014 calendar reporting periods.
- 27 students experienced prone restraint during the 2012, 2013, and 2014 calendar reporting periods.
- 6 students experienced prone restraint at least once within all four reporting periods.

The following graphs show the number of incidents, reports, and students per week for comparisons of 2014 and 2013, fall and spring, respectively.



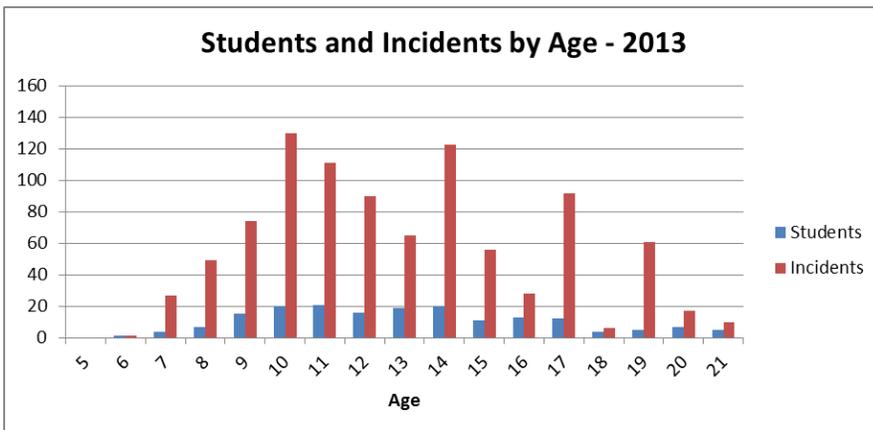
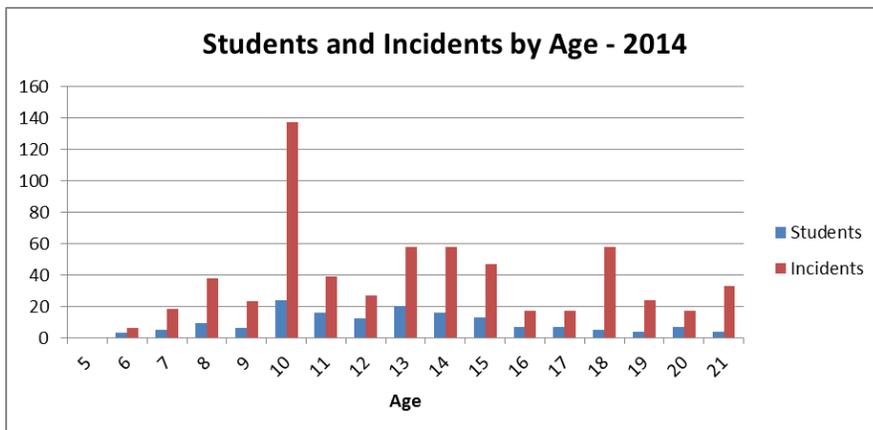
Length of Incident of Prone Restraint

The 2014 data indicates the following:

- 50 percent of the 617 incidents of prone restraint lasted five minutes or less, compared to 56 percent during 2013.
- The number of restraints of five minutes or less also decreased from 525 in 2013 to 310 incidents in 2014.
- Nearly 90 percent of the reported incidents of prone restraint lasted 15 minutes or less.

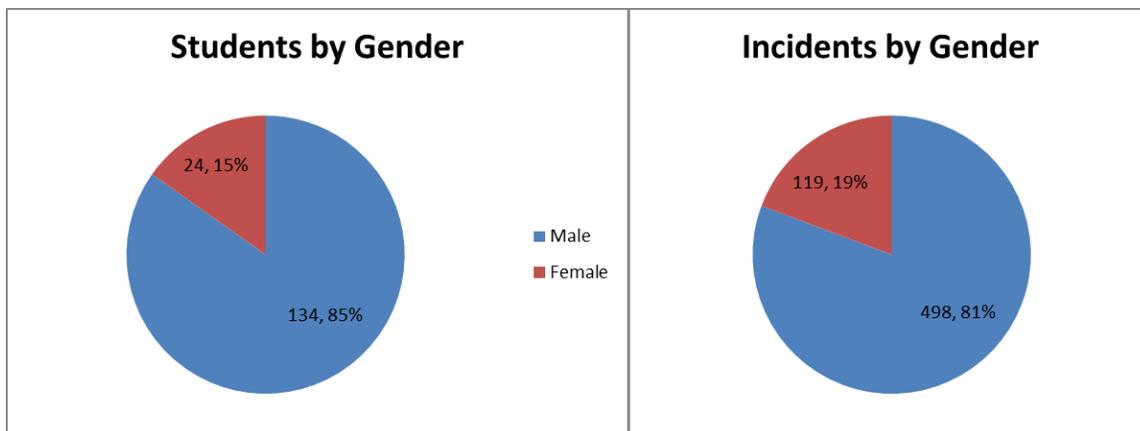
Age of Students Placed in Prone Restraint

During the 2014 calendar year, prone restraint was used on children as young as 6 years old and as old as 21. This is consistent with prior years. Though the number of students and incidents are again down from the previous reporting periods, the relative peak usage of prone restraint by age, both by number of incidents and number of students, continues to be with middle school students. The peaks of incidents at ages 18 and 21 are due to the skewed effect of the outliers described earlier in this report, whereas the peak at age 10 is more the result of an aggregation: 137 incidents across 24 students.



Gender of Students Placed in Prone Restraint

The 2014 calendar year data shows that boys are more than six times more likely than girls to be restrained in a prone position, which is up from five times more likely in the previous reporting period, though consistent with the 2012 reporting period.

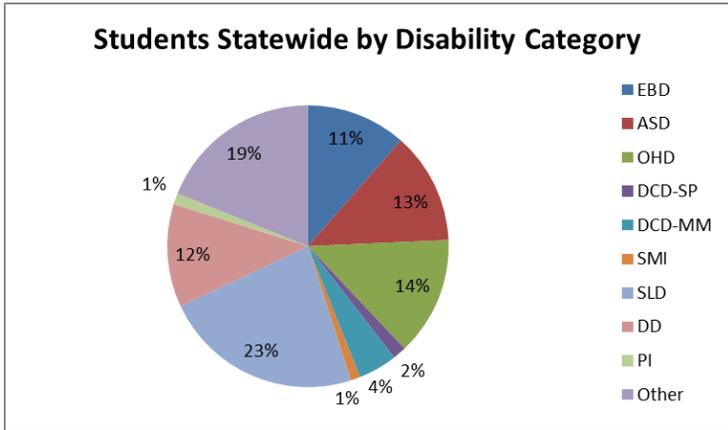
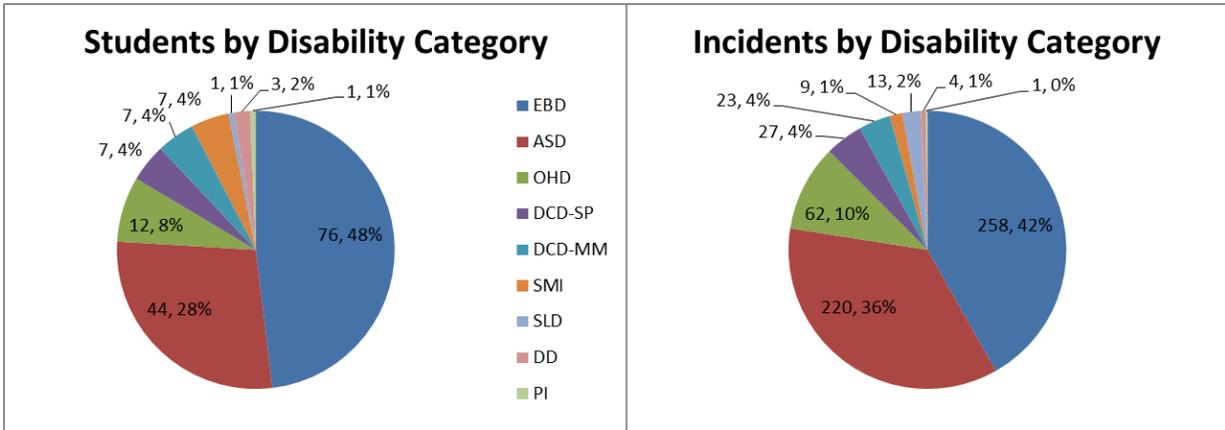


Students and Incidents by Disability Category

Overall, 68 percent of all incidents of prone restraint reported during the 2014 calendar year involved students who were eligible for special education under the following eligibility criteria: Autism Spectrum Disorders (ASD) or Emotional or Behavioral Disorders (EBD). Compared to the 2013 calendar year, this is a decrease from 84 percent of the incidents. Reduced relative usage with students under the ASD category accounts for the decrease.

The first chart below illustrates the number and percentage of students with disabilities subjected to prone restraint. The second chart illustrates the percentage of incidence represented by each specific category. For example, while ASD students represent 29 percent of all students who experienced the use of prone restraint, that same population represents 36 percent of all incidents reported for the same time period. For further comparison, the percentages of these students within the state's total special education population are illustrated in the third chart. For example, the same ASD students who represent 29 percent of all students who experienced the use of prone restraint and represent 36 percent of all incidents reported, are represented in 13 percent of the state's total special education population.³⁶

³⁶ 2014 Child Count Totals by December 1, 2013 by Disability, Race/Ethnicity, and Age, retrieved from MDE Data Reports and Analytics, available at <http://w20.education.state.mn.us/MDEAnalytics/Data.jsp>.



Key

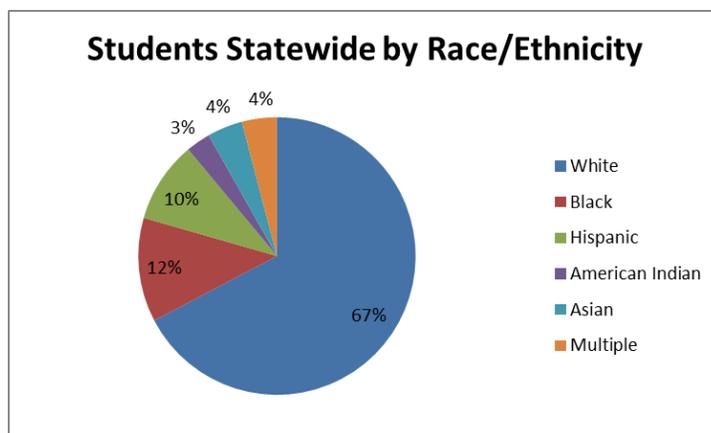
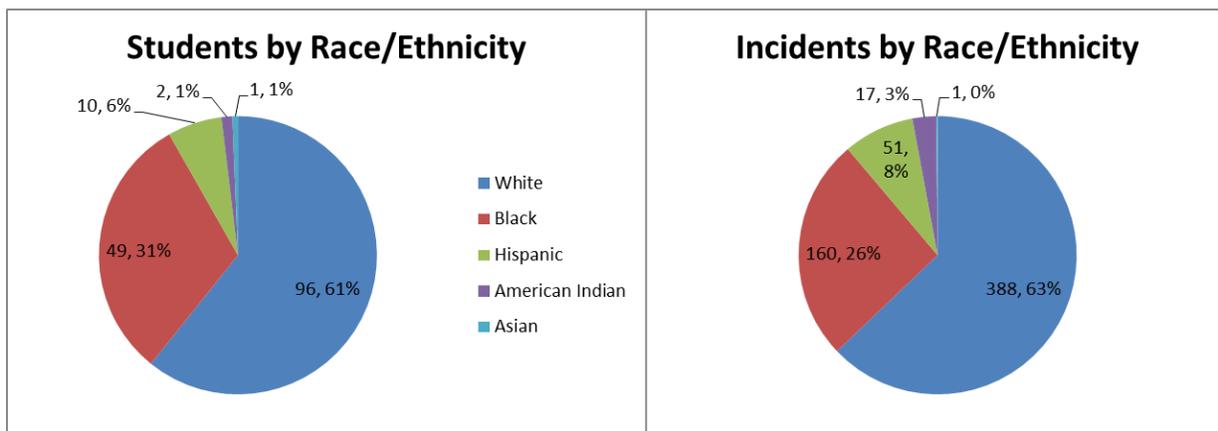
- EBD = Emotional or Behavioral Disorders*
- ASD = Autism Spectrum Disorders*
- OHD = Other Health Disabilities*
- DCD-MM = Developmental Cognitive Disability-Mild to Moderate*
- DCD-SP = Developmental Cognitive Disability-Severe to Profound*
- SMI = Severely Multiply Impaired*
- SLD = Specific Learning Disability*
- DD = Developmental Delay*
- PI = Physically Impaired*

Students Involved In Prone Restraint by Race/Ethnicity

Compared to data from the 2013 calendar year, the proportion of Black students in prone restraint during the 2014 calendar year decreased from 32 percent to 31 percent. The proportion of incidents for Black students also decreased, from 32 percent to 26 percent. At the same time, the proportion of incidents for White students increased from 60 percent to 63 percent, for Hispanic students from seven percent to eight percent, and for American Indian students from less than one percent to three percent.

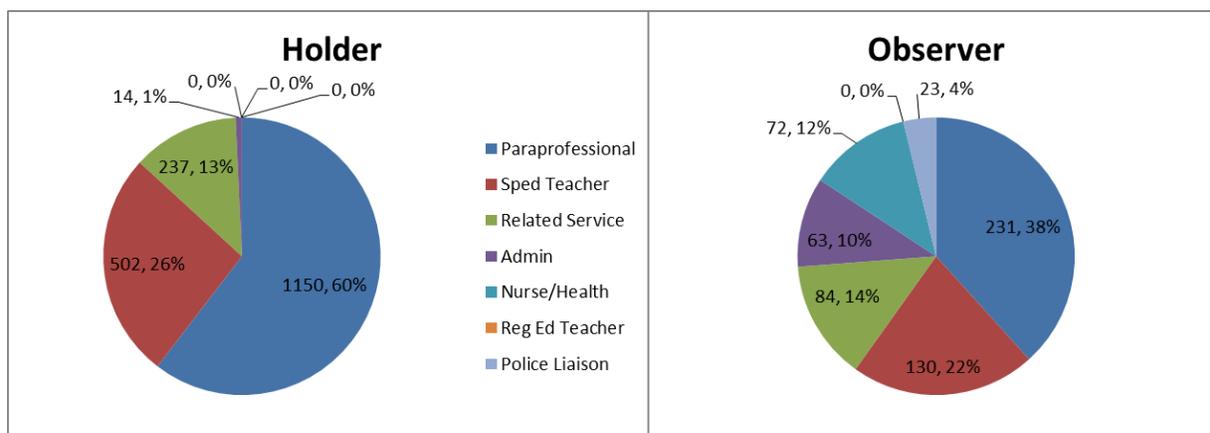
Much of the change in incidents by race/ethnicity can be attributed to the change in students who fall into the group of outliers described earlier in this report, more of whom were White students during 2014, compared to a larger proportion of Black students in 2013. In comparison

to the statewide population of students with disabilities, Black students continue to be overrepresented in prone restraint by number of students and incidents.



Staff Involved in the Use of Prone Restraint

Approximately 420 staff were involved in the use of prone restraint during the 2014 calendar year, either as a holder or an observer, down from approximately 520 in the previous calendar year. The median number of times a staff person was involved was two times (same as 2013), with a range of up to 48 times, which is down from 70 times in 2013. As in 2013, most reports included at least one paraprofessional as a holder (465 reports) and few reports included only paraprofessionals as holders (97). Across seven reports, 10 education staff were reported as holders and listed as not trained. The chart below shows the percentage of times various staff were holders or observers. For example, paraprofessionals were reported as holders 1,150 times across all reports during this reporting period.



Injuries Related to the Use of Prone Restraint

Across 489 prone restraint reports submitted for the 2014 calendar year, districts reported two student injuries and 24 staff injuries, down from seven and 36, respectively, as reported for 2013. Injury descriptions to staff included strained muscles, scratches, bruises, and bites, which included bleeding. The two reported student injuries were not clearly described; however, neither injury was indicated as necessitating a report to the ombudsman.

RESTRICTIVE PROCEDURES SUMMARY DATA

Following the 2013-14 school year, districts reported summary data to MDE on the use of restrictive procedures, which was due by June 30, 2014. On a form provided by MDE, districts reported:

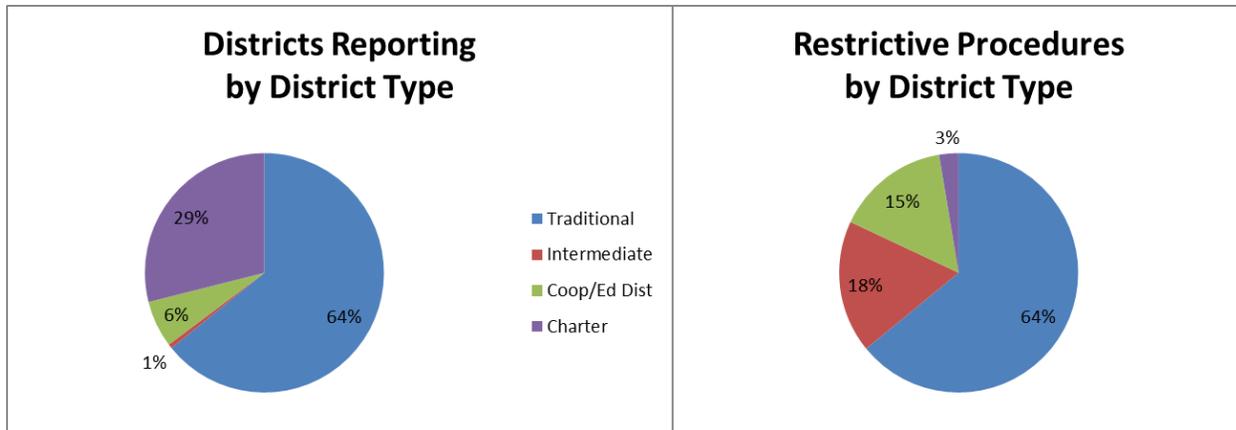
- the total number of students receiving special education services served by the district;
- the total number of incidents of restrictive procedures (includes physical holding, prone restraint, and seclusion);
- the total number of students receiving special education services upon whom a restrictive procedure was used;
- the total number of students receiving special education services upon whom restrictive procedures were used 10 or more school days during the school year;
- the total number of incidents of physical holding (including prone restraint);
- the total number of incidents of seclusion;
- the demographic information for the students (disability, age, race, and gender);
- the number of injuries to students and staff.

MDE received summary data from 522 districts (which includes independent and special school districts, charter schools, cooperatives, education districts, and intermediate school districts). This was a 100 percent response rate, which included district responses of no use of restrictive procedures.

Districts that Reported Use of Restrictive Procedures

Of the 522 districts that reported summary data to MDE, 249 of those districts (compared to 252 districts in 2013) reported use of restrictive procedures, whether physical holding, seclusion, or a combination of both. They include:

- 195 of 335 traditional districts
- 3 of 3 intermediate school districts
- 15 of 33 cooperatives and education districts
- 33 of 151 charter schools



While intermediate districts, cooperatives, and education districts comprise approximately seven percent of the total reporting districts, combined they reported 33 percent of the restrictive procedure use in the state. By contrast, charter schools represent approximately 29 percent of the reporting districts, but reported nearly no use of restrictive procedures. Traditional districts represent approximately 64 percent of the reporting districts and also reported 64 percent of restrictive procedure use. The proportion of restrictive procedures reported for the 2013-14 school year is higher as compared to the 2012-13 data for cooperatives, education districts, and charter schools, with intermediate and traditional districts down slightly.

Of the 249 districts that reported use of restrictive procedures:

- 172 (69 percent) reported use of only physical holding,
- 3 (1 percent) reported use of only seclusion, and
- 74 (30 percent) reported use of both physical holding and seclusion.

While this is consistent with previous reporting, it should be noted that the districts reporting usage changed. Of the 249 districts reporting use of restrictive procedures during the 2013-14 school year, 51 of the districts reported no usage of restrictive procedures the previous school year.

Statewide Data on the Use of All Restrictive Procedures

Across the state, during the 2013-14 school year, districts reported 13,214 physical holds and 6,323 uses of seclusion for a total of 19,537 restrictive procedures. This was a decrease of approximately 11 percent from the 2012-13 school year reporting.

When comparing the data, it should be noted that for the 2011-12 school year, only 474 districts submitted a summary restrictive procedure form, as compared to 513 districts and 522 districts respectively for the 2012-13 and 2013-14 school years.

School Year	Physical Holds	Uses of Seclusion	Restrictive Procedures
2013-14	13,214	6323	19,537
2012-13	15,738	6425	22,163
2011-12	16,604	5236	21,840

Of 138,883 special education students,³⁷ restrictive procedures were used with 2,740 students with disabilities, which is approximately two percent of the special education population. This percentage is the same as reported in the 2014 legislative report. Physical holding was used with 2,433 students, down from the data reported in the 2014 legislative report (2,604) and seclusion was used with 837 students, also down from the data reported in the 2014 legislative report (957).³⁸ Compared to the 2013-14 school year, the average number of physical holds per physically held student was 5.4, down from 6.0; the average number of uses of seclusion per secluded student was 7.6, up from 6.7; and the average number of restrictive procedures per restricted student was 7.2, down from 7.5.³⁹

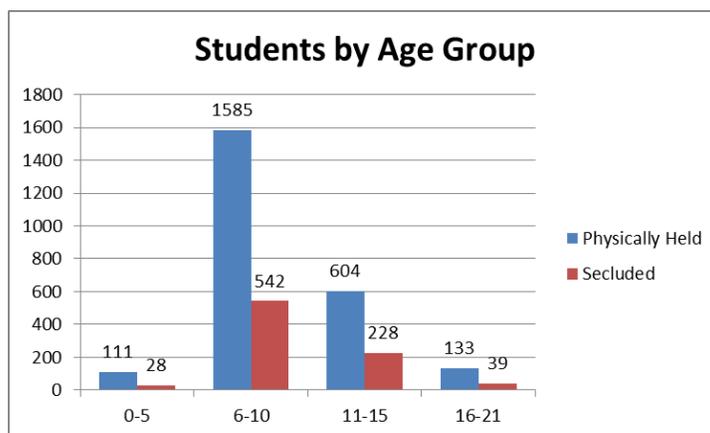
Age of Students in Restrictive Procedures

The majority of restrictive procedures reported for the 2013-14 school year were used with elementary through middle school students, with fewer uses with early childhood and high school students, consistent with the previous legislative reports.

³⁷ The number of special education students is based on an aggregation of districts' self-reported data in conjunction with the restrictive procedures reporting and may not match exactly with other aggregations by MDE of the number of special education students in the state.

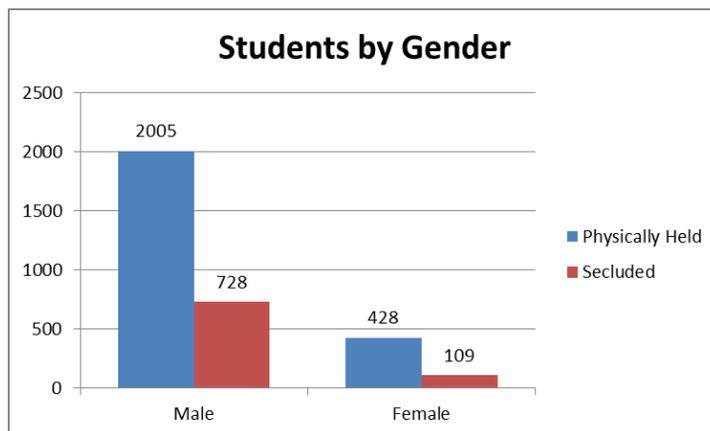
³⁸ The number of physically held students plus the number of secluded students is greater than the total number of students with whom restrictive procedures were used because a number of students were reported as both physically held and secluded.

³⁹ As with the previous footnote, the average number of restrictive procedures per restricted student may be higher than the averages for both physical holding and seclusion because of the number of students both physically held and secluded.



Gender of Students in Restrictive Procedures

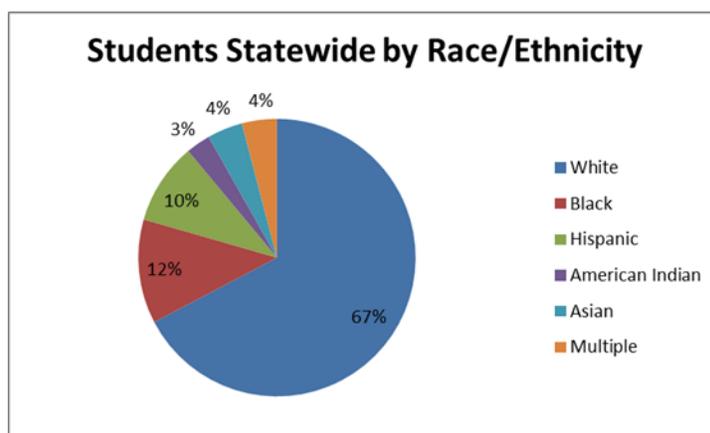
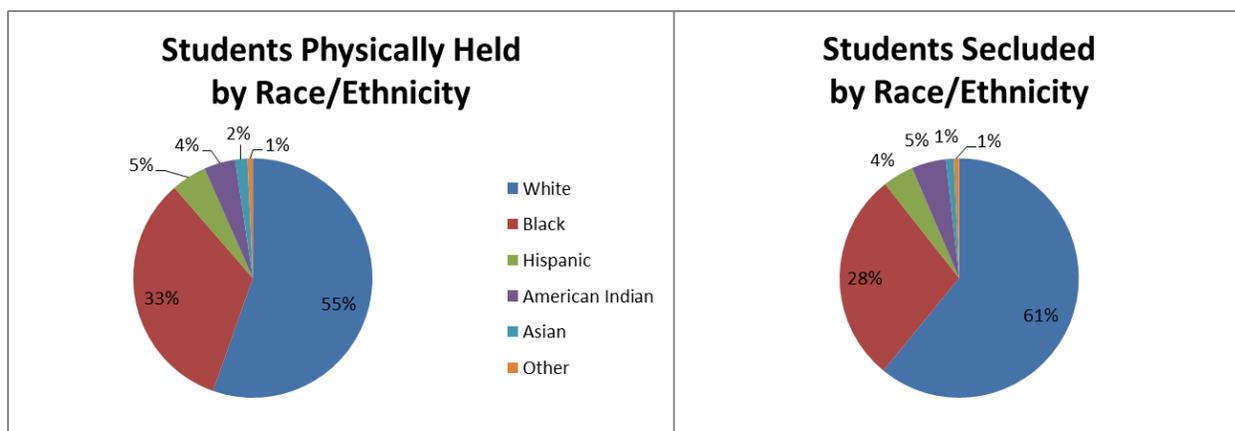
Based upon the data reported for the 2013-14 school year, boys are 4.7 times more likely to be physically held and 6.7 times more likely to be placed in seclusion than girls, consistent with previous legislative reports.



Race/Ethnicity of Students in Restrictive Procedures

Black students, who account for approximately 12 percent of the special education student population,⁴⁰ are overrepresented in both the physical holding and seclusion data, consistent with previous legislative reports. American Indian students, who account for approximately three percent of the special education population, are also overrepresented in the physical holding and seclusion data, though not to as great a degree.

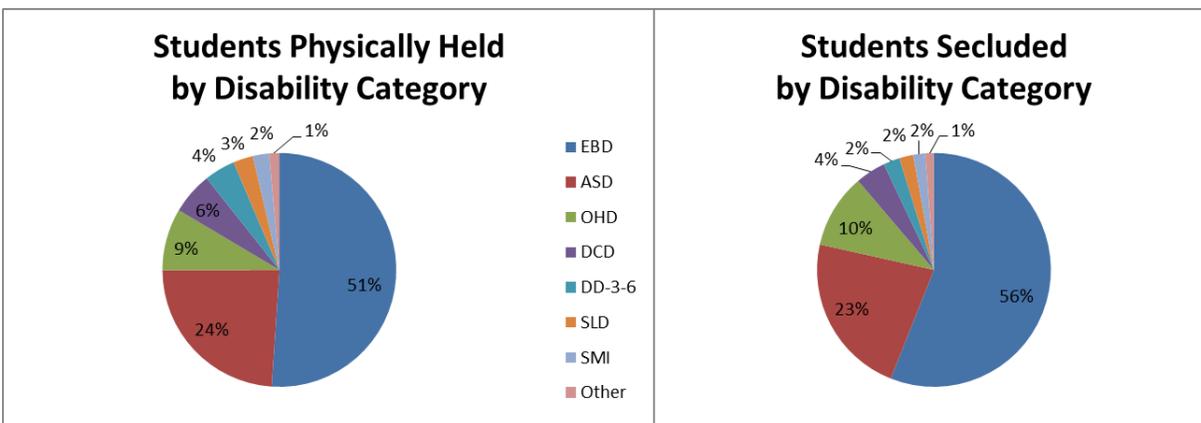
⁴⁰ 2014 Child Count Totals by December 1, 2013 by Disability, Race/Ethnicity, and Age, retrieved from MDE Data Reports and Analytics, available at <http://w20.education.state.mn.us/MDEAnalytics/Data.jsp>.



Disability Categories for Students in Restrictive Procedures

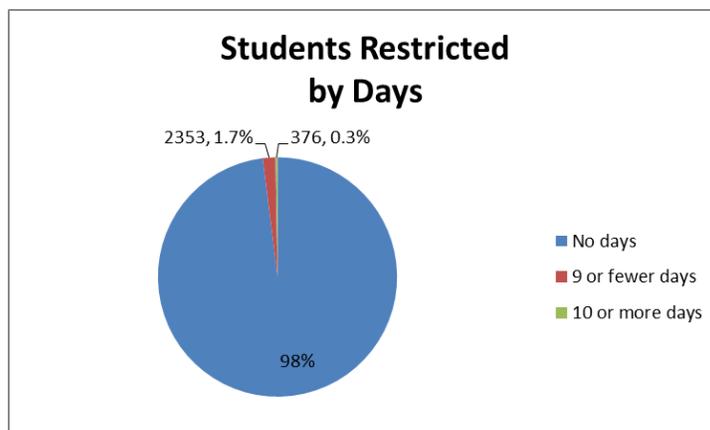
During the 2013-14 school year, students who received special education services by meeting eligibility criteria under the primary disability category of EBD or ASD accounted for three-fourths of the students who experienced the use of restrictive procedures, consistent with previous legislative reports. ASD students make up approximately 13 percent of the special education student population and EBD students make up approximately 11 percent.⁴¹ The remaining one-fourth of restrictive procedures were used on students with Other Health Disabilities (OHD), Developmental Cognitive Disability (DCD), Developmental Delay, ages three through six (DD 3-6), Specific Learning Disability (SLD), and Severely Multiply Impaired (SMI). The categories of disabilities included in the “Other” category are, in order of prevalence: Deaf and Hard of Hearing (DHH), Speech or Language Impairments (SLI), Traumatic Brain Injury (TBI), and Physically Impaired (PI).

⁴¹ 2014 Child Count Totals by December 1, 2013 by Disability, Race/Ethnicity, and Age, retrieved from MDE Data Reports and Analytics, available at <http://w20.education.state.mn.us/MDEAnalytics/Data.jsp>.



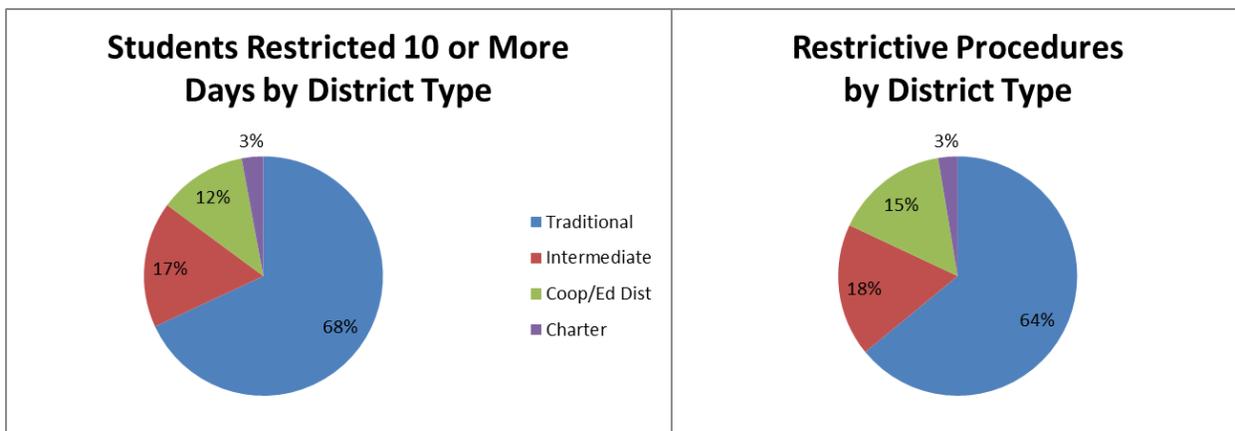
Students Restricted Ten or More Days

New in this legislative report is data on the number of students restricted 10 or more days. As has been noted in the prone restraint data since reporting began, a small number of students account for a large portion of the incidents of prone restraint. A threshold of 10 or more days was chosen for this restrictive procedures summary data point to be consistent with districts' obligation under statute to take additional action when restrictive procedures have been used 10 or more days within a school year.⁴² Districts reported that a total of 376 special education students experienced the use of restrictive procedures over 10 or more days during the 2013-14 school year. These students account for approximately 0.3 percent of the special education student population.



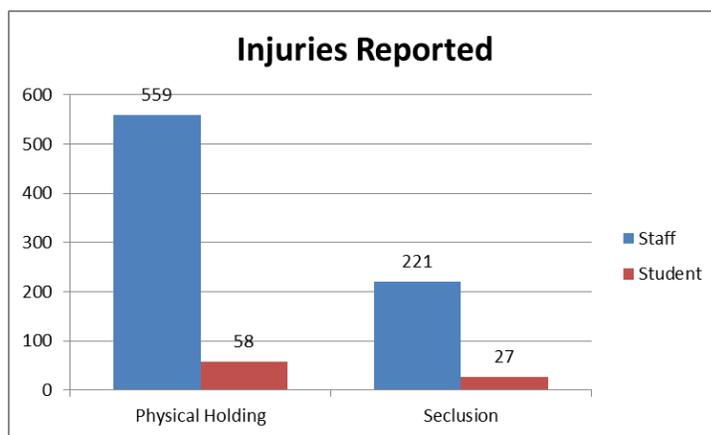
While the restrictive procedure summary data is more limited than individual incident prone restraint reports, the district level data for these outliers in the restrictive procedures population suggest the average number of restrictive procedures may be about 25 incidents of restrictive procedures per student, with 10 or more days of restriction. This would be consistent with the average for the outliers in the prone restraint data. Students who experienced the use of restrictive procedures over 10 or more days across all district types are in rough proportion to the number of incidents of restrictive procedures by district type.

⁴² See Minn. Stat. § 125A.0942, subd. 2(d).



Injuries Related to the Use of Restrictive Procedures

Data about the number of injuries to both students and staff related to the use of restrictive procedures is reported as increased for all categories, with the exception of injuries related to physical holding for students. However, the data was new for the previous reporting period, so may reflect better reporting more than an actual increase in injuries. As stated in the previous legislative report, there is still some likelihood that injury data is underreported, inaccurately reported, and/or inconsistently reported. Several districts again called to inquire what constitutes an “injury” that should be reported, including questions about the severity and connection to the incident.



STATEWIDE PLAN

MDE is committed to ensuring that all students and all staff are safe in educational environments. We are also committed to working with the Minnesota Legislature and all interested stakeholders, including parents, educators, school administrators, and community leaders, to ensure schools have necessary and effective tools to support student safety while working together to eliminate the use of prone restraint and reduce the use of restrictive procedures. Please refer to Appendix A for the statewide plan, including recommendations and goals.

CONCLUSION

MDE respectfully submits this report to provide the Legislature with objective data to inform its continuing policy discussions regarding restrictive procedures and prone restraint. While the number of students affected by this discussion is small, about 0.1 percent of the special education student population in the case of prone restraint and about two percent for restrictive procedures, it is clear that these students have significant and complex needs.

We anticipate the data provided will result in informed decision-making, promoting safe educational environments. We appreciate the opportunity to inform the Legislature about this important issue and commend the Legislature for its continued commitment to this task.

Appendix A

2014 Statewide Plan to Reduce the Use of Restrictive Procedures and Eliminate Prone Restraint in Minnesota

I. Purpose

During the 2014 legislative session, the Minnesota Legislature tasked the Minnesota Department of Education (MDE) with developing a statewide plan with specific and measurable implementation and outcome goals for reducing the use of restrictive procedures.⁴³ To assist with developing a plan, MDE assembled a group of stakeholders. The stakeholder group included representation from advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, state human services department staff, mental health professionals, and autism experts.⁴⁴ Although invited, the stakeholder group did not have a representative from County Social Services. The group developed implementation and outcome goals that would move the state toward a reduction of restrictive procedures in the educational setting.

II. Stakeholder Work Group Charge

By February 1, 2015, and annually thereafter, stakeholders must recommend to the commissioner specific and measurable implementation and outcome goals for reducing the use of restrictive procedures and the commissioner must submit to the legislature a report on districts' progress in reducing the use of restrictive procedures that recommends how to further reduce these procedures and eliminate the use of prone restraints. The statewide plan includes the following components: measurable goals; the resources, training, technical assistance, mental health services, and collaborative efforts needed to significantly reduce districts' use of prone restraints; and recommendations to clarify and improve the law governing districts' use of restrictive procedures. The commissioner must consult with interested stakeholders when preparing the report, including representatives of advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, county social services, state human services department staff, mental health professionals, and autism experts. By June 30 each year, districts must report summary data on their use of restrictive procedures to the department, in a form and manner determined by the commissioner. The summary data must include information about the use of restrictive procedures, including use of reasonable force under section 121A.582.

Minnesota Department of
Education 

⁴³ Minn. Stat. § 125A.0942, Subd. 3(b) (2014).

⁴⁴ *Id.*

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III. Stakeholder Group Members

ARC Minnesota	Jacki McCormack
Autism Society of Minnesota	Jean Bender
Department of Human Services, Disability Services Division	Carol Anthony
Department of Human Services, Disability Services Division	Charles Young
Department of Human Services, Children's Mental Health Division	Karry Udvig
Department of Human Services, Children's Mental Health Division	Nelly Torori
Department of Human Services	Richard Amado
Education Minnesota	Katy Perry
Paraprofessional, Robbinsdale School District	Karen Krussow
Intermediate District 287	Jennifer McIntyre
Intermediate District 917	Melissa Schaller
Minnesota Administrators for Special Education	Jill Skarvold
Minnesota Disability Law Center	Dan Stewart
Minnesota School Board Association	Grace Keliher
National Alliance on Mental Illness	Sue Abderholden
Northeast Metro 916	Connie Hayes
Northeast Metro 916	Dan Naidicz
PACER Center	Jody Manning
PACER Center	Virginia Richardson

IV. Minnesota Department of Education Participants

Director, Compliance and Assistance	Marikay Canaga Litzau
Supervisor, Compliance and Assistance	Sara Winter
Assistant Commissioner	Daron Korte
Compliance Monitoring	Ross Oden
Compliance and Assistance	Pamela Hinze
Supervisor, Interagency Partnerships	Robyn Widley
Supervisor, Special Education	Eric Kloos
Special Education	Aaron Barnes

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V. Process

On September 26, 2014, MDE convened the 2014 Stakeholder Work Group (2014 Stakeholder Group) to review the annual restrictive procedures data for the 2013-14 school year. Additional meetings scheduled to review the quarterly prone restraint data occurred or will occur October 27, 2014, January 23, 2015, April 24, 2015, and July 24, 2015.

As set forth in the 2013 statewide plan, the stakeholders chose to meet quarterly and focus on reviewing the data, ongoing implementation efforts of the 2013 statewide plan, and to discuss successes and barriers in reducing restrictive procedures and the elimination of prone restraint.

Stakeholder Group Meetings

MDE staff convened members of the 2014 stakeholder group three times during the time period of September 26, 2014 and January 23, 2015. MDE staff facilitated an exchange of information and stakeholder input through review of:

- Aggregate data from districts' self-reported use of restrictive procedures for the 2013-14 school year;
- Quarterly aggregate data from districts' self-reported use of prone restraint;
- Existing statutory language;
- Strategies employed by intermediate districts to reduce restrictive procedures and eliminate prone restraint;
- Strategies employed by other districts to reduce restrictive procedures and eliminate prone restraint;
- Work accomplished from the 2013 statewide plan as set forth in Appendix A of the 2014 Legislative Report and input on ongoing implementation of that plan;
- The legislative appropriation and the process to utilize those funds to assist students experiencing the highest use of restrictive procedures, specifically prone restraint; and
- The education sections of the Olmstead Plan and status.

During the initial 2014 Stakeholder Group meeting, MDE informed the stakeholders that it had submitted a Form A proposing that the restrictive procedure statute be amended to specifically prohibit the use of prone restraint as of August 1, 2015, in accordance with the implementation requirements from the Revised Olmstead Plan, Education and Life Long Learning Action Item 1D (Proposed modifications July 10, 2014 and November 6, 2014). As set forth in action item 1D, stakeholders will discuss and recommend revisions to Minnesota Statutes section 125A.0942 subdivision 3(a)(8) to clarify that prone restraint will be prohibited by August 1, 2015 in Minnesota school districts, and will apply to children of all ages. Action item 1E requires MDE to report to the legislature on the districts' progress in reducing the use of restrictive procedures in Minnesota Schools and on stakeholder recommendations regarding Minnesota Statutes section 125A.0942 subdivision 3(a)(8). At the initial meeting, stakeholders did not raise any objection, and the meeting focused on a review of the annual restrictive procedures data and prone restraint data for the quarter ending June 30, 2014.

MDE staff and the stakeholders then reviewed the 2013 statewide plan goals and implementation efforts. MDE also provided an update on the \$250,000 legislative appropriation.

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MDE developed a grant process to target seven districts, including the three intermediate districts with students who experienced the highest usage of restrictive procedures and prone restraint. In addition, MDE was in the process of producing a request for proposal (RFP) for the development of three online training modules addressed in Goal 2(c) of the 2013 statewide plan. During a working lunch, there was a discussion to strategize ways MDE and the Minnesota Department of Human Services (DHS) could leverage services to support students who are experiencing high use of restrictive procedures, specifically prone restraint. MDE staff provided an update on the Olmstead Plan, and stakeholders were given the opportunity to share effective strategies as well as barriers in their efforts to reduce restrictive procedures and eliminate prone restraint.

During the second 2014 Stakeholder Group meeting, MDE sought input from stakeholders on venues for advertising the RFP. Prone restraint data from the quarter ending September 30, 2014 was reviewed. MDE staff provided a summary of the status of the implementation of the goals in the 2013 statewide plan. There was a brief discussion at the meeting about the October 15, 2014 Restrictive Procedures Reduction Discussion Panel (Panel) held to assist the education community in reducing the use of restrictive procedures and eliminating prone restraints in schools by sharing evidence-based best practices and effective strategies and resources. MDE staff, DHS staff, and 2014 Stakeholder Group members who participated on the Panel provided an overview of the training. The 2014 Stakeholder Group discussed what future panel discussions would look like. The 2014 Stakeholder Group also worked on developing questions to gather data about specific students to assist in identifying the students experiencing the highest usage of prone restraint. Ultimately, the 2014 Stakeholder Group chose not to proceed with the questionnaire. Time was again provided for stakeholders to seek ideas and feedback about challenging students.

The 2014 Stakeholder Group focused on the task of eliminating prone restraint and addressing successes and barriers toward reaching that ultimate goal. The stakeholders continued to share a desire to implement and revise as necessary, the 2013 statewide plan to reduce restrictive procedures, including eliminating prone restraint. Based upon a review of the prone restraint data, as well as the discussions held during the restrictive procedures 2014 Stakeholder Group meetings, the stakeholders all agreed on the need to focus resources on those students who experience a high use of restrictive procedures; specifically, prone restraint.

At the January 23, 2015 meeting, the 2014 Stakeholder Group reached consensus to: revise multiple goals, delete one goal from the 2013 Work Plan, add two additional goals, and work toward implementation of the nine goals that should be implemented by one or more state agencies, school districts, or community level entities. A brief discussion on the December 16, 2014 Restrictive Procedures Reduction Discussion Panel: Eliminating Prone Restraint in Schools was also held and included a discussion of future trainings.

In general, the process underscored the stakeholders' desire to reduce or eliminate restrictive procedures. There is shared belief that emergency situations in educational settings could be greatly reduced or eliminated with additional resources – especially mental health services and additional training on positive behavior supports and intervention. Further, that training and an exchange of successful strategies would assist districts in reducing the need for restrictive procedures. For purposes of this report, the goals in the 2013 statewide plan are listed in VI

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below with a corresponding update on whether they have been completed or are in progress. The 2014 Stakeholder Group reviewed progress on the eight goals in the 2013 Work Plan and then made recommendations to revise those goals and to add additional goals. The goals in the 2014 statewide plan are listed in VII below.

During the 2014-15 meetings, the stakeholders continued to discuss the barriers to accessing appropriate day and residential treatment. Much discussion centered on the lack of day treatment facilities that worked with students with severe emotional outbursts. Those students are reportedly “kicked out” of day treatment facilities, and many are then enrolled in level three or level four programs. At one of the meetings, a stakeholder described a successful collaboration between the Minneapolis School District and a co-located day treatment center. While the stakeholders did not believe they could adequately address this goal within the next year, it was noted that some stakeholders are currently involved in other work to address these issues.

Finally, the stakeholder group discussed proposed statutory revisions needed to provide clarification or to support the implementation of some pieces of the proposed statewide plan. As set forth in Appendix A of the 2014 Legislative Report, the 2013 Stakeholder Group previously concluded that there was insufficient data to determine the extent to which reasonable force was being used that resulted in the use of a restrictive procedure on a student with a disability. In the fall of 2015, the 2014 Stakeholder Group will review the data collected related to the use of reasonable force on the 2014-15 annual summary report, and decide whether additional statutory changes would be needed to ensure that districts are not using reasonable force to avoid the reporting requirements in the restrictive procedure statute, or increasing removals of students from the school setting.

As indicated by the recommendations of the 2013 Stakeholder Group, the work on a statewide plan to greatly reduce or eliminate the use of restrictive procedures requires ongoing discussion and study to review what is successful, and continue to monitor the data and revise the goals, as appropriate. MDE will continue to collect and report the restrictive procedures data and convene the stakeholder meetings, once in the fall of 2015 and subsequent meetings as needed.

VI. 2013 Statewide Plan and Updates

Goal 1: On or before July 1, 2014, MDE will:

- a. Based upon a review of the prone restraint reports received by MDE, MDE will develop a process to identify outliers in prone restraint reporting which will assist MDE in identifying schools and/or school districts that may need targeted technical assistance and thereafter contact and offer technical assistance to the identified schools and/or school districts. In determining whether an outlier exists, and in determining where data is an outlier, MDE will consider whether the prone restraint data is markedly different from other prone restraint data from a comparable school district. MDE has been receiving prone reports since the beginning of the 2011-12 school year.

1a Update: Since the first prone reporting began in August 2011, MDE developed a system to review prone reports within two business days. This review included contacting the district when

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the report did not appear consistent or the staff was not trained. MDE staff in the Compliance and Assistance and Special Education divisions met when a high usage of prone restraint was reported on an individual student. During the summer of 2014, MDE staff met to discuss a more formal method to determine where data is an outlier. Beginning with the 2014-15 school year, MDE has identified outliers as any district currently intending to use and rely on the use of prone restraint. As set forth in more detail in goal four below, MDE provided targeted technical assistance by inviting the seven districts still using prone restraint to participate in a December 2014 restrictive procedures panel discussion. Based upon the quarterly report for prone restraint data ending December 31, 2014, five school districts used prone restraint one or more times. Only four districts reported the use of prone restraint during December 2014.

- b. Develop a process for school districts to use for state targeted technical assistance related to reducing the use of restrictive procedures, including eliminating prone restraints.

1b Update: In addition to the restrictive procedures reduction discussion panel trainings, MDE provides the following training: Restrictive Procedures Overview for Individual Districts. This is an overview of Minnesota's restrictive procedures statutes pertaining to children with disabilities, including requirements that must be met before using restrictive procedures and the standards for use. This presentation is intended to assist individual districts that have questions about new statutory changes and requires the individual district requesting the training to actively participate in the presentation process along with, and with assistance from, MDE. MDE provided this training on January 26, 2015. MDE will also review training needs identified by districts in the annual summary forms to determine future trainings.

- c. Develop and post on its website a Post-use Debriefing form. Developed and posted October 2014.

1c Update.: Completed. Delete 1c.

- d. Update the MDE Sample Restrictive Procedures Plan and post it on its website in accordance with Minnesota Statutes section 125A.0942. Update: Original post: November 2011. Edited: April 2012. Edited: January 2014. Edited: September 2014.

1d Update: Completed. Ongoing goal.

- e. Amend the MDE Restrictive Procedures Summary Form to allow school districts the option to identify one to two staff training needs, and to review the need to add or amend additional reporting requirements to address the unintended impacts of reducing restrictive procedures. MDE will update the form to clarify that districts must report all incidents involving students with a disability in which a staff member uses restrictive procedures, as defined in Minnesota Statutes, Section 125A.0941.

1e Update: MDE updated and posted the electronic *Use of Restrictive Procedures District Summary Data* form in April 2014. The amendments include a change to the definition of physical holding to include reasonable force covered by Minnesota Statutes, section 121A.6582, when the actions meet the definition of physical holding in Minnesota Statutes, section 125A.0941. Districts are required to report this data beginning with the

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2014-15 school year and submit the report by June 30, 2015. In addition, the annual summary form was updated to include a training needs section and gives districts the opportunity to describe areas of training related to the reduction of restrictive procedures summary data reports for the 2013-14 school year, which contained training needs. Districts will again report training needs when they submit their annual reports on June 30, 2015. Completed. Delete 1e,

- f. Make publically accessible, in an electronic format on MDE's website, information pertaining to how schools/school districts may access local mental health services for their students including Assertive Community Treatment (ACT) teams and mobile crisis response teams

1f Update: MDE posted the relevant links to the DHS website on June 30, 2014. Completed. Update link as needed

- g. Make publically accessible, in an electronic format on MDE website, information and training pertaining to DHS's Positive Support Community of Practice bi-weekly live stream meetings.

1g Update: Posted link to Positive Supports Community of Practice February 2014. Completed. Update link as needed.

Goal 1 Action Items

- **MDE:** Responsible to implement Goal 1, a-g.
- **DHS:** Provide information to MDE related to Goal 1, f and g.
- **School Districts:** Request or utilize offered targeted technical assistance, identify, develop, and implement post-use debriefing and oversight committee procedures and forms based on model examples; collect and report in summary form the use of reasonable force when it results in the use of a physical hold or seclusion on a student with a disability; and to utilize the resources made available on the MDE website regarding accessing local mental health services and the DHS live stream meetings.

Goal 2: Beginning in March 2014, MDE will continue collaboration with DHS by:

- a. Supporting implementation of evidence-based practices for positive behavior strategies through the channels already developed by DHS's Continuing Care Administration and Children's Mental Health Division, Positive Support Community of Practice;

2a Update: Goal 2(a) is incorporated in the Olmstead work related to children's mental health and continuing care. Currently, DHS is the lead to develop common definitions and MDE has provided input. An initial report has been completed by Rebecca Freeman, DHS consultant from the University of Minnesota, Institute on Community Integration.

- b. Identifying systems for culturally responsive resource identification, consistent with the Positive Support Community of Practice, by collaborating with the Children's Mental Health and Disability Services Division of DHS, including at least the following:

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- i. Prevention;
- ii. quality improvement;
- iii. intensive intervention; and
- iv. systems collaboration.

2b Update: MDE and DHS have collaborated in the following activities related to Goal 2(b), which are designed to increase awareness of cross agency and community resources and provide enhanced opportunities to work together to address children's and system needs to create the support needed to reduce the use of restrictive procedures:

- Olmstead activity related to mental health crisis,
- Suicide prevention planning workgroup with MDH and DHS,
- Workgroups regarding the development of new mental health benefits for children- e.g. psychosocial education, consultation, new option for psychiatric residential treatment facility (PRTF) setting, and school linked mental health project activities.

c. Researching three cross-expertise training models for statewide use:

- i. a continuum of treatment and educational service options for students with a combination of severe mental illnesses and developmental disabilities, including Fetal Alcohol Spectrum Disorder;
- ii. in collaboration with emotional and behavioral disorders (EBD) experts and mental health experts, develop an EBD training model that addresses strategies to reduce restrictive procedures used on students with severe aggressive/self-injurious behaviors; and
- iii. in collaboration with autism spectrum disorder (ASD) experts, develop an ASD training model that addresses strategies to reduce restrictive procedures used on students with severe intellectual impairments and aggressive/self-injurious behaviors.

2c Update: MDE sent a RFP for development of the three training models in an electronic format. The RFP proposals submission deadline was January 15, 2015. They are in the process of being reviewed, and a final review will take place on January 30, 2015. The work is to be completed by June 30, 2015. If MDE approves an RFP vendor and resulting work product, MDE will then post the trainings for Districts and provide additional training as needed.

d. Identifying options for experts and expert review, funding, and other supports for students in need of long term, systemic, and intensive interventions;

2d Update: MDE and DHS have held statewide training on children's therapeutic services and supports (CTSS) funding that incorporated the (Positive Behavior Interventions and Support (PBIS) tier model, including Tier 3, as a service delivery model. MDE and DHS are working together on the School Mental Health Services Frameworks workgroup where MDE and DHS staff, together with county and school district staff, discuss, develop, and

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disseminate integrated frameworks of mental health services delivery in schools (PBIS, CTSS, ACEs, etc.).

- e. Supporting the coordinated implementation of the ASD Medical Assistance benefit authorized by the 2013 Legislature with regard to the respective roles of the education, human services, and healthcare systems in providing effective interventions and improving outcomes, including reduction in the use of restrictive procedures;

2e Update: Interagency meetings are held to coordinate services. This particular topic has not yet been addressed.

- f. Supporting increased access to mental health treatment, including evidence-based practices, and awareness of mental health services in order to address the symptoms and behaviors of children and youth with mental illnesses, including those with intensive service needs, covered through the (Medical Assistance – individualized education plan (MA-IEP) program, School CTSS program, School-linked Mental Health Grant program, co-located Mental Health Services, and Mental Health in Schools Act.

2f Update: DHS and MDE staff meet on an ongoing basis to discuss different topics. MDE and DHS held a joint CTSS training in October 2014. At the December 5, 2014 Special Education Directors Forum held at MDE, MDE and DHS staff presented on MA-IEP issues, including behavior services and special education transportation. Current discussions between MDE and DHS include a discussion of the interplay between school linked mental health providers, community providers, and the provision of services under a student's IEP.

MDE and DHS staff, along with intermediate district staff, participate in an ongoing DHS work group on the issue of crisis services. The work group has discussed the need to develop a process that includes defining what crisis services are, how to access crisis services, and how to track school district use of crisis services. For purposes of the Olmstead Plan, this activity is focusing on DHS mobile crisis teams, which are funded through MA. Note: Some intermediate districts will continue to set up services with external crisis providers.

Goal 2 involves collaboration between MDE and DHS. Its purpose is to continue the current work and to share expertise for maximum use of resources as the agencies continue to work toward identifying evidence-based practices to address the needs of students with disabilities who are experiencing high rates of restrictive procedures. The 2013 Stakeholder Group provided MDE and DHS with the flexibility to determine the priority and scope of implementing goal number two, based upon resource issues and data demonstrating effectiveness.

Goal 2 Action Items

- **MDE and DHS:** Identify resources and experts external to districts, develop referral lists posted to MDE website, and ensure cultural responsiveness.
- **School Districts:** Provide input to MDE regarding resources and experts.
- **Advocacy Organizations:** Identify resources and experts external to districts and ensure parents are informed of the resource directory.

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Goal 3: The Restrictive Procedures Workgroup will provide input to the Mental Health Workforce Summit in order to recommend training to reduce the use of restrictive procedures.

Goal 3 Action Items

- **MDE, DHS and Stakeholder Group:** Participate in listening sessions and planning for the Workforce Summit.

Goal 3 Update: MDE and DHS staff, as well as members of the stakeholder group, participated in listening sessions and planning for the 2014 Mental Health Summit. One stakeholder then attended “HealthForce Minnesota: Mental Health Summit” at Hennepin Technical College on May 28, 2014. No documentation that any training specific to the reduction of restrictive procedures was developed as part of the Summit. The Mental Health Workforce Summit is completed and a legislative report was developed in January 2015.

Goal 4: By August 1, 2014, MDE will collaborate with school districts, including, but not limited to, intermediate school districts, DHS, parent advocacy groups, and community partners to develop a restrictive procedures discussion panel on the legal and practical aspects of reducing the use of restrictive procedures and eliminating the use of the prone restraints to be available to the education community. Panel discussions will be scheduled beginning with the 2014-15 school year.

Goal 4 Update: On July 29, 2014, MDE held a collaboration meeting with stakeholders from DHS, districts, and parent advocacy groups. Subsequently, MDE scheduled and facilitated discussion panels on October 15, 2014 and December 16, 2014. The purpose of the October 15, 2014 discussion panel was to assist the education community in reducing the use of restrictive procedures and eliminating the use of prone restraints in schools by sharing evidence-based best practices and effective strategies and resources. After feedback and input from the 2014 Stakeholder Group, the December 16, 2014 discussion panel’s purpose was to share evidence based best practices and effective strategies and resources to remove the barriers to eliminating the use of prone restraints in schools. That discussion panel targeted districts currently using prone restraint, and persons could attend in person or participate through a live stream. The barriers to eliminating prone restraint identified by the registrants were: 1) students with significant behaviors; 2) unintended negative consequences; 3) insufficient support for schools; 4) costs; and 5) lack of clarity about the laws.

Goal 4 Action Items

- **MDE:** Coordinate setting up the discussion panel.
- **DHS:** Participate in the discussion panel about evidence-based best practices.
- **School Districts:** Intermediate and other districts will participate to share effective strategies and resources. School Districts will make staff available to attend the panel discussions.

Goal 5: Consistent with Minnesota’s 2013 Olmstead Plan, by June 30, 2015 and each subsequent year, a minimum of 40 additional schools will use the evidence-based practice of PBIS so that students are supported in the most integrated setting. Within this environment of school-wide positive behavior support, districts will train school staff and ensure that compatible school-wide and individual positive behavior approaches align.

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Goal 5 Update: MDE is on target to meet this goal. Four hundred eighty-eight (24 percent) of all schools have gone through the PBIS training. Applications for the next PBIS cohort training closed on January 20, 2015. MDE and DHS continue to meet as part of the mental health advisory committee to address PBIS and school linked mental health grants and issues related to mental health. During the 2014-15 school year, the committee will study seven sites that have effective universal PBIS and effective school linked mental health services. The study will include looking at the alignment of school-wide and individual positive behavior approaches.

Goal 6: During the 2014 legislative session, the legislature will consider increasing the general education revenue to allocate state funding for supporting school districts to maintain focus and sustain fidelity of PBIS sites beyond the current two-year support for PBIS implementation. Districts will apply to MDE for state funding through an application process, which will include a requirement that school districts collect and report implementation data. The current cost is anticipated to be \$240,000 and will increase as additional school sites complete two years of PBIS training.

Goal 6 Update: The state legislature did not increase revenue for this purpose. There may be proposed legislation during the 2015 legislative session to accelerate the number of schools completing PBIS training each year.

Goals 5 and 6 Action Items

- **MDE:** Provide ongoing technical assistance support and strive to adjust the fiscal burden partially away from special education.
- **School Districts:** Strive to create staff investment in the PBIS culture and make staff available for training.
- **University of Minnesota:** Provide training and technical assistance for Tier 3 level of PBIS.
- **Legislature:** Legislative action to establish a general fund stream to sustain PBIS training in school sites beyond the current two-year training, which is federally funded.

Goal 7: Annually, beginning February 1, 2015, MDE will submit a report to the Legislature summarizing the state's progress on reducing the use of restrictive procedures statewide with recommendations on how to further reduce their use.

As set forth in the prior statewide plan, the continued meetings of the 2013 stakeholder group will allow the group to continue policy work to ensure that positive school outcomes, positive school success for students with mental health and behavior health needs, including the receipt of necessary services and delivery, is reviewed and modified as necessary.

Goal 7 Update: MDE has submitted an annual legislative report related to the use of restrictive procedures in Minnesota public schools beginning on February 1, 2012. Based upon the recommendations in the 2013 statewide plan, the legislature authorized ongoing meetings of the restrictive procedures Stakeholder Group and annual legislative reports. MDE coordinated 2014 Stakeholder Group meetings, which were held in September, October, and January, to review summary restrictive procedures data and individual incidents of prone restraint. At each meeting, stakeholders were given the opportunity to provide input and share strategies and barriers in reducing the use of restrictive procedures and eliminating the use of prone restraint.

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At the January 23, 2015 Stakeholder Group meeting, MDE staff reviewed the draft Appendix A for input, discussion, and final recommendations. The data contained in the 2015 Legislative Report has been shared at the restrictive procedures work group meetings. The legislative reports include a summary of progress in implementing the statewide plan, and contain additional recommendations to the Legislature to assist in the reduction of restrictive procedures and the elimination of prone restraint. The reports also include data to inform the Legislature and the public on the use of restrictive procedures in public schools, and to provide data comparisons between reporting periods. Appendix A of each report includes a statewide plan and recommendations for legislative changes to the restrictive procedure statutes, and Appendix B provides a summary of other state statutes. This goal will be completed by February 1, 2015.

Goal 7 Action Items

- **MDE:** Submit a report annually and coordinate quarterly meetings of the stakeholder group.
- **School Districts:** Collection and reporting of summary restrictive procedures data and individual incidents of prone restraint.
- **Stakeholder Group:** Meet quarterly to review the data and progress toward goals and to review and revise goals as needed,

Goal 8: During the 2014 legislative session, the legislature will consider establishing a task force to make recommendations on how to integrate planning between the K-12 and post-secondary systems to assist students with disabilities with their transition from school to post-school activities. The task force members would include school district representatives, community based provider representatives, and county social service representatives.

While this goal is broader than the scope of the 2014 Stakeholder Group, the stakeholders wanted to emphasize the need for alignment of resources to allow for a positive transition from K-12 to post-school activities. For students with more significant needs, this planning is essential. The 2013 stakeholder group believes that implementation of these goals will result in the reduction of the use of restrictive procedures in the educational setting.

Goal 8 Update: The Legislature did not create a task force for this purpose.

VII. Goals Recommended by Stakeholder Group

The 2014 Stakeholder Group focused its work on reviewing data and implementation of the 2013 statewide plan. All recommendations by the 2014 Stakeholder Group are intended to reduce school districts' use of restrictive procedures and eliminate the use of prone restraint. As set forth in the 2013 statewide plan, the 2014 Stakeholder Group has provided MDE and DHS with flexibility in determining the priority and scope of implementing goal number two, based upon resource issues and data demonstrating effectiveness.

Goal 1: On or before August 1, 2015, MDE will:

Goal 1a: Based upon a review of the restrictive procedure data, MDE staff will contact the districts using prone restraint, and/or high usages of restrictive procedures, prior to August 1, 2015, to identify the areas of technical assistance needed and then facilitate the provision of onsite targeted technical assistance for individual students as needed. The 2014 Stakeholder workgroup supports legislative proposals during the 2015 Legislative Session for the creation of

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PRTF in the Twin Cities, Youth Assertive Community Treatment (ACT) Teams, and reciprocity for teachers from other states as well as alternative licensure options.

Goal 1b: Develop a process for school districts to use targeted technical assistance related to reducing the use of restrictive procedures, and eliminating prone restraint by August 1, 2015. MDE will meet with the Restrictive Procedures stakeholders, including DHS, to discuss training and resources, and also partner with the National Alliance on Mental Illness (NAMI) and other appropriate advocacy agencies regarding parent resources. Targeted technical assistance may include teams from the intermediate districts or other level four programs to help provide expertise, including practical tools. The Stakeholder Group will explore the possibility of developing a video and contacting the regional centers to notify districts of this training opportunity.

Goal 1c: Update the MDE Sample Restrictive Procedures Plan and post it on its website in accordance with Minnesota Statutes section 125A.0942.

Goal 1d: Make publically accessible, in an electronic format on MDE's website, information pertaining to how schools/school districts may access local mental health services for their students including ACT teams and mobile crisis response teams

Goal 1e: Make publically accessible, in an electronic format on MDE's website, information pertaining to DHS's Positive Support Community of Practice bi-weekly live stream meetings.

Goal 1 Action Items

- **MDE:** Responsible to implement Goal 1, a-e.
- **DHS:** Collaborate with MDE for Goal 1b. Provide information to MDE related to Goal 1d and 1e.
- **School Districts:** Request or utilize offered targeted technical assistance, collect and report in summary form the use of reasonable force when it results in the use of a physical hold or seclusion on a student with a disability; and to utilize the resources made available on the MDE website regarding accessing local mental health services and the DHS live stream meetings.
- **All Stakeholders:** Support the Legislative Proposals outlined in Goal 1a.

Goal 2: Beginning in March 2014, MDE will continue collaboration with DHS by:

- a. Supporting implementation of evidence-based practices for positive behavior strategies through the channels already developed by DHS's Continuing Care Administration and Children's Mental Health Division, Positive Support Community of Practice;
- b. Identifying systems for culturally responsive resource identification, consistent with the Positive Support Community of Practice, by collaborating with the Children's Mental Health and Disability Services Division of DHS, including at least the following:
 - i. prevention;
 - ii. quality improvement;

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- iii. intensive intervention; and
- iv. systems collaboration.

At future Stakeholder meetings, MDE will share resources from the PBIS Center that address cultural inequity.

- c. Researching three cross-expertise training models for statewide use:
 - i. a continuum of treatment and educational service options for students with a combination of severe mental illnesses and developmental disabilities, including Fetal Alcohol Spectrum Disorder;
 - ii. in collaboration with emotional and behavioral disorders (EBD) experts and mental health experts, develop an EBD training model that addresses strategies to reduce restrictive procedures used on students with severe aggressive/self-injurious behaviors; and
 - iii. in collaboration with autism spectrum disorder (ASD) experts, develop an ASD training model that addresses strategies to reduce restrictive procedures used on students with severe intellectual impairments and aggressive/self-injurious behaviors.

If a Request for proposal (RFP) application is accepted and the training materials are developed in accordance with the RFP, the training will be disseminated on MDE's website and DVDs will be made available as an alternate format.

- d. Identifying options for experts and expert review, funding, and other supports for students in need of long term, systemic, and intensive interventions;
- e. Supporting the coordinated implementation of the ASD Medical Assistance benefit authorized by the 2013 Legislature with regard to the respective roles of the education, human services, and healthcare systems in providing effective interventions and improving outcomes, including reduction in the use of restrictive procedures;
- f. Supporting increased access to mental health treatment, including evidence-based practices, and awareness of mental health services in order to address the symptoms and behaviors of children and youth with mental illnesses, including those with intensive service needs, covered through the MA-IEP program, School CTSS program, School-linked Mental Health Grant program, co-located Mental Health Services, and Mental Health in Schools Act.

Goal 2 involves collaboration between MDE and DHS. Its purpose is to continue the current work and to share expertise for maximum use of resources as the agencies continue to work toward identifying evidence-based practices to address the needs of students with disabilities who are experiencing high rates of restrictive procedures. The 2014 Stakeholder Group provided MDE and DHS with the flexibility to determine the priority and scope of implementing goal number two, based upon resource issues and data demonstrating effectiveness.

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Goal 2 Action Items

- **MDE and DHS:** Identify resources and experts external to districts, develop, and update referral lists posted to MDE website, and ensure cultural responsiveness.
- **School Districts:** Provide input to MDE regarding resources and experts.
- **Advocacy Organizations:** Identify resources and experts external to districts and ensure parents are informed of the resource directory.

Goal 3: The Restrictive Procedure Workgroup will provide input to any follow-up meetings related to the Mental Health Workforce Summit in order to recommend training to reduce the use of restrictive procedures.

Goal 3 Action Items

- **MDE, DHS and Stakeholder Group:** Participate in any meetings and planning for a follow-up session to the Workforce Summit.

Goal 4: By August 1, 2015, MDE will collaborate with school districts, including, but not limited to, intermediate school districts, DHS, parent advocacy groups, and community partners to discuss different types of trainings related to the reduction of restrictive procedures to be available to the education community. Stakeholders who will participate in the discussions will include ARC, PACER, and Intermediates 287 and 917.

Goal 4 Action Items

- **MDE:** Coordinate setting up meetings to discuss trainings.
- **DHS:** Participate in the meetings and provide information about evidence based best practices.
- **School Districts:** Intermediate and other districts will participate to share effective strategies and resources. School Districts will make staff available to attend trainings.

Goal 5: Consistent with Minnesota's 2013 Olmstead Plan, by June 30, 2015 and each subsequent year, a minimum of 40 additional schools will use the evidence-based practice of PBIS so that students are supported in the most integrated setting. Within this environment of school-wide positive behavior support, districts will train school staff and ensure that compatible school-wide and individual positive behavior approaches align. During the fall of 2015, the stakeholders will review the data from the MDE and DHS case studies of seven sites with effective universal PBIS and effective school linked mental health services.

Goal 6: During the 2015 legislative session, the legislature will consider increasing the general education revenue to allocate state funding for supporting school districts to maintain focus and sustain fidelity of PBIS sites beyond the current two-year support for PBIS implementation. Districts will apply to MDE for state funding through an application process, which will include a requirement that school districts collect and report implementation data. The current cost is anticipated to be \$240,000 and will increase as additional school sites complete two years of PBIS training. MDE will assign a priority for schools where students are experiencing high usages of restrictive procedures.

Goals 5 and 6 Action Items

- **MDE:** Provide ongoing technical assistance support and strive to adjust the fiscal burden partially away from special education.

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- **School Districts:** Strive to create staff investment in the PBIS culture and make staff available for training.
- **University of Minnesota:** Provide training and technical assistance for Tier 3 level of PBIS.
- **Legislature:** Legislative action to establish a general fund stream to sustain PBIS training in school sites beyond the current two-year training, which is federally funded.

Goal 7: Annually, beginning February 1, 2015, MDE will submit a report to the Legislature summarizing the state's progress on reducing the use of restrictive procedures statewide with recommendations on how to further reduce their use. The 2015 Stakeholder Group will meet in the fall to review annual summary data from the 2014-15 school year, and will determine if additional meetings are necessary. The purpose of the meeting(s) is to allow the group to continue policy work to ensure that positive school outcomes, positive school success for students with mental health and behavior health needs, including the receipt of necessary services and delivery, is reviewed and modified as necessary.

Goal 7 Action Items

- **MDE:** Submit a report annually and coordinate meetings of the stakeholder group.
- **School Districts:** Collection and reporting of summary restrictive procedures data, and individual incidents of prone restraint until August 1, 2015.
- **Stakeholder Group:** Meet to review the data and progress toward goals and to review and revise goals as needed,

Goal 8: During the fall 2015 Stakeholder Group meeting, MDE staff and stakeholders will review the grantees' work plans and outcome results to determine if there are successful models that can be applied to other districts. During the 2015-16 school year, the stakeholders will discuss ways to share the results.

Goal 8 Action Items:

- **MDE:** Provide copies of the grantees' work plans and outcome results to the 2014 Stakeholder Group at the fall 2015 meeting.
- **Grantees:** Timely provide to MDE outcome results for their work plans and participate in discussions at the fall 2014 workgroup meeting.
- **Stakeholder Group:** Meet to review the grantees' work plans and outcome results and determine if there are successful models that can be applied to other districts. Discuss how to share the results.

Goal 9: During the fall 2015 Stakeholder Group meeting, MDE staff and stakeholders will review the student and staff injury data reported by districts in the annual restrictive procedure summary report for the 2013-14 and 2014-15 school years.

Goal 9 Action items:

- **MDE:** Provide a summary of the student and staff injury data reported by districts on the annual summary form for the 2013-14 and 2014-15 school years at the fall 2015 Stakeholder Group meeting.

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- **Districts:** Provide staff and student injury data to MDE on the annual summary restrictive procedure summary form.
- **Stakeholder group:** Review the data at the fall 2015 Stakeholder Group meeting.

VIII. Recommendations

1. Support Stakeholder-Driven Changes to Statute.

The 2014 stakeholder group recommended that the Minnesota Legislature amend Minnesota Statutes, section 125A.0942 to make prone restraint a prohibited procedure, effective August 1, 2015. This recommendation aligns with the Minnesota Revised Olmstead Plan.

The 2014 stakeholder group also recommended that the Minnesota Legislature amend Minnesota Statutes, section 125A.0942 subdivision 3(b) to make the development of a statewide plan permissive. This allows the 2014 stakeholder group to work on the 2014 statewide plan and only make revisions to that plan as necessary.

The 2014 stakeholder group also recommended that the Legislature appropriate \$250,000 to be available beginning with the 2015-16 school year, to ensure students can continue to be educated in the least restrictive environment with appropriate behavior interventions, supports, and expertise, and to avoid student placements into more restrictive environments to receive such services. The funds will be used to reimburse expert teams, as described in Goal 1b. The 2014 stakeholder group agreed that the funds are needed to provide training and services to district staff so that students can be educated in the least restrictive environment.

125A.0942 STANDARDS FOR RESTRICTIVE PROCEDURES.

Subdivision 1. **Restrictive procedures plan.** (a) Schools that intend to use restrictive procedures shall maintain and make publicly accessible in an electronic format on a school or district website or make a paper copy available upon request describing a restrictive procedures plan for children with disabilities that at least:

- (1) lists the restrictive procedures the school intends to use;
- (2) describes how the school will implement a range of positive behavior strategies and provide links to mental health services;
- (3) describes how the school will provide training on de-escalation techniques, in accordance with 122A.09 Subd. 4.
- (3) describes how the school will monitor and review the use of restrictive procedures, including:
 - (i) conducting post-use debriefings, consistent with subdivision 3, paragraph (a), clause (5); and
 - (ii) convening an oversight committee to undertake a quarterly review of the use of restrictive procedures based on patterns or problems indicated by similarities in the time of day, day of the week, duration of the use of a procedure, the individuals

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involved, or other factors associated with the use of restrictive procedures; the number of times a restrictive procedure is used schoolwide and for individual children; the number and types of injuries, if any, resulting from the use of restrictive procedures; whether restrictive procedures are used in nonemergency situations; the need for additional staff training; and proposed actions to minimize the use of restrictive procedures; and

- (4) includes a written description and documentation of the training staff completed under subdivision 5.
- (b) Schools annually must publicly identify oversight committee members who must at least include:
 - (1) a mental health professional, school psychologist, or school social worker;
 - (2) an expert in positive behavior strategies;
 - (3) a special education administrator; and
 - (4) a general education administrator.

Subd. 2. **Restrictive procedures.** (a) Restrictive procedures may be used only by a licensed special education teacher, school social worker, school psychologist, behavior analyst certified by the National Behavior Analyst Certification Board, a person with a master's degree in behavior analysis, other licensed education professional, paraprofessional under section 120B.363, or mental health professional under section 245.4871, subdivision 27, who has completed the training program under subdivision 5.

- (b) A school shall make reasonable efforts to notify the parent on the same day a restrictive procedure is used on the child, or if the school is unable to provide same-day notice, notice is sent within two days by written or electronic means or as otherwise indicated by the child's parent under paragraph (f).
- (c) The district must hold a meeting of the individualized education program team, conduct or review a functional behavioral analysis, review data, consider developing additional or revised positive behavioral interventions and supports, consider actions to reduce the use of restrictive procedures, and modify the individualized education program or behavior intervention plan as appropriate. The district must hold the meeting: within ten calendar days after district staff use restrictive procedures on two separate school days within 30 calendar days or a pattern of use emerges and the child's individualized education program or behavior intervention plan does not provide for using restrictive procedures in an emergency; or at the request of a parent or the district after restrictive procedures are used. The district must review use of restrictive procedures at a child's annual individualized education program meeting when the child's individualized education program provides for using restrictive procedures in an emergency.
- (d) If the [IEP] team under paragraph (c) determines that existing interventions and supports are ineffective in reducing the use of restrictive procedures or the district

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uses restrictive procedures on a child on ten or more school days during the same school year, the team, as appropriate, either must consult with other professionals working with the child; consult with experts in behavior analysis, mental health, communication, or autism; consult with culturally competent professionals; review existing evaluations, resources, and successful strategies; or consider whether to reevaluate the child.

- (e) At the [IEP] meeting under paragraph (c), the team must review any known medical or psychological limitations, including any medical information the parent provides voluntarily, that contraindicate the use of a restrictive procedure, consider whether to prohibit that restrictive procedure, and document any prohibition in [IEP] or [BIP].
- (f) An [IEP] team may plan for using restrictive procedures and may include these procedures in a child's individualized education program or behavior intervention plan; however, the restrictive procedures may be used only in response to behavior that constitutes an emergency, consistent with this section. The [IEP] or [BIP] shall indicate how the parent wants to be notified when a restrictive procedure is used.

Subd. 3. Physical holding or seclusion. (a) Physical holding or seclusion may be used only in an emergency. A school that uses physical holding or seclusion shall meet the following requirements:

- (1) physical holding or seclusion is the least intrusive intervention that effectively responds to the emergency;
- (2) physical holding or seclusion is not used to discipline a noncompliant child;
- (3) physical holding or seclusion ends when the threat of harm ends and the staff determines the child can safely return to the classroom or activity;
- (4) staff directly observes the child while physical holding or seclusion is being used;
- (5) each time physical holding or seclusion is used, the staff person who implements or oversees the physical holding or seclusion documents, as soon as possible after the incident concludes, the following information:
 - (i) a description of the incident that led to the physical holding or seclusion;
 - (ii) why a less restrictive measure failed or was determined by staff to be inappropriate or impractical;
 - (iii) the time the physical holding or seclusion began and the time the child was released; and
 - (iv) a brief record of the child's behavioral and physical status;
- (6) the room used for seclusion must:
 - (i) be at least six feet by five feet;
 - (ii) be well lit, well ventilated, adequately heated, and clean;

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- (iii) have a window that allows staff to directly observe a child in seclusion;
 - (iv) have tamperproof fixtures, electrical switches located immediately outside the door, and secure ceilings;
 - (v) have doors that open out and are unlocked, locked with keyless locks that have immediate release mechanisms, or locked with locks that have immediate release mechanisms connected with a fire and emergency system; and
 - (vi) not contain objects that a child may use to injure the child or others;
- (7) before using a room for seclusion, a school must:
- (i) receive written notice from local authorities that the room and the locking mechanisms comply with applicable building, fire, and safety codes; and
 - (ii) register the room with the commissioner, who may view that room, and (b) By February 1, 2015, and annually thereafter, stakeholders may, as necessary, recommend to the commissioner specific and measurable implementation and outcome goals for reducing the use of restrictive procedures and the commissioner must submit to the legislature a report on districts' progress in reducing the use of restrictive procedures that recommends how to further reduce these procedures. The statewide plan includes the following components: measurable goals; the resources, training, technical assistance, mental health services, and collaborative efforts needed to significantly reduce districts' use of prone restraints; and recommendations to clarify and improve the law governing districts' use of restrictive procedures. The commissioner must consult with interested stakeholders when preparing the report, including representatives of advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, county social services, state human services department staff, mental health professionals, and autism experts. By June 30 each year, districts must report summary data on their use of restrictive procedures to the department, in a form and manner determined by the commissioner. The summary data must include information about the use of restrictive procedures, including use of reasonable force under section 121A.582.
- ~~(8) until August 1, 2015, a school district may use prone restraints with children age five or older if:~~
- ~~(i) the district has provided to the department a list of staff who have had specific training in the use of prone restraints;~~
 - ~~(ii) the district provides information on the type of training that was provided and by whom;~~
 - ~~(iii) only staff who received specific training use prone restraints; and~~
 - ~~(iv) each incident of the use of prone restraints is reported to the department within five working days on a form provided by the department.~~

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Subd. 4. **Prohibitions.** The following actions or procedures are prohibited:

- (1) engaging in conduct prohibited under section 121A.58;
- (2) requiring a child to assume and maintain a specified physical position, activity, or posture that induces physical pain;
- (3) totally or partially restricting a child's senses as punishment;
- (4) presenting an intense sound, light, or other sensory stimuli using smell, taste, substance, or spray as punishment;
- (5) denying or restricting a child's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the child's functioning, except when temporarily removing the equipment or device is needed to prevent injury to the child or others or serious damage to the equipment or device, in which case the equipment or device shall be returned to the child as soon as possible;
- (6) interacting with a child in a manner that constitutes sexual abuse, neglect, or physical abuse under section 626.556;
- (7) withholding regularly scheduled meals or water;
- (8) denying access to bathroom facilities;
- (9) Effective August 1, 2015, prone restraint, and
- (10) physical holding that restricts or impairs a child's ability to breathe, restricts or impairs a child's ability to communicate distress, places pressure or weight on a child's head, throat, neck, chest, lungs, sternum, diaphragm, back, or abdomen, or results in straddling a child's torso.

Subd. 5. **Training for staff.** (a) To meet the requirements of subdivision 1, staff who use restrictive procedures, including paraprofessionals, shall complete training in the following skills and knowledge areas:

- (1) positive behavioral interventions;
- (2) communicative intent of behaviors;
- (3) relationship building;
- (4) alternatives to restrictive procedures, including techniques to identify events and environmental factors that may escalate behavior;
- (5) de-escalation methods;
- (6) standards for using restrictive procedures only in an emergency;
- (7) obtaining emergency medical assistance;

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- (8) the physiological and psychological impact of physical holding and seclusion;
 - (9) monitoring and responding to a child's physical signs of distress when physical holding is being used;
 - (10) recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding is used;
 - (11) district policies and procedures for timely reporting and documenting each incident involving use of a restricted procedure; and
 - (12) school-wide programs on positive behavior strategies.
- (b) The commissioner, after consulting with the commissioner of human services, must develop and maintain a list of training programs that satisfy the requirements of paragraph (a). The commissioner also must develop and maintain a list of experts to help [IEP] teams reduce the use of restrictive procedures. The district shall maintain records of staff who have been trained and the organization or professional that conducted the training. The district may collaborate with children's community mental health providers to coordinate trainings.

Subd. 6. Behavior supports; reasonable force.

- (a) School districts are encouraged to establish effective schoolwide systems of positive behavior interventions and supports.
- (b) Nothing in this section or section 125A.0941 precludes the use of reasonable force under sections 121A.582; 609.06, subdivision 1; and 609.379. For the 2014-15 school year and later, districts must collect and submit to the commissioner summary data, consistent with subdivision 3, paragraph (b), on district use of reasonable force that is consistent with the definition of physical holding or seclusion for a child with a disability under this section.

2. Support Stakeholder Planned Action Items

MDE supports the consensus-based recommendations reached by the 2014 stakeholder group regarding actions that various stakeholders, agencies and the legislature can take to best ensure a reduction in the use of restrictive procedures in the Minnesota education system. As such, MDE recommends the above goals to reduce the use of restrictive procedures and eliminate prone restraints.

3. Strengthen Pre-Enrollment Screening

Pre-enrollment screening for change of placement should be conducted for students exhibiting challenging behaviors in order to pair consequences (both in emergency and in modification) with individual needs. This screening data should include a current (within the past 30 days) functional behavior assessment to ensure that receiving districts are able to design behavior response plans that are specific to the needs of the student.

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Very often, intermediate school districts are the receiving districts in these situations. By relying on thorough pre-enrollment screening based on a detailed report of what prior interventions were used and their effect, intermediates and other receiving districts will be better equipped to address student needs. With this data, intermediate districts will have more effective tools for designing individualized and instructional behavior improvement plans that reflect interventions that are least restrictive for students.

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Legislative Language or Policy Guidance Currently in Effect in All States Relating Specifically to Prone Restraint or Restraint that Restricts or Impairs a Child's Ability to Breathe Within the School Setting

State	Citation	Language	
Alabama	Ala. Admin. Code r. 290-3-1-.02(1)(f)(1) (2014)	Prohibits: "(iv) Physical Restraint that restricts the flow of air to the student's lungs—Any method (face-down, face-up, or on your side) of physical restraint in which physical pressure is applied to the student's body that restricts the flow of air into the student's lungs. Use of this type of restraint is prohibited in Alabama public schools and educational programs."	Applies to all children
Alaska	HB 210 amends Alaska Stat. 14.33.120(c) (2014)	"A teacher, teacher's assistant, or other person responsible for students may not ... (3) physically restrain a student by placing the student on the student's back or stomach or in a manner that restricts the student's breathing."	Applies to children with disabilities
Arizona	The Use of Seclusion and Restraint: A Guidance Document on Best Practices Arizona Dept. Of Educ. (2014)	Prohibit some disciplinary procedures including a "physical restraint that places excess pressure on the chest or back or impedes the ability to breathe or communicate is prohibited."	Applies to all children with disabilities
Arkansas	Arkansas Dept. of Educ. Advisory Guidelines for the Use of Student Restraints in Public School or Educational Settings, p. 13 (2014)	Prone restraint or other restraints that restrict breathing should never be used because they can cause serious injury or death."	Applies to all children

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State	Citation	Language	
California	Cal. Code Reg. tit. 5, § 3052(i)(4)(B)-(C) and (l)(1) and (5) (2013)	<p>(i)(4) Emergency interventions may not include:...(B) employment of a device or material or objects which simultaneously immobilize all four extremities except that techniques such as prone containment may be used as an emergency intervention by staff trained in such procedures; and (C) an amount of force that exceeds that which is reasonable and necessary under the circumstances.</p> <p>(l) Prohibitions. (1) Any intervention that is designed to, or likely to, cause physical pain; (5) “Restrictive interventions which employ a device or material or objects that simultaneously immobilize all four extremities, including the procedure known as prone containment, except that prone containment or similar techniques may be used by trained personnel as a limited emergency intervention pursuant to subdivision (i).”</p>	Applies to children with disabilities
Colorado	Colo. Code Reg. tit. 1, §§ 301-45, 2620-R-2.00 et seq. (2009)	<p>2620-R-2.00(4) defines “positional asphyxia” to mean “an insufficient intake of oxygen as a result of body position that interferes with one’s ability to breathe.”</p> <p>2620-R-2.02(1)(a) “the public education program shall ensure that: (i) no restraint is administered in such a way that the student is inhibited or impeded from breathing or communicating; (ii) no restraint is administered in such a way that places excess pressure on the student’s chest, back, or causes positional asphyxia.”</p>	Applies to all children
Connecticut	Conn. Gen. Stat. §§ 46a-150(4) and 46a-151 Conn. Admin. Regs. §§ 10-76b-510-76b-11	<p>46a-150(4) defines “life-threatening physical restraint” to mean “any physical restraint or hold of a person that restricts the flow of air into a person’s lungs, whether by chest compression or any other means.”</p> <p>46a-151 prohibits the use of life-threatening physical restraint.</p>	Applies to children with disabilities

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State	Citation	Language	
Delaware	Del. Code Chapt. 41, tit. 14 § 4112F (effective 7.1.14)	(b) Prohibitions and restriction on use. (2) Public school personnel may impose physical restraint only in conformity with all of the following standards: ... (b) The physical restraint does not interfere with the student's ability to communicate in the student's primary language or mode of communication; (c) the physical restraint does not interfere with the student's ability to breathe or place weight or pressure on the student's head, throat, or neck; (d) the physical restraint does not recklessly exacerbate a medical or physical condition of the student ...	Applies to all children
District of Columbia	57 D. C. Reg. 9457	2818.1 "Nonpublic special education school or program shall not use any form of prone restraint on a District of Columbia student. Use of such restraints as a policy or practice shall be grounds for denying or revoking a certificate of approval."	Applies to children with disabilities
Florida	Fla. Stat. § 1003.573	(4) Prohibited restraint. "School personnel may not use a mechanical restraint or a manual or physical restraint that restricts a student's breathing."	Applies to children with disabilities
Georgia	Ga. Comp. R. & r. 160-5-1-3.5	"(2)(b) The use of prone restraint is prohibited in Georgia public schools and educational programs."	Applies to all children
Hawaii	Haw. Rev. Stat. § 302A-1141 ⁴⁵	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to children with disabilities
Idaho ⁴⁶		No laws or guidance on restraints.	

⁴⁵ Provides: No physical punishment of any kind may be inflicted upon any pupil, but reasonable force may be used by a teacher in order to restrain a pupil in attendance at school from hurting oneself or any other person or property, and reasonable force may be used ... by a principal or the principal's agent only with another teacher present and out of the presence of any other student but only for the purpose outlined in § 703-309(2)(a)."

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State	Citation	Language	
Illinois	105 Ill. Comp. Stat. § 5/10-20.33 Ill. Admin. Code, tit. 23, § 1.285	No applicable language relating specifically to prone restraint or restraint that restricts or impairs a child's ability to breathe within the school setting.	Applies to all children
Indiana	Indiana SB 0345 (passed 5.13.13) Commission on Seclusion and Restraint in Schools, Model Seclusion and Restraint Plan ⁴⁷ (8.1.13)	Requires a commission to adopt rules and model policy pertaining to seclusion and restraint. Model plan provides: IG. "Prone and supine forms of restraint are not authorized and shall be avoided." IH. "Seclusion and restraint shall never be used in a manner that restricts a child's breathing or harms the child."	Applies to all children
Iowa	Iowa Admin. Code r. 281-103.8	"(1) No employee shall use any prone restraints. For the purposes of this rule, "prone restraints" means those in which an individual is held face down on the floor. Employees who find themselves involved in the use of a prone restraint as the result of responding to an emergency must take immediate steps to end the prone restraint."	Applies to all children
Kansas	32 Kansas Register No. 14, 317 (April 4, 2013)	91-42-2(a)(1)(A) "Policies and procedures shall prohibit the following: (i) The use of prone, face-down, physical restraint; or face-up, physical restraint; physical restraint that obstructs the airway of a student; or any physical restraint that impacts a student's primary mode of communication."	Applies to all children

⁴⁶ Task force established in Aug. 2010 with proposed rules (IDAPA 08.02.03.160-161) however no action was taken.

⁴⁷ Schools are free to adopt a model plan as they see fit. However, any plan adopted by a school must contain, at a minimum, the elements listed in Indiana Code 20-20-40-13.

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State	Citation	Language	
Kentucky	704 Kentucky Admin. Regs. 7:160 (2013)	Section 3(2) "School personnel shall not impose the following on any student at any time: ... (d) Physical restraint that is life-threatening; (e) Prone or supine restraint; or (f) Physical restrict if they know that physical restraint is contraindicated based on the student's disability, health care needs, or medical or psychiatric condition."	Applies to all children
Louisiana	La. Rev. Stat. § 17:416.21(C)	(1)"Physical restraint shall be used only ... (c) In a manner that causes no physical injury to the student, results in the least possible discomfort, and does not interfere in any way with a student's breathing or ability to communicate with others;" . . . (3) "No student shall be physically restrained in a manner that places excessive pressure on the student's chest or back or that causes asphyxia; (4) A student shall be physically restrained only in a manner that is directly proportionate to the circumstances and to the student's size, age, and severity of behavior."	Applies to children with disabilities
Maine	LD 243 ⁴⁸ (passed 2013) 05-071 Department of Education, Chapter 33, Section 6	"2. Prohibited forms and uses of physical restraint ... C) No physical restraint may be used that restricts the free movement of the diaphragm or chest or that restricts the airway so as to interrupt normal breathing or speech (restraint-related positional asphyxia) of a student; D) No physical restraint may be used that relies on pain for control, including but not limited to joint hypertension, excessive force, unsupported take-down (e.g. tackle), the use of any physical structure (e.g. wall, railing or post), punching and hitting."	Applies to all children

⁴⁸ Revised existing statutory provisions pertaining to physical holding and seclusion.

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State	Citation	Language	
Maryland	Md. Regs. Code tit. 13A. § 13A.08.04.05(A)(1)(e)	Provides: "In applying restraint, school personnel may not: (i) Place a student in a face down position; (ii) Place a student in any position that will obstruct a student's airway or otherwise impair a student's ability to breathe, obstruct a staff member's view of a student's face, restrict a student's face, restrict a student's ability to communicate distress, or place pressure on a student's head, neck, or torso; or (iii) straddle a student's torso."	Applies to all children
Massachusetts	Mass. Regs. Code, tit. 603, § 46.05(3) § 46.05(5)(a)	<p>"Safest method. A person administering physical restraint shall use the safest method available and appropriate to the situation subject to the safety requirements set forth in 603 CMR 46.05(5). Floor or prone restraints shall be prohibited unless the staff member administering the restraint has received in-depth training according to the requirements of 603 CMR 46.03(3) and, in the judgment of the trained staff member, such method is required to provide safety for the student or others present."</p> <p>"Safety requirements. Additional requirements for the use of physical restraint: (a) No restraint shall be administered in such a way that the student is prevented from breathing or speaking. During the administration of a restraint, a staff member shall continuously monitor the physical status of the student, including skin color and respiration."</p>	Applies to all children

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State	Citation	Language	
Michigan	<p>Supporting Student Behavior: Standards for the Emergency Use of Seclusion and Restraint, p. 18</p> <p>Dec. 2006</p> <p>Michigan Department of Education</p>	<p>“E. Prohibited Practices. The following procedures are prohibited under all circumstances, including emergency situations: ... any restraint that negatively impacts breathing; prone restraint: school personnel who find themselves involved in the use of a prone restraint as the result of responding to an emergency must take immediate steps to end the prone restraint.”</p> <p>“Prone restraint is the restraint of a person face down.”</p> <p>“restraints that negatively impact breathing include floor restraints, facedown position, or any position in which a person is bent over in such a way that it is difficult to breathe. This includes a seated or kneeling position in which a person being restrained is bent over at the waist. Sitting or lying across a person’s back or stomach can interfere with breathing. When a person is lying facedown, even pressure to the arms and legs can interfere with a person’s ability to move their chest or abdomen in order to breathe effectively.”</p>	Applies to all children

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State	Citation	Language	
Minnesota	Minn. Stat. §§ 125A.094 - .0942	<p>Minn. Stat. § 125A.0942, Subd. 4(9) prohibits “physical holding that restricts or impairs a child’s ability to breathe, restricts or impairs a child’s ability to communicate distress, places pressure or weight on a child’s head, throat, neck, chest, lungs, sternum, diaphragm, back, or abdomen, or results in straddling a child’s torso.”</p> <p>Minn. Stat. § 125A.0942, Subd. 3(a)(8) provides “until August 1, 2015, a school district may use prone restraints with children age five or older if: (i) the district has provided to the department a list of staff who have had specific training on the use of prone restraints; (ii) a district provides information on the type of training that was provided and by whom; (iii) only staff who received specific training use prone restraints; (iv) each incident of the use of prone restraints is reported to the department within five working days on a form provided by the department; and (v) the district, before using prone restraints, must review any known medical or psychological limitations that contraindicate the use of prone restraints.”</p>	Applies to children with disabilities
Mississippi		No laws or guidance on restraints.	

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State	Citation	Language	
Missouri	<p>Mo. Rev. Stat. § 160.263</p> <p>Missouri Dep't of Elementary and Secondary Educ., Model Policy on Seclusion and Restraint (July, 2010), p. 2</p>	<p>State statute requires all school districts to adopt a written policy addressing the use of restrictive behavioral interventions, including but not limited to definitions of restraint, seclusion, and time-out and descriptions of circumstances under which a restrictive behavioral intervention is allowed and prohibited. It also required the state education agency to develop a model policy.</p> <p>The model policy states that “[t]his policy is not an endorsement of the use of seclusion and restraint. A school district may adopt a policy prohibiting the use of seclusion, isolation or restraint.” It further provides that “[p]hysical restraint shall: not place pressure or weight on the chest, lungs sternum, diaphragm, back, neck or throat of the student which restricts breathing.”</p>	Applies to all children
Montana	Montana Admin. R. 10.16.3346	No applicable language relating specifically to prone restraint or restraint that restricts or impairs a child’s ability to breathe within the school setting.	Applies to children with disabilities

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State	Citation	Language	
Nebraska	<p>Nebraska Adim. Code, tit. 92, R. 10, § 011.01(E)</p> <p>Nebraska Educ. Dept., Developing School Policies & Procedures for Physical Restraint and Seclusion in Nebraska Schools, (June, 2010), pp. 12, 27, 29, and 34</p>	<p>“Each school system has a seclusion and restraints policy approved by the school board or local governing body.”</p> <p>At this time Nebraska does not have any statutes, regulations, or state policies regarding restraint or seclusion but schools are required to have school safety and security committees in charge of developing safety and security plans for each school in order to be accredited. Procedures related to these procedures “could be interpreted as coming under the scope of Nebraska’s school safety policies,” p. 12.</p> <p>Each school district may choose to format its policies according to its own practices, p. 27. Model policies include the following language: “The only physical restraints to be used are those taught by the approved Crisis Intervention Training Program,” p. 29 and “Prone or supine forms of physical restraint are not authorized and should be avoided,” p. 34.</p>	Applies to all children
Nevada	Nev. Rev. Stat. §§ 388.521 – 388.5317 ⁴⁹ (1999)	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child’s ability to breathe within the school setting.	Applies to children with disabilities

⁴⁹ Meaningful protections against seclusion and restraint but no specific prohibitions on prone restraint or restraints that restrict or impair a child’s ability to breathe.

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State	Citation	Language	
New Hampshire	N.H. Rev. Stat. Ann. §§ 126-U:1 – 126-U:14	126-U: 4 “Prohibition of Dangerous Restraint Techniques. No school or facility shall use or threaten to use any of the following restraint and behavior control techniques: l) Any physical restraint or containment technique that: a) obstructs a child’s respiratory airway or impairs the child’s breathing or respiratory capacity or restricts the movement required for normal breathing; b) places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child; c) obstructs the circulation of blood; d) involves pushing on or into the child’s mouth, nose, eyes, or any part of the face or involves covering the face or body with anything, including soft objects such as pillows, blankets, or washcloths; or e) endangers a child’s life or significantly exacerbates a child’s medical condition.”	Applies to all children

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State	Citation	Language	
New Jersey	New Jersey Dept. of Educ. Guidance Memo 2012-5 (9.18.12)	“The New Jersey Department of Education, Office of Special Education, endorses the use of [the United States Department of Education, Office of Special Education and Rehabilitative Services (USDE OSERS) May 15, 2012, Guidance Document] when developing Individual Education Programs (IEPs) which address the behavioral needs of students with disabilities.”	Applies to all children
New Mexico ⁵⁰	State of New Mexico Public Educ. Dep’t, Use of Physical Restraint as a Behavioral Intervention for Students with Disabilities, Memorandum (March 14, 2006)	Memorandum, pp. 3-4 “Offers the following guidance to IEP teams and building administrators: . . . No form of physical restraint may be used that restricts a student from speaking or breathing.”	Applies to children with disabilities
New York	N.Y. Comp. R. and Regs., tit. 8, §§ 19.5(b) and 200.22 ⁵¹ (2009)	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child’s ability to breathe within the school setting.	Applies to all children
North Carolina	N.C. Gen. Stat. §§ 115C-391.1 ⁵²	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child’s ability to breathe within the school setting.	Applies to all children

⁵⁰ New Mexico does have a Children’s Mental Health and Developmental Disabilities Act, which provides, under N.M. Stat. Ann. § 32A-6A-10(I), “In applying physical restraint, a mental health or developmental disabilities professional shall use only reasonable force as is necessary to protect the child or other person from imminent and serious physical harm.” Additionally, in 2010, a legislative education study committee was proposed and a Restraint & Seclusion Work Group was created.

⁵¹ New York has meaningful protections against the use of seclusion and restraint, however, such does not include any prohibition on prone restraint or restraints that restrict or impair a child’s ability to breathe.

⁵² North Carolina has meaningful protections against the use of seclusion and restraint, however, such does not include any prohibition on prone restraint or restraints that restrict or impair a child’s ability to breathe.

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State	Citation	Language	
North Dakota		No laws or guidance on restraints.	
Ohio	Ohio Admin. Code § 3301-35-15 (Effective Aug. 1, 2013)	<p>(C) “Prohibition on certain practices. The following practices are prohibited by school personnel under any circumstance: (1) prone restraint; (2) Any form of physical restraint that involves the intentional, knowing, or reckless use of any technique that: (a) involves the use of pinning down a student by placing knees to the torso, head, or neck of the student; (b) uses pressure point, pain compliance, or joint manipulation techniques; or (c) otherwise involves techniques that are used to unnecessarily cause pain.”</p> <p>(D) “Physical restraint. (1) Prone restraint is prohibited ... (2) Physical restraint may be used only if ... (b) The physical restraint does not obstruct the student’s ability to breathe; (c) The physical restraint does not interfere with the student’s ability to communicate in the student’s primary language or mode of communication...”</p>	Applies to all children
Oklahoma	Oklahoma State Dep’t of Educ., Guidelines for Minimizing the Use of Physical Restraint for Students with Disabilities in Oklahoma (May 2010)	“Prone restraints (restraints that position a student face down on his or her stomach or face up on the back) or any maneuver that places pressure or weight on the chest, sternum, lungs, diaphragm, neck, throat, or back must not be used. No restraint that prevents a student from speaking or breathing is allowed.”	Applies to children with disabilities

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State	Citation	Language	
Oregon	OR Admin. R. 581-021-0550 to -0570 (2013)	OAR 581-021-0553: (1) "The use of a chemical restraint, mechanical restraint or prone restraint on a student in a public education program in this state is prohibited." "Prone restraint means a restraint in which a student is held face down on the floor." OAR 581-021-0550. "Physical restraint' does not include prone restraint." OAR 581-021-0550.	Applies to all children
Pennsylvania	22 Pa. Code § 14.133(c)(3)	Provides "The use of prone restraints is prohibited in educational programs. Prone restraints are those in which a student or eligible young child is held face down on the floor."	Applies to children with disabilities

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State	Citation	Language	
Rhode Island	R.I. Bd. of Regents for Elementary and Secondary Education, Physical Restraint Regulations, 6.2(e) and 7.3(a) (September 1, 2002)	<p>“6.2 Prohibitions: Physical restraint/crisis intervention are prohibited in the following circumstances:... (e) As in a restrictive intervention which employs a device or material or objects that simultaneously immobilize all four extremities, including the procedure known as prone containment, except that prone containment may be used by trained personnel as a limited emergency intervention when a documented part of a previously agreed upon written behavioral intervention plan.”</p> <p>“7.3 Safety Requirements. Additional requirements for the use of physical restraint/crisis intervention are: (a) No restraint shall be administered in such a way that the student is prevented from breathing or speaking. During the administration of a restraint, a staff member shall continuously monitor the physical status of the student, including skin color and respiration. A restraint shall be released immediately upon a determination by the staff member administering the restraint that the student is no longer at risk of causing imminent physical harm to him or herself or others. (b) Restraint shall be administered in such a way so as to prevent or minimize physical harm. If, at any time during a physical restraint/crisis intervention, the student demonstrates significant physical distress, the student shall be released from the restraint immediately, and school staff shall take steps to seek medical assistance. (c) Program staff shall review and consider any known medical or psychological limitations and/or behavioral intervention plans regarding the use of physical restraint/crisis intervention on an individual student.”</p>	Applies to all children

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State	Citation	Language	
South Carolina	South Carolina Dep't of Educ., Guidelines on the Use of Seclusion and Restraint (2011), p. 8	"Prone restraints (with the student face down on his or her stomach) or supine restraints (with the student face up on the back) or any maneuver that places pressure or weight on the chest, lungs, sternum, diaphragm, back, neck or throat are prohibited."	Applies to children with disabilities
South Dakota		No laws or guidance on restraints.	
Tennessee	Tenn. Code Ann. § 49-10-1305(d)	"Any form of life threatening restraint, including restraint that restricts the flow of air into a person's lungs, whether by chest compression or any other means, to a student receiving special education services ... is prohibited."	Applies to children with disabilities
Texas	19 Tex. Admin. Code § 89.1053(c)	"Use of restraint. A school employee, volunteer, or independent contractor may use restraint only in an emergency ... with the following limitations. (1) Restraint shall be limited to the use of such reasonable force as is necessary to address the emergency... (3) Restraint shall be implemented in such a way as to protect the health and safety of the student and others. (4) Restraint shall not deprive the student of basic human necessities."	Applies to children with disabilities

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State	Citation	Language	
Utah	Utah Code §§ 53A-11-805 Utah State Office of Education, Least Restrictive Behavioral Interventions LRBI Guidelines, Positive Behavioral Supports and Selection of Least Restrictive Behavioral Interventions ⁵³	“Behavior reduction intervention which is in compliance with section 76-2-401 and with state and local rules adopted under section 53A-15-301 is excepted from this part.”	Applies to children with disabilities
Vermont	Vt. Code R. §§ 4500 et seq.	4500.3(9) defines prone physical restraint “means holding a student face down on his or her stomach using physical force for the purpose of controlling the student’s movement.” 4502.1.1 provides “prone and supine physical restraints are more restrictive than other forms of physical restraint and may be used only when the student’s size and severity of behavior require such a restraint because a less restrictive restraint has failed or would be ineffective to prevent harm to the student or others.” 4501.1(c) prohibits school personnel and contract service providers from imposing on a student “any physical restraint, escort, or seclusion that restricts or limits breathing or communication, causes pain or is imposed without maintaining direct visual contact.”	Applies to all children

⁵³ Utah has guidance found in this document. Nothing that discusses prone or restricts and impairs a child’s ability to breathe.

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State	Citation	Language	
Virginia	Virginia Depart. of Educ., Guidelines for the Development of Policies and Procedures For Managing Student Behaviors in Emergency Situations in Virginia Public Schools (2009)	No applicable language relating specifically to prone restraint or restraint that restricts or impairs a child's ability to breathe within the school setting.	Applies to all children
Washington	Wash. Admin. Code § 392-172A-03125 (2013)	3(a) "Force and restraint in general. No force or restraint which is either unreasonable under the circumstances or deemed to be an unreasonable form of corporal punishment as a matter of state law may be used. See RCW 9A.16.100 which cites the following uses of force or restraint as uses which are presumed to be unreasonable and therefore unlawful ... (iv) interfering with a student's breathing."	Applies to all children
West Virginia	W. Va. Code St. R. § 26-99	"A school employee and/or independent contractor may use restraint in an emergency as defined above with the following limitations: Restraint shall be limited to the use of such reasonable force as is necessary to address the emergency. Procedures and maneuvers that restrict breathing (e.g. prone restraint), place pressure or weight on the chest, lungs, sternum, diaphragm, back, neck or throat, or may cause physical harm are prohibited."	Applies to all children

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State	Citation	Language	
Wisconsin	2011 Act 125 Seclusion and Restraint (2012)	Section 2(3)(d) "None of the following maneuvers or techniques are used: 1) Those that do not give adequate attention and care to protecting the pupil's head. 2) Those that cause chest compression by placing pressure or weight on the pupil's chest, lungs, sternum, diaphragm, back, or abdomen. 3) Those that place pressure or weight on the pupil's neck or throat, on an artery, or on the back of the pupil's head or neck, or that otherwise obstruct the pupil's circulation or breathing. 4) Those that constitute corporal punishment."	Applies to all children
Wyoming	Wyo. Stat. § 21-2-202 Wyo. Educ. Rules 42-1 to 42-8 (Jan. 2012)	42-7(b)(i)(B): "Schools shall not utilize aversive interventions, mechanical restraints, or prone restraints at any time"	Applies to all children

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EXHIBIT 6-25: HC 1C – OVERVIEW OF BEHAVIORAL HEALTH HOMES

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Olmstead Plan:

Health Care and Community Supports Administrations Overview of Behavioral Health Homes

January 2015

For more information contact:

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Introduction

On January 28, 2013, Governor Mark Dayton issued an executive order establishing an Olmstead Sub-Cabinet to develop and implement a comprehensive Minnesota Olmstead Plan. The main purpose of the Olmstead Plan is to move the state forward, towards greater integration and inclusion for people with disabilities.

In accordance with objective 1C under the Healthcare and Healthy Living section of the Olmstead Plan the Health Care and Community Supports administrations are charged with:

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

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

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

The following report provides a summary of the work accomplished in meeting these objectives.

Background

The 2010 Patient Protection and Affordable Care Act (ACA) established the “State Option to Provide Coordinated Care through a Health Home for Individuals with Chronic Conditions”, which provides funding for a two-year enhanced (90-percent) federal match for health home services for eligible Medicaid enrollees. This enhanced federal funding gives states critical resources to build provider capacity and provide an additional window of time needed to realize a return on their investment.

The federal health home model expands upon the concept of the more commonly used term, medical homes (in Minnesota referred to as Health Care Homes) by serving the whole person across the primary care, long-term services and supports, and mental health and substance use disorder treatment components of the health care delivery system. Health homes coordinate a variety of services including primary care and specialty care, and ensure referrals to community supports and services are effectively managed. The key feature of health homes, comprehensive care management, supports the person in managing chronic conditions and achieving their self-management goals by facilitating the provision of clinical services that contribute to improved health outcomes.

The Community Supports and Health Care Administrations of DHS are working together to design a behavioral health home (BHH) model which will operate under a “whole person” philosophy and assure access to and coordinated delivery of primary care and behavioral health services for adults and children with serious mental illness (SMI).

The administrations are working together because of the known barriers to health care access, early mortality and high co-occurrence of chronic health conditions for individuals with SMI. These conditions are generally associated with modifiable risk factors more prevalent in the adult SMI population including smoking, chemical dependency, and poor nutrition. Children who are exposed to psychological trauma are proven to have a significant risk of poorer physical health as adults and also much more likely to have serious emotional disturbance.

People with SMI often lack access to adequate health care and those with access are less likely to receive care for comorbid chronic conditions that meets clinical practice guidelines. Quality care for people with SMI requires coordination between health care and behavioral health systems and integrated treatment for co-occurring mental health and substance abuse disorders.

DHS is developing a framework that will require a standard of integrated care which encompasses mental, behavioral, physical health conditions and considers the influence of multiple conditions, social factors, social function, and consumer preferences to personalize assessment, treatments, and goals of care.

DHS believes that more integrated care, regardless of setting, contributes to improved health and decreases the risk of adverse outcomes.

Consumer and Stakeholder Engagement to Inform Design

Consumer Engagement

In planning for behavioral health homes, DHS has contracted with the National Alliance on Mental Illness (NAMI) Minnesota to engage people living with mental illness across the State in an opportunity to shape policy. Through their participation in focus groups, Medicaid participants from a very wide range of communities are providing feedback on topics that will inform the development of Minnesota’s behavioral health home model. The focus group questions concentrate on topics such as: accessing physical and mental health care, transition of care experiences, methods of obtaining health information, opinions surrounding the facets of integrated care, the ways in which individual, cultural, spiritual, and gender values should be incorporated into the care process.

A preliminary report was completed in December of 2014; see Appendix A, which provides an overview of focus groups completed to date. Focus groups began in September 2014 and at this time, 22 focus groups have been conducted, reaching 182 individuals with mental illness, family members, and transition aged youth. A total of 28 focus groups were scheduled, six groups were rescheduled; five for non-attendance and one due to inclement weather. In total, eight additional focus groups are scheduled to be conducted and two non-English focus group transcripts are pending translation. The

final report, due March 2015, will include a detailed analysis of the data and recommendations for its integration within BHH policy.

Stakeholder Engagement

Stakeholder engagement activities include short and longer-term advisory workgroups, a Request for Information, and a learning community.

An initial short-term advisory workgroup for preliminary input on behavioral health home planning was held in the winter of 2013. This group was one of five workgroups providing input to DHS as part of what was called the Adult Mental Health Reform initiatives informing the Reform 2020 report.

A long-term BHH Advisory Group was developed and began meeting in August of 2013 and has met 11 times. The group is scheduled to meet at least every two months and represents over 26 different stakeholder groups.

A Request for Information (RFI) was issued in April 2013 seeking public input and comments regarding improved integration and coordination of behavioral health and primary care services for Medical Assistance (MA) consumers. Findings were used to inform the design of the framework.

DHS has also established a Behavioral Health Home First Implementers learning community of providers that are interested in becoming certified behavioral health homes. This group will share best practices about how to best meet person's individual needs including person-centered planning and supporting integrated service delivery. Behavioral Health Home First Implementers will also receive support from DHS in preparation for certification. Thirty-five agencies across the state indicated interest in participating in this group. An initial needs assessment was conducted and will inform the development of curriculum focused on health home certification and on topics related to integration of mental and physical health. The group will use different modalities for sharing information, including regional meetings, webinars around specific health home topics, and group-based technical assistance. The group will begin meeting in February of 2015 and will for 18 months. An analysis will be completed to determine if the modality is effective in increasing the capacity to provide integrated care; if it is funding will be sought to continue learning community activities.

Proposal Design

Goals and Guiding Principles

DHS is developing a framework for health homes to serve the needs of complex populations covered by Medical Assistance. DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality. See Appendix B for the design and implementation timeline.

The goals of the health home framework are to:

1. Improve health outcomes (preventative, routine, treatment of health conditions) of individuals enrolled.
2. Improve experience of care for the individual.
3. Improve the quality of life and wellness of the individual.
4. Reduce health care costs.

The guiding principles of behavioral health homes are:

1. BHH services are distinguished by the presence of a multi-disciplinary team that shares information and collaborates to deliver a holistic, coordinated plan of care.
2. BHH services are an opportunity to better meet the needs of individuals experiencing serious mental illness and their families by addressing the individual's physical, mental, and behavioral health, including wellness goals.
3. BHH services will take a person-centered approach and will engage and respect the individual and family in their health care and recovery/resiliency.
4. BHH services are to respect, assess and use the cultural values, strengths, languages, and practices of the individual and family in supporting the individual's health goals.

Eligibility

Behavioral health home services will be made available to adults with serious mental illness (SMI) or a serious and persistent mental illness (SPMI), and children and youth experiencing a severe emotional disturbance (SED) as defined in MN Statute 245.462 subdivision 20(a) or 245.4871 subdivision 15 (2) and has a current diagnostic assessment as defined in MN Rule 9505.0372 subpart 1 items B or C, as performed or reviewed by a mental health professional employed or contracted by the behavioral health homes.

Potentially eligible individuals will be identified through the Medicaid claims system. DHS will provide certified behavioral health homes with a list of individuals that they already serve that are eligible for BHH services. Certified behavioral health homes will also recruit and identify potentially eligible individuals.

Participation in behavioral health homes is voluntary and eligible individuals will receive state-developed materials to inform them of the choice to participate in a BHH.

After eligibility for BHH services has been determined and information about the services has been provided to the eligible individual, the individual will be given the option to opt in to receiving BHH services. The opt-in process will include an informed consent form created by the State that will include the individual rights and responsibilities as a consumer of these services.

Behavioral health home services may not duplicate services or payments under targeted case management, assertive community treatment (ACT) or home and community-based waivers (HCBW)

where there is case management services provided. Individuals will need information on the various case management options to determine where their needs are best met.

Services

In a behavioral health home, consumers identified with serious mental illness will have their comprehensive physical and behavioral health needs addressed in a coordinated manner. This includes care planning to address chronic conditions (e.g. addressing steps to meet the consumers health goals), ongoing coordination of care between behavioral and physical health (e.g. comprehensive review of all prescribed medications), and also coordination with medical and behavioral specialists not at the BHH site (e.g. appropriate use and timing of elective surgery). Where appropriate non clinical service coordination will be added so that individuals in this model will have health care coordinated with social supports. Appropriate family and consumer support includes education to improve self-management.

“Health Home Services” as articulated by the Affordable Care Act, Section 2703 and in Minnesota State law (256B.0757) requires:

1. Comprehensive care management, using team-based strategies
2. Care coordination and health promotion
3. Comprehensive transitional care between health care and community settings
4. Individual and family support, including authorized representatives
5. Referral to community and social support services, and
6. The use of health information technology to link services, as feasible and appropriate

Several of these services, including health and wellness, direct education and support to family members, and intentional support with transitions, are not traditionally covered under Medicaid and offer an opportunity to provide more person-centered care.

Initial engagement

Behavioral health homes will be responsible to conduct specific activities as part of the initial engagement with clients:

Recruitment

- Take referrals.
- Recruit potential clients.
- Initiate contact with potential clients.
- Schedule intake appointments.
- Engage in community outreach.

Intake

- Check Medicaid eligibility for potential clients.
- Provide clients with BHH program materials, including the rights and responsibilities document, and inform clients about the choice to participate.
- Gather client consent.

- Determine if a diagnostic assessment has occurred within the last 12 months and obtain results. If the diagnostic assessment has not occurred within the last 12 months, assist the client in scheduling an appointment with the licensed mental health professional to complete the updated assessment.
- Set up an appointment with the client for an initial assessment.

A Behavioral health home will be responsible for conducting minimum activities under each of the six federally required services.

Comprehensive Care Management

Comprehensive care management is a collaborative process designed to manage medical, social, and mental health conditions more effectively based on population health data and tailored to the individual patient.

Behavioral health homes will be responsible to conduct the following activities as part of the comprehensive care management services:

(Activities applicable to all patients collectively)

- Design and implement new activities and workflows that increase patient engagement and optimize clinical efficiency.
- Design and implement communication and care coordination tools, to ensure that care is consistent among a client's many providers, as well as between the provider and the BHH.
- Deploy electronic and non-electronic tools to effectively make use of best practices and evidence to guide care efficiently and correctly.

Population Health Management

- Use a searchable electronic health record and patient registry to collect individual and practice-level data that allows providers to identify, track, and segment the population, improve outcomes over time, manage BHH services, provide appropriate follow-up, and identify any gaps in care.
- Select common clinical conditions and target cohorts on which to focus and define the patient population.
- Use the patient registry information to report outcomes to DHS as needed.
- Monitor and analyze data to manage the patient panel
- The integration specialist must review the patient registry regularly to track individuals' medications, lab results, and symptom management and use this data to adjust treatment as needed.
- The registry must contain:
 - (1) For each participant, the name, age, gender, contact information, and identification number assigned by the health care provider, if any
 - (2) Sufficient data elements to issue a report that shows any gaps in care for groups of participants with a chronic or complex condition; and
 - (3) Additional fields to be determined by DHS.

(Activities specific to an individual patient within targeted populations)

- Meet with each client and evaluate their initial and ongoing needs. Elements to evaluate include the patient's clinical condition, feasibility of completing various interventions, and the patient's values, preferences and readiness to engage in self-management and treatment.
- Utilize care strategies including health information technology and other tools to communicate and coordinate with the patient and with other caregivers to ensure that the care plan is being executed safely and efficiently.
- Measure services and interventions offered; the reason for implementation or non-implementation, and outcomes of each intervention.

Care Coordination

Care coordination is the compilation, implementation, and monitoring of the individualized, holistic health action plan with the client's family or identified supports through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Overarching activities of care coordination include the provision of case management services necessary to ensure individuals and their identified supports have access to medical, behavioral health, pharmacology and recovery support services (e.g. housing, access to benefits, vocational, social, and educational, etc.).

Specific care coordination activities are conducted with individuals and their identified supports, medical, behavioral health and community providers, and across and between care settings.

Behavioral health homes will be responsible to conduct the following activities as part of the care coordination services:

Initial assessment

- Assess the client's immediate safety and transportation needs and identify any barriers to participating in BHH services.
- Develop and implement an immediate needs plan for the client.

Comprehensive wellness assessment

- Conduct a comprehensive wellness assessment. The assessment process must begin within 30 days of intake and be completed within 60 days.
- Include a face-to-face meeting between the client and the systems navigator. The integration specialist must also meet with the client to complete components of the wellness assessment. In a mental health setting, the integration specialist must be an RN and focus on the individual's health care needs. In a primary care setting, the integration specialist must be a mental health professional and focus on the individual's mental health needs.
- Talk with internal and external professionals to gather information for the health action plan and make initial connections to begin establishing relationships required for ongoing care coordination.
- The assessment must include the skills, strengths, current resources, and current needs in the following areas:
 - Review of the diagnostic assessment;
 - Mental health and chemical/substance use and abuse knowledge of symptoms and illness management and treatment resources, and the individual's view of recovery;

- Screenings for substance abuse using CAGE-AID or GAIN-SS tools, alcohol, and tobacco. A substance abuse screen is not required if a substance abuse disorder is already known and documented.
- Health as it relates to chronic conditions, health wellness and literacy, lifestyle, self-management, and nutrition, access to health care, including information about the client's primary care doctor, primary care clinic, and dentist;
- Culture and spiritual beliefs and practices;
- Employment and education;
- Social functioning, including the use of leisure time;
- Interpersonal functioning including relationship with family and social support network;
- Self-care and independent living capacity;
- Income, financial assistance and legal;
- Risks and vulnerabilities;
- Housing;
- Transportation;
- Program utilization; (e.g. food support, Minnesota Family Improvement Program, Minnesota Supplemental Aid, Child Care Assistance Program)
- Access to food;
- Access to child care;
- Social services and community supports
- Self-navigation and self-advocacy skills; and
- Other domains as appropriate.
- Obtain appropriate releases of information as needed to gather information needed for the comprehensive wellness assessment. DHS will create a release of information template for BHHs to utilize if they do not have such a form already developed. All releases of information must follow Minnesota state privacy laws.
- Conduct a portion of the assessment in the client's home/living situation. The client has the right to refuse services in their home.

Health action plan development

- Draft an initial health action plan based on the comprehensive assessment within 60 days of intake.
- Talk with the client to ensure that the health action plan is based on their identified needs and goals.
- Demonstrate the client-centered nature of the plan by including the client's goal statement in first person language and the client signature. Provide a copy of the plan to the client.
- Update the comprehensive assessment and health action plan at least every 6 months thereafter.

Ongoing care coordination

- Maintain regular and ongoing contact with the client and/or their identified supports to prevent unnecessary inpatient readmissions, emergency department visits and/or other adverse outcomes such as homelessness, loss of established care/service providers, and loss of employment/schooling.
- Monitor client progress on goals in the health action plan and the need for plan alterations.

- Monitor the use of routine and preventative primary care, dental care, and well-child physician visits.
- Conduct appropriate referrals.
- Assist the client in setting up needed appointments, preparing for appointments, and accompanying the client to appointments as appropriate.
- Assist the client in follow-up care and follow-through on recommendations from the appointment(s).
- Initiate and maintain coordination with client's providers and formal and informal supports to ensure that the client has the resources necessary to follow the health action plan.
- Identify and share individual level information in a timely manner with professionals and providers that are involved in the individual's care.
- Demonstrate engagement of area hospitals, primary care practices and behavioral health providers to collaborate for care coordination.
- Maintain current releases of information as needed for communication with providers that are involved in the client's care.
- Ensure linkages to medication monitoring if it is an identified need.
- Coordinate communication and collaboration within the BHH team on behalf of the client.
- Foster communication with and between the individual, their providers and their identified supports.

Health and Wellness Promotion Services

Health and wellness promotion services encourage and support healthy living and motivate individuals and/or their identified supports to adopt healthy behaviors and promote better management of their health and wellness. Health and wellness promotion services place a strong emphasis on skills development through health education and wellness interventions so individuals and/or their identified supports can monitor and manage their chronic health conditions to improve health outcomes.

Behavioral health homes will be responsible to conduct the following activities as part of the health and wellness promotion services:

- Provide clients with information to increase their understanding of the illnesses/health conditions identified in the comprehensive wellness assessment, and educate clients on how those conditions relate to and impact various facets of their life.
- Work with clients to increase their knowledge of illness-specific management as well as overall daily health maintenance.
- Support clients in activities aimed at increasing their self-management and reaching their health goals.
- Support clients in recovery and resiliency.
- Help clients and/or clients' identified supports to make healthy lifestyle choices within their budget.
- Provide onsite coaching, classes, and information on topics including: wellness and health-promoting lifestyle interventions, substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy support, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and promoting independence and skill development related to self-administration of medications.

Comprehensive Transitional Care

Comprehensive transitional care activities are specialized care coordination services that focus on the movement of individuals between or within different levels of care or settings or while shifting from the use of reactive care and treatment to proactive care via health promotion and health management. Transition services are designed to streamline plans of care and crisis management plans, reduce barriers to timely access, reduce inappropriate hospital, residential treatment, and nursing home admissions, interrupt patterns of frequent emergency department use, and prevent gaps in services which could result in (re)admission to a higher level of care or longer lengths of stay at an unnecessary level of care.

Behavioral health homes will be responsible to conduct the following activities as part of the comprehensive transitional care services:

- Ensure adequate and continuous client services and supports following and in between services and settings such as, hospitalization, homelessness, shelters, domestic violence shelters, residential treatment, prison, juvenile justice, children and family services, treatment foster care, foster care, special education and other settings and services with which the client may be involved.
- Participate in discharge planning in collaboration with the individual and the appropriate facility staff to assist in the development and implementation of the transition of the client to the least restrictive setting possible.
- Advocate with the client to ensure that clients/families are included in transition planning.
- Work with other agencies to ensure that information is shared between agencies regarding a transition.
- Establish a protocol for contacting clients and/or their identified supports and services following discharge from hospitals, residential treatment, and other settings, to assure clients are reconnected to ongoing services and community and social supports.

Referral to Community and Social Support Services

Referral to community and social support services occurs in collaboration with the client and/or their identified supports. The BHH provider identifies and provides referrals to a variety of services and assists clients in setting up appointments, preparing for appointments, and accompanying the client to appointments as appropriate.

Behavioral health homes will be responsible to conduct the following activities as part of the referral to community and social supports services:

- Connect clients to community resources as identified in their comprehensive wellness assessment, including but not limited to, medical and behavioral health care, entitlements and benefits, respite, housing, transportation, legal services, educational and employment services, financial services, wellness and health promotion services, specialized support groups, substance use prevention and treatment, social integration and skill building, and other services as identified by the individual and/or their identified supports.
- Check in with the client and their family after a referral is made in order to confirm if they need further assistance in scheduling or preparing for appointments, or assistance in following up after connecting with community resources.

- Maintain adequate knowledge of agencies and resources in order to connect individuals and/or their caregivers to a wide array of support services to help them overcome access or service barriers, increase self-efficacy skills and improve overall health.

Individual and Family Support Services

Individual and family support services are activities, materials, or services aimed to help clients reduce barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-efficacy skills, and improve health outcomes.

Behavioral health homes will be responsible to conduct the following activities as part of the individual and family support services:

- Assist clients and families with accessing self-help resources, peer support services, support groups, wellness centers, and other care programs focused on the need of the individuals and their families and/or identified supports.
- Assist clients with obtaining and adhering to prescribed medication and treatments.
- Offer family support and education activities.
- Support clients and/or clients' identified supports in improving their social networks.
- Teach individuals and families how to navigate systems of care in order to identify and utilize resources to attain their highest level of health and functioning within their families and community.

NOTE: Utilization of health information technology is federally required to link services, as possible and appropriate. BHH provider standards may evolve as experience is gained and as permitted by Minnesota law.

Provider Requirements

Federal requirements

Behavioral health home providers must have the capacity to perform the health home functions specified below by Centers for Medicare and Medicaid Services (CMS):

- 1) Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- 2) Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- 3) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- 4) Coordinate and provide access to mental health and substance abuse services;
- 5) Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
- 6) Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- 7) Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;

- 8) Coordinate and provide access to long-term care supports and services;
- 9) Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
- 10) Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- 11) Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

State requirements

DHS will certify behavioral health homes and providers must be enrolled as a Medicaid provider. Behavioral health homes must serve as the central point of contact for consumers and ensure person-centered development of a health action plan and implementation of services which improve experience of care, health outcomes and reduce avoidable health care costs.

At a minimum, BHH providers will be expected to:

- Be enrolled as a Medicaid provider and comply with the Medicaid program requirements.
- Successfully complete the State certification process and maintain certification by meeting standards as developed by the State.
- Demonstrate processes that allow them to understand and serve the BHH population.
- Maintain the required BHH team structure as described above and provide the federally required services of comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, referral to community and social support services, and use of health information technology to link services.
- Conduct comprehensive screenings and assessments that address behavioral, medical, and social service and community support needs.
- Create and maintain an individualized health action plan for each consumer that encompasses behavioral and physical health and social services and community supports.
- Use health information technology to link services, identify and manage care gaps; and facilitate communication among health home team members and other providers.
- Use an electronic health record and patient registry to collect individual and practice-level data that allows them to identify, track, and segment the population and improve outcomes over time.
- Establish processes in order to identify and share individual level information in a timely manner with professionals and providers that involved in the individual's care.
- Demonstrate engagement of area hospitals, primary care practices and behavioral health providers to collaborate with the Health Home on care coordination.
- Track individuals' medications, lab results, and symptom management and use this data to adjust treatment as needed.
- Demonstrate commitment by leadership to pursue integration and support practice transformation.
- Establish a continuous quality improvement plan, and collect and report data that will inform state and federal evaluations.

BHH teams will be integrated with both primary care and behavioral health providers:

- In a behavioral health setting, the required integrated team must include a nurse care manager.
- In a primary care setting, the team must include a licensed mental health professional.

Behavioral health home providers must also:

- Directly provide, or subcontract for the provision of, all required health home services.
- Maintain documentation of all team member qualifications in their personnel files.
- Participate in federal and state-required evaluation activities including documentation of behavioral health home services.
- Maintain compliance with all of the terms and conditions of a certified behavioral health home provider or will be discontinued as a provider of services.
- Provide a 60 day notice if they plan to determinate the delivery of behavioral health home services. Providers must inform consumers that they will no longer provide services and support the individual in finding a new behavioral health home provider.

Team Members

BHH services will be administered through a team based approach. The members listed below are the minimum requirements for a behavioral health home team, with the exception of an optional external professional. In order to qualify as one of these team members, a person must meet at least one of the qualifications listed below their title. One person can fill more than one membership roll.

Team Member: Consumer

Roles and Responsibilities

The decision to participate in BHH services rests with the consumer. The BHH model is designed to promote consumer's trust in their care team and to ensure holistic treatment of consumer's medical and behavioral health. Consumers play a vital part in the development and management of their health under the BHH model, therefore consumers are responsible for voicing their needs, concerns, questions, barriers, strengths, skills, desires and goals to their Behavioral Health Home team with the support and assistance of the Qualified Health Home Specialist and the Care Coordinator as needed. Consumers are responsible for communicating regularly with the Behavioral Health Home team, including reaching out to appropriate team members as needed and returning phone calls, emails, and all other appropriate forms communication. They are responsible for engaging in the planning and implementation processes of their treatments and therapies.

Team Member: Team Leader

Required Qualification

- Clinic manager
- Other executives

Roles and Responsibilities

The team leader provides the BHH with executive leadership as a champion for integration. They determine the size and overall composition of the BHH team. They are responsible for ensuring that needed memorandums of understanding are in place and that the BHH has access to resources and

tools including but not limited to overhead, health information technology, protected time on a calendar, support staff, medical records, and screening tools. They serve as the outward facing liaison to the wider community and provide administrative outreach to diverse communities. The team leader determines quality improvement and communication protocols for the BHH and is responsible for overseeing the certification and recertification process, and ensuring that the BHH meets all required reporting and evaluation responsibilities.

Team Member: Integration Specialist (Care Management)

Required Qualification

- Registered Nurse when BHH services are offered in a mental health setting.
- Mental health professional as defined in [M.S. 245.4871](#) Subd. 27, 1-6 or [M.S. 245.462](#) Subd. 18 1-6 when BHH services are offered in a primary care setting.

Roles and Responsibilities

The integration specialist position illustrates the importance that the BHH program places on integration of primary care and mental health. The integration specialist is the reciprocal professional whose required qualifications are contingent on the setting of the BHH. If the BHH is located in a mental health setting, the integration specialist must be a Registered Nurse whereas if the BHH is located in a primary care setting, the integration specialist must be a mental health professional.

With the guidance of their supervisor and in collaboration with the BHH team, the integration specialist is the primary team member responsible for providing the comprehensive care management within the BHH. The integration specialist will utilize the patient registry to manage medical, social, and mental health conditions based on population health data and tailored to the individual patient. The integration specialist is responsible for activities that are applicable to all patients collectively and to individual patients within the targeted populations.

The integration specialist is responsible for individual and family support services in relation to the management of population health. The integration specialist may also contribute to the provision of the other health home services and is also available to run wellness groups for clients as appropriate. In some settings, the integration specialist may serve as the supervisor of systems navigator or the same individual may serve both positions in settings where client populations are small.

Team Member: Behavioral Health Home Systems Navigator (Care Coordination)

Required Qualification

Case manager as defined in [M.S. 245.4871](#) Subd.4, [M.S 245.462](#) Subd. 4 or
Mental health practitioner as defined in [M.S. 245.4871](#) Subd. 26. or [M.S 245.462](#) Subd. 17

Roles and Responsibilities

With the guidance of their supervisor and in collaboration with the BHH team, the BHH systems navigator is the primary entity responsible for providing the care coordination within the BHH. The BHH systems navigator may contribute to the provision of health and wellness promotion services. In settings with a large client population, there may be multiple BHH systems navigator within one BHH.

Conversely, in settings with small client populations, there may be one individual that fulfills the roles of both integration specialist and systems navigator. They are also available to conduct wellness groups as appropriate contingent on their individual training.

Team Member: Qualified Health Home Specialist

Required Qualification

- Community health worker as defined in [M.S. 256B.0625](#) Subd. 49
- Peer support specialist as defined in [M.S. 256B.0615](#)
- Family peer support specialist (upcoming definition and certification at DHS),
- Case management associate as defined in [M.S. 245.462](#) Subd.4 (g) or [M.S. 245.4871](#) Subd. 4 (j),
- Mental health rehabilitation worker as defined in [M.S. 256B.0623](#) Subd. 5 (4)

Roles and Responsibilities

The qualified health home specialist serves as a coach whose primary focus is to support and assist clients in reaching their goals. They interact with the clients on the phone or in person on a regular basis to build trusting relationships and assist the client with identifying barriers to accessing care. They can meet with a client before appointments, help clients organize health concerns and prioritize issues to discuss with health providers. They can also meet with clients after office visits to review provider instructions and check for client understanding and access to resources to follow provider instructions. They provide ongoing motivation, encouragement, and positive feedback when the client makes constructive changes or progress.

With the guidance of their supervisor and in collaboration with the BHH team, the qualified health home specialist is the primary entity responsible for the health and wellness promotion services and assists the BHH systems navigator in coordinating care, serving as the secondary entity responsible for care coordination services.

The qualified health home specialist is responsible for providing individual and family support services on a regular basis for overall client needs. The qualified health home specialist may contribute to the provision of the comprehensive transitional care and referral to community and social support services. Qualified health home specialists are also available to conduct wellness groups as appropriate contingent on their individual training. There may be multiple qualified health home specialists dependent on the size of the BHH.

Team Member: Consulting Physicians

Required Qualification

- Primary care physician
- Psychiatrist
- Psychologist
- Specialized MD/ therapist

Roles and Responsibilities

The consulting physician is not a required team member but rather an option contingent on the needs of the client. The consulting physician is responsible for ongoing case consultation and recommendations for the health action plan and may contribute to the provision of BHH services through case consultation.

Team Member: External Professionals

Required Qualification

Professionals from organizations that provide:

- Housing
- Food
- Special education
- Criminal/justice system
- Chemical dependency
- Respite care
- Social support services
- Employment services

Roles and Responsibilities

The external professional is not a required team member but rather an option contingent on the needs of the client. As needed and appropriate, external professionals will provide recommendations for the health action plan and ongoing consultation, and may contribute to the provision of BHH services through case consultation.

Health Home Monitoring, Quality Improvement and Performance Measures

There are specific state monitoring, quality improvement reporting, and evaluation requirements expected under the federal health home provision. In addition, DHS has identified further performance measures to demonstrate outcomes for those served by BHH and to monitor service providers.

Monitoring

DHS will ensure there is a defined methodology, including data sources and measurement specifications, for:

- Tracking avoidable hospital readmissions
- Calculating cost savings that result from improved chronic disease management, and
- Tracking the use of health information technology in providing health home services to improve coordination and management of care and consumer adherence to recommendation made by their provider.

Quality Improvement

As part of the continuous quality improvement process, DHS is required to report on a set of CMS quality measures including:

- reduction in hospital admissions,
- emergency room visits, and
- skilled nursing facility admissions.

Evaluation

DHS must provide assurance that it will report to CMS information submitted by behavioral health home providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act as described by CMS. DHS must also assure the completion of a state evaluation that assesses the impact of behavioral health home services on consumer and family experience; health care utilization, and costs.

Additional State Performance Measures

DHS must create a set of performance measures specific to the targeted populations of adults and children with serious mental illness. These measures will include:

- Follow-up after hospitalization for mental illness,
- Use of Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Services Intensity Instrument (ECSII),
- Consumer experience of care,
- Use of routine and preventative primary care,
- Use of dental care,
- Well-child physician visits,
- Screening for alcohol and other drug use, and
- Depression remission using PHQ-9 for adults.

State Plan Amendment

The Medicaid Health Home State Plan Option, authorized under the Affordable Care Act (Section 2703), allows states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions, of which serious mental illness is an identified chronic condition. States are required to submit a State Plan Amendment (SPA) and enter into negotiations the Centers for Medicare and Medicaid Services (CMS). Services may not begin until federal approval is obtained.

The BHH SPA is in draft form and will be posted for public comment in February 2015. DHS is scheduled to submit the SPA in 2nd quarter of 2015. As noted previously, DHS must also obtain a legislative appropriation to implement the proposal as currently developed. If the legislative proposal does not move forward this legislative session the model, services, and payment must fit under the existing Health Care Program.

Fiscal Analysis

A 2013 program utilization and claims analysis identified that approximately 109,644 people in Minnesota Health Care Programs (MHCP) met criteria of SMI, SPMI, and SED. As noted previously, BHH services are voluntary and an individual cannot receive duplicative case management/care coordination services such as target case management (TCM), home and community base waived case management (HCBS), or Assertive Community Treatment (ACT). This same analysis determined that

23,334 people received TCM, 16,388 received HCBW services, and 1,931 received services through ACT. This leaves a total of 73,212 individuals who are potential consumers of BHH services.

Our goals within the Olmstead Plan include:

- By January 1, 2017, 15% (10,981) of eligible individuals will choose to access care through this model;
- By January 1, 2018, 20% (14,642) of eligible individuals will choose to access care through this model;
- By January 1, 2019, 25% (18,303) of eligible individuals will choose to access care through this model.

Our original timeline had Minnesota implementing BHH services on July 1, 2015; however, the Governor's budget proposal pushes back the start time of BHH services by six months to January 1, 2016. The fiscal estimate, with an effective date of January 1, 2016, has a net cost to the General Fund of \$6.9 million in the FY2016-17 biennium and \$23.8 million in the FY2018-19 biennium once the federal match is no longer 90%.

MHCP claims data indicate that persons meeting the criteria to be served in a behavioral health home are very expensive relative to other consumers. Even after removing costs for behavioral health and chemical dependency services, long term care services, and access services, those meeting the criteria for behavioral health homes have an additional \$4,100 in annual professional, inpatient hospital, and pharmacy claims when compared with other consumers. The services offered under this proposal are expected to reduce this difference in cost.

A legislative appropriation is necessary to provide the administrative dollars necessary to develop the operation framework including MMIS system changes, certification portal, contractual reporting mechanism's necessary to allow designated providers to report on all mandated quality measures and state required outcome measures.

Conclusion

The implementation of behavioral health homes is a first step in the development of a framework to provide services in a person-centered system of care. This framework will facilitates access to and coordination of the full array of primary, acute, and behavioral health care and findings from implementation will be used determine populations to serve under subsequent models.

For More Information

For additional information, please contact Jennifer Blanchard at Jennifer.Blanchard@state.mn.us

Appendix A

Minnesota Behavioral Health Home Planning and Community Engagement

Preliminary Report- Final Report Available March 2015

By the Department of Human Services in partnership with National Alliance on Mental Illness (NAMI) Minnesota

12/15/2014

Background:

The Community Supports and Health Care Administrations of Minnesota's Department of Human Services (DHS) are working together to design a Behavioral Health Home (BHH) model which will operate under a "whole person" philosophy and assure access to and coordinated delivery of primary care and behavioral health services for adults and children with serious mental illness.

DHS is developing a framework that will require a standard of integrated care which encompasses mental, behavioral, physical health conditions and considers the influence of multiple conditions, social factors, social function, and consumer preferences to personalize assessment, treatments, and goals of care. DHS believes that more integrated care, regardless of setting, contributes to improved health and decreases the risk of adverse outcomes, including hospital admissions. DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality. DHS may build on this framework to serve other complex populations in the future.

Methods:

In planning the Minnesota Behavioral Health Homes (BHH), the Department of Human Services has contracted with the National Alliance on Mental Illness (NAMI) Minnesota to engage people living with mental illness across the State in an opportunity to shape policy. Through their participation in focus groups, Medicaid participants from a very wide range of communities are providing feedback on topics that will inform the development of Minnesota's Behavioral Health Home model. The focus group questions concentrate on topics such as: accessing physical and mental health care, transition of care experiences, methods of obtaining health information, opinions surrounding the facets of integrated care, the ways in which individual, cultural, spiritual, and gender values should be incorporated into the care process.

This report provides an overview of focus groups completed to date. Focus groups began in September 2014 and at this time, 22 focus groups have been conducted, reaching 182 individuals with mental illness, family members, and transition aged youth. Please see table 1 for details. A total of 28 focus groups were scheduled, six groups were rescheduled; five for non-attendance and one due to inclement weather. In total, eight additional focus groups are scheduled to be conducted and two non-English focus group transcripts are pending translation. The final report will include a detailed analysis of the data and recommendations for its integration within BHH policy.

Results:

Initial analysis of focus group data reveals the following themes:

Relationship: Trust and relationships with providers were the most salient themes that have emerged across all focus groups thus far. Having a good relationship with providers was identified as affecting the following: fostering trust, receiving appropriate care, increased follow-through with care plans, increased medication adherence, and increased hope for recovery.

Trust: Most focus group participants mentioned trust as an important component in determining issues such as: when and how care was accessed, level of disclosure to providers, perceived level of personal wellness one has the ability to achieve, the quality of provider recommendations, and the likelihood of their adherence to their provider's recommendations. In each of the focus groups, participants discussed factors that either cultivated or impeded trust between them and their health providers. The following factors were consistently identified as contributors to building trust: providers asking questions about the whole person instead of just focusing on the illness, providers sharing information about themselves, providers actively listening, providers taking time to give and discuss information (rather than simply providing pamphlets), and found to be most important, was the perception that the providers cared. In contrast, the following factors were identified as impeding trust: provider rushing appointments, not being listened to (identified as a sign that providers didn't care), providers recommending medications without enough perceived participant input or information, and providers recommending medications without the discussion of other treatments.

Barriers to Wellness and Care: The following elements were discussed as the barriers that impede a participant's ability to receive effective medical care and manage their needs: wait times, cost, previous negative experiences, emergency room use when not connected to a primary care provider and being barred from making appointments or using the ER when money is owed. Many participants reported negative experiences with care where they felt stereotyped, disrespected, or where medical issues were dismissed by providers as a symptom of their mental illness.

Barriers that impeded participant's ability to receive effective mental health care included: unavailability of appointments when needed, lack of providers, lack of systems to respond to an emerging crisis, inadequate transition services and planning, HIPAA regulations that prevent families/support network from being involved in care or being given information, and lack of a care system for mental illnesses that are not yet crisis's but are unmanageable by the consumer or family members.

Overall, similarities in positive and negative experiences were loosely based on location, cultural group, and age. In two focus groups a particular service provider was spontaneously identified as a place where parallel positive experiences seemed to occur regularly. This hospital/clinic described by participants was structured and functioned in a manner similar to the projected Behavioral Health Home model and resulted in reported high levels of care, trust, wellness, adherence, and satisfaction.

Education: Most participants reported getting the majority of their information about health conditions or wellness on the internet, or by talking to a trusted friend, family member, or someone with the same experience. Many participants expressed a preference for getting health or mental health information from their providers but they had not had positive experiences in attempting to obtain it from them. Participants had experienced that providers did not have the time to give information to them or their family members in way where the implications of the information was discussed, but rather opted to give written information to be read at home.

Self-Advocacy: Adults and youth with mental illness along with their family members, all discussed the need for self-advocacy as a means for getting their needed care, needed support services, and

preferences considered in treatment planning. These participants discussed the distress they experienced by not knowing how to navigate the system, what questions to ask, or who to turn to for help. Individuals with mental illness voiced an inability to self-advocate at times. Additionally, they indicated that it was difficult to know that self-advocacy was needed when they were in crisis, when they were experiencing certain mental illness symptoms, or when they were experiencing chronic disease flare-ups. For many of them, the need to engage in self-advocacy occurred in response to situations where it was felt that providers were not listening, were not including information felt to be important, or were not making recommendations that aligned with their or their family's desires. Family members discussed experiencing a continuing need to advocate for the consumer while highlighting the stress they experience in researching their loved one's illness and exploring the possible systems and services that could be utilized for assistance.

Discussion and Recommendations:

These focus group findings exemplify a broad range of experiences, preferences, values and views that highlight the difficulty of addressing complex and diverse health needs in a model of services and systems meant to be universally responsive to diverse target populations. However, a number of practical recommendations identified in the spectrum of groups emerged. Practices such as increased appointment time for a new patient's first few appointments would allow the provider and patient to get to know each other better, thereby initiating a strong basis for trust within their future relationship. Simple behaviors such as new providers saying to patients, "I am going to be your doctor," and employing a practice of asking "get to know you" questions in addition to the "what is the problem" questions are believed to provide a fruitful set of initial discussions. Integrating the final focus groups and analyzing the data from the complete set will be fruitful terrain for additional recommendations grounded in consumer experience.

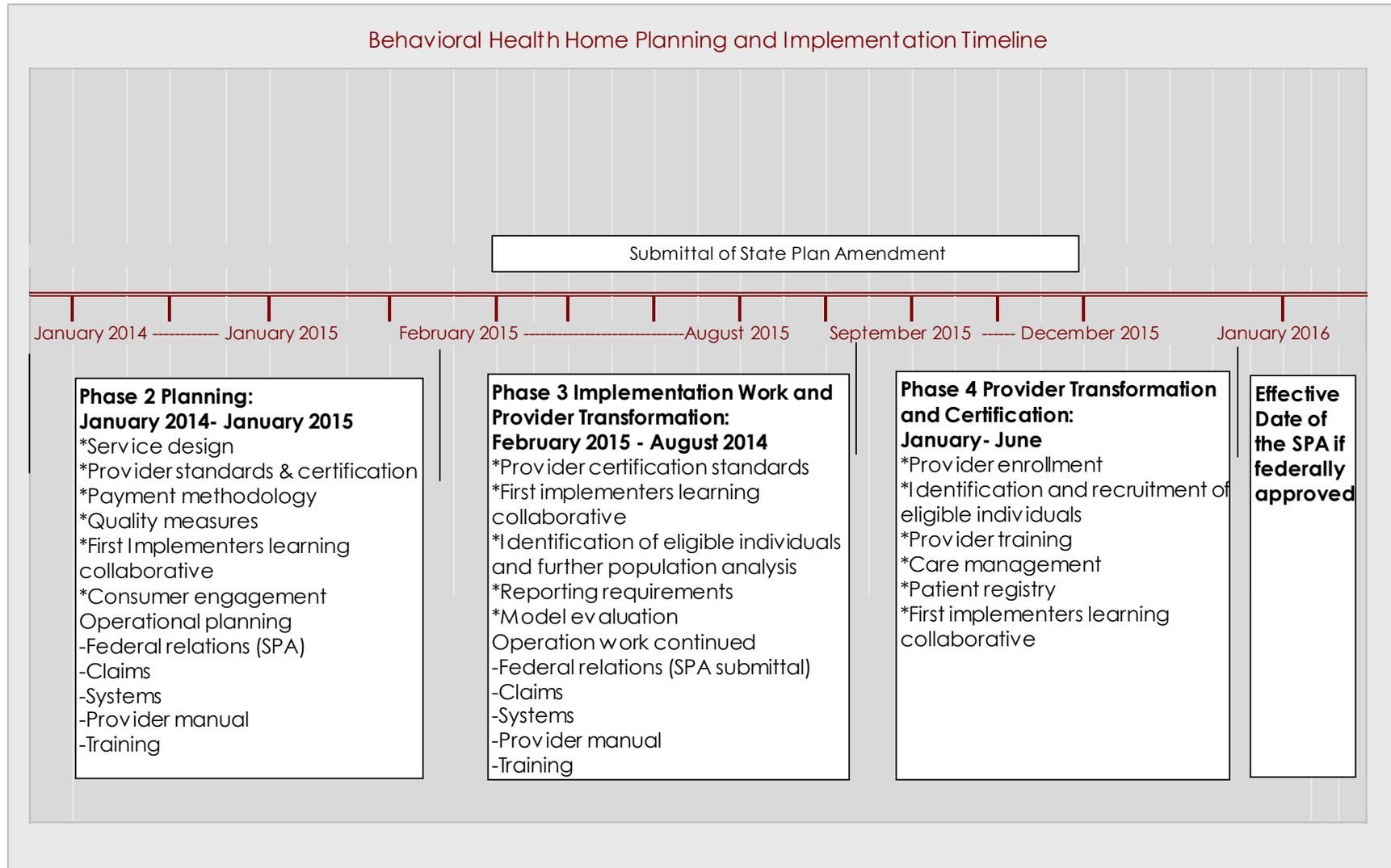
Conclusion:

The range of experiences elucidated in the completed and forthcoming focus groups will be further elaborated on in the final report due in March 2015. Additional information will include detailed demographics of the participants, more health discussion themes, specific examples of participant experiences, a full analysis of the data, and focused recommendations to implement within the BHH program. This data has the potential to be extremely valuable not only for this program, but for anyone providing health services for this population.

Table 1:

Adult Participants			
Subgroup	Date	Location	# Attending
Spanish Speaking	11/18/2014	Centro Cultural Center	22
Russian	12/9/2014	Jewish Family Center	8
Veterans	11/18/2014	St. Cloud Library	6
Criminal Justice	10/14/2014	Phillis Wheatley Community Center	4
Criminal Justice	10/15/2014	Phillis Wheatley Community Center	4
African American	10/24/2014	Ujamaa	8
Homeless	10/19/2014	St. Stephens	22
Bemidji (Northwest region)	10/6/2014	Hope House	8
Brainard (Central region)	10/14/2014	1 st Lutheran	16
Worthington (Southwest)	10/28/2014	Southwest Mental Health	7
Winona (Southeast)	11/3/2014	Connection Support Group	35
Hoffman (Western)	12/10/2014	Hoffman Community Center	10
Hmong Elders	12/16/2014	Park Ave Elder Center	11
Transition-Age Youth			
Subgroup	Date	Location	# Attending
Homeless/American Indian	10/20/2014	Aun Dah Yun	5
Homeless	10/24/2014	The link	2
Spanish Speaking	10/26/2014	Aqui Para Ti	2
Brainard (Central Region)	10/14/2014	Northern Pines Youth Act	8
Duluth (Northeast)	11/6/2014	Amberwing	4
Family Members			
Subgroup	Date	Location	# Attending
Parents with Mental Illnesses	10/27/2014	Phillis Wheatley	3
Bemidji (Northwest region)	10/6//2014	Hope House	5
Worthington (Southwest)	10/28/2014	SW Mental Health	7
Duluth (Northeast)	11/6/2014	Amberwing	2

Appendix B



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EXHIBIT 6-26: HC 2G – BASELINE DATA FOR CURRENT CARE

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Olmstead Plan: Baseline Data for Current Care

Health Care Research and Quality
January 2015

For more information contact:

Minnesota Department of Human Services
Health Care Research and Quality
P.O. Box 64986
St. Paul, MN 55164-2648
651-431-2648

Executive Summary

On January 28, 2013, Governor Mark Dayton issued an executive order establishing an Olmstead Sub-Cabinet to develop and implement a comprehensive Minnesota Olmstead Plan. The main purpose of the Olmstead Plan is to move the state forward, towards greater integration and inclusion for people with disabilities.

In accordance with objective 2G under the Healthcare and Healthy Living section of the Olmstead Plan¹, the Health Care Research and Quality (HRQ) Division within the Minnesota Department of Human Services has established baseline data for current care of people with disabilities. Specifically, baseline data for health care service use are being reported for medical, dental, chiropractic, and mental health care, for persons with and without disabilities enrolled in Minnesota's Medical Assistance (MA) program. The source of the data in this report is Minnesota Health Care Programs paid claims data, which does not include Medicare claims data.

HRQ selected several measures of health care utilization from the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HRQ also created measures for chiropractic care and certified peer support services.

Specific measures were chosen for three age groups: children aged 0-20, adults aged 21-64, and seniors aged 65 and older. For each measure examined, the rate of service use by MA enrollees with disabilities was compared with the rate of service use by MA enrollees without disabilities.

The findings are summarized below:

- Across all age groups, 48.3% percent of all comparisons (14 out of 29 comparisons) showed significantly *greater* service use among persons with disabilities than persons without disabilities.
 - For children, this percentage was 45.5% (5 out of 11 comparisons).
 - For adults under 65, this percentage was 63.6% (7 out of 11 comparisons).
 - For seniors 65 and older, this percentage was 28.6% (2 out of 7 comparisons).
- Across all age groups, 20.7% percent of all comparisons (6 out of 29) showed significantly *less* service use among persons with disabilities than persons without disabilities.
 - For children, this percentage was 27.3% (3 out of 11 comparisons).
 - For adults under 65, this percentage was 9.1% (1 out of 11 comparisons).
 - For seniors 65 and older, this percentage was 28.6% (2 out of 7 comparisons).
- Across all age groups, 31.0% percent of all comparisons (9 out of 29 comparisons) had non-significant differences in service use between the disabled and non-disabled populations.
 - For children, this percentage was 27.3% (3 out of 11 comparisons).
 - For adults under 65, this percentage was 27.3% (3 out of 11 comparisons).
 - For seniors 65 and older, this percentage was 42.9% (3 out of 7 comparisons).

¹ The approved version of the Olmstead Plan as of November 2013 can be seen at the following location: [Olmstead Plan](#)

In general, MA enrollees with disabilities used health care services at rates equal to or higher than MA enrollees without disabilities. This trend was more apparent among adults under 65, than among children and seniors over 65.

Introduction

On January 28, 2013, Governor Mark Dayton issued an executive order establishing an Olmstead Sub-Cabinet to develop and implement a comprehensive Minnesota Olmstead Plan. The main purpose of the Olmstead Plan is to move the state forward, towards greater integration and inclusion for people with disabilities.

This report presents baseline data for current health care of people with disabilities, in accordance with Objective 2G under the Healthcare and Healthy Living section of the Olmstead Plan. The Health Care Research and Quality (HRQ) Division of the Department of Human Services selected utilization measures of four different types of health care: medical, dental, chiropractic, and mental health. These measures are reported for persons enrolled in the Medical Assistance (MA) program. Rates of health care service use by MA enrollees with disabilities, or who are very likely to have disabilities, are compared with rates of service use by MA enrollees without disabilities.

Overview of Population

The population in this report includes all individuals who were enrolled in the MA program for at least one month during Calendar Year 2013. Individuals were placed into one of three age groups, according to their age as of December 31, 2013. Individuals aged 0-20 were classified as children. Individuals aged 21-64 were classified as adults. Finally, individuals 65 and older were classified as seniors.

MA enrollees were categorized by disability status, with each individual classified as either having a disability, or not having a disability. The classification of an individual by disability status was performed based on the eligibility type associated with MA enrollment, and the score the individual received on an algorithm used by DHS to identify persons who are highly likely to have a disability.

Additionally, the definition for disability included additional components for the children and seniors. Specifically, children were classified as having a disability if they had a paid Minnesota Health Care Programs claim during Calendar Year 2013 with one or several specified diagnosis codes or billing codes indicating a disabling condition or functional limitations. Seniors aged 65 and older were classified as having a disability based on scores on an assessment of their ability to carry out activities of daily living. Details of all three age-specific disability definitions can be found in Appendices A- C.

Overview of Utilization Measures

This report includes 17 measures of health care service use selected by HRQ based on their relevance to the domains of care specified in the Olmstead Plan. Fifteen measures in this report were developed by the National Committee for Quality Assurance (NCQA) and are known as Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS is a national set of standardized performance measures originally designed for the managed care industry. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

For more information on methods and technical specification of HEDIS measures, see the link below² from the National Committee for Quality Assurance (NCQA). Importantly, HEDIS is considered the gold standard in health care performance measurement. The 15 HEDIS measures included in this report are as follows:

² These materials can be seen at the following location: [Measuring quality. Improving health care](#)

- Adults Access to Preventive/Ambulatory Health Services (AAP)
- Comprehensive Diabetes Care (CDC)
- Colorectal Cancer Screening (COL)
- Cholesterol Management for Patients With Cardiovascular Conditions (CMC)
- Breast Cancer Screening (BCS)
- Annual Dental Visit (ADV)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Childhood Immunization Status (CIS)
- Human Papillomavirus Vaccine for Female Adolescents (HPV)
- Appropriate Treatment for Children With Upper Respiratory Infection (URI)
- Follow-Up After Hospitalization for Mental Illness: 7-Days (FUH-7 Days)
- Follow-Up After Hospitalization for Mental Illness: 30-Days (FUH-30 Days)

There were a number of factors that led HRQ to choose these particular HEDIS measures for certain age groups in this report. First, while there are many HEDIS measures, DHS currently only reports on a subset of 26 of these measures. DHS does not report on any of the hybrid HEDIS measures, which require resources for medical chart review. Second, many HEDIS measures are age-specific, and are not appropriate to report for all age groups. For example, the HEDIS measure "Childhood Immunization Status" references only children who are two years of age, and is not reported for adults or seniors. Similarly, the HEDIS measure "Colorectal Cancer Screening" is only reported for individuals who are between 50 and 75 years of age.

Finally, HRQ chose to focus on measures of the use of preventive, primary care, and screening services. These measures are consistent with the Olmstead Plan goals to support overall good health of people with disabilities, and to increase the health of people with disabilities so that the rates of chronic diseases such as heart disease and diabetes are comparable to the rates of those people without disabilities.

One domain of care that is explicitly mentioned in the Olmstead Plan, chiropractic care, did not have an associated HEDIS measure. Consequently, HRQ developed a measure for the use of chiropractic care that measures how many persons received an evaluation or a manipulation from a chiropractor over the course of a calendar year.

This report also includes a measure of the utilization of Certified Peer Support Services for mental health that was developed by HRQ, and is reported for adults under 65. A full description of Certified Peer Support Services can be found on the DHS website³. The number of MA enrollees receiving Certified Peer Support Services during Calendar Year 2013 was extremely small. However, individuals with disabilities were much more likely to receive these services than individuals without disabilities (see Figure 10).

³[Certified Peer Support Services](#)

Limitations

This report contains limitations that should be noted with respect to the interpretation of the report. Importantly, the source of the data in this report is Minnesota Health Care Programs paid claims data, which does not include Medicare claims data. Therefore, for persons who are dually enrolled in both MA and Medicare, use of health care services that are covered by Medicare may be underreported. This underreporting is expected to impact the rates reported for persons with disabilities in this report, but not the rates for persons without disabilities.

It should also be noted that this report addresses issues involving service use, which is not directly correlated with healthcare access. Therefore, conclusions about differences in healthcare access cannot be obtained from observation of differences in service use.

For More Information

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Table 1. Health care service use measures for children aged 0-20, Calendar Year 2013

Measure	Service use rates		Number of persons in numerator		Number of persons in denominator	
	Disability	Non-Disability	Disability	Non-Disability	Disability	Non-Disability
Well-Child Visits in the First 15 Months of Life	55.0%	57.0%	400	7,073	727	12,418
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life†	56.5%	60.1%	3,505	20,266	6,206	33,703
Adolescent Well-Care Visits	33.9%	32.9%	4,967	16,281	14,668	49,558
Children and Adolescents' Access to Primary Care Practitioners*	93.7%	89.9%	26,008	101,579	27,751	112,976
Childhood Immunization Status: Combination 3*	73.2%	66.0%	542	6,215	740	9,411
Human Papillomavirus Vaccine for Female Adolescents	17.3%	18.7%	125	680	722	3,638
Appropriate Treatment for Children With Upper Respiratory Infection†	88.2%	91.0%	3,620	24,383	4,105	26,799
Annual Chiropractic Evaluation*	3.2%	2.6%	1,653	9,964	52,138	386,828
Annual Dental Visit†	50.7%	54.9%	16,360	72,372	32,272	131,786

Measure	Service use rates		Number of persons in numerator		Number of persons in denominator	
	Disability	Non-Disability	Disability	Non-Disability	Disability	Non-Disability
Follow-Up After Hospitalization for Mental Illness: 7 days*	27.5%	19.3%	455	293	1,654	1,521
Follow-Up After Hospitalization for Mental Illness: 30 days*	50.8%	36.6%	841	557	1,654	1,521

Note 1: * denotes there was a significant difference between the two populations at $\alpha = .01$, with greater service use by persons with disabilities.

Note 2: † denotes there was a significant difference between the two populations at $\alpha = .01$, with greater service use by persons without disabilities.

Table 2. Health care service use measures for adults aged 21-64, Calendar Year 2013

Measure	Service use rates		Number of persons in numerator		Number of persons in denominator	
	Disability	Non-Disability	Disability	Non-Disability	Disability	Non-Disability
Cervical Cancer Screening [†]	52.0%	68.5%	21,393	27,245	41,115	39,797
Adults' Access to Preventive/Ambulatory Health Services*	95.0%	87.3%	87,656	63,623	92,317	72,846
Cholesterol Management for Patients with Cardiovascular Conditions	76.6%	81.1%	1,589	340	2,075	419
Breast Cancer Screening	61.4%	58.8%	7,041	1,579	11,468	2,687
Comprehensive Diabetes Care	75.4%	74.2%	13,529	3,839	17,953	5,172
Colorectal Cancer Screening*	54.9%	41.1%	13,030	3,188	23,737	7,749
Annual Dental Visit*	48.2%	40.6%	44,461	29,605	92,317	72,846
Annual Chiropractic Evaluation*	8.9%	7.7%	12,458	21,605	139,732	282,324
Follow-Up After Hospitalization for Mental Illness: 7-Day*	23.3%	15.3%	1,986	250	8,511	1,639
Follow-Up After Hospitalization for Mental Illness: 30-Day*	48.5%	29.6%	4,124	485	8,511	1,639
Certified Peer Services*	0.24%	0.01%	342	30	139,732	282,324

Note 1: * denotes there was a significant difference between the two populations at $\alpha = .01$, with greater service use by persons with disabilities.

Note 2: † denotes there was a significant difference between the two populations at $\alpha = .01$, with greater service use by persons without disabilities.

Table 3. Health care services use measures for seniors aged 65 and older, Calendar Year 2013

Measure	Service use rates		Number of persons in numerator		Number of persons in denominator	
	Disability	Non-Disability	Disability	Non-Disability	Disability	Non-Disability
Adults' Access to Preventive/Ambulatory Health Services*	95.4%	91.9%	28,643	14,547	30,036	15,833
Cholesterol Management for Patients with Cardiovascular Conditions	76.2%	79.5%	921	431	1,209	542
Breast Cancer Screening†	52.2%	55.3%	2,626	1,536	5,035	2,777
Comprehensive Diabetes Care†	76.6%	80.2%	3,797	1,752	4,956	2,185
Colorectal Cancer Screening*	52.0%	48.6%	4,717	2,900	9,069	5,968
Annual Dental Visit	35.2%	34.1%	10,587	5,403	30,036	15,833
Annual Chiropractic Evaluation	4.3%	4.5%	1,872	1,087	43,435	24,332
Follow-Up After Hospitalization (FUH) for Mental Illness: 7 days	21.3%		66		309	
Follow-Up After Hospitalization (FUH) for Mental Illness: 30 days	41.1%		127		309	

Note 1: * denotes there was a significant difference between the two populations at $\alpha = .01$, with greater service use by persons with disabilities.

Note 2: † denotes there was a significant difference between the two populations at $\alpha = .01$, with greater service use by persons without disabilities.

Note 3: Percentages and significance testing was not conducted for FUH for the non-disabled population due to an extremely small sample.

Adults' Access to Preventive/Ambulatory Health Services

Medical Care Measure: Calendar Year 2013

Adults' Access to Preventive/Ambulatory Health Services (AAP) measures the percentage of individuals who had an ambulatory or preventive care visit.

Individuals included in the denominator of the AAP measure met the following criteria:

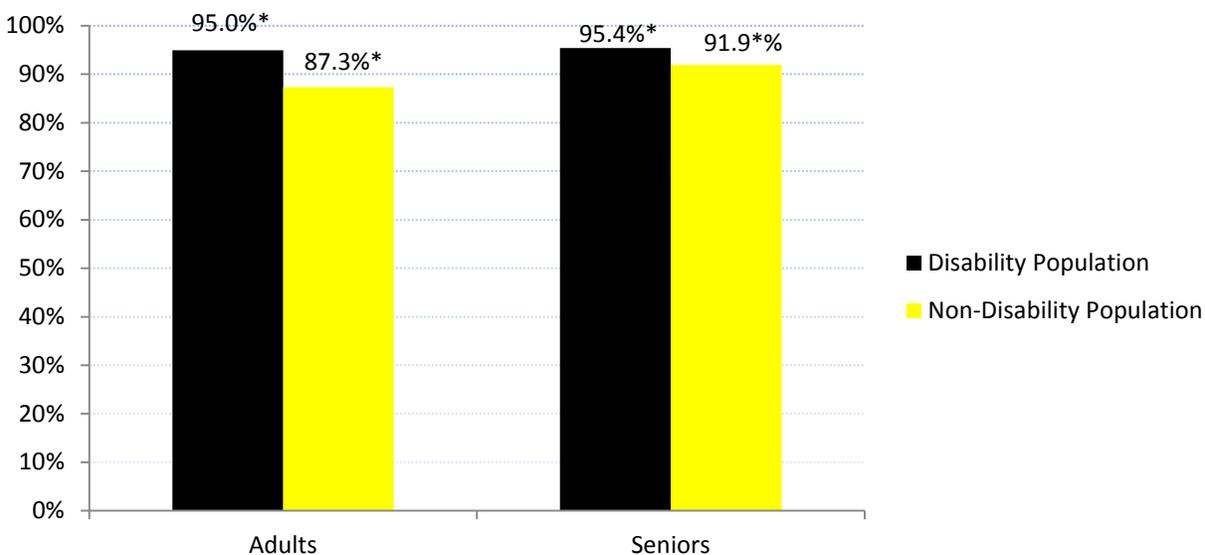
- Individuals age 21-64 (adults) or 65 and older (seniors) as of December 31, 2013.
- Continuously enrolled during the measurement year 2013. Medicaid beneficiaries may not have more than a single month gap in enrollment.

In the calendar year 2013, within the population of seniors, approximately 95 percent of persons with disabilities received an ambulatory or preventive care visit. By contrast, approximately 92 percent of persons without disabilities received such a visit. This difference was statistically significant.

In the calendar year 2013, within the population of adults under age 65, approximately 95 percent of persons with disabilities received an ambulatory or preventive care visit. By contrast, approximately 87 percent of persons without disabilities received such a visit. This difference was also statistically significant.

Figure 1 below shows a graph comparing the rate of Adults' Access to Preventive/Ambulatory Health Services by age group and disability status.

Figure 1: Utilization Rates for Adults' Access to Preventive/Ambulatory Health Services by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Cholesterol Management for Patients with Cardiovascular Conditions

Medical Care Measure: Calendar Year 2013

Cholesterol Management for Patients With Cardiovascular Conditions (CMC) measures the percentage of individuals who were discharged alive for acute myocardial infarction (AMI, heart attack), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year:

- LDL-C screening.
- LDL-C control (<100 mg/dL).

Individuals included in the denominator of the CMC measure met the following criteria:

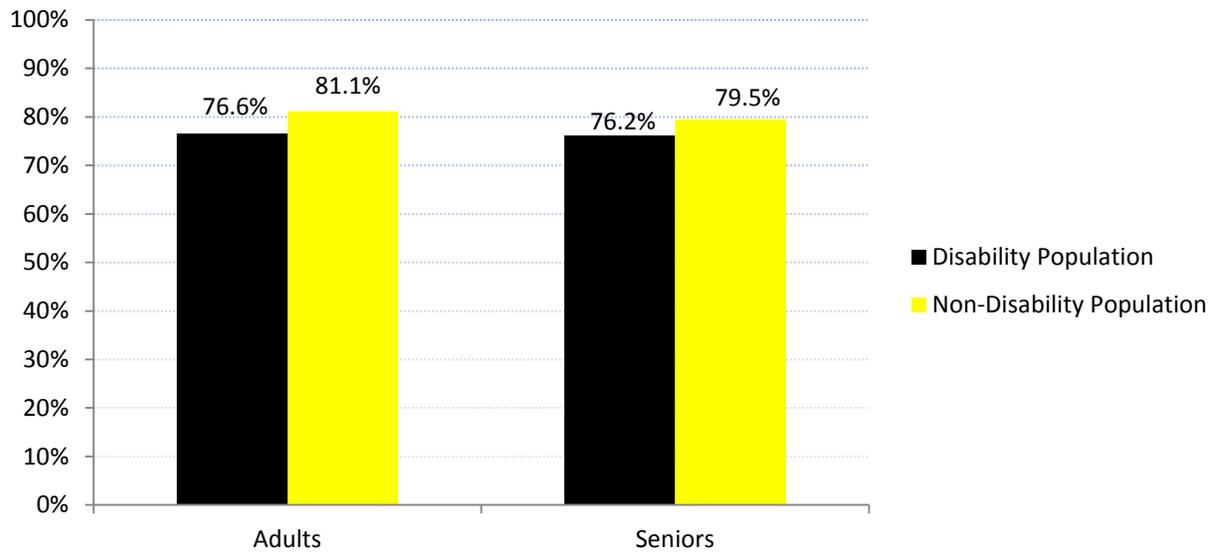
- Individuals age 21-64 (adults) or 65-75 (seniors) as of December 31, 2013.
- Continuously enrolled during the measurement year 2013 and the year prior. Medicaid beneficiaries may not have more than a single month gap in enrollment.
- Possessed at least one of the following:
 1. Discharged alive from an acute inpatient setting with an AMI.
 2. Discharged alive from an acute inpatient setting with a CABG.
 3. Members who had PCI in any setting.

In the calendar year 2013, within the population of seniors, approximately 76 percent of persons with disabilities received adequate cholesterol management. By contrast, approximately 80 percent of persons without disabilities received adequate cholesterol management. This difference was not statistically significant.

In the calendar year 2013 within the population of adults under 65, approximately 77 percent of persons with disabilities received adequate cholesterol management. By contrast, approximately 81 percent of persons without disabilities received adequate cholesterol management. This difference was also not statistically significant.

Figure 2 below shows a graph comparing the rate of Cholesterol Management for Patients with Cardiovascular Conditions by age group and disability status.

Figure 2: Utilization Rates for Cholesterol Management for Patients with Cardiovascular Conditions by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Breast Cancer Screening

Medical Care Measure: Calendar Year 2013

Breast Cancer Screening (BCS) measures the percentage of women who had a mammogram to screen for breast cancer during the measurement year.

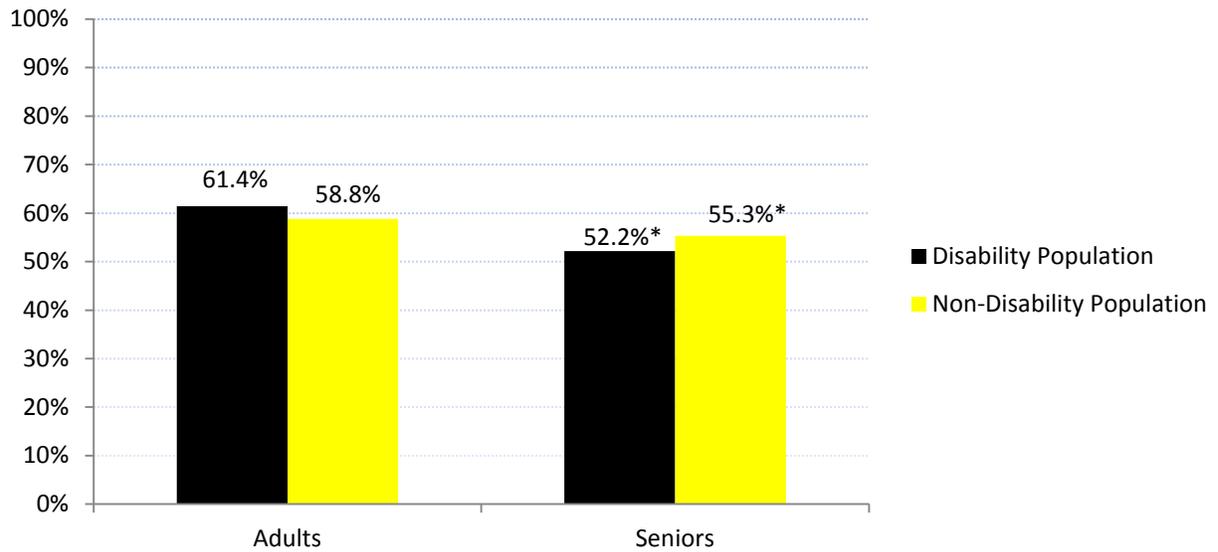
Individuals included in the denominator of the BCS measure met the following criteria:

- Women age 21-64 (adults) or 65-74 (seniors) as of December 31, 2013.
- Continuously enrolled October 1 two years prior to the measurement year through December 31 of the measurement year. Medicaid beneficiaries may not have more than a single month gap in enrollment.

In the calendar year 2013, within the population of seniors, approximately 52 percent of women with disabilities received a breast cancer screening. By contrast, approximately 55 percent of women without disabilities received a breast cancer screening. This difference was statistically significant.

In the calendar year 2013 within the population of adults under 65, approximately 61 percent of women with disabilities received a breast cancer screening. By contrast, approximately 59 percent of women without disabilities received a breast cancer screening. This difference was not statistically significant.

Figure 3 below shows a graph comparing the rate of Breast Cancer Screening by age group and disability status.

Figure 3: Utilization Rates for Breast Cancer Screening by Age Group and Disability Status

Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Cervical Cancer Screening

Medical Care Measure: Calendar Year 2013

The Cervical Cancer Screening (CCS) measure the percentage of women who were screened for cervical cancer. Both of the following meet the criteria for such a screening:

- Women age 21-64 who had cervical cytology performed every 3 years.
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

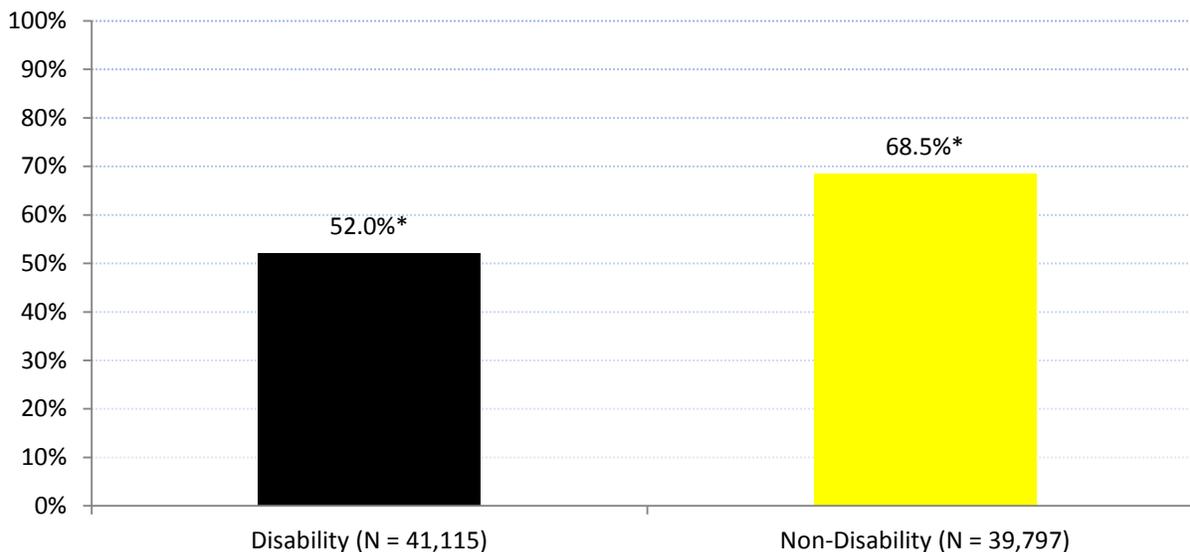
Individuals marked for inclusion in the denominator of the CCS measure met the following criteria:

- Women age 21-64 as of December 31, 2013.
- Continuously enrolled during the measurement year 2013. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, approximately 52 percent of women with disabilities received a cervical cancer screening. By contrast, approximately 69 percent of women without disabilities received such a screening. This difference was statistically significant and the only adult measure where the persons with disabilities had significantly less representation than the non-persons with disabilities.

Figure 4 below shows a graph comparing the rate of Cervical Cancer Screening by disability status.

Figure 4: Utilization Rates for Cervical Cancer Screening by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Comprehensive Diabetes Care

Medical Care Measure: Calendar Year 2013

Comprehensive Diabetes Care (CDC) measures the percentage of individuals with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing

Individuals included in the denominator of the CDC measure met the following criteria:

- Individuals age 21-64 (adults) or 65-75 (seniors) as of December 31, 2013.
- Continuously enrolled during the measurement year 2013. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Individuals who were identified as having diabetes with at least one of the following methods:

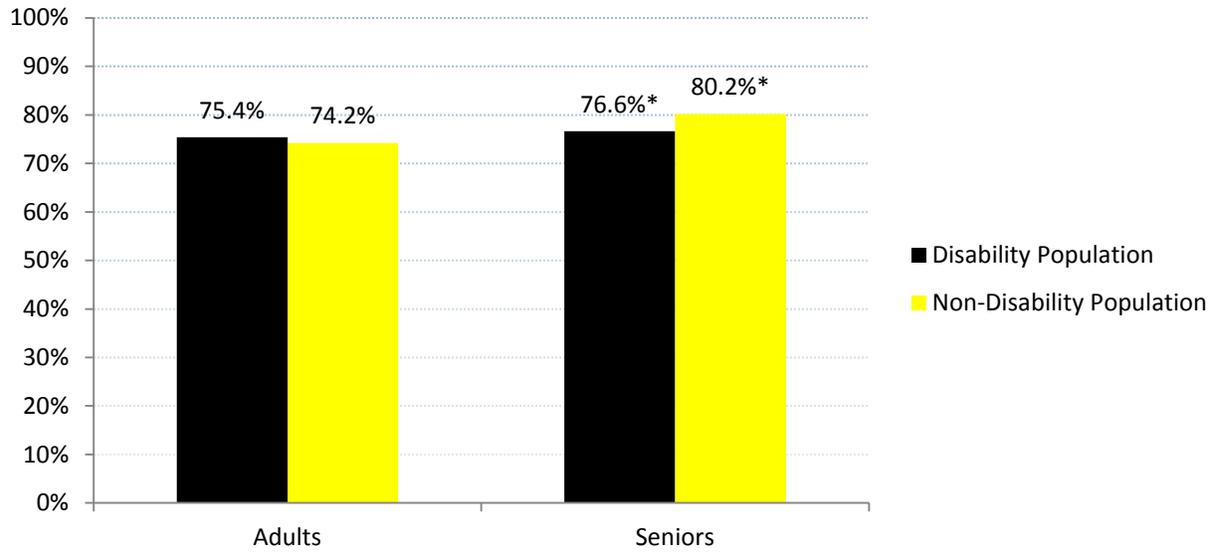
1. Possessed two or more outpatient or observation visits, or nonacute encounters on different dates of service with a diagnosis of diabetes.
2. At least one acute inpatient encounter with a diagnosis of diabetes.
3. At least one ED visit with a diagnosis of diabetes.
4. The individual was dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

In the calendar year 2013, within the population of seniors, approximately 77 percent of persons with disabilities received comprehensive diabetic care. By contrast, approximately 80 percent of persons without disabilities received comprehensive diabetic care. This difference was statistically significant.

In the calendar year 2013, within the population of adults under 65, approximately 75 percent of persons with disabilities received comprehensive diabetic care. By contrast, approximately 74 percent of persons without disabilities received comprehensive diabetic care. This difference was not statistically significant.

Figure 5 below shows a graph comparing the rate of Comprehensive Diabetes Care by age group and disability status.

Figure 5: Utilization Rates for Comprehensive Diabetes Care by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Colorectal Cancer Screening

Medical Care Measure: Calendar Year 2013

The Colorectal Cancer Screening (COL) measure gives the percentage of individuals who received one or more screenings for colorectal cancer. Any of the following meet the criteria for such a screening:

- Fecal occult blood test during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

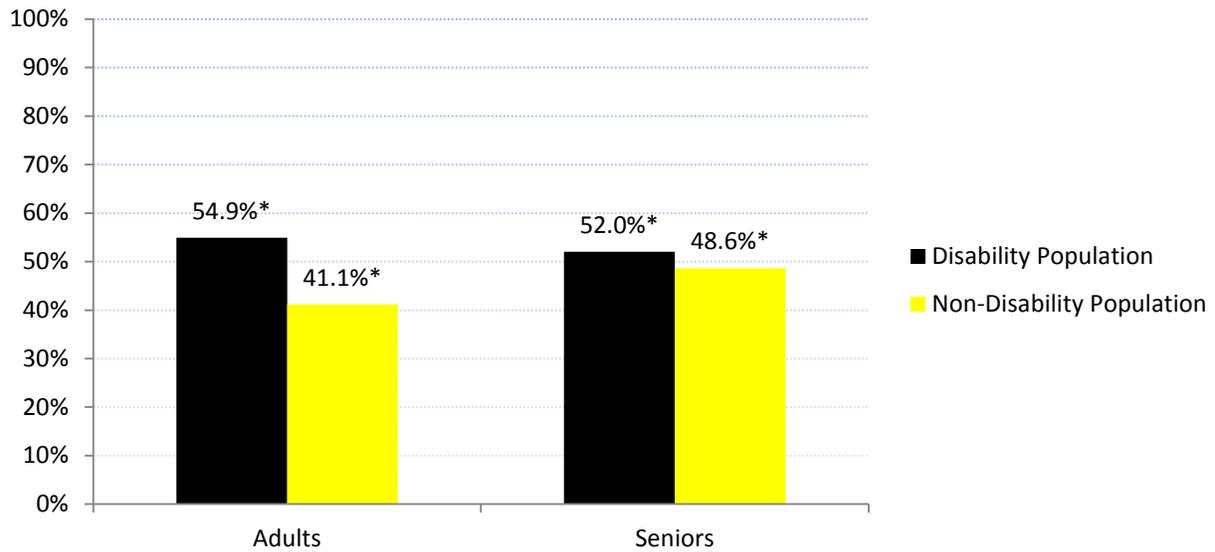
Individuals included in the denominator of the COL measure met the following criteria:

- Individuals age 21-64 (adults) or 65-75 (seniors) as of December 31, 2013.
- Continuously enrolled during the measurement year 2013 and the year prior. Medicaid beneficiaries may not have more than a single month gap in enrollment.

In the calendar year 2013 within the senior population, approximately 52 percent of persons with disabilities received a colorectal cancer screening. By contrast, approximately 49 percent of persons without disabilities received such a screening. This difference was statistically significant.

In the calendar year 2013 within the adult population, approximately 55 percent of persons with disabilities received a colorectal cancer screening. By contrast, approximately 41 percent of persons without disabilities received such a screening. This difference was statistically significant.

Figure 6 below shows a graph comparing the rate of Colorectal Cancer Screening by age group and disability status.

Figure 6: Utilization Rates for Colorectal Cancer Screening by Age Group and Disability Status

Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Annual Dental Visit

Dental Care Measure: Calendar Year 2013

Annual Dental Visit (ADV) measures the percentage of individuals who had at least one dental visit during the measurement year.

Individuals included in the denominator of the ADV measure met the following criteria:

- Individuals age 0-20 (children), 21-64 (adults), or 65 and older (seniors) as of December 31, 2013.
- Continuously enrolled during the measurement year 2013. Medicaid beneficiaries may not have more than a single month gap in enrollment.

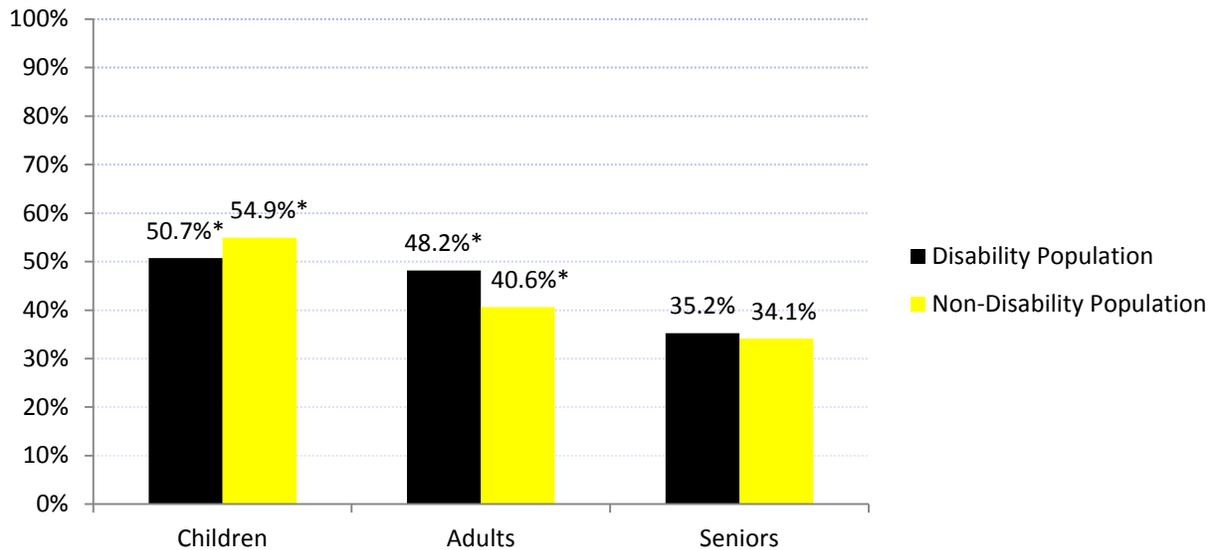
In the calendar year 2013, within the senior population approximately 35 percent of persons with disabilities received a dental visit. By contrast, approximately 34 percent of persons without disabilities received such a screening. This difference was not statistically significant.

In the calendar year 2013, within the adult population approximately 48 percent of persons with disabilities received a dental visit. By contrast, approximately 41 percent of persons without disabilities received such a screening. This difference was statistically significant.

In the calendar year 2013, within the child population approximately 51 percent of persons with disabilities received a dental visit. By contrast, approximately 55 percent of persons without disabilities received such a screening. This difference was statistically significant.

Figure 7 below shows a graph comparing the rate of Annual Dental Visit by age group and disability status.

Figure 7: Utilization Rates for Annual Dental Visit by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Annual Chiropractic Evaluation

Chiropractic Care Measure: Calendar Year 2013

Annual Chiropractic Evaluation (ACE) measures the percentage of individuals who had at least one chiropractic-related evaluation during the measurement year.

Individuals included in the denominator of the ACE measure met the following criteria:

- Individuals age 0-20 (children), 21-64 (adults), or 65 and older (seniors) as of December 31, 2013.
- Enrolled in Medical Assistance for at least one month during the calendar year 2013.
- Was associated with a procedure code that was in turn associated with evaluation services from a chiropractor or chiropractic manipulation during the measurement year 2013.

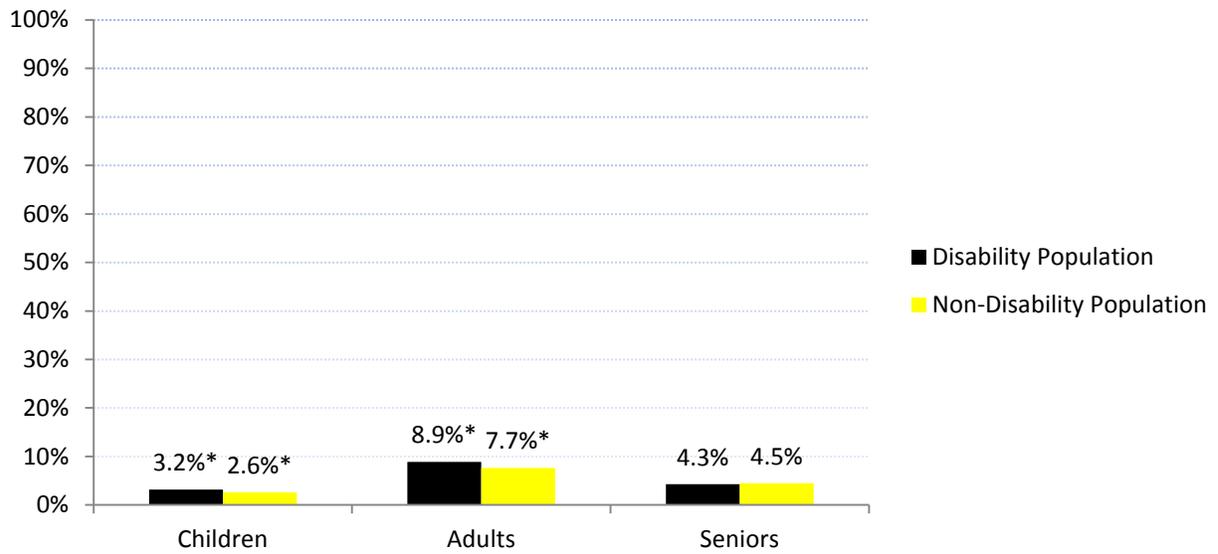
In the calendar year 2013, within the senior population, approximately 4.5 percent of persons with disabilities received a chiropractic evaluation. By contrast, approximately 4.3 percent of persons without disabilities received such an evaluation. This difference was not statistically significant.

In the calendar year 2013, within the adult population, approximately 8.9 percent of persons with disabilities received a chiropractic evaluation. By contrast, approximately 7.7 percent of persons without disabilities received a chiropractic evaluation. This difference was statistically significant.

In the calendar year 2013, within the child population, approximately 3.2 percent of persons with disabilities received a chiropractic evaluation. By contrast, approximately 2.6 percent of persons without disabilities received a chiropractic evaluation. This difference was statistically significant.

Figure 8 below shows a graph comparing the rate of Annual Chiropractic Evaluation by age group and disability status.

Figure 8: Utilization Rates for Annual Chiropractic Evaluation by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Follow-Up After Hospitalization for Mental Illness

Mental Health Care Measure: Calendar Year 2013

Follow-Up After Hospitalization for Mental Illness (FUH) measures the percentage of individuals who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 7 days of discharge.
- The percentage of discharges for which the member received follow-up within 30 days of discharge.

Individuals included in the denominator of the FUH measure met the following criteria:

- Individuals age 0-20 (children), 21-64 (adults), or 65 and older (seniors) as of December 31, 2013.
- Continuously enrolled during from the date of discharge through 30 days after discharge.
- Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement year.

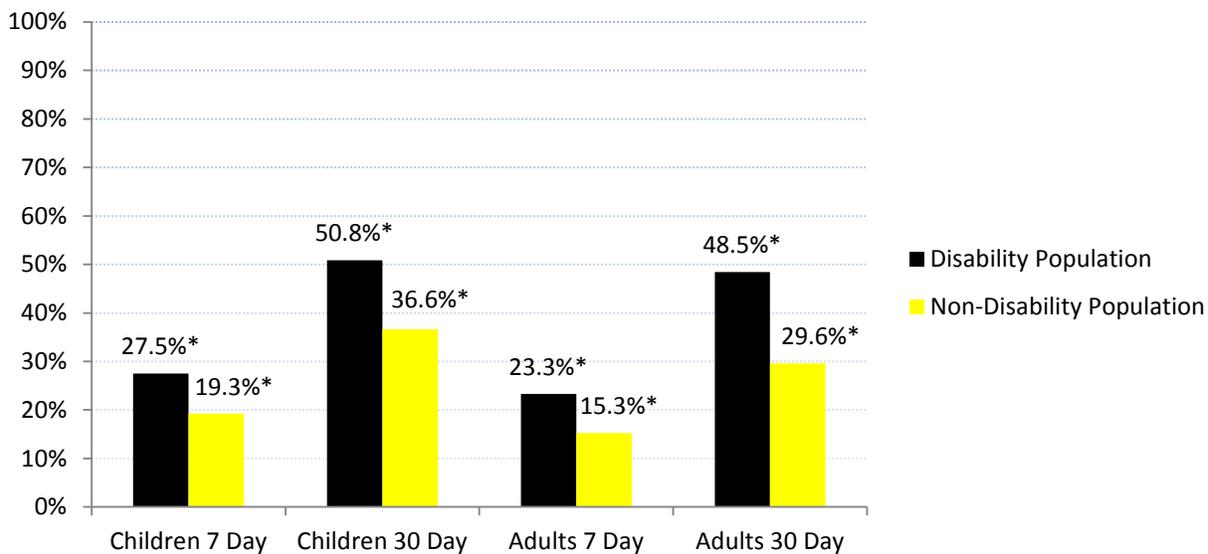
Within the calendar year 2013, approximately 28 percent of children and 23 percent of adults under 65 with disabilities received a follow-up within 7 days of discharge. By contrast, approximately 19 percent of children and 15 percent of adults under 65 without disabilities received a follow-up within 7 days of discharge. All differences were statistically significant.

Within the calendar year 2013, approximately 51 percent of children and 49 percent of adults under 65 with disabilities received a follow-up within 30 days of discharge. By contrast, approximately 37 percent of children and 30 percent of adults under 65 without disabilities received a follow-up within 30 days of discharge. All differences were statistically significant.

Within the calendar year 2013, approximately 21 percent of seniors with disabilities received a follow-up within 7 days of discharge (21.4%; Numerator= 66; Denominator=309). By contrast, within the calendar year 2013, approximately 41 percent of the seniors with disabilities received a follow-up within 30 days of discharge (41.1%; Numerator= 127; Denominator=309). Owing to the very small sample size of the FUH measure in the non-disabled population, comparisons with a non-disabled population could not be made for the senior age category.

Figure 9 below shows a graph comparing the rate of Follow-Up After Hospitalization for Mental Illness by age group and disability status.

Figure 9: Utilization Rates for Follow-Up After Hospitalization for Mental Illness by Age Group and Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Certified Peer Services

Mental Health Measure: Calendar Year 2013

The Certified Peer Support Services (CPS) measure gives the percentage of individuals who received self-help or peer services within the measurement year of 2013.

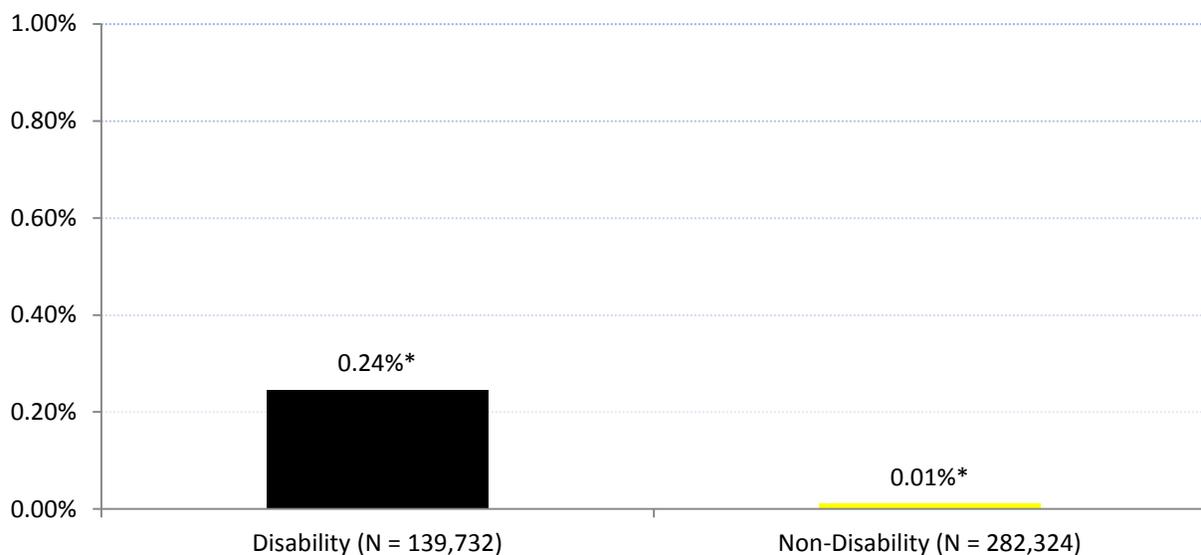
Individuals included in the denominator of the CPS measure met the following criteria:

- Individuals age 21-64 as of December 31, 2013 (adults)
- Enrolled in Medical Assistance for at least one month during the calendar year 2013 with a paid MHCP claim with a procedure code (H0038) for self-help or peer services

Within the calendar year 2013, a very small percentage of the population received certified peer services. Specifically, approximately 342 persons with disabilities received certified peer services. By contrast, approximately 30 persons without disabilities received such services. This difference was statistically significant, and the ratio of disability to non-disability individuals receiving services was large.

Figure 10 below shows a graph comparing the rate of Certified Peer Services by disability status.

Figure 10: Utilization Rates for Certified Peer Services by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Well-Child Visits in the First 15 Months of Life

Medical Care Measure: Calendar Year 2013

Well-Child Visits in the First 15 Months of Life (W15) measures the percentage of children who turned 15 months old during the measurement year and who had six or more visits with a primary care provider (PCP) during their first 15 months of life.

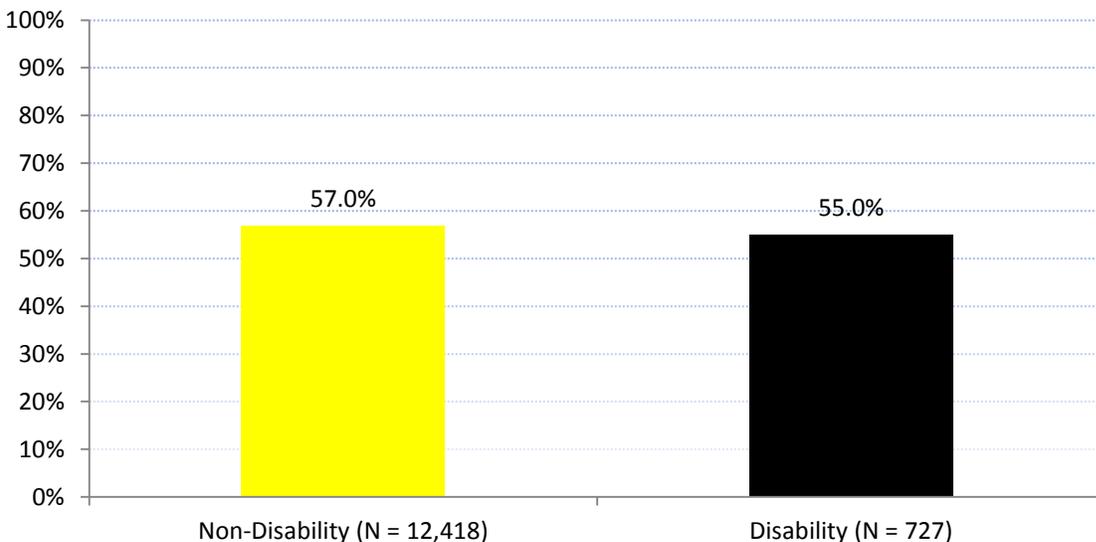
Children included in the denominator of the W15 measure met the following criteria:

- Children age 15 months during the measurement year 2013.
- Continuously enrolled during the time period from 31 days of age through 15 months of age. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, 55 percent of children with disabilities received at least six well-child visits. By contrast, 57 percent of children without disabilities received at least six well-child visits. This difference was not statistically significant.

Figure 11 below shows a graph comparing the rate of Well-Child Visits in the First 15 Months of Life by disability status.

Figure 11: Utilization Rates for Well-Child Visits in the First 15 Months of Life by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Medical Care Measure: Calendar Year 2013

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) measures the percentage of children three to six years of age who had one or more well-child visits with a primary care provider (PCP) during the measurement year.

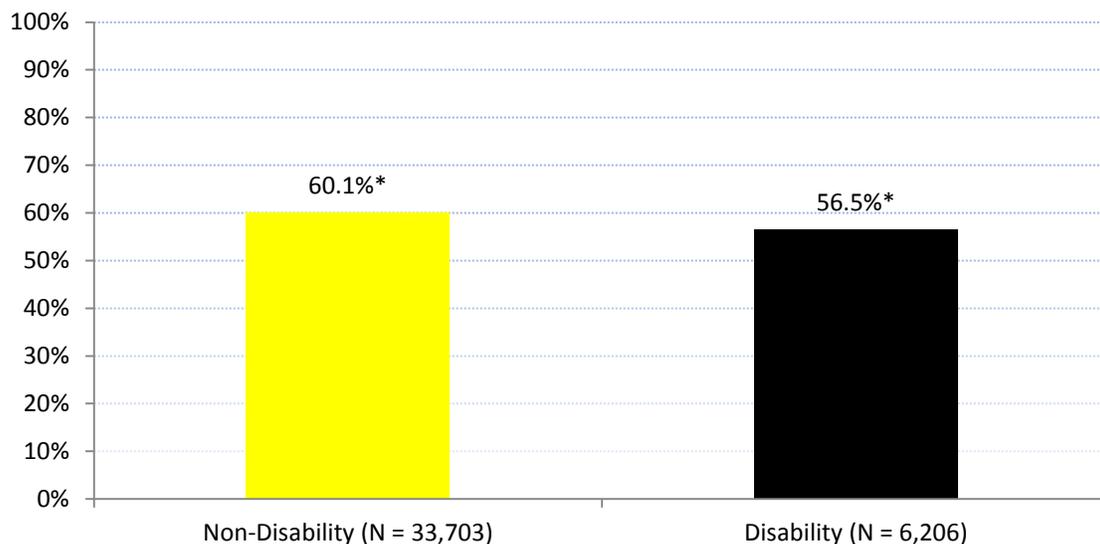
Children included in the denominator of the W34 measure met the following criteria:

- Children age three to six years as of December 31st of the measurement year 2013.
- Continuously enrolled during the measurement year 2013. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, approximately 56 percent of children with disabilities received at least one well-child visit with a PCP. By contrast, approximately 60 percent of children without disabilities received at least one well-child visit with a PCP.

Figure 12 below shows a graph comparing the rate of Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life by disability status.

Figure 12: Utilization Rates for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Adolescent Well-Care Visits

Medical Care Measure: Calendar Year 2013

Adolescent Well-Care Visits (AWC) measures the percentage of children 12–20 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an OB/GYN practitioner during the measurement year.

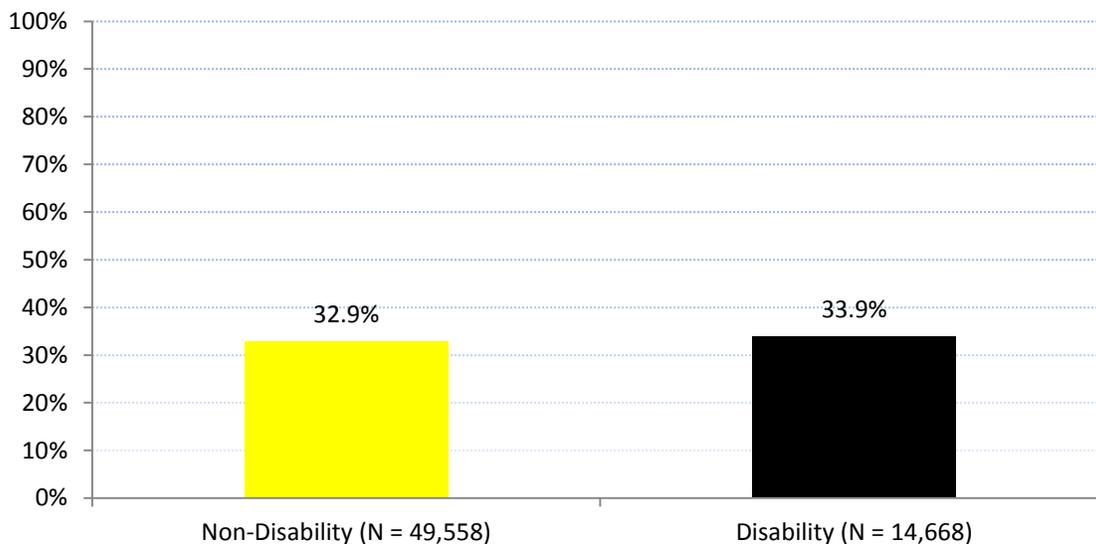
Children included in the denominator of the AWC measure met the following criteria:

- Individuals age 12-20 years as of December 31, 2013.
- Continuously enrolled during the measurement year 2013 and the year prior. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, approximately 34 percent of children with disabilities received at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner. By contrast, approximately 33 percent of children without disabilities received at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner. This difference was not statistically significant.

Figure 13 below shows a graph comparing the rate of Adolescent Well-Care visits by disability status.

Figure 13: Utilization Rates for Adolescent Well-Care visits by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Children and Adolescents' Access to Primary Care Practitioners

Medical Care Measure: Calendar Year 2013

Children and Adolescents' Access to Primary Care Practitioners (CAP) measures the percentage of children 12 months to 19 years of age who had a visit with a primary care provider (PCP).

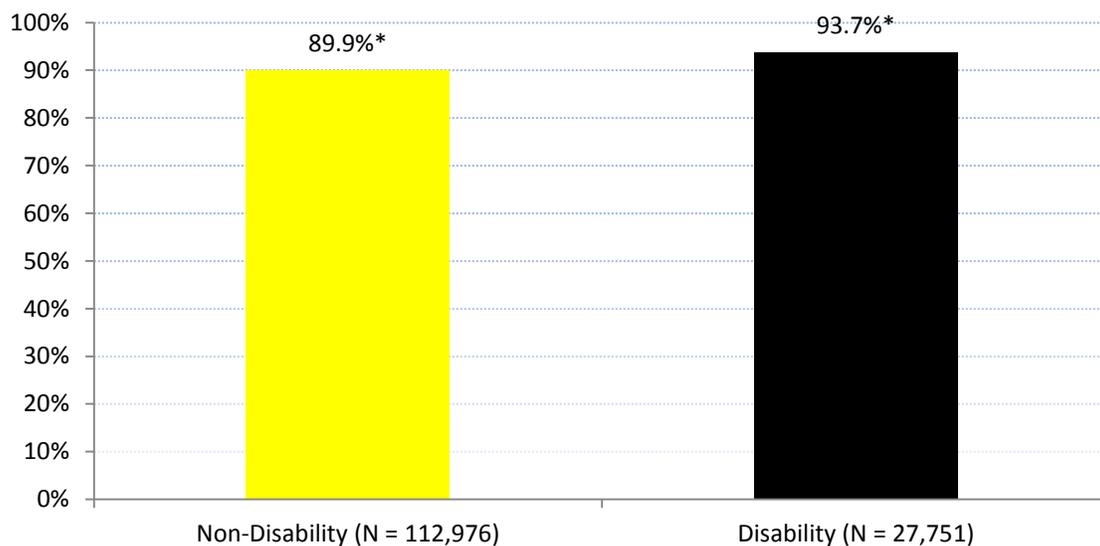
Children included in the denominator of the CAP measure met the following criteria:

- Individuals age 12 months to 19 years as of December 31, 2013.
- Continuously enrolled during the measurement year 2013 (for children age one to six) and the year prior (for individuals age seven to 19). Medicaid beneficiaries may not have more than a single month gap in enrollment during each year.

Within the calendar year 2013, approximately 94 percent of children with disabilities received a visit with a PCP. By contrast, approximately 90 percent of children without disabilities received a visit with a PCP. This difference was statistically significant.

Figure 14 below shows a graph comparing the rate of Children and Adolescents' Access to Primary Care Practitioners by disability status.

Figure 14: Utilization Rates for Children and Adolescents' Access to Primary Care Practitioners by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Childhood Immunization Status

Medical Care Measure: Calendar Year 2013

Childhood Immunization Status (CIS) measures the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. For the purposes of this report, a single combination is analyzed, and is listed below:

- Immunization for DTaP, IPV, MMR, HiB, HepB, VZV, and PCV.

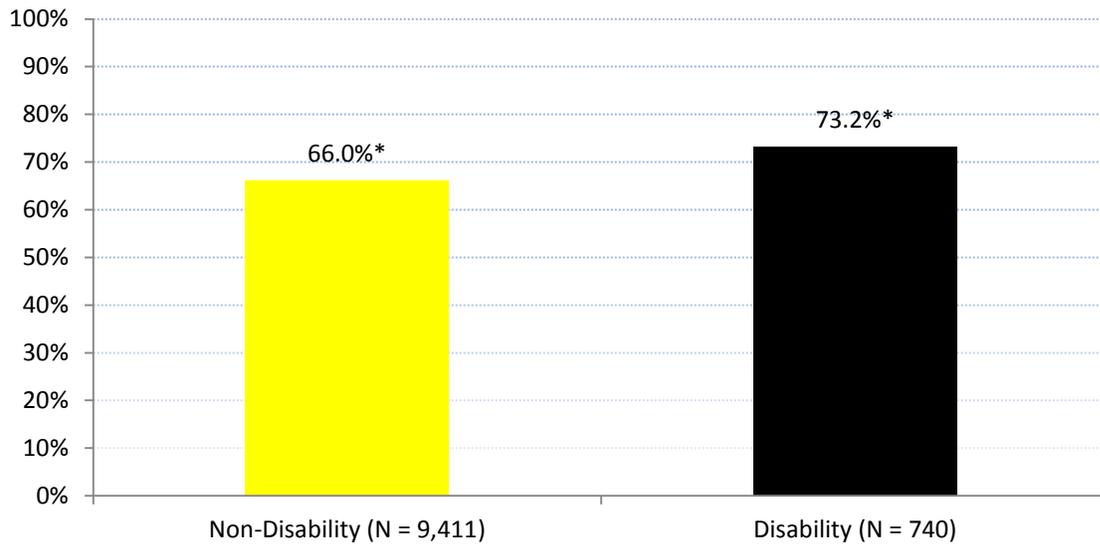
Children included in the denominator of the CIS measure met the following criteria:

- Children age two during the measurement year 2013.
- Continuously enrolled during the period 12 months prior to the child's second birthday. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, approximately 73 percent of children with disabilities received the aforementioned immunizations. By contrast, approximately 66 percent of children without disabilities received the aforementioned immunizations. This difference was statistically significant.

Figure 15 below shows a graph comparing the rate of Childhood Immunization Status by disability status.

Figure 15: Utilization Rates for Childhood Immunization Status by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Human Papillomavirus Vaccine for Female Adolescents

Medical Care Measure: Calendar Year 2013

The Human Papillomavirus Vaccine for Female Adolescents (HPV) measure gives the percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

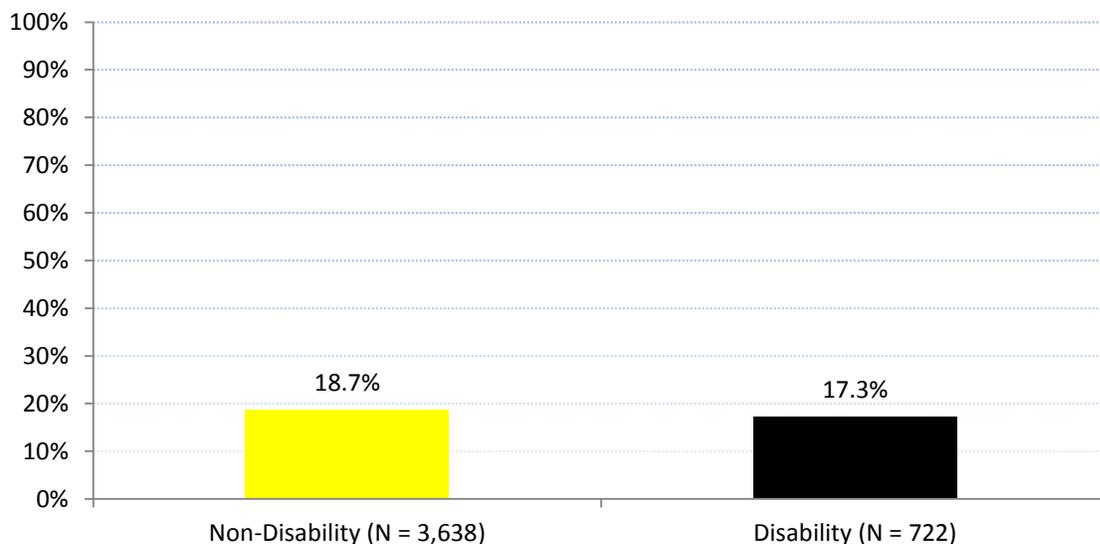
Children included in the denominator of the HPV measure met the following criteria:

- Females age 13 during the measurement year 2013.
- Continuously enrolled during the measurement year 2013 and the year prior. Medicaid beneficiaries may not have more than a single month gap in enrollment.

Within the calendar year 2013, approximately 17 percent of female children with disabilities received a HPV vaccine by their 13th birthday. By contrast, approximately 19 percent of female children without disabilities received a HPV vaccine by their 13th birthday. This difference was not statistically significant.

Figure 16 below shows a graph comparing the rate of Human Papillomavirus Vaccine for Female Adolescents by disability status.

Figure 16: Utilization Rates for Human Papillomavirus Vaccine for Female Adolescents by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Appropriate Treatment for Children with Upper Respiratory Infection

Medical Care Measure: Calendar Year 2013

The Appropriate Treatment for Children with Upper Respiratory Infection (URI) measure gives the percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

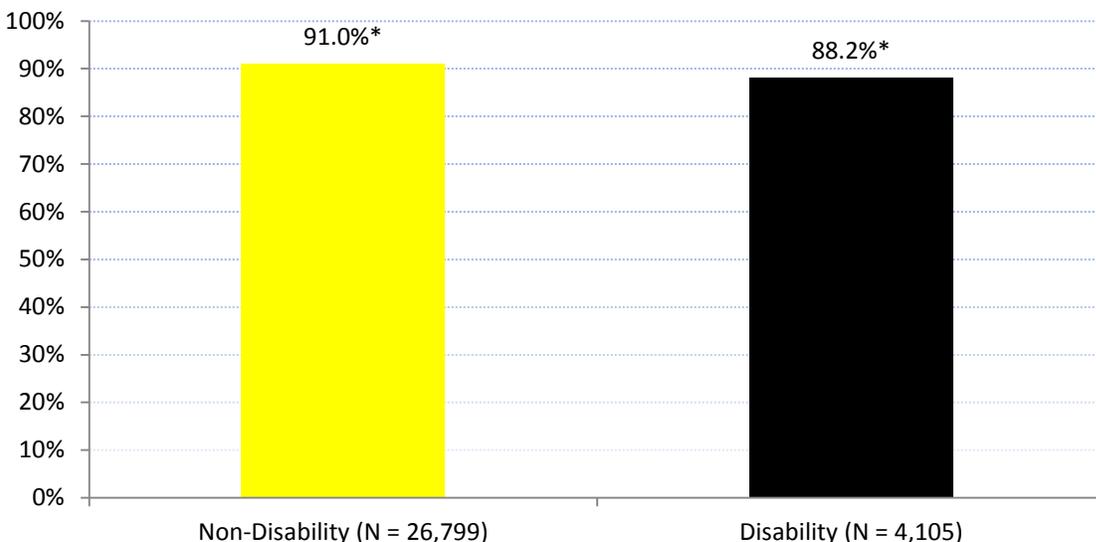
Children included in the denominator of the URI measure met the following criteria:

- Children aged three months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.
- Continuously enrolled during the measurement year 2013 and the year prior. No gaps in enrollment during the continuous enrollment period are allowed for this measure.

Within the calendar year 2013, approximately 88 percent of children with disabilities were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. By contrast, approximately 91 percent of children without disabilities were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. This difference was statistically significant.

Figure 17 below shows a graph comparing the rate of Appropriate Treatment for Children with Upper Respiratory Infection by disability status.

Figure 17: Utilization Rates for Appropriate Treatment for Children with Upper Respiratory Infection by Disability Status



Data Source: Administrative Claims Data provided to DHS by Providers and MCOs.

Note 1. * denotes that there was a significant difference between the two populations within age category at $\alpha = .01$.

Conclusion

On January 28, 2013, Governor Mark Dayton issued an executive order establishing an Olmstead Sub-Cabinet to develop and implement a comprehensive Minnesota Olmstead Plan. The main purpose of the Olmstead Plan is to move the state forward, towards greater integration and inclusion for people with disabilities.

The rates derived from this report will serve as a baseline for future studies, in order to monitor and evaluate the degree to which utilization changes over time for individuals with disabilities in receiving services. Ideally, improving access to services will be illustrated in corresponding changes to utilization rates of services over time.

Appendix A - Disability Classification for Children

Purpose:

To establish the denominator for health care utilization measures to be reported for action item 2G in the “Healthcare and Healthy Living” section of the Olmstead Plan, for children aged 0-20.

Background:

DHS Health Care Research and Quality Division (HRQ) is producing several measures of health care utilization in order to establish baseline data for medical, dental, chiropractic, and mental health care for persons with disabilities. Measures will be reported for persons enrolled in Medical Assistance with disabilities (as defined below), and for a comparison group of persons enrolled in Medical Assistance without disabilities.

Dates used:

Calendar Year 2013 (1/1/2013 – 12/31/2013)

Inclusions:

Persons enrolled in Medical Assistance (major program MA) at any point during the measurement year, and aged 0-20 inclusive as of the end of the measurement year (12/31/2013).

Exclusions:

Persons who are not enrolled in Medical Assistance at any point during the measurement year, and who are not aged 0-20 as of 12/31/2013.

Source of data:

DHS health care program enrollment and claims data

Definition:

MA child enrollees with disabilities will be defined as those who:

1. Have a paid claim during calendar year 2013 with one or several specified diagnosis codes or billing codes indicating a disabling condition or functional limitations, OR
2. Have been enrolled in MA with an eligibility type indicating disability at any point during the measurement year, OR
3. Have a score of 25 points or greater using a modified version of the algorithm developed at DHS for screening recipients as likely to have a disability, for the State Medical Review Team (SMRT).

Details:

1) Diagnosis codes and billing codes that indicate disabling conditions or functional limitations are listed in the following table:

Qualifier	Description
Epilepsy	Diagnosis code indicating Epilepsy: (345.00, 345.01, 345.10, 345.11, 345.20, 345.21, 345.30, 345.31, 345.40, 345.40, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.80, 345.81, 345.90, 345.91)
Cystic Fibrosis	Diagnosis code indicating Cystic Fibrosis: (277.00, 277.01, 277.02, 277.03, 277.09)
Developmental Disability	Diagnosis code indicating a significant degree of Developmental Disability: (318.0, 318.1, 318.2)
Congenital hereditary muscular dystrophy	Diagnosis code indicating congenital hereditary muscular dystrophy: (359.0)
Infantile Cerebral Palsy	Diagnosis code indicating Infantile Cerebral Palsy: (343.0, 343.1, 343.2, 343.3, 343.4, 343.8, 343.9)
Children 4 and over using diapers	Billing codes associated with children 4 and over using diapers: (T4529, T4530, T4531, T4532)
Children who buy wheelchairs or walkers	Billing codes associated with children who buy wheelchairs or walkers: (E1037, E1229, E1231-E1239, E0130, E0135, E0140, E0141, E0143, E0144, E0147-E149)
School based IEP service	HCPCS code indicating the child received a school based individualized education program (IEP) service: (T1018).
Cochlear device	HCPCS code indicating the child received or is currently using a cochlear implant: (L8614, L8615, L8616, L8617, L8618, L8619, L8627, L8628, L8629, L8621, L8622, L8623, L8624).
PCA services	HCPCS code indicating the child received personal care attendant (PCA) services: (T1019).

2) Medical Assistance eligibility types indicating disability are listed in the following table:

Eligibility Type Code	Description
15	1619A (Supplemental Security Income)
16	1619B (Supplemental Security Income)
BT	BLIND/TEFRA
BX	BLIND
DC	DISABLED/CHILD AGE 18 THROUGH 20
DP	EMPLOYED DISABLED WITH PREMIUM
DQ	DISABLED/QMB ONLY
DS	DISABLED/SLMB
DT	DISABLED/TEFRA

3) Modified SMRT Algorithm description:

The SMRT algorithm was designed at DHS to screen health care program enrollees based on diagnoses and services reported on claims, enrollee age, and other enrollee information, to identify those who are likely to have a disability. The algorithm was modeled after criteria used by the Social Security Administration for determining eligibility for Supplemental Security Income (SSI).

The algorithm considers 18 months of claims history, and weights each of several factors using a point system. A person who has at least 25 points is identified as being likely to have a disability

It should also be noted however, that this is a *modified* version of the original SMRT algorithm. Specifically, it is modified in order to prevent duplication with other aspects of the definition for disability noted in other sections. When there was conceptual overlap between the original SMRT algorithm and other qualifying criteria, that component was removed from SMRT.

The components of the SMRT algorithm are as follows:

1. **Inpatient Stays:** count of the number of months during which the recipient had an inpatient stay
 - a. Greater than or equal to 10 months = 20 points
 - b. 8-9 months = 10 points
 - c. 4-7 months = 6 points
 - d. 1-3 months = 2 points
 - e. 0 months = 0 points
2. **Severe Mental Health:** count of the number of distinct dates of service for which there was a claim with a severe mental health diagnosis (ICD-9-CM diagnosis codes 295.00 – 297.9)
 - a. Greater than or equal to 10 dates of service = 20 points
 - b. 8-9 dates of service = 10 points
 - c. 4-7 dates of service = 6 points
 - d. 1-3 dates of service = 2 points
 - e. 0 dates of service = 0 points
3. **Age:** recipient age as of the end of the measurement period
 - a. Greater than or equal to 40 = 3 points
 - b. Less than 40 = 0 points
4. **Chemical Dependency in conjunction with Mental Illness:** recipient has a diagnosis of chemical dependency (ICD-9-CM diagnosis codes 291.0 – 292.9 or 303.00 – 305.9) on one or more claims, AND a diagnosis of severe mental illness (ICD-9-CM diagnosis codes 295.00 – 297.9) on one or more claims; number of points assigned varies by recipient age
 - a. Age is greater than or equal to 40 = 5 points
 - b. Age is less than 40 = 2 points
5. **Presumptive Disability or Blindness:** recipient has a diagnosis on the list of presumptive disabilities on one or more claims
 - a. Diagnosis code present = 8 points
6. **Homeless:** recipient has a diagnosis code indicating homelessness (ICD-9-CM diagnosis codes V60.0 or V60.1) on one or more claims
 - a. Diagnosis code present = 3 points
7. **Group Residential Housing (GRH):** recipient has been in the GRH program during the 18 month look back time period

- a. Enrolled in GRH = 5 points
- 8. **Diabetes:** recipient has a diagnosis of diabetes mellitus (ICD-9-CM diagnosis codes 250.00 – 250.93) on one or more claims
 - a. Diagnosis code present = 3 points
- 9. **HIV:** recipient has a diagnosis indicating Human Immunodeficiency Virus infection (ICD-9-CM diagnosis codes 042, V08, 079.53) on one or more claims
 - a. Diagnosis code present = 4 points
- 10. **Quadriplegia and Other Paralysis:** recipient has a diagnosis indicating quadriplegia, hemiplegia, or other paralysis (ICD-9-CM diagnosis codes 342.00 – 342.12, 342.80 – 342.92, 344.00 – 344.42, 344.81 – 344.9) on one or more claims
 - a. Diagnosis code present = 8 points
- 11. **Disability indicator in MAXIS:** recipient has a disability indicated in MAXIS; number of points assigned varies by recentness of the indication
 - a. Indication 10 or more years ago = 0 points
 - b. Indication 5-10 years ago = 3 points
 - c. Indication 2-5 years ago = 5 points
 - d. Indication within past 2 years = 10 points
- 12. **Emphysema:** recipient has a diagnosis of emphysema (ICD-9-CM diagnosis codes 491.20, 491.21, 492.0, 492.8, 506.4, 518.1) on one or more claims
 - a. Diagnosis code present = 4 points
- 13. **Morbid Obesity:** recipient has a diagnosis of morbid obesity (ICD-9-CM diagnosis code 278.01) on one or more claims
 - a. Diagnosis code present = 4 points
- 14. **Compassionate Allowance Diagnosis:** recipient has a diagnosis on the list of Social Security Administration list of Compassionate Allowances conditions on one or more claims
 - a. Diagnosis code present = 25 points
- 15. **Developmental Disability:** recipient has a diagnosis of developmental disability (ICD-9-CM diagnosis codes 315.00 – 315.09, 315.1, 315.2, 315.31 – 315.32, 315.39, 315.4 – 315.5, 315.8, 317, 319) on one or more claims
 - a. Diagnosis code present = 8 points
- 16. **Rule 36:** recipient is living in a residential facility for adults with mental illness.
 - a. Living in Rule 36 facility = 5 points
- 17. **ESRD:** recipient has a diagnosis of end stage renal disease (ICD-9-CM diagnosis code 585.6) on one or more claims
 - a. Diagnosis code present = 25 points

Estimated size of the denominator:

The estimated number of MA enrollees aged 0-20 during Calendar Year 2013 who would be classified as disabled using this definition is 52,138. This number amounts to 11.9% of all MA enrollees aged 0-20 (438,966) during 2013.

Appendix B - Disability Classification for Adults

Purpose:

To establish the denominator for health care utilization measures to be reported for action item 2G in the “Healthcare and Healthy Living” section of the Olmstead Plan.

Background:

DHS Health Care Research and Quality Division (HRQ) is producing several measures of health care utilization in order to establish baseline data for medical, dental, chiropractic, and mental health care for persons with disabilities. Measures will be reported for persons enrolled in Medical Assistance with disabilities (as defined below), and for a comparison group of persons enrolled in Medical Assistance without disabilities. This analysis will be limited to persons aged 21-64.

Dates used:

Calendar Year 2013 (1/1/2013 – 12/31/2013)

Inclusions:

Persons enrolled in Medical Assistance (major program MA) at any point during the measurement year, and aged 21-64 inclusive as of the end of the measurement year (12/31/2013).

Exclusions:

Persons who are not enrolled in Medical Assistance at any point during the measurement year, and who are not aged 21-64 as of 12/31/2013.

Source of data:

DHS health care program enrollment and claims data.

Definition:

MA enrollees with disabilities will be defined as those who:

1. Have been enrolled in MA with an eligibility type indicating disability at any point during the measurement year, OR
2. Have a score of 25 points or greater using the algorithm developed at DHS for screening recipients as likely to have a disability, for the State Medical Review Team (SMRT).

Details:

1) Medical Assistance eligibility types indicating disability are listed in the following table:

Eligibility Type Code	Description
15	1619A (Supplemental Security Income)
16	1619A (Supplemental Security Income)
BC	BREAST AND CERVICAL CANCER PROGRAM (Effective 07/01/2002)
BD	BLIND/PRESCRIPTION DRUG (Effective 07/01/2002)
BQ	BLIND/QMB (QUALIFIED MEDICARE BENEFICIARY) ONLY
BS	BLIND/SLMB (SERVICE-LIMITED MEDICARE BENEFICIARY)
BT	BLIND/TEFRA
BW	BLIND/QWD
BX	BLIND
DC	DISABLED/CHILD AGE 18 THROUGH 20
DI	EMPLOYED DISABLED WITH NO PREMIUM (No longer used effective 01/01/04)
DP	EMPLOYED DISABLED WITH PREMIUM
DQ	DISABLED/QMB ONLY
DS	DISABLED/SLMB
DT	DISABLED/TEFRA
DW	DISABLED/QWD (No longer used.)
DX	DISABLED
1B	BLIND QUALIFYING INDIVIDUAL QI-1
1D	DISABLED QUALIFYING INDIVIDUAL QI-1

2) SMRT Algorithm description:

The SMRT algorithm was designed at DHS to screen health care program enrollees based on diagnoses and services reported on claims, enrollee age, and other enrollee information, to identify those who are likely to have a disability. The algorithm was modeled after criteria used by the Social Security Administration for determining eligibility for Supplemental Security Income (SSI).

The algorithm considers 18 months of claims history, and weights each of several factors using a point system. A person who has at least 25 points is identified as being likely to have a disability.

The components of the SMRT algorithm are as follows:

1. **Inpatient Stays:** count of the number of months during which the recipient had an inpatient stay
 - a. Greater than or equal to 10 months = 20 points
 - b. 8-9 months = 10 points
 - c. 4-7 months = 6 points
 - d. 1-3 months = 2 points
 - e. 0 months = 0 points
2. **Severe Mental Health:** count of the number of distinct dates of service for which there was a claim with a severe mental health diagnosis (ICD-9-CM diagnosis codes 295.00 – 297.9 or 301.83)
 - a. Greater than or equal to 10 dates of service = 20 points
 - b. 8-9 dates of service = 10 points
 - c. 4-7 dates of service = 6 points
 - d. 1-3 dates of service = 2 points
 - e. 0 dates of service = 0 points
3. **Age:** recipient age as of the end of the measurement period
 - a. Greater than or equal to 40 = 3 points
 - b. Less than 40 = 0 points
4. **Chemical Dependency in conjunction with Mental Illness:** recipient has a diagnosis of chemical dependency (ICD-9-CM diagnosis codes 291.0 – 292.9 or 303.00 – 305.9) on one or more claims, AND a diagnosis of severe mental illness (ICD-9-CM diagnosis codes 295.00 – 297.9) on one or more claims; number of points assigned varies by recipient age
 - a. Age is greater than or equal to 40 = 5 points
 - b. Age is less than 40 = 2 points
5. **Presumptive Disability or Blindness:** recipient has a diagnosis on the list of presumptive disabilities on one or more claims
 - a. Diagnosis code present = 8 points
6. **Homeless:** recipient has a diagnosis code indicating homelessness (ICD-9-CM diagnosis codes V60.0 or V60.1) on one or more claims
 - a. Diagnosis code present = 3 points

7. **Group Residential Housing (GRH):** recipient has been in the GRH program during the 18 month look back time period
 - a. Enrolled in GRH = 5 points
8. **Diabetes:** recipient has a diagnosis of diabetes mellitus (ICD-9-CM diagnosis codes 250.00 – 250.93) on one or more claims
 - a. Diagnosis code present = 3 points
9. **HIV:** recipient has a diagnosis indicating Human Immunodeficiency Virus infection (ICD-9-CM diagnosis codes 042, V08, 079.53) on one or more claims
 - a. Diagnosis code present = 4 points
10. **Quadriplegia and Other Paralysis:** recipient has a diagnosis indicating quadriplegia, hemiplegia, or other paralysis (ICD-9-CM diagnosis codes 342.00 – 342.12, 342.80 – 342.92, 344.00 – 344.42, 344.81 – 344.9) on one or more claims
 - a. Diagnosis code present = 8 points
11. **Disability indicator in MAXIS:** recipient has a disability indicated in MAXIS; number of points assigned varies by recentness of the indication
 - a. Indication 10 or more years ago = 0 points
 - b. Indication 5-10 years ago = 3 points
 - c. Indication 2-5 years ago = 5 points
 - d. Indication within past 2 years = 10 points
12. **Emphysema:** recipient has a diagnosis of emphysema (ICD-9-CM diagnosis codes 491.20, 491.21, 492.0, 492.8, 506.4, 518.1) on one or more claims
 - a. Diagnosis code present = 4 points
13. **Morbid Obesity:** recipient has a diagnosis of morbid obesity (ICD-9-CM diagnosis code 278.01) on one or more claims
 - a. Diagnosis code present = 4 points
14. **Compassionate Allowance Diagnosis:** recipient has a diagnosis on the list of Social Security Administration list of Compassionate Allowances conditions on one or more claims. This diagnosis list has been updated as of 2014 with information provided by Debra Wagner and Kathleen Hendricks
 - a. Diagnosis code present = 25 points
15. **Developmental Disability:** recipient has a diagnosis of developmental disability (ICD-9-CM diagnosis codes 315.00 – 315.09, 315.1, 315.2, 315.31 – 315.32, 315.39, 315.4 – 315.9, 317, 318.0 – 318.2, 319) on one or more claims
 - a. Diagnosis code present = 8 points
16. **Rule 36:** recipient is living in a residential facility for adults with mental illness (living arrangement of 52 or 57 or paid claim with procedure code H0019 for Intensive Residential Treatment Services)
 - a. Living in Rule 36 facility = 5 points
17. **End Stage Renal Disease (ESRD):** recipient has a diagnosis of ESRD (ICD-9-CM diagnosis code 585.6) on one or more claims
 - a. Diagnosis code present = 25 points

Estimated size of the denominator:

The estimated number of MA enrollees aged 21-64 during Calendar Year 2013 who would be classified as disabled using this definition is 139,732. This number amounts to 33.1% of all MA enrollees aged 21-64 (422,086) during 2013.

Appendix C - Disability Classification for Seniors

Purpose:

To establish the denominator for health care utilization measures to be reported for action item 2G in the “Healthcare and Healthy Living” section of the Olmstead Plan.

Background:

DHS Health Care Research and Quality Division (HRQ) is producing several measures of health care utilization in order to establish baseline data for medical, dental, chiropractic, and mental health care for persons with disabilities. Measures will be reported for persons enrolled in Medical Assistance with disabilities (as defined below), and for a comparison group of persons enrolled in Medical Assistance without disabilities. This analysis will be limited to persons aged 65 and over.

Dates used:

Calendar Year 2013 (1/1/2013 – 12/31/2013)

Inclusions:

Persons enrolled in Medical Assistance (major program MA) at any point during the measurement year, and aged 65 and over inclusive as of the end of the measurement year (12/31/2013).

Exclusions:

Persons who are not enrolled in Medical Assistance at any point during the measurement year, and who are not aged 65 and over as of 12/31/2013.

Source of data:

DHS health care program enrollment and claims data

Definition:

MA enrollees with disabilities will be defined as those who:

- 1) Have been enrolled in MA with an eligibility type indicating disability at any point during the measurement year, OR
- 2) Have a score of 25 points or greater using the algorithm developed at DHS for screening recipients as likely to have a disability, for the State Medical Review Team (SMRT), OR
- 3) Possesses a classification of dependency based on scores on Activities of Daily Living (ADL) measures.

Details:

1) Medical Assistance eligibility type indicating disability is listed in the following table:

Eligibility Type Code	Description
DP	EMPLOYED DISABLED WITH PREMIUM

2) SMRT Algorithm description:

The SMRT algorithm was designed at DHS to screen health care program enrollees based on diagnoses and services reported on claims, enrollee age, and other enrollee information, to identify those who are likely to have a disability. The algorithm was modeled after criteria used by the Social Security Administration for determining eligibility for Supplemental Security Income (SSI).

The algorithm considers 18 months of claims history, and weights each of several factors using a point system. A person who has at least 25 points is identified as being likely to have a disability.

The components of the SMRT algorithm are as follows:

1. **Inpatient Stays:** count of the number of months during which the recipient had an inpatient stay
 - a. Greater than or equal to 10 months = 20 points
 - b. 8-9 months = 10 points
 - c. 4-7 months = 6 points
 - d. 1-3 months = 2 points
 - e. 0 months = 0 points
2. **Severe Mental Health:** count of the number of distinct dates of service for which there was a claim with a severe mental health diagnosis (ICD-9-CM diagnosis codes 295.00 – 297.9 or 301.83)
 - a. Greater than or equal to 10 dates of service = 20 points
 - b. 8-9 dates of service = 10 points
 - c. 4-7 dates of service = 6 points
 - d. 1-3 dates of service = 2 points
 - e. 0 dates of service = 0 points
3. **Age:** recipient age as of the end of the measurement period
 - a. Greater than or equal to 40 = 3 points
 - b. Less than 40 = 0 points
4. **Chemical Dependency in conjunction with Mental Illness:** recipient has a diagnosis of chemical dependency (ICD-9-CM diagnosis codes 291.0 – 292.9 or 303.00 – 305.9) on one or more claims, AND a diagnosis of severe mental illness (ICD-9-CM diagnosis codes 295.00 – 297.9) on one or more claims; number of points assigned varies by recipient age
 - a. Age is greater than or equal to 40 = 5 points
 - b. Age is less than 40 = 2 points
5. **Presumptive Disability or Blindness:** recipient has a diagnosis on the list of presumptive disabilities on one or more claims
 - a. Diagnosis code present = 8 points
6. **Homeless:** recipient has a diagnosis code indicating homelessness (ICD-9-CM diagnosis codes V60.0 or V60.1) on one or more claims
 - a. Diagnosis code present = 3 points

7. **Group Residential Housing (GRH):** recipient has been in the GRH program during the 18 month look back time period
 - a. Enrolled in GRH = 5 points
8. **Diabetes:** recipient has a diagnosis of diabetes mellitus (ICD-9-CM diagnosis codes 250.00 – 250.93) on one or more claims
 - a. Diagnosis code present = 3 points
9. **HIV:** recipient has a diagnosis indicating Human Immunodeficiency Virus infection (ICD-9-CM diagnosis codes 042, V08, 079.53) on one or more claims
 - a. Diagnosis code present = 4 points
10. **Quadriplegia and Other Paralysis:** recipient has a diagnosis indicating quadriplegia, hemiplegia, or other paralysis (ICD-9-CM diagnosis codes 342.00 – 342.12, 342.80 – 342.92, 344.00 – 344.42, 344.81 – 344.9) on one or more claims
 - a. Diagnosis code present = 8 points
11. **Disability indicator in MAXIS:** recipient has a disability indicated in MAXIS; number of points assigned varies by recentness of the indication
 - a. Indication 10 or more years ago = 0 points
 - b. Indication 5-10 years ago = 3 points
 - c. Indication 2-5 years ago = 5 points
 - d. Indication within past 2 years = 10 points
12. **Emphysema:** recipient has a diagnosis of emphysema (ICD-9-CM diagnosis codes 491.20, 491.21, 492.0, 492.8, 506.4, 518.1) on one or more claims
 - a. Diagnosis code present = 4 points
13. **Morbid Obesity:** recipient has a diagnosis of morbid obesity (ICD-9-CM diagnosis code 278.01) on one or more claims
 - a. Diagnosis code present = 4 points
14. **Compassionate Allowance Diagnosis:** recipient has a diagnosis on the list of Social Security Administration list of Compassionate Allowances conditions on one or more claims. This diagnosis list has been updated as of 2014 with information provided by Debra Wagner and Kathleen Hendricks
 - a. Diagnosis code present = 25 points
15. **Developmental Disability:** recipient has a diagnosis of developmental disability (ICD-9-CM diagnosis codes 315.00 – 315.09, 315.1, 315.2, 315.31 – 315.32, 315.39, 315.4 – 315.9, 317, 318.0 – 318.2, 319) on one or more claims
 - a. Diagnosis code present = 8 points
16. **Rule 36:** recipient is living in a residential facility for adults with mental illness (living arrangement of 52 or 57 or paid claim with procedure code H0019 for Intensive Residential Treatment Services)
 - a. Living in Rule 36 facility = 5 points
17. **End Stage Renal Disease (ESRD):** recipient has a diagnosis of ESRD (ICD-9-CM diagnosis code 585.6) on one or more claims
 - a. Diagnosis code present = 25 points

3) Classification of Dependency based on Activities of Daily Living Scores.

Case mix summary classifications are created using information obtained from the Minnesota Long Term Care Consultation Services Assessment Form (DHS-3428)⁴. Specifically, DHS uses branching logic to place individuals into different case mixes, depending on their combination of scores on activities of daily living (ADL). The full logic for placing individuals into classifications can be seen on DHS Case Mix Classification worksheet⁵.

Additionally, DHS considered individuals who possessed dependency scores on certain individual ADLs to be disabled for the purposes of the Olmstead Plan. Those ADLs involved critical activities of life: toileting, transferring, and eating.

Case Mix Summary Classification	Description
D	Medium ADL
E	Medium ADL Behavior
F	Medium ADL Special Nursing
G	High ADL
H	High ADL Behavior
I	Very High ADL (Eating 3-4)
J	High ADL, Severe Neurological Impairment/3+ Behavior
K	High ADL, Special Nursing
V	Ventilator Dependent - EW
Toileting score greater than 0	Not toileting independent
Transferring score greater than 1	Requires help of at least one for transferring
Eating score greater than 1	Requires active assistance for eating

Estimated size of the denominator:

The estimated number of MA enrollees aged 65 and over during Calendar Year 2013 who would be classified as disabled using this definition is 43,435. This number amounts to 64.1% of all MA enrollees aged 65 and over (67,767) during 2013.

⁴ This file can be obtained at the following location: [Minnesota Long Term Care Consultation Services Assessment Form](#)

⁵ This file can be obtained at the following location: [AC, BI, CADL, EW Case Mix Classification Worksheet](#)

Appendix D - Consultation

Below is a list of DHS subject matter experts who have been consulted during the development of this report.

DHS Staff Name	Division	Area of expertise
Meg Heinz	Health Care Eligibility and Access Division	Eligibility Policy
Kathleen Hendricks	Health Care Eligibility and Access Division - State Medical Review Team	State Medical Review process
Jolene Kohn	Aging and Adult Services Division	Program and Policy management
Susan Kurysh	Purchasing and Service Delivery Division	ICD 9 and billing codes
Patrick Lee	Purchasing and Service Delivery Division	Benefits Billing codes
Rick Moldenhauer	Alcohol and Drug Abuse Division	Diagnosis codes for chemical dependency
Heather Petermann	Health Care Administration Policy Development and Implementation	Health Care Homes
Libby Rossett-Brown	Aging and Adult Services Division	Program and Policy management
Lisa Rotegard	Aging and Adult Services Division	Home and Community Based Services
Jenny Roth	Purchasing and Service Delivery Division	Benefits Policy
Jeff Schiff	Health Care Administration State Medicaid Medical Director	Children's Health
Barbara Skoglund	Health Care Eligibility and Access Division	Eligibility Policy
Jerry Storck	Adult Mental Health Division	Diagnosis codes for mental health conditions
Sarah Thorson	Disability Services Division	Children and youth with disabilities; waived services
Debra Wagner	Health Care Eligibility and Access Division - State Medical Review Team	State Medical Review process

Appendix E – Glossary of Acronyms and Terms

The following is a description of various acronyms and terms listed in this report that are not defined within the report itself.

Acronym	Description
AMI	Acute myocardial infarction
PCI	Percutaneous coronary interventions
IVD	Ischemic vascular disease
LDL-C	Low-density lipoprotein cholesterol
CABG	Coronary artery bypass graft
ED	Emergency department
QMB	Qualified Medicare Beneficiary
SLMB	Service Limited Medicare Beneficiary
TEFRA	Tax equity and Fiscal Responsibility Act
ICD-9-CM	The International Classification of Diseases, Ninth Revision, Clinical Modification
MAXIS	System that processes information to determine eligibility for public assistance programs and mails benefits and notices to public assistance recipients. MAXIS is not an acronym.
QWD	Qualified Working Disabled
Rule 36	Rule 36 establishes standards for adult mental health residential facilities in Minnesota. Compliance with this rule is required for facilities that provide residential mental health treatment for more than four adults.

This information is available in accessible formats for individuals with disabilities by contacting your county worker. For other information on disability rights and protections to access human services programs, contact the agency's ADA coordinator.

**EXHIBIT 6-27: HC 2I – BARRIERS IN TRANSITIONING YOUTH
TO ADULT HEALTH CARE**

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REPORT TO THE OLMSTEAD SUBCABINET

HEALTHCARE AND HEALTHY LIVING 2I

AUTHORS:
MINNESOTA DEPARTMENT OF HEALTH

SUBMISSION DATE:
FEBRUARY 26, 2015

Summary Statement

This report provides a system analysis describing barriers that need resolution for transitioning youth with special health care needs to adult health care. It also includes a plan for addressing those barriers.

Background

As stated in Minnesota's Olmstead Plan, youth with special health care needs will receive the services necessary to make transitions to adult health care. As children with disabilities become young adults with disabilities, Minnesota must do a better system-wide job of helping youth with special health care needs receive the services necessary to make transitions to adult health care. With good transitions from youth to adult services, people receive ongoing access to coordinate care that can prevent institutionalization. According to the 2010 National Survey of Children with Special Health Care Needs, nationally only 40% of youth with special health care needs receive the services necessary to make transitions to adult health care. In Minnesota in 2010, 47.1% of youth made this transition⁵⁹.

Action Item HC 2I

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

Deliverables Submitted by MDH

Below is an overview of the MDH deliverables completed and submitted to the OIO for HC 2I:

Deadline	Action	Item Submitted	Content	Date Submitted
9/30/14	Part 1: Complete a <u>system analysis</u> describing barriers that need resolution.	Olmstead Benchmark Report (which is the analysis)	The document outlines three barriers that need resolution.	10/8/14
	Part II: Develop a <u>plan</u> for addressing these barriers.	Olmstead HC 2I Plan for Addressing Barriers	Barriers, strategies, implementation mechanisms, target dates and responsible person.	Initial Plan: 1/23/15 Revised Plan: 2/20/15

The Olmstead Benchmark Report and the Olmstead HC 2I Plan for Addressing Barriers can be found on the following pages.

Olmstead Benchmark Report

October 8, 2014

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

Action # 21

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, an 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.

Olmstead HC 2I Plan for Addressing Barriers

Name: Barb Lundeen PHN MDH Children and Youth with Special Health Needs		January 23, 2015		
RESPONSIBILITY #1: Complete a system analysis describing barriers that need resolution: develop a plan for addressing these barriers				
Barrier from system analysis	Strategies	Implementation mechanism	Target date	Responsible person
<p>A. Lack of intentional health care planning for transitioning of care</p> <p>It was found that providers are not discussing transfer of care to an adult provider</p> <p>Refer to final benchmark report dated Oct 8th, 2014</p>	<p>Each of the four clinics in the transitions in health care project with Family Voices of Minnesota (FVM) will test tools and develop strategies to engage youth and their families in transition programs and policies that can be spread to other clinics in Minnesota</p> <p>Develop educational information and resources particularly for multicultural families</p>	<p>As a MDH Grant recipient, Family Voices of MN will assist clinics to:</p> <ul style="list-style-type: none"> • build strong teams of advocates for adopting a successful model of care for the transition of YSHCN • document strategies for working with adult partners • provide opportunities to meet adult physicians or become familiar with the physicians • Present their findings at the Health Care Home Learning Community. There will be 500 people attending the conference. • Develop a tool kit to be presented as part of learning days • Address disparity issues and the success of utilizing community health workers will be presented • Develop education and outreach 	<p>June 30,2015</p> <p>May 13, 2015</p> <p>May 13, 2015</p> <p>June 30, 2015</p>	<p>Children and Youth with Special Health Needs (CYSHN) section at MDH along with Family Voices of Minnesota (FVM)</p> <p>Hennepin County Medical Center/FVM project</p>

Name: Barb Lundeen PHN MDH Children and Youth with Special Health Needs			January 23, 2015	
RESPONSIBILITY #1: Complete a system analysis describing barriers that need resolution: develop a plan for addressing these barriers				
Barrier from system analysis	Strategies	Implementation mechanism	Target date	Responsible person
	Provide training for professionals working with transition age youth across the system.	<p>for youth, families, and other caring adults.</p> <p>Present to parents at a charter school and evaluate the impact of parent satisfaction.</p> <p>A cohort from north western Minnesota and another from the metro will meet to discuss and develop strategies.</p> <p>Plan for and spread of the training</p>	<p>Dec. 30, 2015</p> <p>Dec 30, 2015</p> <p>Dec. 30, 2016</p>	<p>CYSHN staff</p> <p>CYSHN staff along with other state partners form DHS, MDE and DEED</p>
B. Lack of Local Public health involvement in transition	Continue to encourage Local Public Health to establish partnerships with education, human services, pediatric/adult health care providers and other local community resources for persons with disabilities.	<p>Attend MCH areas around the state and discuss transition services for youth with special health needs</p> <p>Participate in Transitions Community of Practice.</p> <p>Encourage the involvement of local public health agencies in local community transition interagency committees.</p>	Ongoing	CYSHN staff
C. Youth and	Professional	Health care transitions will be	Dec. 30, 2016	CYSHN staff

Name: Barb Lundeen PHN MDH Children and Youth with Special Health Needs		January 23, 2015		
RESPONSIBILITY #1: Complete a system analysis describing barriers that need resolution: develop a plan for addressing these barriers				
Barrier from system analysis	Strategies	Implementation mechanism	Target date	Responsible person
families often fear losing health insurance if they become employed	development for health care professionals that incorporate employment transition related outcomes	incorporated to the interagency cohort trainings		

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EXHIBIT 6-28: HC 2J.1 – TRANSITIONING YOUTH TO ADULT HEALTH CARE

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REPORT TO THE OLMSTEAD SUBCABINET

HEALTHCARE AND HEALTHY LIVING 2J.1

AUTHORS:
MINNESOTA DEPARTMENT OF HEALTH

SUBMISSION DATE:
FEBRUARY 26, 2015

Olmstead Final Report on HC 2J.1

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

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

Brief description: Increase number of children with special health needs receiving the services necessary to make transitions to adult health care.

Refer to Action # 2I Benchmark Report Oct. 8, 2014 for background information.

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.

Benchmark #1

Monitor the data for changes in the number of youth with special health needs who receive the services necessary to make appropriate transitions to all aspects of adult life, including adult health care, work and independence. Explore new data that would indicate that children and youth with special health needs are receiving the necessary services. (Additional information was submitted on the measurable goal worksheet.)

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 47% on Minnesota youth with special health needs receive the services necessary to make appropriate transitions to adult health care, work and independence.

Collection of data for the National Survey of Children’s Health (NSCH) used to alternate with collection for the National Survey of Children with Special Health Care Needs so that new data are available every 2 years for one or other of the surveys and every 4 years for a particular survey. The 2011/12 NSCH was released in early 2013. The next fielding of these surveys are pending results from the current review and revision process, but it is projected that data collection will commence in 2015.

<http://childhealthdata.org/learn/faq#again>

Benchmark #2

Develop an online Transition in Health Care toolkit for primary care providers and clinic care coordinators across Minnesota so that they discuss and plan with youth and their families for the changing health care needs as the youth transition to adult health care.

Family Voices of Minnesota transition project was funded by Minnesota Department of Health Children and Youth with Special Health Needs program. The timeline on the grant with Family Voices of Minnesota was extended to June 30, 2015 to accommodate presenting results and products at the next Health Care Home learning days in May 2015. There are currently four medical clinics that have tested the tools. There will be approximately 500 attendees at the learning days from all areas of Minnesota. Currently the tool kit is available through the National website Got Transition <http://www.gottransition.org> and Family Voices of MN <http://www.familyvoicesofminnesota.org>. It is important that families know about the resources and tools so they can request their primary care provider to use them. The tool kit is adaptable for use at each clinic. Evidence of this impact will be measured through the ongoing monitoring of the NSCH Survey and through anecdotal stories from families and providers. A family from CentraCare in St. Cloud reported a positive experience using the toolkit when their daughter transitioned to adult medicine. The family met with the pediatrician and the adult primary care physician at a joint clinic visit and a care plan was developed and transitioned with the youth. The parent said the tools were very helpful.

Benchmark #3

Promote implementation of the transitions in health care online toolkit through the Children and Youth with Special Health Needs website and through intra and interagency connections.

Benchmark #1 explains that the tool kit has been developed and is being used at four clinics as part of the transitions in health care project with FVM. Health Partners has committed to spread the transition tools throughout their health system. The toolkit will be spread throughout health care homes beginning in May, 2015. The tool kit will remain on the Got Transition website and on the Family Voices of MN website. It will be spread through the interagency partners in benchmark #4.

Benchmark #4

Partner with the Minnesota Department of Education, Vocational Rehabilitation and the Department of Human Services to develop and implement a cross agency focus so that youth with special health needs receive the services necessary to make transitions to all adult systems including adult health care.

Currently all four departments are working together on a quality improvement project titled “students transition to adult system appropriately.” Two school districts have been identified to help discuss and plan for the spread of this QI interagency project. Northern Lights in Duluth is one chosen area. Duluth Essentia Medical Clinic is one of the four clinics in the transition project with Family Voices of MN mentioned above. The other district is Independent School District 916. Health Partners has clinics in

this locality of the metro. The first meeting of the cohort is planned for March 2015. The state partners have been reviewing literature and best practices. The project will develop protocol for child-to-adult handoff including health transition. The agencies will develop a baseline for proficiency in interagency coordination and look at ways to assess improvement. The project will look at the percentage of professionals demonstrating proficiency in transition from child to the adult system. Historically, different agencies begin transition planning at different ages. There currently is not consistency about when to plan or deliver services. In 2015 the cohort will develop consistent ways to identify young adults who are transitioned appropriately to adult services. Modules on interagency partnerships will be created with a plan to spread throughout Minnesota in 2016. An evaluation process will be included.

HEALTHCARE AND HEALTHY LIVING GOALS

Action item HC 2J.1 – Page 80

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

BASELINE: There are 76,735 children aged 12-17 in Minnesota with special health needs. Of those youth, 36,065 or 47.1% receive the services necessary to make transitions to adult health care.

MEASURABLE GOAL:

- By December 31, 2014, the number of Minnesota’s transition age youth with disabilities who receive the services necessary to make transitions to adult health care will increase to 38,368 (50%).
- By December 30, 2016, the number of Minnesota’s transition age youth with disabilities who receive the services necessary to make transitions to adult health care will increase to 42,204 (55%).
- By December 30, 2018, the number of Minnesota’s transition age youth with disabilities who receive the services necessary to make transitions to adult health care will increase to by 46,041 (60%).

NOTES:

According to the 2012 Minnesota County Health Tables there are 715,660 youth between ages 10-19. There are approximately 397,588 children between ages 12-17.

According to the National Survey of Children with Special Health Care Needs 19.3% of children ages 12-17 have a special health care need. That means there are approximately 76,735 children and youth with special health needs ages 12 – 17. Currently 36,065 or 47.1% of families report that they receive the services necessary to make transitions to adult health care. Nationally the percentage is only 40.0%

The goal to increase by 5% is based on work being done through the Transitions in Health Care grant and historical trends. The Transitions project is working with four health care homes throughout Minnesota to enhance transitioning to adult health care. The numbers transitioning should continue to rise with spread throughout other medical clinics. However, 2013 Minnesota birth rates dropped to their lowest levels in 20 years. If this continues the number of children with special health needs will likely decrease.

At this time the only source of statewide data is the National Survey of Children with Special Health Needs (SLAITS) which is done every three years. The last data collection was from 2009-2010 and released in 2013. In the future, the National Survey for Children’s Health and the National Survey for Children with Special Health Care Needs are being combined into a single survey, to be conducted annually. State-level estimates will be available bi-annually. Work is underway to revise, standardize, and pretest the instrument. The next full survey will be fielded in summer– fall 2016. Public data is planned to be released (late) spring 2017.

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**EXHIBIT 6-29: COMMUNITY ENGAGEMENT PLAN (OV 3A, CE
1A, CE 1B, CE 2A)**

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Olmstead Community Engagement Plan

Author: Olmstead Implementation Office for CE 2A, CE 1A, CE 1B, and OV 3A

Date submitted to Subcabinet: / / Date Approved by Subcabinet: / / Date submitted to Court: / /

2/27/2015

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Olmstead Public Engagement

Introduction:

November 1, 2013 Minnesota submitted an Olmstead Plan to United States District Judge Donovan Frank. The Olmstead Plan is a requirement of the *Jensen v. Department of Human Services* settlement agreement, but it is also the right thing for the State of Minnesota to do. [Minnesota's Olmstead Plan](#) highlights seven areas that all contribute to a person's ability to live, work, learn and enjoy life in the most integrated setting appropriate to their needs and desires. At the center and embedded in the plan are two calls 1)to begin with the individual; and 2)for people with disabilities to be engaged in the development, processes and policies that affect their daily lives. The inclusion of the voices of the people with disabilities is paramount to the Community Engagement's outcomes.

Frequently when people think about planning, they focus on the things – the buildings, the programs, the vehicles, the transit or other systems. However, planning is really about people. It is about people in the communities that we call home. Where we work, live, learn and hopefully enjoy life. It is in these communities that we connect with one another.

As a result, the planning process must also be grounded in the needs of people, the locations where they live, work, and learn, as well as the broader community. It is where what we can do connects with how we live, work, travel and grow. And in order to understand the values, dreams and desires of people with disabilities as well as the broader community or a specific neighborhood or city, we need to engage the people from that context in discussion.

Minnesota is a state that has been regarded as a leader in serving people with disabilities. This collective success has been built on traditions of shared action by government, nonprofit and philanthropic organizations, community groups and business leaders, aiming to enhance our communities and state as a whole. This plan defines community engagement, outlines how we engage, why we need to create opportunities and how we will measure engagement. This shared tradition requires that we acknowledge that each person and organization is an asset and reflects a valid and important point of view.

Together, we create shared values, dreams and desires. Our broader community should be a reflection of these shared values, dreams and desires. The only way to achieve that outcome is through inclusive public engagement.

About the State of Minnesota

Minnesota is a vibrant and diverse state. It consists of nearly 5.5 million people, of which about 563,422 identify as having a disability. These 5.5 million people live in 87 counties. More than half of that population lives in the Twin Cities Metropolitan area.

The state is known for its strong natural and cultural assets – rivers, lakes, green space, vibrant arts community, and rich cultural action – as well as a civic tradition of shared action. That state also has a resilient economy with a range of businesses and organizations that have been able to weather the ups and downs of national trends.

Over the next several years, the state’s population will continue to become older and more diverse. Currently about one third of those over age 65 report having a disability; as the population ages this number is also likely to increase. Not only is our population aging but we are also becoming more diverse in other aspects. It is estimated that by 2040 40% of the population, in the Twin Cities metropolitan area alone, will be persons of color¹.

I. What is Community Engagement?

From Outreach to Engagement

Planning, and the type of organizational change reflected in Minnesota’s Olmstead Plan, requires collaboration to create shared values and outcomes. To truly foster that collaboration equitably, the Minnesota Olmstead Plan, calls for the development of guidelines and criteria for those using public dollars for projects or events to ensure that people with disabilities are incorporated in the planning processes. Additionally, it states that plans for facilities and events should be informed by attention to the input from people with disabilities. The Plan also calls for people with disabilities to have increased opportunities to hold leadership roles and to meaningfully participate in policy development. The state needs a full range of voices at the table to understand issues, explore alternatives, and create a shared action plan to address issues.

This will require a shift from the traditional outreach and participation processes to an engagement model that fosters shared problem solving, supportive partnerships and reciprocal relationships. Though one entity may have the authority or budget to complete an action item², success requires coordinated collaboration of a range of partners, which bring the range of perspectives and expertise to strengthen the process.

Community engagement is a process that recognizes the value of creating ongoing, long-term relationships for the benefit of the greater community. It brings an interactive, collective problem-solving element into the process that capitalizes on the collective strengths of various stakeholders.

People are experts in assessing the long-term needs of their personal experiences and interactions with the places they live, learn, work and enjoy life. This community engagement plan recognizes people with disabilities as full and equal partners in the state’s decision-making processes at all levels. Specifically, it outlines the responsibilities and commitments of the Olmstead Plan Subcabinet agencies and the Olmstead Implementation Office to engage the public and key constituencies in planning and policy development, and provides guidance for communities in the state to help establish consistency in best practices for engagement.

¹ Metropolitan Council. (n.d.). *Thrive MSP 2040 Complete Plan*. Retrieved from Metropolitan Council: <http://www.metrocouncil.org/METC/files/63/6347e827-e9ce-4c44-adff-a6afd8b48106.pdf>

² Agencies that are not a part of the Olmstead subcabinet may use other terms to describe a task, project, goal, activity, etc.; However, as this is a part of the Olmstead plan we use “action item” throughout the document which is interchangeable with whatever term other agencies may utilize.

Principles for Engagement

Minnesota's Olmstead Plan places a high priority on community engagement as it is one of the seven domains of the plan. This plan serves as the base for four different but related action items within the Olmstead Plan.³ The state's community organizations, and the historically underrepresented and under resourced communities they work for, are important resources and assets to our state that also deserve greater recognition. Collaborations between the subcabinet agencies, the Olmstead Implementation Office and community organizations should be a model for public engagement in our state.

Successful engagement efforts will reflect the following principles and values:

1. Engagement efforts provide information for state agency decision making. Efforts should be timed to provide an opportunity for people to influence the policies and plan content.
 - Participants should understand when and how their efforts will influence and change planning efforts and action item/policy development.
 - The experience should reflect shared learning and multi-directional problem-solving. Engagement should address issues that people with disabilities or the broader community have identified, not merely the action item-specific needs of the agency.
 - The time and investment of all participants is valuable.
 - Discussions and problem-solving should occur early in an action item process and on an ongoing basis to solidify long-term relationships.
 - Meetings, problem-solving sessions, and other in-person interactions should be planned with advance notice to participants, a clear understanding of what to expect at the meeting, opportunities to participate at other times, in other ways, promoted widely and via multiple means (web, email, newspapers, radio and television stations, community organizations, posting flyers in public places, etc.), at times and places where people naturally convene, with an opportunity to enhance community connections. Accommodations should be made for transportation, childcare, personal care attendants, etc.
2. Engagement efforts involve residents and communities as full and equitable partners in public decision-making. Some residents and communities may require different approaches to ensure participation.
 - Opportunities for participation should be flexible, appropriate to the scale of the action item or planning effort, and responsive to the needs of the participants.
 - Community members should understand the tangible benefits for their participation in an action item. Whenever possible and appropriate, funds should be made available to community organizations (primarily non-profit organizations) to participate and engage their communities.
3. Planning for engagement efforts should include input and direction from directly affected communities.
 - Each action item and planning effort will require different approaches. Effective engagement involves preliminary consultation about the community's values related to

³ OV 3A page 32 of the Olmstead Plan, CE 1A, CE 1B, and CE 2A page 83 of the Olmstead Plan.

- an issue, the appropriate method and venue for engagement, and establishing expectations for ongoing communication and engagement.
- Each action item and planning effort should include an assessment of the affected communities and appropriate measures of success, inclusion, and culturally appropriate approaches and communication techniques.
4. Engagement efforts should work to mitigate existing racial, ethnic, cultural or linguistic barriers and include diverse races, cultures, genders, sexual orientations, and socio-economic and disability statuses. Engagement efforts should be culturally competent, in that they reflect and respond effectively to racial, ethnic, cultural and linguistic experiences of people and communities.
 5. Engagement efforts will be coordinated to provide sufficient context about how all policy and systems plans work together. Materials will be presented in plain language, and with detail appropriate to the audiences. Translation of materials and interpretation services will be provided when necessary. Among the items participants should clearly learn:
 - Timeline for decision-making and current status of the process
 - Who has the power to make decisions?
 - When will decisions be made?
 - How will my input be used? How will I be able to track and watch my input affect the process?
 - How can I directly interact with decision-makers?
 6. The Olmstead Implementation Office and state agencies will periodically report back to constituencies and communities regarding outreach and engagement efforts to communicate progress.
 7. Whenever possible, people with disabilities and/or community organizations will serve as experts for planning and implementing outreach strategies.
 8. Whenever possible and allowed they should be compensated/reimbursed for expenses.

Engaging Equitably

The disability community is historically an underrepresented group. It is also a group that is quite diverse as disability does not discriminate based on skin color, age, socio-economic status, ethnicity, etc. Anyone can join this group at any time; this places new emphasis on the importance of engaging communities equitably, to intentionally engage historically underrepresented and under resourced communities - such as communities of color, individuals with disabilities, aging adults, Lesbian, Gay, Bi-Sexual, Transgender, Queer, Intersex, Pansexual, Asexual, and Allies (LGBTQIPAA), and youth – in a way that more directly addresses existing social inequalities.

Equitable outcomes are shared outcomes – they reflect the values and needs of the community collectively – including the neighborhood, city, county, or broader community – as it relates to planning and policy making, whether broadly or on a specific action item. These outcomes specifically address communities traditionally left out of the decision-making process. Engaging equitably means approaches to problem-solving need to be flexible and accessible to people and recognize that a one-size-fits-all approach may be equal, but does not equip participants to be successful.

In public decision-making processes, community engagement is an intentional, strategic, purposeful process to connect and empower individuals and communities. It is multi-dimensional and flexible to meet residents where they are and engage diverse and historically underrepresented communities to achieve equitable outcomes. An accessible, respectful community engagement process is proactive, culturally appropriate, inclusive, and ongoing, with both short-term and long-term impact.

True community engagement goes beyond consultation to authentically facilitate community involvement in decision-making. It recognizes the value of building relationships and leadership capacity among agencies, community organizations, and residents. It provides ongoing relevance and awareness, and helps leverage community momentum and interest.

True community engagement results from intentionally organizing individuals and communities to understand issues, identify concerns and considerations, and engage in problem-solving. It cannot strictly begin and end with one or more self-contained action items, but needs to build upon each effort by deepening community connections and understanding. While enriched by participation by individuals, it must not strictly rely on volunteer efforts or people with means and time to participate, but must be structured with the understanding that accommodations and financial support may be required to deepen involvement. It is also understood that financial support may not be possible in many cases.

Why Create Opportunities for Community Engagement?

Community engagement efforts strengthen planning processes and policy development. Minnesota's Olmstead Plan supports robust community engagement efforts because they create better results. It also recognizes the value of long-term relationships between the Subcabinet, Olmstead Implementation Office, state agencies, and people with disabilities, local governments, law makers and the community at-large.

Community engagement provides valuable opportunities for planners, policymakers, and the public to interact and discuss key issues of public policy. Together, they connect the day-to-day experiences of the state's residents, the technical knowledge and expertise of government agency staff, and the understanding of state-wide needs.

Creating Additional Opportunities for Ongoing Community Engagement

Advisory bodies

The subcabinet agencies along with the Olmstead Implementation Office and others have various advisory bodies that provide key opportunities for stakeholder participation. These existing advisory bodies, along with additional groups, should continue to be utilized as a part of engagement efforts. Through the implementation of this plan these bodies can be enhanced by expanding their diversity and increasing opportunities for leadership throughout the activities in which they are engaged. They allow members, representing a cross-section of key stakeholder groups, to help shape policies and action items. Advisory bodies may conduct studies, recommend action to the subcabinet, agencies, or Olmstead Implementation Office, and/or provide expert advice.

Assure Inclusion

The Olmstead community engagement process will be a proactive public engagement process that provides public access to key decisions. The community engagement process should provide timely information about issues and processes to people with disabilities, affected agencies and other interested parties and segments of the broader community affected by plans, programs and action items, events and policies statewide.

In addition, the subcabinet, Olmstead Implementation Office and agencies will collaborate directly with the public and traditionally underrepresented populations (people with disabilities, people of color, immigrants, low-income populations, aging adults and youth), as well as community advocates, and partners in statewide public engagement. The Olmstead Community Engagement Plan acknowledges the importance of flexibility when planning engagement to meet the specific needs of Minnesota communities. Agency Staff will build relationships with community organizations to effectively plan for inclusive engagement opportunities.

Engagement opportunities will be structured to meet the needs of audiences, to assure participation is meaningful both to participants and decision-makers.

The Olmstead engagement process will be iterative, with periodic evaluation and adjustment to assure expected outcomes will be achieved. Technical assistance and training will be provided to agency staff, counties and local governments, as well as other interested stakeholders to ensure understanding of the Olmstead engagement process.

The Olmstead subcabinet and Olmstead Implementation Office will also provide information and opportunities to comment in multiple formats. Anyone having trouble accessing information should contact the Olmstead Implementation Office to inform them of any issues. These issues will be addressed by the office.

- To ensure compliance with the Americans with Disabilities Act (ADA), Olmstead meeting notices and comment opportunities will provide multiple input methods. Public meetings are to be held at ADA-accessible locations, and notices and information are published on the Olmstead website.
- Public meeting notices are published at least 14 days in advance to provide needed planning time for people who rely on public transit, Metro Mobility or special arrangements to get to events.
- Larger type materials, Braille or raised-print notices, recorded material, and other formats are available upon request.
- Material displayed on the Olmstead website will be accessible. Printed material is available in electronic formats for participants to use on personal equipment.
- Materials will be written in plain language, allowing for easier understanding and translation into languages other than English.

- Materials may be translated into languages other than English, based on needs of participants. Interpreters and/or captioning services will be made available when necessary at public events (including sign language interpreters).
- Amplification systems will be used at public events, whenever possible.
- Public notices may contain statements in languages other than English to encourage participation and provide instruction on requesting an interpreter at a public event.

Strategies

This plan identifies engagement strategies that reflect commonly used practices in planning efforts, as well as communications and engagement practices used by other government agencies and organizations.

Engagement strategies should embody two overriding principles: engagement is about building long-term lasting relationships, and it's important to be present in and connected to communities in order to build long-term relationships. This means participating in other community conversations, events and activities, even when the Subcabinet, Olmstead Implementation Office or subcabinet agencies do not have a specific role in an event of conversation.

General strategies for Community Engagement

- Leverage partnerships and feedback from Governor appointed disability councils, groups and boards.
- Collaborate directly with the public and traditionally underrepresented populations (people with disabilities, people of color, immigrants, low-income populations, ageing adults, and youth), as well as community advocates, and partners in public engagement. Collaboratively set goals and outcomes for engagement efforts.
- Appoint policymaker and technical groups to advise agency work on Olmstead items, both at the policy level and in operational divisions as appropriate. When necessary, include business and community interests on these advisory boards or create specific groups to address the needs and engage these interests. These boards should have a specific role in directing the activity they are advising and setting meeting agendas. Each meeting agenda should include a progress report on the action item.
- Create opportunities for the general public to engage in similar conversations and decision-making as advisory groups. Whenever possible, create opportunities for all these stakeholders to interact and discuss relevant issues together to advise the process and decision-making.
- Coordinate with the subcabinet, Olmstead Implementation Office, agencies and community-based engagement efforts in cities, counties, and other areas on related topics and major initiatives, to the extent possible.
- Sponsor periodic listening sessions and workshops to feature policies, key topics, and other content from the Olmstead Plan.
- Use online interactive spaces, including social media platforms, to gather feedback and foster discussion about Olmstead activities and policy plan content.

- Plan informal activities to provide members of the community with information and an opportunity to inform and influence planning processes. Informal activities would include reaching out to the disability community, being present at community events, and coordinating with other Olmstead related surveys.

Communication strategies for Community Engagement

- Assess desired methods for updating audiences and constituencies specifically affected by an effort. Build this regular reporting into the communications and outreach plan for each effort.
- Develop and implement a promotional campaign (includes web pages, social media content, new releases, newsletter articles, background for presentations, working with partners to disseminate content).
 - Create editorial calendar to highlight topics in various Olmstead products – including traditional and social media.
 - Develop and host content for the Olmstead web site.
 - Create content on the Olmstead web site to describe the key actions and policy topics. Make it prominent on the site. Update content regularly via editorial calendar. Highlight aspects that are timely.
 - Use the Olmstead web site to highlight content and illustrate efforts and discussion, and summarize progress and feedback.
- Create topic for electronic mailing system that stakeholders and the public can sign up for or be subscribed to.
- Work with action item staff to assign a point of contact for questions from the public and stakeholders. Communicate updates periodically through the Olmstead web site, newsletters, etc.
- Send updates and summaries regularly to local government agencies and external groups, as necessary.

Community Engagement Oversight

The Olmstead Implementation Office is responsible for oversight of the community engagement plan and will respond to inquiries regarding Olmstead community engagement activities and implementation of this plan. Any issues that have not been resolved through cooperative efforts between the Olmstead Office and subcabinet agencies responsible for participation processes will be brought to the subcabinet for review.

Olmstead Subcabinet agencies are responsible for integrating this plan into their work and providing funding for engagement efforts related to their Olmstead work. Agencies are also responsible for reporting on their engagement efforts to the Subcabinet through the Olmstead Implementation Office reporting structure.

Counties, Cities and other local governments are encouraged to adopt the principles and guidelines set forth in this plan and integrate them into their public work. Action items funded with public dollars may be asked to report their engagement activities and outcomes as well.

Measuring Success of Olmstead Plan's Community Engagement

At the beginning of any Olmstead related effort, the agency staff will perform an assessment of groups that will be directly affected or may have an interest. For statewide Olmstead efforts, that will always include a broad array of stakeholders from across the state. Audience assessments will specifically address groups that are historically underrepresented in planning and policy making efforts.

Following this initial assessment, staff will consult with community organizations, and other stakeholders to confirm the audience needs and to begin planning for engagement related to the effort. This will include discussion about goals for engagement and desired outcomes.

Once goals have been identified and/or established, a combination of qualitative and quantitative measures will be used to evaluate the success of the community engagement activities. Evaluation will take place on an ongoing basis throughout the action item. Periodic evaluations will be followed by mid-action item assessment to assure strategies will result in expected outcomes and staff will make necessary adjustments.

At the conclusion of an action item, staff from the agency leading the engagement effort will first survey participants to assess how well they engage their communities. The qualitative approach can include various approaches including individualized interviews, debriefing meetings, email correspondences, etc. The following elements should be included:

1. What methods and structure were used to make an engaging experience for participants?
2. How did participants feel their time and opinions were valued? Or not valued?
3. Did participants understand the goal of the outreach effort and their role?
4. How were participants contributions reflected in the final product?
5. Would people participate in another outreach activity?
6. How did participants get regular updates about progress on the action item?
7. At what points in the action item did participants get updates about progress on the action item?
8. Share participant opinions regarding the overall quality of their experience with the agency and the engagement effort.

Staff from the agency leading the engagement effort will also call together partner agencies for a meeting to debrief on the outreach efforts, including what worked, what didn't, lessons learned and what could be improved for future efforts. In addition, the agency staff leading the engagement effort will survey partners who were involved in setting goals and expectations for the effort to assess whether expected outcomes were achieved.

A number of quantitative measures will also be collected:

1. Number of people participating in community engagement activities
2. Number and diversity of organizations participating in action items and policy efforts
3. Number of individuals who participate in related discussions on the Olmstead or Agency web sites, social media platforms, and online information-gathering sites

4. Number of state, county, city and township governments whose staff and/or policymakers participated in action item efforts
5. Earned media related to action item efforts (and comparisons, as available)

These measures will be gathered by the Olmstead Implementation Office as a part of the status/implementation reporting process currently used by the subcabinet agencies. In addition, on an ongoing basis, Olmstead Implementation Office staff will work with members of the state disability community and representatives from different segments of the broader community to assess needs and measure the level of engagement in subcabinet operations. This may include, but is not limited to, convening focus groups, conducting surveys, convening independent review boards, and on-on-one interviews. These assessments will be presented to the full subcabinet during updates that are established to measure progress toward Olmstead community engagement goals.

Why Is There a Need For a Community Engagement Plan?

Guidance for Local Communities

This community engagement plan provides guidance for engagement on Olmstead efforts, as well as collaborative efforts with federal, state and local organizations. The Olmstead Implementation Office, under the subcabinet, will also be tracking best practices and highlighting community engagement work that supports the principles in this plan and expands the state's understanding of successful community engagement.

As identified in Minnesota's Olmstead Plan, the Olmstead Implementation Office will provide technical assistance and information resources to support opportunities for people with disabilities to serve in leadership roles and have meaningful participation in policy development.

When planning for engagement efforts, government agencies should create an inclusive list of all aspects of the community that may be affected or have a role in fulfilling the goals of the action item or event. At the beginning of this process, agencies should engage members of affected groups and collaborate on planning engagement efforts that will facilitate broad involvement and result in better, more equitable outcomes.

Agencies and/or local governments should also identify key staff resources to serve as points of contact for the public, as well as funds to support creating an appropriate environment for engagement. People need to feel welcome, that their participation is valued, and that their time is respected in order to engage fully.

In addition, as noted earlier in this plan, engagement efforts should follow these principles:

- **Equity:** residents and communities are partners in decision-making
- **Respect:** residents and communities should feel heard and their interests included in decisions.
- **Transparency:** residents and communities should be engaged in planning and decisions should be open and widely communicated.
- **Relevance:** engagement occurs early and often throughout a process to assure the work is relevant to residents and communities.
- **Accountability:** residents and communities can see how their participation affects the outcome; specific outcomes are measured and communicated.
- **Collaboration:** engagement involves developing relationships and understanding the value of residents and communities bring to the process. Decisions should be made with people, not for people.
- **Inclusion:** Engagement should remove barriers to participation that have historically disengaged residents and communities.
- **Cultural Competence:** Engagement should reflect and respond effectively to racial, ethnic, cultural and linguistic experiences of residents and communities.

Best Practices for Engagement

The principles, examples, and information included in this community engagement plan are based on an existing plan drafted by the Metropolitan Council. The Metropolitan Council’s plan from which this is based is the result of collaboration and shared learning with partners both within the Twin Cities region and from the good work of communities around the country. Additional literature was reviewed as well⁴ to ensure best practices were included.

The Olmstead Implementation Office will, in addition to this plan, maintain a toolbox on our web site highlighting best practices for engagement, and provide links to key information and resources on engagement. This will be a growing, living resource. The toolbox can be accessed at www.mn.gov/olmstead.

The Olmstead Implementation Office Needs Information

These worksheets should be used by planning and program staff to assist in assessing your process, purpose, audiences, potential barriers, impacts and strategies through the perspectives of the participants to inform the overall approach to creating an engagement plan for your action item. This will also provide the information that the Olmstead Implementation Office will need to conduct an assessment of what our community engagement work looks like and how well we engage communities.

⁴ Family Voices of Minnesota. (2014). *Developing a Structure for On-going Communication Between Families of Children, Youth or Young Adults with Disabilities and the Minnesota Department of Human Services*.
The Arc Minnesota. (2014). *Self Advocate Input and Involvement Report for the Disability Services Division*. St. Paul.

Engagement Planning Worksheet

This worksheet is a subjective tool. Fill out the worksheet as completely as you can. There are several places, identified with an asterisk (*) where it may be appropriate to consult with the Olmstead Implementation Office prior to finalizing any engagement plans. Olmstead Implementation Office staff can also help you identify existing community partnerships that may benefit your effort.

1. Action item Name and Objective(s)

Briefly describe your action item and what the action item will accomplish. Include a timeline and any other process-related information that may affect engagement decisions. In your timeline, indicate opportunities to conduct mid-action item evaluations of engagement efforts.

2. What is the purpose of engagement on your action item? What engagement goals does your action item hope to achieve?*

3. Who will specifically be affected by your action item (both potential positive and negative impacts)? Specify how they will be affected.

Examples include: specific disability populations, cities, counties, neighborhoods. Use data when available to identify populations affected.

4. Will your action item directly or indirectly address any of the following groups or issues?

People have many different identities and these identities don't always fit neatly into the categories that agencies have in place. This list is not meant to be comprehensive and is meant to cover a broad array of commonly noted identities or issues. Please check those that apply.

- | | |
|---|---|
| <input type="checkbox"/> People with disabilities | <input type="checkbox"/> Other racial/ethnic groups |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Aging Adults |
| <input type="checkbox"/> Physical/mobility | <input type="checkbox"/> LGBTQIPAA ⁵ communities |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Developmental/Intellectual Disabilities |
| <input type="checkbox"/> Deaf/Hard of Hearing | <input type="checkbox"/> Communities of color |
| <input type="checkbox"/> Institutional racism, ableism or other disparity | <input type="checkbox"/> People who use a language other than English |
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Traumatic Brain Injury |

Describe specifically how:

⁵ Lesbian, Gay, Bi-Sexual, Transgender, Queer, Intersex, Pansexual, Asexual, and Allies

5. **What do you know about public and stakeholder perspective on the issues involving this action item? What information will they need? How can we otherwise address any concerns?***

6. **What specific outcomes are anticipated with this action item? What decisions will result from this action item?**

7. **How can stakeholders be involved in the decision-making process?**

8. **Are there specific opportunities with this action item to promote inclusion, reduce disparities, or otherwise address equity considerations?***

9. **Are there specific opportunities with this action item to build leadership capacity in the community?***

10. **What resources will you need for engagement?**
 - Internal action item management
 - Lead outreach/engagement staffer
 - Other staff
 - Community resources
 - Funding

11. **Will you be using contracted services for this action item? Are there opportunities to support local or community-based professionals or organizations to do any work on this action item?**

12. **As part of the planning process, staff will likely meet with external stakeholders to discuss goals for engagement. Do you have recommended community stakeholders we should interview or meet with?⁶**

⁶ Pages 1-16 of this document were adapted with permission from the Metropolitan Council's Public Engagement Draft Plan.

Quantitative Measurement Worksheet

This worksheet is a tool to capture quantitative data. This should be used by planning and program staff to assist in tracking the number of people you have participating in your process, how they are participating, as well as what diversity groups they may identify with. This may be used at any point during the process and notes should be made to reflect if participants are potentially counted multiple times during a process or not. For example: If there are three in person meetings and Pat is a person with a disability that participates in all three meetings, Pat could potentially be counted three times. It is preferable to have individuals counted only once however some modes of participation are not conducive to this type of tracking and that should be noted by the agency gathering the data.

Type	Number Participating	Diversity Groups (check all that apply) <i>People have many different identities and these identities don't always fit neatly into the categories that agencies have in place. This list is not meant to be comprehensive and is meant to cover a broad array of commonly noted identities or issues. Please check those that apply.</i>
People		<input type="checkbox"/> People with disabilities <input type="checkbox"/> Mental Health <input type="checkbox"/> Physical/mobility <input type="checkbox"/> Blind <input type="checkbox"/> Deaf/Hard of Hearing <input type="checkbox"/> Developmental/Intellectual Disabilities <input type="checkbox"/> Autism Spectrum Disorders <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Other racial/ethnic groups <input type="checkbox"/> Aging Adults <input type="checkbox"/> People who use a language other than English <input type="checkbox"/> Institutional racism, ableism or other disparity <input type="checkbox"/> Communities of color <input type="checkbox"/> LGBTQIPAA ⁷ communities
Organizations		
Web sites, social media platforms, online information gathering sites		
State, county, city and township governments staff/policymakers		
Earned Media		

⁷ Lesbian, Gay, Bi-Sexual, Transgender, Queer, Intersex, Pansexual, Asexual, and Allies

Qualitative Measurement Worksheet

This worksheet is a qualitative tool to capture the story of our community engagement work from the participant perspective. It should be used by planning and program staffs to assist in assessing how people with disabilities you have participating in your process feel about the engagement process. This is not for the opinions of the staff working on the action item. It should be used at the end of an action item, but could also be used as a part of a mid-point check in.

- 1. What methods and structures were used to make an engaging experience for participants?**
- 2. Explain how participants felt their time and opinions were valued? Or not valued?**
- 3. Did participants understand the goal of the outreach effort and their role?**
- 4. How were participant contributions reflected in the final product?**
- 5. Would people participate in another engagement activity?**
- 6. How did participants get regular updates about progress on the action item?**
- 7. At what points in the action item did participants get updates about progress on the action item?**
- 8. Share participant opinions regarding the overall quality of their experience with the agency and the engagement effort.**

II. Inclusion in Public Processes – CE 2A

The Minnesota Olmstead Plans calls for the state to “*evaluate, revise as necessary, and disseminate guidelines and criteria when public dollars are used for ensuring that people with disabilities are incorporated in public planning processes, and that plans for public facilities and events are informed by attention to inclusion of people with disabilities. The guidelines and plans for incorporating them in public processes will be reported to the Olmstead Subcabinet or their designee.*” ([CE 2A from page 83 of the Plan](#))

Background

Engaging people with disabilities and other underrepresented groups leads to strengthened planning processes and policy development. It can create better results and connections for people and communities; and it can be a way for people to share knowledge and expertise. Minnesota has been recognized for the good work done when engaging people with disabilities in large publicly funded projects in the past, i.e. the Twins stadium now known as Target Field. However, this type of engagement does not always happen or it is not always as successful as the Twins example, therefore we need some guidelines and criteria to assist those working on these types of projects in their work.

What Can Be Done

The Olmstead Community Engagement Plan will be used as the base for the plan called for in the action item CE 2A. Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The Olmstead Implementation Office will provide technical assistance and training related to the engagement plan to counties, cities, and others involved in publicly funded projects as needed to ensure understanding.

In addition to these measures, the Olmstead Implementation Office is also working with the State Treasury and Bonding Office and Minnesota Management and Budget to determine appropriate data sources for the creation of a baseline measurement of publicly funded action items at the state level. This information will be the first step toward ensuring that people with disabilities are included and engaged in action items that are publicly funded and that their input is used in meaningful ways. This baseline measure will be established by June 30, 2015. In addition to the baseline measurement and goals to be set related to publicly funded projects cities, counties and other local governments will be provided with this community engagement plan and toolbox to aid them in engaging people with disabilities in their projects. The Olmstead Implementation Office will offer education sessions to train county and other local government staff at least two times per year on the Olmstead Community Engagement Plan. The purpose of these sessions will be to familiarize staff with the plan and its requirements as well as teach them to train others on the same material.

Inclusion in Public Processes Challenges

Many projects receive some level of public funding, however it is generally only the large projects like new public facilities such as sports stadiums that get a great deal of attention. It is important to include a wide variety of voices on all types of projects. At this time, we lack a broad data source that would identify all publicly funded facilities and events. Knowing that, we will start with those large projects that require bonding and revise this plan as other data sources become available.

As many counties and other local governments may not be familiar with the best practices for community engagement outlined in the Olmstead Community Engagement Plan it will be important to provide training for these groups.

Specific Goals and Timelines

Goal	Timeline
The OIO in collaboration with State Treasury and Bonding Office and Minnesota Management and Budget will create a baseline and set goals for identifying publicly funded projects.	By June 30, 2015
The OIO will provide training sessions on the Olmstead Community Engagement Plan for subcabinet agency staff beginning with agency leads at least quarterly.	Beginning by June 30, 2015
The OIO will provide “train the trainer” education sessions on the Olmstead Community Engagement Plan beginning with subcabinet agencies at least 2 times per year.	Beginning by June 30, 2015

III. Policy Development and Meaningful Participation – CE 1A

The Minnesota Olmstead Plan calls for “*the state to develop a plan to increase opportunities for people with disabilities to meaningfully participate in policy development and provide the plan to the Olmstead Subcabinet by December 31, 2014.*” ([CE 1A from page 83 of the Plan](#))

Background

Each agency has various groups and individuals that they work with to get input on disability related issues. These groups should continue to be used and can be even more effective and diverse by implementing the strategies included in the Olmstead Community Engagement Plan.

Engaging people with disabilities is an important part of the Olmstead Plan and leads to strengthened planning processes and policy development. It can create better results and connections for people and communities; and it can be a way for people to share knowledge and expertise.

What are Policy Development and Meaningful Participation?

The Minnesota Olmstead plan calls for increasing the capacity for people to exercise their right to participate in their community and in ways that are meaningful to that individual. There are likely as many ways to have meaningful participation in policy making as there are people in Minnesota, this plan addresses only a few ways in which we can do that.

Given that there are many ways to define meaningful participation this document and we cannot address them all at one time, this document uses the following definition for meaningful participation.

Meaningful participation assures that people with disabilities are included in planning processes and development of policies that affect their daily lives. This includes participation at all phases (assessment, planning, implementation or service delivery and evaluation). People with disabilities are engaged respectfully as experts and partners. Their contributions can be seen in the work, processes are transparent and barriers to participation have been removed wherever possible.

What Can Be Done

The Olmstead Community Engagement Plan will be used as the base for the plan called for in the action item CE 1A. Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The measurement processes within the Olmstead Community Engagement Plan will be used to assess engagement of people with disabilities and the level of meaningfulness of that engagement process. The Olmstead Implementation Office will provide technical assistance and training related to the engagement plan to ensure understanding.

The Olmstead Implementation Office utilizes an advisory council comprised of representatives from the 23 Governor appointed groups, councils and boards listed in the Olmstead Plan ([page 133](#)). Each of these groups has received invitations to designate a representative for the Olmstead Advisory group. As of the date of this plan, there are 6 members of this group. The group has been used to share input on different topics related to the Olmstead Plan and at different points in the process from planning and

development to final review and feedback throughout. We would like this group to expand and work on more action items going forward. Additionally, the OIO will work with the subcabinet and the agency representatives to seek additional funding that would be used to support this group. This could be in the form of a legislative request or grant proposals from private philanthropic organizations. At least one request will be made by December 31, 2015.

The combined membership of the Governor appointed groups, councils and boards is 150 people. Many are people with disabilities, family members, or advocates. These groups have a collective power that can be used to effect the transformational change intended by the Minnesota Olmstead Plan. The Olmstead Implementation Office will continue to work with these groups and others to affect change.

Measuring Policy Development and Meaningful Participation

Each subcabinet agency is required to submit status/implementation reports to the Olmstead Office regarding their action items on a bi-monthly basis. These reports are reviewed for compliance including whom, how and when people with disabilities have been included in the action item process.

In addition to the status/implementation reports, upon adoption by the subcabinet, the community engagement plan and toolbox will be disseminated to the subcabinet agencies for implementation. The worksheets included in the community engagement plan will then become a reporting requirement that will be submitted to the Olmstead Office for the purpose of measuring community engagement in policy development. Beginning with the September 2015 status reports, information related to engagement will be gathered from the worksheets and be used to create a baseline measurement by December 31, 2015. From this baseline goals will be set and this plan will be amended.

The Olmstead Implementation Office advisory group will serve as an additional measurement, which will be expanded over time. By 2019, the goal is to have 30 people with disabilities participating in the Olmstead Office advisory group. Following the implementation of the engagement plan additional measures may be developed to document the increased opportunities for people with disabilities to participate meaningfully in policy development.

The Olmstead subcabinet and Olmstead Implementation Office will work with the Governor's appointed councils, groups and boards to engage them in the creation of a plan that aligns one or more of their goals with a related action within the Olmstead Plan by December 31, 2015.

Policy Development and Meaningful Participation Challenges

As noted in the Olmstead Community Engagement Plan, engagement is a long-term commitment to build relationships with the community. Not all agencies have fully developed positive relationships with diverse communities. This may be a challenging new way to approach the work that they do and it will take time to develop the relationships necessary for robust community engagement in the future.

Additionally, individuals and community organizations should be compensated/reimbursed for expenses whenever possible. This may require agencies to change internal policies or find funding sources that may be different from what they are accustomed to. Often times additional funding may not be possible.

As there are many different ways for people to participate that they find meaningful and this plan cannot begin to address all of them; it is important that we continually review this plan and revise as needed to be sure that we are engaging people in a manner that is meaningful for them as well as the agencies.

Specific Goals and timelines

Goal	Timeline
In conjunction with the subcabinet and agencies the OIO will develop at least one funding proposal to support Olmstead Advisory Group.	By December 31, 2015
The OIO will create a baseline and set goals for increased engagement based on data collected from agencies starting two months after the adoption of the Olmstead Community Engagement Plan.	Anticipated completion by December 31, 2015
The OIO in conjunction with the subcabinet will increase number of members of the Olmstead Advisory group to 30 members.	December 31, 2019
The OIO will work with Governor's appointed councils, groups, etc. to create a plan that aligns one or more of their goals with an Olmstead goal.	December 31, 2015

IV. Self-Advocacy and Peer Supports– CE 1B

The Minnesota Olmstead Plan states that *“in consultation with people with disabilities, family members, and diverse community groups, the state will assess the size and scope of peer supports and self-advocacy programs; based on this information that state will set annual goals for progress. Recommendations, including funding and any necessary legislative changes, will be made to the subcabinet.”* ([CE 1B on page 83 of the Plan](#))

Background – Self-Advocacy

There are a number of self-advocacy training groups/programs throughout the state and nationally. These groups and training programs have their roots in the developmental and intellectual disability community. However, over the years they have expanded to include other disability groups as well. As noted by both anecdotal comments and research conducted by the Association of University Centers on Disabilities the future of these groups is dependent on four primary things.

- Infrastructure to support self-advocacy and peer supports
- Community Services and Supports
- Outreach and Communication
- Change in Public Perceptions

The Olmstead Implementation Office reviewed literature regarding self-advocacy and peer supports and consulted with people with disabilities, family members, community groups and state agencies in order to assess the size and scope of programs in Minnesota. A listing of these stakeholders is included at the end of this document. Stakeholders were asked to share experiences and recommendations during the planning process as well as throughout the writing of this plan.

We learned that groups are formed in a number of ways. Some are started by gathering individuals that share similar interests, while other form within or in conjunction with organizations. Groups range from informal discussions hosted on social media sites to more formal groups that provide training and support for self-advocates. Since there are so many types of groups and variations in how they operate it was difficult to find a source that listed everyone. We did find one source that provides some of this information in the form of a state-by-state listing of groups that can be searched at [self-advocacy online](#). As of December 2014 Minnesota has 23 organizations listed on this site. Some larger groups stood out during the research for this plan.

- People First
- Self-Advocates Minnesota
- The Arc Greater Twin Cities Self-Advocacy Advisory Committee

In addition to these groups there are also training programs available to help people with disabilities better understand the policy making process and how to be most effective in sharing their story with others. While there are many programs, two stood out during the research for this plan.

- NAMI “In Our Own Voice”
- Olmstead Academy

Background – Peer Support Services

Peer support services differ in some ways from self-advocacy although there are also some similarities. Peer support services are primarily a product coming from the mental health community, although some feel that the concept could be applied more broadly across disability types. Certified Peer Specialists can be a billable service under Medicaid rules and have been allowed in Minnesota since 2007. There are four Medicaid Rehabilitation Services that can include the use of Certified Peer Specialists.

- Adult Rehabilitative Mental Health Services (ARMHS) certified by DHS
- Assertive Community Treatment (ACT) teams approved by DHS
- Crisis Response -Stabilization providers certified by DHS
- Intensive Residential Treatment Services (IRTS) providers licensed by DHS

Peer support specialists self-identify and work with their peers to assist them in their recovery process. Peer support specialists can perform a variety of tasks and in Minnesota, there are two different levels of certification, with separate qualifications for each level⁸. Continuing education is also required in order to maintain certification.

Currently the Minnesota Department of Human Services (DHS) has adopted the use of Recovery Opportunity Center’s curriculum for the training program. 325 individuals have been trained and certified as Peer Specialists and based on past surveys of graduates 50-60% of graduates have been employed as a Certified Peer Specialist at one time.

Peer Support Services Challenges and Limitations

Without any, one of the four areas noted previously it is difficult for groups to continue, much less grow their numbers. Funding and infrastructure seem to be the biggest barriers for most groups. Others are bound by the constraints such as manageable group size or number of opportunities for participants to share their stories or work with others.

Many groups struggle with finding a regular meeting space, transportation, as well as competition from other advocacy groups. Some training curriculums, while providing outstanding information are also quite intensive for both participants and instructors limiting the number of times they can be offered.

Certified Peer Specialists may have a difficult time finding employment opportunities once they graduate as many providers do not offer these services as a part of their service options, or there are other barriers to employment such as transportation, background checks, etc. Low reimbursement rates may also deter providers from offering these types of services.

⁸ More information can be found at

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dDocName=dhs16_149185&RevisionSelectionMethod=LatestReleased

Measuring Self-Advocacy and Peer Supports?

As noted in the limitations section, there are several factors that hinder broad measurement at this time. That being noted three groups/programs were selected as the baseline measurement from which to set goals and work toward expansion of opportunities. These groups are a point from which to start but in no way represent the only opportunities for increasing self-advocacy and peer supports.

- Self-Advocates Minnesota (SAM) – 100 core participants
- Olmstead Academy - maximum of 21 participants per class
- NAMI “In Our Own Voice” – maximum of 16 participants per session

Self-Advocates Minnesota (SAM) has chapters throughout the state. While there are currently an estimated 100 core participants they touch the lives of many more. The goal is to increase the number of core participants in SAM to 150 by 2019.

The Olmstead Academy had its inaugural year, kicking off in the fall of 2014. This program was initially funded through a grant and most participants identify as having a developmental or intellectual disability, however, a legislative request has been submitted for funding to continue the program. Additionally, the program can be licensed to other groups and communities, such as those that have a primary language other than English or identify with a different disability type. The goal is to expand this offering to 6 groups/communities by 2019.

“In Our Own Voice” is a public education program created by NAMI (National Alliance on Mental Illness) in which two trained speakers share compelling personal stories about living with mental illnesses and achieving recovery, showing in person that there is hope for recovery. Presenters are trained how to effectively share their story with others to change attitudes and stereotypes regarding mental illnesses. Class size is limited to 16 participants per session. Participants are asked to present four times during the year following training with opportunity to present more often and to continue for more than one year. “In Our Own Voice” presenter trainings in Minnesota are dependent upon funding and grant renewals. Typically, NAMI Minnesota trains new presenters once per year with interest in training more often if funds are available. An Olmstead goal has been set to increase the training from 1 time per year to 2 times per year by 2016 and maintaining that going forward.

What Can Be Done

The Olmstead Implementation Office and subcabinet agencies will provide technical assistance to each of these programs as needed. The Olmstead Implementation Office will report on the progress toward the goals as a part of our annual report. Additionally, we will add links to our website to assist people in finding self-advocacy and Peer support services, groups and training. As noted in the principles for engagement section of the Olmstead Community Engagement Plan people and/or organizations involved in action items should be compensated/reimbursed for expenses. In order to provide compensation/reimbursement many agencies may have to make changes to internal policies and seek additional funding. It will be critical to include this in the planning process for any engagement activities. As the groups selected do not represent all of the possible opportunities for increasing self-

advocacy, the Olmstead Implementation Office will continually work with groups and organizations to explore the creation of additional partnerships in the future.

Peer Support Services is a highly complex area that requires further research to be conducted before setting goals. The Olmstead Implementation Office will continue to work with the Department of Human Services and other stakeholders to develop goals by June 30, 2015. Once those goals have been established this plan will be amended.

Specific Goals and timelines

Goal	Timeline
The OIO in collaboration with Self-Advocates Minnesota (SAM) will work to increase the core membership of SAM from 100 individuals to 150 individuals.	By December 31, 2019
The OIO in collaboration with Advocating Change Together will work to expand the Olmstead Academy model to 6 other groups.	By December 31, 2019
The OIO in collaboration with National Alliance on Mental Illness (NAMI) will work to increase the training for the "In Our Own Voice" program from one time a year to two.	By December 31, 2016
The OIO in collaboration with the Department of Human Services will conduct further research on Peer Support Services and develop a baseline and set goals.	By June 30, 2015

V. Leadership – OV 3A

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

By December 31, 2014 leadership opportunities will be identified and implemented.” ([OV 3A from page 32 of the Plan](#))

Background

Leadership is individual and can be difficult to define. It may be a paid position; it could be a volunteer position. Some roles may involve sharing experiences to inform decision makers, others may be in a decision-making role. Leadership roles are as diverse as the population. The Olmstead Office consulted with members of the Olmstead Office advisory group and other people with disabilities to find out what people felt a leadership opportunity is. It was determined that people define leadership roles differently. Some people see their role as a self-advocate as a leadership role. Some felt that their participation in advisory groups, councils and boards satisfied a leadership role. Some see employment with a state agency as a leadership role. Others were less defined but felt that the role needed to have decision-making capacity.

The Olmstead Plan has a separate action item related to increasing self-advocacy, however, it is applicable here as well as some individuals feel that self-advocacy is a leadership role. State agencies should set an example for the rest of the state in terms of including people with disabilities in leadership roles. Some ways this can be accomplished through would be through the use of advisory groups, councils and boards, as well as through increased employment of people with disabilities.

The Minnesota Governor’s Council on Developmental Disabilities created a leadership training program called Partners in Policymaking®. This program was developed to teach parents and self-advocates *“the power of advocacy, and change the way people with disabilities are supported, viewed, taught, live and work.”* (Minnesota Governor's Council on Developmental Disabilities) Through programs such as this and others, people with disabilities have learned that they can determine how they define a leadership role. Other groups such as the Minnesota Citizen Advocacy Academy and Courage Center have also held leadership trainings.

State agencies, Counties and local governments as well as private businesses will need to continue to think creatively as to how we can create greater opportunities for people with disabilities to take on leadership roles. Some people with disabilities have received Bush Foundation Fellowships or participated in the Blandin leadership program and these types of opportunities should be explored as additional routes to increased leadership opportunities.

What Can Be Done – Leadership #1 – Active Engagement with Governor Appointed Councils, Groups and Boards

The Olmstead Community Engagement Plan will be used as the base for the plan called for in the action item OV 3A. Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The Olmstead Implementation Office will also provide technical assistance and training related to the engagement plan to counties, cities, and others involved in publicly funded projects as needed to ensure understanding.

Additional leadership roles will be determined through a survey conducted with the Governor’s Appointed Councils, groups, boards, etc. to ascertain:

- how many of their members are persons with disabilities,
- what types of roles they serve in,
- and what types of technical support/training is supplied by the group or may be required
- as well as how this impacts monitoring and reviewing of community services and support and other policy development.

This survey will be completed by May 1, 2015 with results informing additional goals to be set and incorporated into this plan.

The Olmstead Implementation Office will engage with each of the Governor Appointed Councils, Groups, and/or Boards and work with them to develop a plan for coordination around one or more of their goals with a related action within the Olmstead Plan by December 31, 2015.

What Can Be Done – Leadership #2 – Increase Participation of Self-Advocates

The Olmstead Community Engagement Plan will be used as the base for the plan called for in the action item OV 3A. Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The Olmstead Implementation Office will also provide technical assistance and training related to the engagement plan to counties, cities, and others involved in publicly funded projects as needed to ensure understanding.

In terms of self-advocacy, the Olmstead Implementation Office is working with the Minnesota Consortium for Citizens with Disabilities (MN-CCD) to track the number of self-advocates participating in Tuesdays at the Capitol, a weekly event held at the capitol to inform and educate self-advocates and legislators; as well as share personal stories with law makers. This will begin in January 2015 and go through the remainder of the 2015 legislative session. By June 30, 2015, goals will be set based on this information and incorporated into this leadership plan.

What Can Be Done – Leadership #3 – Increase State Agency Employment

The Olmstead Community Engagement Plan will be used as the base for the plan called for in the action item OV 3A. Each of the subcabinet agencies will be provided with the community engagement plan and toolbox to supplement the engagement processes they already use. The Olmstead Implementation

Office will also provide technical assistance and training related to the engagement plan to counties, cities, and others involved in publicly funded projects as needed to ensure understanding.

Given the complexity of defining, what a leadership role is it is difficult to set one particular goal for increasing leadership opportunities. Although it is not the only type of leadership, one baseline for measuring increased leadership opportunities will be state agency employment. According to a recent Governor's executive order, approximately 2,635 current state employees identify as having a disability. The goal will be to increase that number to 3,540 by 2019.

As set forth in the executive order 14-14 this will be monitored and reported by Minnesota Management and Budget as well as individual agencies. This information will be shared with the public via agency websites as well as through the Olmstead Implementation Office reporting process. This group is also working to include opportunities for people with disabilities to gain access to state agency employment through internship programs that lead to long term employment.

Leadership Current Challenges and Limitations

As previously noted, leadership is defined by the individual and this plan does not address all of the different types of leadership opportunities that may be or could be available.

There are barriers to employment for people with disabilities that are currently being reviewed and worked on at the state level by a committee overseen by Minnesota Management & Budget (MMB), although it should be noted that this group will not be able to remove all barriers to employment.

Additionally, there is limited funding currently available to support individuals and/or groups when they participate in engagement activities making it difficult for some to participate in leadership roles. There are also social perceptions that create barriers to people with disabilities holding leadership roles. These limitations are not addressed in the scope of this plan.

What Can Be Done

The Olmstead Implementation Office will support the efforts being developed by Minnesota Management and Budget towards meeting the goals of the executive order. In addition the Olmstead Implementation Office will continue to review and monitor additional opportunities for leadership roles through the implementation of additional action items such as self-advocacy and peer supports and other groups such as advisory groups, councils and boards.

The Governor Appointed Group survey will be conducted and results will be used to set additional goals for increased leadership opportunities by May 1, 2015. Self-advocacy goals will be set by June 30, 2015 following data collection based on participation in Tuesday's at the Capitol and integrated into the plan as well.

Specific Goals and Timelines

Goal	Timeline
Minnesota Management and Budget, Office of Affirmative Action will monitor and share information related to progress on Executive Order 14-14, to increase state agency employment for persons with disabilities from 2,635 individuals to 3,540 individuals.	By December 31, 2019
The OIO in conjunction with the subcabinet will conduct a survey of all Governor’s appointed disability councils, boards, groups, etc. to ascertain how many of their members are persons with disabilities, what types of roles they serve in, and what types of technical support/training is supplied by the group or may be required as well as how this impacts monitoring and reviewing of community services and support and other policy development.	By May 1, 2015
The OIO will work with Governor appointed councils, groups, etc. to create a plan that coordinates one or more of their goals with an Olmstead goal.	By December 31, 2015
The OIO in collaboration the Minnesota Consortium for Citizens with Disabilities (MN-CCD) will develop a baseline and set goals to increase self-advocacy using data collected during the 2015 legislative session “Tuesday’s at the Capitol” sessions.	By June 30, 2015

Stakeholder Input

The following groups and/or individuals shared input related to this plan.

Olmstead Implementation Office Advisory Group – Consisting of representatives from the various Governor Appointed Disability Groups, Councils, Boards, etc.

The Arc Greater Twin Cities Self-Advocacy Advisory Committee

Advocating Change Together

Metropolitan Council

Centers for Independent Living

Minnesota Management and Budget Affirmative Action Office

Minnesota Consortium for Citizens with Disabilities

Subcabinet agencies

Advocate Aces

Shooting Stars

Believers in Self-Advocacy

NAMI-MN

University of Minnesota Research and Training Center on Community Living

EXHIBIT 6-30: OLMSTEAD SUBCABINET PROCEDURES

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OLMSTEAD SUBCABINET PROCEDURES

PREAMBLE

On January 28, 2013, Governor Dayton created the Olmstead Subcabinet to develop and implement a comprehensive Minnesota Olmstead Plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs in the most integrated setting, consistent with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).¹ On January 28, 2015, the Governor issued a second Executive Order defining the Subcabinet's duties, and requiring the Subcabinet to adopt procedures to execute its duties.²

On April 25, 2013, the federal district Court in *Jensen, et. al. v. DHS, et. al.*, ordered the State and the Department of Human Services (DHS) to develop and implement a comprehensive *Olmstead* Plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs in the most integrated setting, consistent with the *Olmstead* decision.³

On November 1, 2013, Minnesota issued the Olmstead Plan, which was revised on July 10, 2014.

On March 11, 2014, the Court ordered the Plan to be implemented in accordance with the Court's orders.⁴ On January 9, 2015, the Court provisionally approved Minnesota's Olmstead Plan, as revised.⁵

Article I PURPOSE OF PROCEDURES

The purpose of these procedures is to set forth clear and orderly processes for the Subcabinet to implement the Olmstead Plan in furtherance of the Orders of the Governor and the Court.

¹ Executive Order 13-01, January 28, 2013.

² Executive Order 15-03, January 28, 2015.

³ *Jensen, et. al. v. Department of Human Services, et. al.*, Civil No. 09-cv-1775 (DWF/FLN) Doc. 212.

⁴ *Id.* at Doc. 280; *see also* Doc. 344.

⁵ *Id.* at Doc. 378.

Article II MEMBERSHIP

A. COMMISSIONER MEMBERS.

Subcabinet members are appointed by the Governor. Members are the Commissioner, or the Commissioner's designee, of the following State agencies⁶:

1. Department of Human Services;
2. Minnesota Housing Finance Agency;
3. Department of Employment and Economic Development;
4. Department of Transportation;
5. Department of Corrections;
6. Department of Health;
7. Department of Human Rights; and
8. Department of Education.

B. COMMISSIONER DESIGNEES.

Each Commissioner member may designate one person from the Commissioner's agency to serve in his or her stead on the Subcabinet, and only that designee may serve until such time as the Commissioner replaces the designee with a different designee. A Commissioner may establish or replace a designee by providing written notice to the Chair.

C. EX OFFICIO MEMBERS.

The Ombudsman for the State of Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities are *ex officio* members of the subcabinet.⁷ The *ex officio* members are voting members and may serve on subcabinet committees.

D. CHAIR.

A Subcabinet chair will be designated by the Governor.

⁶ Executive Order 15-03, January 28, 2015.

⁷ *Id.*

E. MEMBER EXPECTATIONS

Members are expected to:

1. Attend assigned meetings;
2. Serve on workgroups and subcommittees as the chair requests;
3. Prepare for active participation in discussion and decision-making by consulting with agency staff, and by reviewing meeting materials;
4. Act as the liaison between the Olmstead Subcabinet and the member's agency or office;
5. Inform the member's agency or office about subcabinet activities and actions;
6. Perform such other duties as required to fulfill the obligations of the subcabinet.

Article III **DUTIES OF THE CHAIR**

The Subcabinet chair shall:

- A. Chair subcabinet meetings and develop meeting agendas in consultation with the Executive Committee;
- B. Serve on the Executive Committee;
- C. Designate lead compliance staff, who shall report to the Chair;
- D. Be responsible for establishing, amending, and updating Subcabinet procedures;
- E. Provide direction to the Olmstead Implementation Office (OIO); supervise the performance of the Executive Director of the OIO; and annually evaluate the Executive Director's performance;
- F. Provide direction to lead compliance staff assigned to the Subcabinet; supervise performance of lead compliance staff; and annually evaluate lead compliance staff's performance;
- G. Direct OIO and compliance staff to annually prepare a budget, staffing plan and work plan that is sufficient to carry out OIO and compliance activities in a timely and high-quality manner;

H. Appoint chairpersons and other members of committees, in consultation with other subcabinet members;

I. Provide leadership to the Subcabinet;

J. Serve as a spokesperson for the Olmstead Subcabinet.

Article IV **OPEN MEETINGS**

All subcabinet, committee, and workgroup meetings shall be open to the public and conducted in accordance with Minnesota Statutes, Chapter 13D.

Article V **COMMITTEES**

A. EXECUTIVE COMMITTEE.

The subcabinet shall establish an executive committee comprised of three Commissioner Members, which shall include the subcabinet chair and the Commissioner of Human Services, or his or her designee. All three members shall have a vote. A majority of executive committee members or their designees shall constitute a quorum.

1. RESPONSIBILITIES OF EXECUTIVE COMMITTEE.

The executive committee is responsible for preliminary review of agenda items before presentation to the subcabinet, for developing recommendations to the subcabinet, and for conducting the interim business of the subcabinet.

2. AUTHORITY OF THE EXECUTIVE COMMITTEE.

The executive committee shall have authority to act on behalf of the subcabinet during the interim between regularly scheduled subcabinet meetings.

3. MEETINGS.

The Executive Committee shall meet at least once during the 30 days prior to each regularly scheduled meeting of the subcabinet, or at the call of the chair.

B. OTHER SUBCABINET COMMITTEES.

The chair, in consultation with the subcabinet, may establish any other committees comprised of members of the subcabinet as necessary to carry out the subcabinet's responsibilities.

C. SPECIALTY COMMITTEES.

The Subcabinet may establish specialty committees that may include members outside of the Subcabinet. Each specialty committee shall develop a charter that describes the scope of its work, and shall report regularly to the Subcabinet if directed. The Chair shall approve members of any specialty committee.

Article VI
SUBCABINET MEETINGS

A. SCHEDULE.

The subcabinet shall hold regularly scheduled meetings on a bi-monthly basis. The subcabinet may hold additional meetings as directed by the chair.

B. RULES.

All subcabinet and committee meetings shall be conducted in accordance with Robert's Rules of Order, newly revised, 11th edition, unless otherwise specified in these procedures.

C. QUORUM.

A majority of the Subcabinet members or their designees shall constitute a quorum necessary to conduct Subcabinet business.

D. VOTES.

Voting will be conducted by voice vote. A roll call vote may be taken on any issue at the request of one or more of subcabinet members present. In accordance with Minnesota Statutes, section 13D.021, a roll call is required if any member participates by telephone or other electronic means. Commissioners' designees shall have a vote if the Commissioner is not present. In accordance with Minnesota Statutes, section 13D.02, subdivision 4, votes on an action taken in the meeting shall be recorded in a journal kept for that purpose. The journal must be open to the public during all normal business hours where records of the subcabinet are kept.

F. ACCESSIBILITY.

Subcabinet meetings shall be held in locations and be conducted in a manner accessible to people with disabilities. Subcabinet materials shall be provided in forms accessible to people with disabilities.

F. NOTICE.

A schedule of regular meetings shall be kept on file in the OIO office and shall be posted on the Olmstead website. Notice of special meetings shall be given according to the requirements of Minn. Stat. §13D.

G. AGENDA AND MATERIALS.

The OIO shall prepare and distribute meeting agenda and materials to the subcabinet members seven calendar days before regularly scheduled meetings.

Article VII
SUBCABINET DUTIES

The subcabinet's duties, established by Executive Order 15-03, are:

A. GENERAL DUTY.

The Subcabinet shall implement Minnesota's Olmstead Plan.

B. SPECIFIC DUTIES.

1. Provide oversight for and monitor the implementation and modification of the Olmstead Plan, and the impact of the Plan on the lives of people with disabilities;
2. Provide ongoing recommendations for further modification of the Olmstead Plan;
3. Ensure interagency coordination of the Olmstead Plan implementation and modification process;
4. Convene periodic public meetings to engage the public regarding Olmstead Plan implementation and modification;
5. Engage persons with disabilities and other interested parties in Olmstead Plan implementation and modification and develop tools to keep these individuals aware of the progress on the Plan;
6. Develop a quality improvement plan that details methods the subcabinet must use to conduct ongoing quality of life measurement and needs assessments and implement quality improvement structures;
7. Establish a process to review existing state policies, procedures, laws and funding, and any proposed legislation, to ensure compliance with the Olmstead Plan,

and advise state agencies, the legislature, and the Governor's office on the policy's effect on the plan;

8. Establish a process to more efficiently and effectively respond to reports from the Court and the Court Monitor;
9. Convene, as appropriate, workgroups consisting of consumers, families of consumers, advocacy organizations, service providers, and/or governmental entities of all levels that are both members, and non-members, of the subcabinet;
10. Appoint an Executive Director of the Olmstead Implementation Office (OIO); and
11. Adopt procedures to execute its duties, establish a clear decision-making process, and to further define and clarify the role of the OIO.

Article VIII
OLMSTEAD IMPLEMENTATION OFFICE

A. **REPORTING.**

The Executive Director of the OIO shall report to the subcabinet chair.

B. **DUTIES.**

The duties of the OIO are:

1. To carry out the responsibilities assigned to the subcabinet, as directed by the chair of the subcabinet;
2. To carry out all action items assigned to either the subcabinet or to the OIO in the Olmstead Plan;
3. To prepare, reproduce, and distribute subcabinet meeting materials and to otherwise provide staff support for subcabinet meetings, as directed by the subcabinet chair;
4. To keep and publish minutes of subcabinet and executive committee meetings. The minutes shall provide a record of all matters presented to the subcabinet, including all reports and materials presented, and all motions, actions, and votes taken. The draft minutes shall be published on the Olmstead website within seven calendar days of the meeting.
5. To develop communication tools to explain Minnesota's Olmstead Plan, including a fully-accessible overview of the plan itself;

6. To monitor the quality of life and process measures of the Olmstead Plan;
7. To update the subcabinet on implementation;
8. To draft an annual report to be issued by the subcabinet;
9. To maintain social media and web site presence to keep the public aware of progress on the plan;
10. To monitor audit and performance reports from all public agencies on issues relevant to the Olmstead Plan;
11. To develop and implement the Olmstead Quality Improvement Plan; and
12. To collaborate across all relevant departments.

Article IX **COMPLIANCE**

A. SUBCABINET RESPONSIBILITY.

The subcabinet shall oversee compliance with the Olmstead Plan, the Governor's Executive Order/s/, the Orders of the Court, the requirements of the Court Monitor as delegated by the Court, and any other law or rule applicable to the duty to implement the Olmstead Plan.

B. STAFF RESPONSIBILITIES.

1. Compliance staff shall monitor Olmstead Plan implementation; identify and track risks of non-compliance; analyze performance; and provide other compliance services requested by the subcabinet.
2. Compliance staff is responsible for producing the court-ordered bi-monthly status report to the subcabinet and for presenting the report to the subcabinet at the bi-monthly meetings.
3. Compliance staff has the responsibility to keep both the chair of the subcabinet and the Commissioner of Human Services, or his or her designee, informed of all matters related to compliance.

C. COMPLIANCE PROCEDURES.

1. For each Olmstead Plan item, compliance staff shall create clear materials describing the degree to which the item is complete, timely, and sufficient to meet Olmstead Plan, Court, or Court Monitor requirements, as applicable.
2. Staff from an agency with an Olmstead Plan item on the subcabinet agenda must appear at the meeting to present the item to the subcabinet. Staff shall describe the degree to which the item is complete, timely, and sufficient to meet Plan requirements.
3. For items that are untimely, incomplete, or deficient, the agency must provide a written explanation to the subcabinet.
4. The subcabinet shall not approve a Plan item unless it is substantially complete.
5. If the subcabinet finds an item untimely, incomplete, deficient, or otherwise lacking in compliance, the subcabinet shall direct staff to remedy any deficiencies and to provide a time and plan for remedial action.

Article IX **WORKGROUPS**

The subcabinet may convene workgroups consisting of consumers, their families, advocacy organizations, service providers, and/or other governmental entities. Workgroups may include members of the subcabinet. Each workgroup shall develop a charter that describes the scope of its work, and shall report regularly to the Subcabinet if directed.

Article X **AMENDMENTS**

The subcabinet may amend these procedures as appropriate to carry out subcabinet duties. Amendment shall be by majority vote.