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Five Year State Plan for FFYs 2017-2021

THE MINNESOTA
GOVERNOR'S
COUNCIL^{ON}
DEVELOPMENTAL
DISABILITIES

FIVE YEAR STATE PLAN FFYs 2017-2021

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FIVE YEAR STATE PLAN FOR FFYs 2017-2021

SECTION I: COUNCIL IDENTIFICATION

The Minnesota Governor's Council on Developmental Disabilities (GCDD) was established on October 28, 1971. The GCDD is authorized under Minnesota Statute 16B.054 and 16B.055. Colleen Wieck is the Executive Director.

State Plan period: October 1, 2016 through September 30, 2021.

Membership Rotation Plan: The GCDD is composed of 25 members appointed for three-year terms with a maximum of two consecutive terms. Each member is appointed by the Governor from among state residents. The GCDD members represent the Departments of Education; Employment and Economic Development, and Human Services; the Institute on Community Integration (University Center for Excellence) and the Minnesota Disability Law Center (Protection and Advocacy system). Nongovernmental agencies and private nonprofit organizations are also represented.

Current GCDD Members:

Senator John Hoffman, Chair

Michelle Albeck

Alex Bartolic

Marrie Bottelson

Emilie Breit

Mary Hauff

Pamela Hoopes

David R. Johnson

Eric Kloos

Jim Lovold

Lynne Megan

Kate Onyeneho

Carolyn Perron

David Quilleash

Mary Raasch

Robbie Reedy

Jennifer Rightler

Linda Simenstad

Bonnie Jean Smith

Michael Stern

Katheryn Ware

Alan Wilensky

SECTION II: DESIGNATED STATE AGENCY

The Designated State Agency (DSA) for the GCDD is the Minnesota Department of Administration. The DSA was designated in 1991. Matt Massman is the Commissioner of the Department.

The GCDD does not provide or pay for direct services to persons with developmental disabilities. The GCDD does not have a Memorandum of Understanding with the DSA.

Roles and Responsibilities of the DSA related to the GCDD: The Minnesota Department of Administration is one of the oldest state agencies. The Department's mission is to benefit all Minnesotans by leading innovation, creating solutions, and providing exceptional services. A wide range of activities serve citizens and state government.

As the DSA, the Department of Administration provides administrative services for the GCDD including financial management and reporting, human resources, information technology support, disaster recovery planning, real estate management services, risk management insurance, and overall supervision and support services.

SECTION III: COMPREHENSIVE REVIEW AND ANALYSIS

A. Portrait of the State Services

Health/Healthcare

Minnesota has been a consistent leader in promoting and implementing initiatives that improve access, quality, and cost-effectiveness of services provided through publicly funded health care programs. These combined efforts have improved access to health care for low income, special need, and uninsured Minnesotans. At the same time, changes in program delivery, funding, and federal initiatives add to the complexity facing consumers.

Health Insurance Coverage for People with Disabilities

Minnesota opened the new statewide health insurance exchange, MNsure, in 2014, where Minnesotans can shop for, compare, and enroll in public and private health insurance options. Since MNsure's inception, the statewide uninsured rate has fallen dramatically- from 9.0% in 2013 to 4.3% in 2015. As of May 2015, over 95% of Minnesotans have health coverage- the highest percentage in state history. A total of 61,874 people enrolled in a qualified health plan (QHP) through MNsure in 2015. Additionally, 120,129 people enrolled in Medicaid and 37,769 enrolled in MinnesotaCare.

According to a recent analysis by the State Health Access Data Assistance Center (SHADAC), those who are still uninsured tend to be Hispanic, a noncitizen, a Spanish speaker and have a low educational attainment level. The children who are without health insurance coverage by race is as follows: American Indian (19%), Hispanic (13%), African American (6%), Asian (5%), White (4%) and two or more races (6%).

People with disabilities constituted 11.4% of the enrollees in Medical Assistance (Medicaid) in 2014. In 2013, people with disabilities made up 16.9% of the Medicaid-eligible population in Minnesota, but accounted for 45.6% of Medicaid spending. As of 2014, 93.5% of Minnesotans with disabilities have health insurance. Of these, 57% have private insurance coverage and 73% have public health coverage (some have both types of coverage). The types of insurance coverage for people with disabilities are employer-sponsored coverage (36.2%), private coverage (11.8%), and Medical Assistance (43.2%). The racial profile for Medical Assistance enrollment is as follows: White (60%), African Americans (17%), Hispanic/Latino (8%) and other (15%).

Minnesota offers a number of innovative programs to meet the unique coverage and health care needs of people with disabilities throughout the state. The Medical Assistance for Employed People with Disabilities program (MA-EPD), employed adults with disabilities can qualify for insurance through MA with incomes up to 300% FPL. Special Needs Basic Care (SNBC) is a managed care program for persons with disabilities between the ages of 18 and 64. Some SNBC plans integrate MA with

Medicare services for persons who are dually eligible. The program served 48,358 individuals as of July 2014.

Minnesota Children and Youth with Special Health Needs (MCYSHN)

Of the approximately 169,000 children and youth with special health care needs (CYSHN) in Minnesota, more than 32,000 (19%) have had a developmental delay at some point in their lives; 23,600 (14%) currently have a developmental delay. Those who have a current developmental delay are significantly less likely to have private insurance, in comparison to those who have never had a developmental delay (37.5% vs. 68.5%). CYSHN with current developmental delay are five times more likely to have both public and private insurance than those who have never had a developmental delay. One measure of health care quality is the extent to which CYSHN can access health services through primary care meeting the criteria of a "medical home" or health care home in Minnesota. Among those with a current developmental delay, 20.4% have a health care home. Among those who have never experienced a developmental delay, 53.1% have a health care home.

Maternal/Child Health Care

The Minnesota Department of Health's Maternal and Child Health section disburses federal Title V block grants to support public health programs that promote child and adolescent health, such as the Child & Teen Checkups (C&TC) and Family Planning Special Project (FPSP) programs. C&TC provides early periodic screening, diagnosis, and treatment program for children & adolescents who are eligible for Medical Assistance. In 2015, 60% of children who were eligible for C&TC received at least one initial or periodic screening. FPSP is a grant program to fund family planning programs throughout the state, which reached 78,000 people in 2015 through outreach activities, classes, and health fairs.

Mental Health for Children/Adults

In 2015, Minnesota approved \$51 million in new funding for mental health services and treatment. This funding increases access to early intervention services, crisis teams and crisis beds; and access to community supports such as respite care, Assertive Community Treatment teams and supportive housing. More beds will be available to offer intensive services at Anoka Regional Treatment Center. Percent of school-age children who have a serious emotional disturbance, which is a mental health problem that has become longer lasting and interferes significantly with the child's functioning at home and school: 9%. Percent of preschool children who have a serious emotional disturbance: 5%. Each year about 70,100 children and youth receive publicly funded mental health services in Minnesota. Most services are community- and home-based services, such as case management, day treatment, home-based therapies and outpatient therapy. Over the past 10 years, MA and MinnesotaCare funding for children's mental health services increased from 38% to 61%; however, county funding decreased from 38% to 22% during the same time period.

Institutional Care

MN has shifted long-term services and supports from institutional to home and community-based settings. The last resident with a developmental disability to leave a state hospital was in July 2000. In 2013, 1.5% of Medical Assistance-eligible people with disabilities in Minnesota lived in an institution rather than the community. A physician certifies a person's need for a nursing facility, boarding care facility or an intermediate care facility (ICF/DD), and recertifies annually. The ICF provides health or rehabilitative services for those who require active treatment for developmental disabilities. Each recipient has an individual service plan. Several state programs – Medical Assistance and Minnesota Health Care Programs, Durable Medical Equipment program – cover health costs.

Prevention and Wellness

Health reform helps Minnesotans prevent health problems rather than treating them after they arise. Statewide prevention efforts examples: more access to preventative health screenings without co-pays, community-based efforts through SHIP (Statewide Health Improvement Program), and more investment in health care homes and coordinated care through the State Innovation Model grant from the Centers for Medicare & Medicaid Services. Over the past year, immunization coverage among children aged 19-35 months increased by 12% from 66% to 78%. In the past two years, premature deaths decreased by 5%. Minnesota has the lowest rates of premature death among states, according to a report by America's Health Rankings. From 1990 to 2014, infant mortality has decreased from 8.9 to 5.0 deaths per 1,000 live births.

Multiple public and private statewide efforts are currently working to promote prevention efforts in our communities. The Minnesota Department of Health has launched the Eliminating Health Disparities Initiative, addressing gaps in outcomes in diabetes, obesity, cervical cancer screenings, and tobacco cessation in communities of color. Through the Blue Cross Blue Shield Center for Prevention, a statewide campaign called "Pulling Together" to promote exercise, healthy food access, diabetes prevention, and community living is underway.

Long-term services and supports

As of 2014, MN was one of 16 states that provided assistance to people in applying for Supplemental Security Income (SSI) and Disability Insurance (DI) from the Social Security Administration. Since the early 1990s, MN DHS contracts with 55 agencies to help people on public programs who have disabilities to increase their incomes and decrease their state health care and benefit costs. Under a pay-for-performance model, 1,417 people were approved for SSI/DI benefits by the end of 2014, with a total of 28,074 receiving both SSI/DI benefits. Additional information about LTSS is found in the informal and formal supports section.

Home and community-based services

MN has shifted long-term services and supports from institutional to home and community-based settings. In 2013, 93 percent of Medical Assistance-eligible people with disabilities lived in the community rather than an institution. The number of MN home care providers is about 1,650, up from 1,100 in 2010. In FY 2013, Minnesota spent \$1,682,313,990 for DD community services, a .7% increase over the previous year. In FY 2013, of the persons with DD in out-of-home residential settings, 18,164 (93%) were in settings of 1-6 persons; 536 (3%) were in settings of 7-15 persons; and 784 (4%) were in settings of 16+ persons. In FY 2013 in Minnesota, home and community based services waiver spending was 73% of total DD spending (compared to 51% nationally). MN spent an average of \$64,252 per person on the DD waiver. Of the people with developmental disabilities receiving Minnesota long-term care services, 91.9% received home and community-based services in 2013, up from 90.9% in 2009. Funding for community-based services in Minnesota has grown from 49% in 1995 to 91% in 2015, while funding for institutions has declined from 51% in 1995 to 9% in 2015. In FY 2015, an average of 16,080 people were served each month by the DD Waiver program at an average monthly cost of \$6,171 in state and federal funds. (\$74,052 annual average spending per person, for a total annual cost of \$99,229,680.)

Employment

In Minnesota, people with disabilities make up 8.9% of the working age population (16-64). According to the U.S. Census Bureau Statistics from 2013, Minnesota ranks 5th in the nation for people with disabilities engaged in employment, with 46% of the state's working age people with disabilities currently employed. Although Minnesota has seen great progress in this area, much improvement is still needed, as the unemployment rate among people with disabilities (10.3%) is more than double that of the rate for people without disabilities (4.6%). According to the American Community Survey, the top three racial or ethnic groups not participating in the labor force are African Americans (32%), Hmong (30%) and Somali (26%). Approximately 180,000 adults have not earned a high school diploma or equivalent which results in 43% of this group being unemployed or not participating in the labor force.

Job Training, Job Placements, and Vocational Rehabilitation Services (VRS)

Vocational Rehabilitation Services through the Minnesota Department of Employment and Economic Development provides job counseling, ongoing support, and job placement assistance for people with disabilities throughout the state.. According to the Minnesota State Rehabilitation Council 2015 Report, 17,979 people received services from VR in FFY 2015, down from 18,459 people from 2014. 42% of those accepted for service were transition-aged youth, age 16-24. Of those who received services, 5,430 were new participants. Of the 17,979 people who receive services from VRS in 2015,

the percentage of people with developmental or cognitive disability was 8%, serious mental illness-35%, learning disability- 19%, autism spectrum disorder- 11%, and cerebral palsy- 2%. The composition of diverse racial and ethnic participants in VRS in 2015 was 12.8% African American, 4% Hispanic/Latino, 2.5% American Indian, 2.4% Asian and 0.5% Hawaiian/Pacific Islander.

In 2015, 3,104 Vocational Rehabilitation participants obtained employment, up from 2,869 in 2014. Of those 3,104 participants in 2015, 72% found competitive employment. 27.5 percent of those finding employment utilized ongoing supports, up from 25 percent in 2014 and 20 percent in 2013. 32% received job placements in clerical or sales, 9.7% in health care, 12.5% in industrial trades, 12% in professional or managerial positions, and 25% in service careers. For every \$1.00 VRS spends on services, case management and administration, \$8.90 goes back into Minnesota's economy through wages earned by VRS participants. The \$8.90 has a broader impact on the economy, resulting in an additional \$17.80 of economic activity.

Worksite Accommodations

The State Rehabilitation Council has focused on employer relationships and stakeholder partnerships. The state has produced media noting that: most workers with disabilities don't need accommodations, and most accommodations are low-cost. In 2010, the Council funded Market Response International to conduct a random survey of 500 for-profit businesses in Minnesota. The survey was designed to measure awareness, attitudes and impact of the ADA among the businesses. Older buildings have the lowest percentage of accommodations. Six out of ten respondents report that their building or property was originally designed or later remodeled for greater accessibility. Companies with smaller annual revenue were less likely to have accommodations in their building/property than higher revenue companies (regardless of location).

Work Incentives/Benefits

From July-December 2013, a total of 9,196 people were enrolled in the Medical Assistance for Employed People with Disabilities (MA-EPD) program; 38.4% were enrolled in an HCBS waiver; an 17.7% of participants had a developmental disability. According to the National Core Indicators 2015 Report, only 39% of employed people with disabilities received paid vacation and/or sick time benefits at their place of employment. Benefits counseling is provided by Work Incentives Connection, a local nonprofit, and through DB101 sponsored by DHS.

Transition age students

In a 2012 survey of state VRS staff, 56% said they had seen a large increase in the past two years in the amount of time spent with transition-age youth with challenging disability-related barriers to employment; 53% of the staff wanted additional training in career development services. Passed in 2014, the Workforce Innovation and

Opportunity Act (WIOA) provides year-round employment and training services for transition age youth (out-of-school youth between 16 and 24 and in-school youth between 14 and 21). Vocational Rehabilitation Services, in conjunction with the Department of Education, will provide these services. 42 percent (7,753) of those accepted for VR services in 2014 were transition-aged youth, age 16-24.

Competitive Integrated Employment, Sheltered Employment, Data About Employment

Data sets show consistent employment disparities. The 2014 American Community Survey estimates 44% of working age adults with disabilities in Minnesota were employed compared with 90% of people without disabilities. According to the National Core Indicators 2015 Report, 26% of people with disabilities reported having a paid job in the community, 54% attend a day program, and 26% volunteer in the community during the day. Of the respondents with paid employment, 91% reported that they liked their job, while 26% would like to work somewhere else. 86% of respondents enrolled in day programs reported that they liked their day program. Of those with employment, 22% worked in individually-supported positions, 36% in competitive employment, and 42% in group-supported positions.

Extended Employment (state funded program)

Nearly five thousand Minnesotans with significant disabilities received the ongoing employment support necessary to add nearly four million work hours to the state's productive capacity, earning nearly \$28 million in personal income. For each state dollar invested in 2014, program participants earned on average \$2.22, increasing financial independence and potentially reducing dependency on public support systems. 35% of participants in statewide extended employment programs were identified as having an intellectual or developmental disability.

State Employment

In 2014, Gov. Mark Dayton issued Executive Order 14-14 directing an increase in state employment of individuals with disabilities. The percentage of state employees with a disability declined from about 10% in 1999 to less than 4% in 2013. The 2015 Minnesota State Workforce Report states that approximately 6% of state employees are people with disabilities. The executive order from Gov. Dayton sets a goal of at least 7% by August 2018. It requires statewide model and agency plans, revised hiring processes, greater supported work awareness and on-the-job demonstration project.

Employment First Policy

As part of its planning process, the Olmstead Subcabinet adopted a Minnesota Employment First Policy on Sept. 29, 2014, requiring all state agencies to integrate a vision, values and guiding principles in their work, and assigning three agencies (Human Services, Education, and Employment and Economic Development)

responsibility to define, operationalize and document a process to ensure a person-centered approach and informed choice are used. The three agencies must align programs, funding and policies, and develop uniform data collection and reporting procedures. The operational planning process has been initiated. The policy was the culmination of an Employment First coalition effort that began in 2007.

Supported employment services

The Vocational Rehabilitation (VR) program remains the primary source of entrants to Supported Employment (SE). In 2014, VR referred 337 of the 582 individuals in need of ongoing employment support services in competitive jobs to service providers funded by the EE program, or 58% of entrants to SE; other public organizations referred 21% of the SE entrants.

Day training and habilitation services

The FY2013 data for ICF/DD residents shows that an average of 1,398 participants were enrolled in DT&H programs every month; average monthly cost per recipient was \$1,768. DT&H services received a rate increase of 1% in April 2014.

Individual Placement and Supports (IPS)

In Minnesota, people with a severe mental illness have a 59% success rate for placement when engaged in the IPS program. For SFY 2014, 639 people worked in integrated competitive employment for an average of 16 hours per week at a \$10.27 average hourly wage – higher success rates than other programs serving this population. Because of its success, the 2015 Legislature converted former one-time allocations into baseline funding, and appropriated \$10 million more for the next biennium.

Providing Options in Employment

Not all people with disabilities seek competitive employment in the community. While the state's Olmstead Plan promotes choice, Minnesota has adopted an Employment First policy that promotes competitive, integrated employment. The Olmstead Subcabinet resolves the two perspectives by insisting on an informed choice process that ensures people are aware of their options, including an experiential understanding of their opportunities.

Informal and formal services and supports

Social Services

The Department of Human Services (DHS) is the primary supervisory state agency and there are 87 counties and 11 American Indian tribes that administer services. People must apply for services through their local county social service agency. There are a

wide range of social services, income support, health care and long-term services available.

Child Welfare

In 2014, over 72,000 child maltreatment reports were recorded, with over 20,000 reports processed by Minnesota county and tribal agencies. Of the accepted reports, over 14,000 received a Family Assessment response. Both African American and American Indian children had the highest rates of contact with child protection. Over 12,000 children spent time in out-of-home care in 2014, a 5% increase from 2013. Nearly 40 percent of children in out-of-home care had at least one disability.

Aging

Of the people over 65 in Minnesota, over 40% currently have a disability. African American and Native Americans over 65 are one-third more likely to have a disability than whites over 65. Use of the HCBS waiver by people over 65 is projected to grow from 70% in 2014 to 80% in 2018. According to the Minnesota Department of Employment and Economic Development, only 10 percent of the state's labor force will be baby boomers by 2025, and will need a greater amount of services, care, and support as they transition into retirement.

Independent Living and Other Services

The Minnesota Statewide Independent Living Council is a federally mandated council of community volunteers who work with the state's Centers for Independent Living, VRS, and other state agencies to develop a state plan for independent living. The eight Minnesota Centers for Independent Living (CILs) provided advocacy services, independent skills training, information and referral, peer counseling and transition supports. The independent living philosophy and person-centered thinking and planning are foundational to how CILs operate. The centers coordinate with stakeholders and participants through the State Council for Independent Living.

Supported Living Services

In 2013, as part of its Reform 2020 (Medicaid reform effort), MN established the Community First Services and Supports (CFSS) service to replace the Personal Care Assistance program, giving participants more choice and control over services, including the option to be the employer of their own support workers. When CFSS is implemented in the state, it will provide assistance and support to persons with disabilities, the elderly, and others with special health care needs living independently in the community. In FY 2013 in MN, \$284,989,320 was spent on 13,711 participants (an average per family of \$20,785) for family supports, including: respite care, family counseling, home adaptations, in home training, sibling support, education, behavioral management services, specialized equipment, and cash subsidy.

Semi-independent Living Services

SILS include training and assistance in managing state funded money, preparing meals, shopping, personal appearance and hygiene and other activities needed to maintain and improve an individual's capacity to live in the community. SILS are state and county funded. (FY2013 total expenditures: \$7,675,000; CY 2013 total recipients: 1,560. Funding for FY2015 was \$8,319,490).

Supervised Living Facility

MDH provides licensure to treatment and rehabilitation programs within SLF facilities such as detoxification programs, CD treatment programs, residential facilities for adults with mental illness, and residential intermediate care facilities for persons with DD. A report to the Olmstead Subcabinet reported on race and out of home placements in a variety of residential settings from board and lodge to supervised living facilities. The numbers were not reported according to disability type. Of the individuals residing in residential settings, African-Americans were overrepresented with 11 percent of residential placements. In children's settings, American Indians were overrepresented with 8 percent of residential placements.

Family Support

Minnesota offers the Family Support Grant Program to provide cash grants to families of children with disabilities to prevent or delay out-of-home placement of children and provide access to certain services and supports. Average monthly recipients: 1,810. In fiscal year 2015, \$2,698,346 in state funds were spent on the Family Support Grant Program, with a maximum grant of \$3,113.99 allowed per family. The Consumer Support Grant also provides cash grants to replace fee-for-service home care services payments (FY2013 – monthly average enrollees: 1,756; monthly average allocation: \$788).

HCBS Waiver Programs

In 2012, Minnesota ranked second in the nation (behind Oregon) in the ratio of funds used to serve people at home or in the community rather than in institutions. On average, home and community-based services are more fiscally responsible than institutions, and also serve to better integrate people with disabilities into the community. In state fiscal year 2014, an average of 15,938 people were served each month by the DD Waiver program at an average monthly cost of \$6,171 in state and federal funds. The total percentage of spending for the DD waiver program was 73%. In each month in FY14, an average of 1,383 people were served in the Brain Injury (BI) Waiver each month; an average of 383 people were served in the Community Alternative Care Waiver, and an average of 17,999 people were served in the Community Access for Disability Inclusion (CADI) Waiver. The CADI Waiver provides funding for home and community-based services for children and adults who would otherwise require the level of care provided in a nursing facility. The DD Waiver

provides funding for home and community-based services for children and adults with developmental disabilities or related conditions who would otherwise require the level of care provided in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD).

New Waiver Licensing and Standards

In 2014, the State initiated new Home and Community-Based Services (HCBS) licensing and standards under Chapter 245D, to replace (among others) the provider requirements for most DD services formerly under Chapter 245B, as well as some other services.

Crisis Respite Services

Crisis respite services are short-term care and intervention services that are provided to a person due to the need for relief and support of the caregiver and/or protection of the person or others living with that person. Medical and behavioral needs are met.

Home Care Services

Home care provides medical and health-related services and assistance with day-to-day activities to people in their home (FY2013 – monthly average recipients: 3,668; average monthly cost/recipient: \$388).

Faith-based Community Efforts

Approximately eight metro area churches in the Twin cities area have completed training on “Inclusive Congregations: The Place I Belong,” and five regional churches have received the designation of “Church with programs designed for individuals with special needs or providing welcoming environment” by Inclusive Innovations, LLC, a local nonprofit inclusion consulting firm. Many churches throughout the state have founded “disability ministries” programs to ensure that their congregations are more welcoming and inclusive to people with disabilities.

Volunteer Activities

In Minnesota, 34% of people with development disabilities responding to the NCI adult consumer survey reported they were engaged in volunteer work, compared to 32% in all NCI-participating states. For example, Phoenix Alternatives, Inc. (PAI), offers community volunteer opportunities for adults with autism and other disabilities. PAI connects clients who have DD, ASD or TBI to places where they can volunteer and experience satisfaction of making our community a better place to live.

Disability Linkage Line

The Disability Linkage Line is a free, statewide information and referral sources for disability-related questions, staffed by certified options counselors. In 2014, the line received 65,299 inquiries, serving 29,128 people. Of these, 96% said they would recommend the line to a friend. Question topics included health insurance, public benefits, housing, financial assistance, legal, supports, and employment.

Interagency Initiatives

Olmstead Subcabinet

Minnesota's most significant interagency initiative affecting disability services at this time is the Olmstead Sub-Cabinet established by Gov. Mark Dayton in January 2012. The commissioners of eight state agencies are charged with developing a comprehensive Olmstead Plan. The executive director of the Governor's Council on Developmental Disabilities and the Ombudsman for Mental Health and Developmental Disabilities are the two ex-officio voting subcabinet members. The plan has been in development for over three years. The state agreed to create the plan as part of a court settlement agreement (Jensen et al v. Minnesota Department of Human Services). Minnesota's Olmstead Plan was approved by the U.S. federal court on September 29, 2015. The plan's goal is "people with disabilities are living, learning, working, and enjoying life in the most integrated setting."

Olmstead planning is changing the landscape of interagency work. Multi-agency teams are developing measurable goals in the areas of employment, housing, transportation, supports and services, lifelong learning and education, healthcare and healthy living, and community engagement. Two more goals were approved by the court in 2016 for preventing abuse and neglect of people with disabilities and expanding access to assistive technology. In some cases, standing groups such as the Minnesota Council on Transportation Access are being repurposed for Olmstead; in others, new entities such as the Interagency Employment Panel, have been created. The intent is for the new initiatives to become ongoing entities for continuous Olmstead plan development. The interagency groups also have formal connections with advocates, service providers, local governments, and other stakeholders.

Diversity & Inclusion Council

On January 20, 2015, Governor Mark Dayton signed Executive Order 15-02, which established the Diversity and Inclusion Council to ensure inclusion of all Minnesotans in specific state programs. The Diversity and Inclusion Council is organized around three areas: (a) state employment, (b) state contracting and purchasing, and (c) community engagement. The Diversity and Inclusion Council is focused on racial and ethnic diversity as well as disability diversity (aligned with the Olmstead Plan). Commissioners of state agencies for the Council with Governor Dayton serving as Chair. Specific measurable goals and dashboards are being developed.

One legislative change has been to allow professional/technical contracts with targeted group vendors including businesses owned by disabilities. The contracts can be awarded up to \$25,000 without bidding. This legislative change should increase the amount of business conducted with targeted vendors. The Governor has also selected a Diversity and Inclusion Chief Officer who works directly in the Governor's Office to assist state agencies.

Ongoing Initiatives

1. Assistive Technology: The GCDD supports the Administration Department's STAR program's coordination with related programs in DHS, DEED and other state
2. Employment: The Governor's Workforce Development Council is the state Workforce Investment Board. An initiative since 2014 is state realignment for the federal WIOA direction.
3. Youth: The MN State Interagency Committee brings together state agencies, local agencies and other stakeholders to address education policy coordination for youth and disability issues. A current initiative is developing new measures to track interagency accountability.
4. Disability collaboration: The GCDD collaborates with the State Council on Disability and other small disability agencies. A current initiative is public celebration and awareness of the ADA 25th anniversary.
5. MN Disability website: The GCDD, along with eight other state agencies, councils and commissions, maintains the Disability Minnesota website (www.mndisability.gov/public/) which provides a single entry point to over 100 state programs, products and services across the range of disability issues. It also provides access to disability-related laws, statutes and regulations.

Quality Assurance

Monitoring

Several agencies are involved with monitoring abuse, neglect and exploitation: MN Office of the Attorney General; the Ombudsman Office for Mental Health and Developmental Disabilities; the Office of Health Facility Complaints (Department of Health); and the Medicaid Fraud Unit, Surveillance and Utilization Review System and the Licensing Division, all in the Department of Human Services. The GCDD works closely with each agency.

Legal and Human Rights

As of July 1, 2015, the Minnesota Adult Abuse Reporting Center (MAARC) Hotline was available as a statewide resource for reporting maltreatment of vulnerable adults.

Preliminary numbers for the MAARC hotline for 2015-2016 show 51,408 reports of alleged maltreatment of vulnerable adults. This uptick is due to availability of the centralized reporting system 24/7 rather than 160 separate phone lines available during working hours. Interagency efforts are underway to create a statewide Prevention of Abuse campaign as part of the Olmstead Plan. This Plan will be presented to the Olmstead Subcabinet and submitted to the Court by September 30, 2016. The Minnesota Department of Health and Department of Human Services license a broad range of facilities and both departments investigate maltreatment of vulnerable adults in these licensed settings. In 2014, reports of maltreatment of vulnerable adults totaled 35,877 in Minnesota. Of these reports, 46.9 percent were caregiver neglect; 23.3 percent self-neglect; 17.1 percent financial exploitation; 10.3 percent physical abuse; 10 percent were emotional/mental abuse; and 3.2 percent sexual abuse. The most common citations in the Minnesota Department of Health 2015 ICF Deficiency Report, were "Staff Treatment of Clients" and "Life Safety Code Standard."

Disability Justice Resource Center

The Disability Justice Resource Center works to help members of the legal community better understand complex disability justice issues for people with disabilities, and identify and eliminate biases against people with disabilities. It has an online collection of statutes, regulations, case law and commentaries. The site has been funded through a "cy pres" fund created as part of the Jensen class action suit.

Person-Centered Planning Services

Minnesota's Olmstead Plan defines person-centered planning as an organized process of discovery and action meant to improve a person's quality of life, and considers it as the foundation to overcoming system biases and supporting people's ability to engage fully in their communities. Since 2012 the State has trained and provided technical assistance to 4,655 people on person-centered thinking and planning; and developed a person-centered organizational development tool and trained 470 provider staff from across the state.

Minnesota reached 1,300 people at a two-day 2015 conference on person-centered perspectives; gave grants to 607 provider agencies to further person-centered practices; and selected and pilot tested a quality of life survey. Funding has been granted to fully implement the survey in the 2016-17 biennium.

Prohibited Practices in DHS Services

On Aug. 31, 2015, with adoption of the Positive Supports Rule, prohibitions on certain procedures (with limited exceptions) apply to all HCBS waived services and all other DHS licensed facilities if they serve people with developmental disabilities. A prohibition on prone restraint went into effect for public schools on August 1, 2015. According to a Legislative Report in Calendar Year 2015, data showed that boys were six times more likely to be restrained and more likely to have a diagnosis of ASD or EBD. The

proportion of African American students experiencing restraint declined from 31% to 25% while the proportion of incidents decreased from 26% to 17% for this same group of students. Of all restraint and seclusion incidents in schools, the racial breakdown was as follows: Asians--1%; American Indians--2%; Hispanic/Latino --4%; African Americans--17% and the remainder were Caucasians.

Education/Early Intervention

General K-12 Education

Minnesota has 328 elementary and secondary independent school districts, 168 charter schools and many specialty districts including 13 special education &/or vocational cooperative districts. Total projected public school K-12 student enrollment in 2016 in Minnesota is 864,185, while public charter school enrollment is 47,747, and non-public school enrollment is 68,213. 2.7% of students are identified as American Indian/Native American, 7.4% are Asian/Pacific Islander, 8.7% are Hispanic, 12% are Black, and 69.5% are White. 8.3% of students are identified as English Language Learners, 15.1% are enrolled in special education programs, and 38% qualify for free & reduced price lunch (a measure of poverty).

Special Education

In the 2016 school year, 130,633 K-12 public school students are projected by Minnesota Department of Education to be enrolled in special education, supported by 9,625 FTE special education teachers. The racial breakdown of special education students is as follows: White (66.4%), African American (12.5%), Hispanic (9.7%), Asian (4.1%), American Indian (2.9%) and 2 or more (4.4%). The MN Department of Education supports special education through policy development, compliance and assistance, early learning services, data analytics, school-wide positive behavioral interventions and supports, personnel development, universal design projects, and regional centers of excellence for early childhood professionals.

Part C Early Intervention

Part C of the Individuals with Disabilities Education Act (IDEA) serves infants and toddlers through age 3 with developmental delays or diagnosed conditions with a high probability of resulting in developmental delays. There were 733 infants and toddlers (birth to one) with IFSPs out of a total population of 69,399 in the same age group.

There were 5,449 infants and toddlers (birth to three) with IFSPs out of a total population of 208,464 in the same age group.

Infants and toddlers who were experiencing poverty at the time of exit or by the time they turned age 3 were significantly less likely to have exited demonstrating age-

expected skills (36.6%) compared to children who were not experiencing poverty (45.1%).

Families who were experiencing poverty at the time their children exited Part C were more likely to report that early intervention helped them to help their child develop and learn (88.7%) compared to families not experiencing poverty (87.5%). Only Hispanic and multi-racial families reported that early intervention helped them to help their child develop and learn at a rate that met the department's established target.

Families who were experiencing poverty at the time of exit were slightly more likely to report that early intervention helped them communicate their child's needs (91.7%) compared to families not experiencing poverty (90.7%). Only American Indian and multi-racial families reported that early intervention helped them communicate the needs of their children at a rate that met the department's established target.

Early Childhood

In Minnesota, Head Start served 17,019 children in FY 2015, about 29 percent of income-eligible children under 5. Of these, 13 percent had a diagnosed disability. In addition to federal, state and county agencies, Head Start involves tribal governments, school districts and community action agencies.

Under Part B of IDEA, participating children are served in the least restrictive environment, which can include Head Start, school readiness programs, childcare facilities or community-based programs. The number of Minnesota children receiving early intervention and special education services under IDEA reported in 2015 (2012-13 data) was 15,175, ages 3 through 5. IDEA reports in 2015 show that the percent of population who are children with disabilities, ages 3 through 5 are 7.1% for Minnesota and 6.2% for the nation. For ages 6 through 21, 9.5% for Minnesota, and 8.7% for the nation.

Private Schools

Private Schools: About 10 percent of Minnesota children attend private or independent K-12 schools. Under state statute, students with disabilities attending private schools may not be denied special instruction and services on a shared time basis through the public school district. Transportation to and from the non-public school may be provided by the school district. Schools cannot discriminate on the basis of disability, and must ensure physical and program access for persons with disabilities.

Educational Support/Performance

MDE supports educational performance by evaluating efforts to implement IDEA. The 2013-2018 Part B State Performance Plan sets state targets. As of June 30, 2015, Minnesota has met federal requirements on all data indicators. One area of concern is the dropout rates and this affects American Indians at a higher rate (20.1%) than any other race including: Hispanic (10.9%), African American (8.7%), Asian (4.3%) and

White (3.6%). Other support and training, include resources and consultation for educators involved with learner with low incidence disabilities, an issue in less populated rural areas. Other resources for teachers include Education Minnesota's Minnesota Educator Academy.

SEAP

Members of the Special Education Advisory Panel advise the state's special education programs. The panel includes parents, legal advocates, local school staff and administrators, higher education, social work and other support staff, and state agency representatives.

Community Resources

Resources include Early Childhood Family Education (ECFE), Minnesota Association for Children's Mental Health, PACER Center, the Arcs, Autism Society of Minnesota and many other advocacy groups.

Housing

Transition into Community Living

In 2015, MN's Olmstead Plan established a person-centered, informed-decision vision in which people with disabilities will choose where they live, with whom, and in what type of housing. In this vision, supports and services will allow sufficient flexibility to support individual choices on where they live and how they engage in their communities. The Plan noted its focus is not about closing potentially segregated settings. In 2015, the Legislature authorized initial policy changes to the Group Residential Housing program, intended to increase the flexibility of housing benefits to allow more individuals to move from segregated to integrated settings.

The State received federal funding in 2014 and 2015 for 160 Section 811 housing vouchers for people with disabilities exiting out of segregated settings into their own homes. Both the Minnesota Housing Finance Agency and DHS have begun planning to align housing and service supports.

In SFY 2014, there were an estimated 38,079 people with disabilities living in potentially segregated settings. These settings included nursing facilities, intermediate care facilities, assisted living, and corporate foster care homes. Over the last 10 years, 6,017 were moved from segregated settings into integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of housing. With this number as a baseline, by 2019 the state goal is to move another 5,547 (about 92% increase) into the most integrated housing with a signed lease. There is sufficient funding authorized and forecasted to meet this target.

In 2014, a total of 18,185 people with disabilities resided in HCBS waiver residential settings, while 1,629 people lived in ICF/IDD settings. In 2013, the RISP State Profile showed the continued move away from institutional settings toward community settings. This trendline is most dramatic when comparing the waiver numbers with declining ICF populations. According to the 2013 RISP, there was a total of 31,174 people with developmental disabilities in known residential settings. There were 11,003 individuals living in family settings, 2,715 living in their own homes, 1,168 living in family foster care or host homes and 1,700 people in ICF settings. Data was not furnished for community residential services but the capacity for community-based 4-person group home settings is 13,000 according to DHS sources. The capacity for day training and habilitation is 15,000, according to DHS sources.

Housing Support/Services

Bridges Rental Assistance Program – A program administered by MN Housing that provides rental housing assistance for people with low-incomes who have a serious mental illness. Average assistance per household was \$5,444 (704 households in FY2014); nearly 33% of households participating in the program comprised people of color and Hispanic households. In 2015 the State legislature authorized an additional \$2.5 million to support the expansion of the program.

Housing Access Services is a partnership, authorized in 2008, between Arc of MN and DHS to support people with disabilities in moving to homes of their own. Initially only part of the DD waiver, it now is open to people eligible under any waiver (whether in the waiver program or not.) Since 2009, over 1,300 people with disabilities have moved into their own homes through this program. In 2014, approximately 256 individuals were moved into a home of their own.

The Moving Home Minnesota initiative was implemented in June 2013 to help people move from nursing homes or other institutions to homes in the community. This program is expected to serve between 2,000 and 2,500 people over five years.

Return to the Community is an initiative of DHS to help nursing home residents who want to return to homes in the community make that transition into the community. It provides long-term care options counseling to people who have entered a nursing home. Community living specialists offer in-person assistance via the Senior Linkage Line® and Disability Linkage Line®. Between April and June 2014, 241 people moved from the nursing home back to the community through this initiative.

Transportation

The transportation section of the state Olmstead Plan pledges that “people with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections.”

Public Transit

In the Twin Cities metropolitan area, all regular route buses and trains are fully accessible. Outside of the Twin Cities, where public transit is available, it is accessible but is more limited in schedule and range.

Paratransit

In the 89 communities in the jurisdiction of the Metropolitan Council, ADA paratransit service, Metro Mobility, is available for people who have extreme difficulty using regular route transit service because of a disability or health condition. In 2015, Metro Mobility provided 2.1 million rides to 19,983 active users certified for Metro Mobility service. The service is first-door-through-first-door for people who are ADA-certified. Outside of the Twin Cities, services tend to provide curb-to-curb service and sometimes depend upon volunteer drivers.

Community Access

Services have partnered with local planning agencies to develop coordination plans covering all of Greater (non-Twin Cities area) Minnesota as well as the interstate Fargo-Moorhead area.

Council on Transportation Access

The 2015 Annual Report from the Minnesota Council on Transportation Access indicates the need to identify best practices and strategies for coordination of interagency access initiatives, identify stakeholders to provide input for removing barriers and expanding access, and create performance standards for transportation services across the state. In 2016, the Council on Transportation will also continue to advocate aggressively for eliminating barriers to coordination, implementing coordination strategies, enacting necessary legislation and appropriating resources to achieve the stated objectives.

Transit Gaps

In a 2013 DHS survey, 60% of MN counties reported non-medical transportation service gaps, and 58% reported medical transportation gaps. Access to transportation also was identified as a barrier to home and community relocation of people with disabilities, as well as a barrier to employment.

Light Rail Accessibility

There are heavy concentrations of people with disabilities living along the Green Line where 44% of St. Paul Public Housing Hi-Rise buildings are located. In Sept. 2014 (third month of Green Line services) 7 of 14 stations in St. Paul had more than 1,000 boardings by people with disabilities – and more than 2,000 boarded at Central Station.

The District Councils Collaborative of St. Paul and Minneapolis (DCC) has also studied walkway accessibility around the Twin Cities' Central Corridor light rail project and identified problems that don't get captured in standard tests, such as sidewalk potholes and debris. Recommendations from the various reports of the DCC related to accessibility call for adding high-visibility crosswalks to increase pedestrian safety and accessibility throughout the corridor, providing longer signal times for people to cross the streets, adding more signage to identify pedestrian crossings, and removing snow on sidewalks to lessen pedestrian barriers in the winter.

Child Care

Child Care in Minnesota

All child care programs (with religious exemptions) must comply with ADA Title III. Potential discrimination is addressed by both PACER Center, a parent advocacy group, and the Minnesota Licensed Family Child Care Association. The Minnesota Department of Education provides guidance at www.parentsknow.state.mn.us, including encouragement to include mainstream preparation as part of a child's individualized education program.

Statewide information resources include the Minnesota Online Special Needs Directory (<http://www.tc.umn.edu/~coop0001/>).

The Center for Inclusive Child Care is a comprehensive resource network for promoting and supporting inclusive early childhood and school-age programs and providers. Families of children with disabilities can receive training and consultation. The network offers family tip sheets at <http://www.inclusivechildcare.org/>, funded by MDE.

Child Care Assistance

Minnesota provides three public child care assistance programs: (1) MFIP/DWP child care assistance is for parents who receive Minnesota Family Investment Program benefits or Diversionary Work Program benefits; (2) Basic Sliding Fee child care assistance is for parents who are working, looking for work, or going to school; (3) Transition Year child care assistance is for parents who are no longer eligible for MFIP or DWP benefits. Each program has income limits. While the programs can benefit families with disabilities, the State acknowledges that some social workers and advocates may have limited knowledge of options.

For state fiscal year 2015, a monthly average of 15,328 children from 7,588 families received Minnesota Family Investment Program child care assistance. For state fiscal year 2015, a monthly average of 15,267 children from 8,121 families received Basic Sliding Fee assistance. As of September 2015, a total of 6,386 families were on the waiting list for Basic Sliding Fee child care. Child Care Assistance Program funding for 2015 was \$247 million. This includes: \$142 million for Minnesota Family Investment Program; and child care assistance of \$105 million, including federal, state and county

funding for Basic Sliding Fee child care assistance. In FY 2015, the average total monthly assistance per family on Basic Sliding Fee was \$1,030; for a Minnesota Family Investment Program family receiving child care assistance, the average total monthly assistance per family was \$1,486.

The racial and ethnic groups served by the Child Care Assistance Program in 2015 were: African American- 44.3%; American Indian- 1.7%; Asian & Pacific Islander- 2.3%; Hispanic- 6.1%; Multiple races- 6.9%; White- 34.7%; and Other Race- 4.1%. Those using the Basic Sliding Fee Program had the same percentages for racial group participation, except for 31.5% African American families and 46.5% White families.

Recreation

State of Minnesota Resources

Minnesota has several recreational resources beginning with the State Department of Natural Resources, the Minnesota State High School League and the Tourism Division (Explore Minnesota) of the Department of Employment and Economic Development. Explore Minnesota provides a searchable website for sports activities and travel in Minnesota. The end user can search for accessible parks, campgrounds, and trails across Minnesota. Similarly the Minnesota Department of Natural Resources provides accessible recreational activities and opportunities for people with disabilities of all ages. The agency also maintains accessible campsite, lodging, trails, fishing piers, trout stream sites, etc., as well as hunting and fishing licenses for people with disabilities. The Minnesota State High School League provides high school students with disabilities the opportunity to participate in adapted sports such as bowling, soccer, floor hockey, and softball.

Accessible Playgrounds

More playgrounds are being built with an eye toward accessibility and usability. Six universal playgrounds have already opened across Minnesota, and others are scheduled to open including Woodbury and St. Paul.

Adaptive Recreation and Inclusion Programs

Several cities and schools across Minnesota team up to provide comprehensive recreational programs for residents of all ages who experience a range of disabilities. In addition to specialized activities, adaptive programs provide opportunities for people with disabilities to become integrated into programs that are available to the majority of the public. These programs strive to provide its participants with skills needed to successfully participate in community-based recreation programs.

Camps

There are statewide directories of camp programs available online that can be searched by camp type, activity, and disability type including learning disabilities, ADHD, physical disabilities, autism, intellectual disability, etc. There are camps available for those who need intensive sensory integration treatment approaches or are theme centered camps such as science and high tech. There are also camps that assist and support individuals with high medical needs. Camps are located in all parts of Minnesota and can be day camps or residential camps.

Large Provider Sports and Recreation

Providers such as Courage Kenney, Fraser, Jewish Community Center, and St. David's offer a variety of fitness classes and sports programs. Some providers create places where all individuals, families, and communities come together for child care, fitness, recreation, and socialization in a safe, inclusive, and welcoming environment designed to provide everyone with a sense of belonging. They provide full inclusive opportunities for children, teens, and adults through various programs, camps, and sports programs.

Friendship Programs

The Highland Friendship Club provides an array of year-round activities designed to give teens and young adults with disabilities the chance to connect with friends with and without disabilities and create a typical social life. Bridging Hearts is an online social network created to connect young adults with learning disabilities, ages 20-39. Several social and recreational activities are available to meet online friends. Life Pages is a website to help people find information about recreation and leisure activities, services, and advocacy. Life Pages offers information for Minnesotans of all ages and abilities who want to enrich their leisure lifestyle as well as their connections.

Horseback Riding

There are horseback riding programs located throughout Minnesota. These programs range from recreational programs for individuals of all ages to specialized, therapeutic programs for riders of specific age groups. Some programs teach specific skills to enable independent riding or grooming horses.

Hockey

The Minnesota Special Hockey program exists for the enrichment of the athlete with a developmental disability. In addition to physical hockey skills, the program emphasizes the development of desirable individual characteristics such as dependability, self-reliance, concentration, teamwork, willingness to share, and personal accountability. The game of hockey is used by Special Hockey to develop within each player the characteristics that will help the player to be more successful both inside and outside a hockey environment.

Skiing

There are several ski resorts offering one-to-one instruction in adaptive skiing techniques that accommodate people with a variety of physical disabilities and visual impairments. Downhill skiing and snowboarding lessons are available for beginning to advanced skiers. A developmental race program is also offered. Locations are Trollhaugen, Welch Village, Afton Alps, Buck Hill, Hyland Ski and Snowboard Area, and Duluth.

Wilderness Inquiry

Wilderness Inquiry is a nonprofit adventure travel organization. They are all about access, inclusion, and opportunity, creating opportunities for people with disabilities to more thoroughly experience nature. They operate in a manner that facilitates full participation by everyone, including people of all backgrounds, ages, and abilities.

YMCA and YWCA

The Y's offer adaptive lessons modified for individuals with disabilities. An individual assessment will be done by a certified instructor in order to determine placement in swim lessons.

B. Analysis of the State Issues and Challenges

Criteria for eligibility for services

The Minnesota Department of Health publishes a 250 page guidebook on program eligibility - available online at <http://www.health.state.mn.us/divs/fh/mcshn/maze/maze0910.pdf>

The following section provides brief descriptions of eligibility criteria.

Special Services, Waiver Services, and Long Term Services/Supports: For DHS health care programs/Medicaid, criteria include U.S. citizenship or certain immigration status, income, assets, disability determination by the SSA or through the State Medical Review Team.

Medical assistance (MA): Coverage requirements are: a MN resident; a U.S. citizen or qualifying noncitizen; Social Security number (or exception); meet the income/asset limits, and any other program rules. Income limit is based upon age, who lives with you, and other factors including pregnancy, blindness or a disability. People not meeting the income limit may qualify with spenddown.

MA for Employed People with Disabilities: Ages 16 to 65 years, employed, disability, but not on SSI, asset limits apply, earnings must be a minimum of \$65.00 per month.

HCBS Waiver: For people with DD, any age, certified as having DD, needs an ICF level of care, MA eligible, asset limits, and residence requirements.

TEFRA: MA eligibility is due to a child's disability but family income exceeds MA limits, sliding fee scale applies, must be under age 19, the child must live with a parent, the disability is certified.

MinnesotaCare: Income and asset limits apply, no disability required, sliding fee scale for health care coverage.

Home Care Services: Person must be enrolled in MA or TEFRA and be assessed for services to assist activities of daily living; prior authorization is needed; services must be ordered by a physician; must be provided in own home.

Family Support Grant: The person must be under 21 years, certified as disabled, and live in family home; Adjusted Gross Income must be \$91,458 or less; cannot be on any HCBS waiver at the same time.

Consumer Support Grant: The person must be MA eligible and eligible for home care, able to direct own supports, lives in own home, not on a waiver and needs ongoing supports.

Cash, food assistance programs - based on income; example is MN Supplemental Aid, small extra monthly cash payment for adults on SSI.

Food Support: Helps people buy food, eligibility is based on income and size of household.

Group Residential Housing: Monthly payment for room and board if a person has a disability and is over age 18. Expenditures totaled \$90.8 million in 2008.

NOTE: Noncitizens can receive assistance as a refugee, asylee, Cuban, Haitian, or an individual fathered by a U.S. citizen during the Vietnam War. These individuals are referred to as “qualified immigrants,” eligible for SSI, food supports, MA, etc.

Early Intervention Services: MN’s Help Me Grow programs provide services for children, birth - age 2 (infant/toddler intervention) w/developmental delays or diagnosed physical/mental condition with high probability of delay resulting; and 3-5 years (preschool special education) with learning, speech, or play delays.

VRS: Individual with a most significant disability - severe physical/mental impairment resulting in serious functional limitation in terms of employment in 3 or more functional areas; requires multiple services over extended period of time.

Long Term Services/Supports: PASS—SSI eligibility, allows return to work by setting aside funding to achieve a work goal. Ticket to Work—Both SSI and SSDI beneficiaries can get help to obtain work using a ticket with an Employment Network (an agency that helps people get work).

Independent Living Services: Anyone with a significant disability, as defined in 34 CFR 364.4(b), is eligible for IL services under State ILS and Center for Independent Living programs authorized under Chapter 1 of Title VII of the Act. The determination of an individual’s eligibility for IL services must meet the requirements of 34 CFR 364.51.

Analysis of the barriers to full participation of unserved and underserved groups of individuals with developmental disabilities and their families

Health Care Disparities Monitoring

The Minnesota Community Measurement Project compares patients enrolled in Minnesota Health Care Programs (MHCP) with patients enrolled in other health care programs. Those in programs such as Medical Assistance represent a population with lower socioeconomic status, as well as a disproportionate number of persons of color, American Indians, persons with disabilities, and older Minnesotans. In addition to lower socioeconomic status, these patients often experience significant personal challenges that create barriers to receiving appropriate health care. In many cases, the structure of the health care system prevents them from receiving appropriate care.

This year, 11 of the 13 statewide performance rates for MHCP patients were significantly lower than for patients enrolled with Other Purchasers.

For four measures, controlling high blood pressure (71%), breast cancer screening (69%), cervical cancer screening (75%), and childhood immunizations (82%), the Hispanic ethnic group had the highest rate of screening compared to the Non-Hispanic group.

For three of those four measures, controlling high blood pressure (70% and 71%), breast cancer screening (62% and 61%), cervical cancer screening (69% and 68%), and the Asian/Pacific Islander/Native Hawaiian ethnic group had the same or nearly the same rates as the White ethnic group.

For three of those four measures, breast cancer screening (48%), cervical cancer screening (63%), and childhood immunizations (66%), the American Indian/Alaskan Native ethnic group had the lowest rate of screenings.

African Americans had lower rates of controlling high blood pressure (60%), breast cancer screening (57%) and childhood immunizations (73%) compared to statewide averages.

Minnesota is continuing to become more diverse in race and ethnicity. However, access to services and supports continues to be a problem as evidenced by the percentage of individuals receiving home and community based services or Medicaid funding compared to the percentage of Whites. This is a targeted disparity goal listed under Cultural Outreach. Another area of disproportionality is special education where students from minority backgrounds are often overidentified.

Refugee and Immigrant Populations

A Minnesota-specific concern is that the state's refugee and immigrant populations are predominately people of color. In any given year, 25 to 50 percent of MN's immigrants are refugees, compared to eight percent nationally. The Twin Cities has the world's largest Hmong population outside of Asia, and the largest Oromo population outside of Ethiopia. Minnesota has the largest Somali population in the nation. The Disabled Immigrants Association, based in Minneapolis, provides information, referrals, peer support, transportation and other services to immigrants with disabilities, with a focus on Somali immigrants.

Disadvantages related to Poverty: In repeated surveys conducted by the Council, individuals who become disabled later in life, live in poverty, and live in rural areas are least likely to have access to the Internet. In addition, poverty plays a critical role in access to health care when co-pays increase. Poverty also plays a part in the development of secondary conditions.

Regarding ESL: One consequence of Minnesota's influx of refugees and immigrants is a growth in the number of people with limited English proficiency, but also in the diversity of primary languages. Students in Minnesota schools report speaking more than 200 languages at home. While this has long been true in the state's two major cities, the number of people speaking other languages is increasing in suburban and rural areas as well. Language courses and translation services are not as available outside the core cities. The State Demographer estimates that there are more than 100,000 Minnesotans who speak English less than very well. Individuals who speak Spanish and Hmong are the leading language speakers who report they did not speak English very well.

DHS provides Multilingual Referral Lines, in ten non-English languages that help clients with limited English proficiency to be referred to appropriate state or county human services providers. There is no cost to clients. The referral agency is asked to contact the client, and provide interpretation as needed.

School Discipline

For two years, some MN school districts have been required to set aside some special education funding for academic and behavioral interventions to keep students in regular education. They had been singled out for placing too many students of color in special education programs. The St. Paul school district had a 40% reduction in special education referrals. Statewide, including voluntary programs, \$5.5 million was set aside to provide interventions to 2,707 students in 2012-13. In previous years, about 9% of students with interventions entered special education.

Rural, Urban

Unemployment is greater in the most rural parts of Minnesota. Some areas have very few supports and services options available, and transportation to access those services is often lacking or inadequate.

Attitudes

In surveys undertaken by the Council, individuals with DD say they are not making key decisions about their own lives because of outdated attitudes. The barrier of attitudes is a key consideration in the State's Olmstead Plan deliberations, where training and program measurement are among the tools being considered for attitudinal and performance change.

Assistive Technology (AT) Users

According to one state-funded study, the most underserved group in receiving AT is African American females in public schools. (Related information is in the following section). As noted above, AT may not be as easily available in rural areas.

The GCDD works closely with the State Demographer's Office to determine the most unserved and underserved areas within Minnesota, and has used that data in program development. The GCDD also uses customer and market surveys with the ability to analyze results by age, severity of disability, and geographic location.

The availability of assistive technology

DHS Disability Services Division administers the Assistive Technology Grants program, providing person-centered assistive technology, technical assistance and case consultation to people. (2014 DHS RFP for corporate foster care). Medical Assistance funding streams for assistive technology and modifications, for SFY 2012 totaled \$75.1 million (for 158,936 people) including people with disabilities, older adults and people with chronic health conditions.

Breakdown: State Plan durable medical equipment and supplies, \$57.6 million in support of 131,937 people; Fee-for-service home and community-based waivers and Alternative Care, \$15.4 million in support of 16,194 people; and Elderly Waiver managed care participants, \$2.1 million for 10,805 people.

AT is also provided by DEED, MDE and local schools; but Medical Assistance funds most AT equipment. The Department of Administration STAR program provides information and referral, device loan and device training. The Tech4Home project helps people with disabilities remain in or move to homes of their own through assessment and provision of AT.

Minnesota's waiver services include monitoring technology to promote community living and independence in some residential services.

STAR Program

STAR is Minnesota's assistive technology (AT) program funded under the federal AT Act of 1998. The program promotes the reutilization of AT. STAR offers device demonstrations allowing consumers to compare features and benefits of devices. It also provides loaned devices to consumers during a time of need or to try before purchasing. A network of partner organizations around the state also provides AT loans. STAR maintains an online device exchange to donate, sell and buy used, usable technology.

STAR offers AT training, including an online learning site, Tools for Your Future, funded by the Minnesota State Colleges and Universities system. Potential consumers are made aware of the resource through conferences, workshops, recycling events and online communications. STAR is guided by a governor-appointed Minnesota Assistive Technology Advisory Council.

Analysis of the adequacy of current resources and projected availability of future resources to fund services

Employment Funding/VRS

The inadequacy of current resources is highlighted by the VRS order of selection: three of the four priority categories are closed. Current funding is limited to people with the most significant disabilities, persons whose condition results in serious limitations in three or more functional areas. In Minnesota, category four has been closed for years. Categories two and three have been closed intermittently.

VRS assesses qualitative adequacy. Examples of needs include: adding a career development section to transition plans; alternative transition meeting locations beyond schools; more engagement between counselors and clients; more varieties of work experience; and better information for potential employers. The new demands of WIOA mean that additional funding is necessary to fulfill all the requirements.

Transit Funding

In 2012 and 2015, DHS expanded its biennial service gaps analysis to include people with disabilities. Transportation was most frequently identified as a gap (66 percent of all counties). Regional planning efforts do not include increased funding as a strategy, but do include strategies to make better use of current funding. These include: service centralization (scheduling, etc.), regional provider databases, expanded regional steering committees, new call centers or websites, and shared vehicle, facilities or other resources. More flexible funding policies has been identified as a priority.

With federal funding, the MnDOT Office of Transit funds 30 to 35 new accessible transit vehicles per year, and (with local match) innovative transit services beyond the requirements of the ADA. The Legislature will consider a transportation bill during a special session scheduled for the summer of 2016. The Olmstead measurable goals related to transportation depend upon legislative appropriations.

Special Education

The cost of Minnesota special education continues to increase. In 2013, the StarTribune reported that the cost rose 70% in the past decade, and contended that increased services to children with mild autism was a partial cause. A legislative auditor report the same year concluded that costs are increased, in part, because 75% of state special education rules exceed what is required by federal regulations. The same legislative auditor report said that school districts are diverting general education aid to pay for special education costs.

School districts receive state aid and some federal aid to pay for special education services. If these funds are insufficient to pay for the costs of the programs, districts must use other general fund revenue. (Minn. Stat. §§ 125A.75-

125A.79). In the most recent analysis the cross-subsidization from general education revenues was over \$619 million in 2014.

Waivers

Federal waiver programs, based on eligibility requirements specific to each waiver, are not an entitlement. The continuing caseload waiting lists apparently indicate inadequate funding. However, in Minnesota, another factor is that while the State manages the waivers, they are administered by lead agencies including counties, tribes and health plans (for the elderly waiver). Each year the administrative process has resulted in available funds being unspent. Recent state policy changes (noted elsewhere here) are expected to result in a reduction of waiver waiting lists.

The CADI waiting list has been reduced by over 1000 people in the last year, but the DD waiver waiting list is being reduced more slowly because of legislative enrollment caps. The Department of Human Services has not issued an estimated cost for elimination of the DD waiting list.

Independent Living Services

Minnesota continues to have 11 unserved counties (13%) meaning that no core services are available to residents. Community needs are seldom addressed, there is no designated contact or referral and no detailed information gathered about needs.

There are 47 underserved counties (54%), meaning limited access to and availability of core services. There are limited contacts with information and referral available. The independent living services centers note that they are the only programs attempting to provide core independent living services to people of all disabilities.

Analysis of the adequacy of health care and other services, supports, and assistance that individuals with developmental disabilities who are in facilities receive

According to the [2014-2015 National Core Indicators Adult Consumer Survey](#), people with disabilities in Minnesota reported their health as Excellent- (24%), Very Good (43%) Fairly Good (29%), while only 4% rated their health as "poor." However, disparities still exist between people with disabilities in Minnesota and those who are not currently living with a disability. According to the [2012 National Survey of Children's Health](#), 68.1% children with special health care needs (CSHCN) in Minnesota were rated as having excellent health, in comparison with 88.1% of non-CSHCN children, while 13.6 % of children with CSHCN experience fair or poor health, compared with 0.8% of non-CSHCN children. According to the [CDC's 2014 Disability & Health Data System Report](#), people with disabilities were nearly twice as likely to be obese as people with no disability (40% & 24%, respectively); 29% of people with disabilities reported experiencing 14 physically unhealthy days per month, compared

with 3.6% of people without disabilities. While people with disabilities were just as likely as people without disabilities to have health insurance (89.2%/92.7%), 20.5% of people with disabilities were not able to see a doctor due to cost in 2014, while only 7.6% of people without disabilities could not see a doctor due to finances.

According to the [MDH SQRMS 2015 Report](#), there is a need to address disparities in healthcare for people with disabilities, but the lack of a uniform and agreed-upon definition of disability across state agencies and healthcare providers has stood in the way of capturing this data element in a standard way in electronic health records, and thus being able to accurately map and track health disparities for people with disabilities in our state. MDH must submit a report to the Legislature in 2016 with recommendations on quality measurement and disability that are aligned with the Olmstead Plan and federal standards. Specific goals in Minnesota's [Olmstead Plan](#) address health care disparities for people with disabilities, by seeking to improve the amount of people accessing preventive care by 833 people over baseline, and adults and children with disabilities accessing dental care by 1,055 and 1,229, respectively.

Minnesota Department of Health will be mapping health outcomes across populations through the [2017 Healthy Minnesota Statewide Health Assessment](#), and could be one possible partnership for more accurately mapping the current state of health outcomes for people with disabilities in Minnesota. The [Minnesota Health Access Survey](#) maps statewide health coverage rates by race, socioeconomic status, and gender, and could potentially be a resource for mapping coverage status for people with disabilities throughout the state.

To the extent that information is available, the adequacy of home and community-based waivers services (authorized under section 1915(c) of the Social Security Act(42 U.S.C. 1396n(c)))

Choice

Waiver service adequacy is illustrated in the National Core Indicator program. In 2013-14, the adult consumer survey showed – in every category – that Minnesota was below average (compared to all NCI-reporting states) on matters of choice. In Minnesota 42% of respondents (compared to 51% in all NCI states) reported they chose or had some input in where they live. Also: 29% (compared to 44% in all NCI states) chose or had some input in choosing the people with whom they live or they lived alone. Among people with a paid job in the community, 67% (83%) chose or had some input in where they work. Among people with a day program or regular activity, 43% (59%) chose or had some input in where they go during the day. 37% (65%) chose or were aware they could request changing staff who help them at home, job, day program or regular activity. 72% (82%) decide or have input in choosing their daily schedule. 88% (91%) decide or have input in how to spend free time. 85% (87%) choose or have input in choosing how to spend their money. 48% (63%) chose or are aware they could request to change their case manager/service coordinator.

Work

NCI data showed that 31% of responding Minnesotans (compared to only 16% in all NCI-reporting states) have a paid job in the community. The work was 26% (33%) in individually-supported positions, 13% (34%) in competitive positions, and 62% (34%) in group-supported positions. In a typical two-week period, people worked 31.1 (224.2) hours in individually-supported employment, 19.4 (40.5) hours in competitive positions, and 29.9 (31.9) in group-supported employment. Average gross wages in two weeks was \$235.00 (\$197.89) individually supported, NA (\$227.44) competitive, and \$108.89 (\$170.73) group supported. The average hourly wage was \$7.75 (\$8.33) in individually-supported jobs, NA (\$8.20) in competitive jobs, and \$4.05 (\$5.69) in group-supported jobs. 85% (84%) worked 10 of the last 12 months in their positions. 26% (25%) received paid vacation or sick time. The percentage of workers in the most common jobs were 12% (18%) in food preparation and service, 33% (33%) in building and grounds cleaning or maintenance, 4% (15%) in retail, 19% (9%) in assembly, manufacturing or packaging. Among people without a paid job in the community, 58% (49%) would like a paid job in the community. 40% (25%) of all respondents have integrated employment as a goal in their service plan. 58% (71%) attend a day program or regular activity; 34% (32%) do volunteer work.

Satisfaction

NCI data showed that 89% of Minnesota respondents (90% in NCI-reporting states) said they like their home. 26% (26%) wanted to live somewhere else. 64% (65%) talk with their neighbors at least some of the time. Of those with a paid community job, 89% (93%) like where they work. Also among those with a paid community job, 37% (30%) want to work somewhere else. Among those with a day program or regular activity, 87% (88%) like their program or activity; and 42% (34%) want to go somewhere else or do something else during the day.

Service Coordination

NCI data showed that 94% of Minnesota respondents (95% in NCI-reporting states) reported they met their case manager (or service coordinator); 83% (88%) said their case manager asks them what they want. 90% (88%) said their case manager helps them get what they need. 71% (75%) report that if they leave a message, their case manager calls back right away. 96% (94%) said their staff come when they are supposed to. 92% (92%) said they get the help they need to work out problems with their staff. 74% (87%) helped make their service plan.

Health

NCI data showed that, in the past year, 62% of Minnesota respondents (88% in NCI-reporting states) had a physical exam; 72% (79%) had a dental exam; 58% (59%) had an eye exam or vision screening. In the past five years, 75% (65%) had a hearing test. Among female respondents, in the past three years 56% (67%) had a pap test; in the

past two years, 85% (75%) had a mammogram. Among respondents 50 year and older, in the past year 8% (19%) had a colorectal cancer screening.

United Cerebral Palsy's 2015 state by state comparison regarding inclusion ranked Minnesota as seventh best in the nation. It noted that the state has no large facility keeping people isolated from the community but noted that (based on 2012 data) Minnesota has a waiting list that would require 17% annual program growth to accommodate the need. As of 2013, 91% of program participants were involved with HCBS, receiving 90% of program dollars.

In January 2014, Minnesota began a new Disability Waiver Rate System, following a CMS ruling that the state's disability waivers were out of compliance with federal requirements for uniform rate determination. Rate setting transferred from counties and tribes to the state. After one year of experience, there has been minimal fiscal impact, but larger impacts are anticipated in the next five years, with some service rates varying greatly. Supported employment service supports may require higher expenses than the new standard, according to one analyst.

As service rates go through a five year transition process, a provider coalition has contended that confusion has led to rate inadequacy, resulting in some providers not being able to assist people.

In 2015, DHS surveyed counties on the availability of services for people with disabilities over the past two years. The most frequently identified service gaps were chore service, companion service, respite care, transportation and adult day care.

DHS February 2016 forecast. State Medicaid spending is projected to increase from \$11.3 billion in SFY 2016 to over \$13.6 billion in SFY 2019. Of this, long term care waivers and home care is projected to increase from \$2.9 billion in 2016 to \$3.9 billion in 2019. Of this total, Medicaid DD waiver spending is projected to increase from \$1.28 billion in 2016 to \$1.48 billion in 2019. The average monthly number of DD waiver recipients will increase from 16,685 in 2016 to 18,400 in 2019.

From the same DHS 2016 forecast:

The payments to ICFs/DD are projected to decline from \$141 million in 2016 to \$140 million in 2019 while the average monthly number of recipients will decline from 1599 in 2016 to 1522 in 2019.

The Community First Services and Supports Program will begin in 2017 and will replace the current personal care assistance program. This new waiver is projected to cost \$158 million and is a transfer of funding from the PCA program.

C. Rationale for Goal Selection

During the year-long process in producing the State Plan, Council members had the opportunity to review past progress of grant recipients, review the input survey results, review the Comprehensive Review and Analysis, and directly write the goals. At a special meeting held on January 13, 2016 Council members were led through a series of small group exercises by an outside facilitator. The Council members were able to synthesize, analyze, create themes and discuss goals. The conversion of input into goals is a dynamic process. The goals were then reviewed at additional meetings and public comments were considered.

Below are separate rationales for each goal area.

Employment:

1. The CRA documents the continued unemployment rate of people with developmental disabilities including:
 - Broad demographics including employment/unemployment data especially for people with developmental disabilities.
 - A description of employment topics and the broad range of current programs.
 - Existing resources spent for employment, transition, special education and waivers.
2. The Council sponsored two major input surveys and the results point to the importance of employment as a driver of improved IPSII. Employment continues to be one of the highest rated areas of need across both the individual results and the provider/professional results, as such, these results were used to prioritize the Employment Goal.
3. This goal was written to align to the Olmstead Plan, especially the Olmstead Employment Goals addressing youth with developmental cognitive disabilities in transition, adults with developmental disabilities receiving home and community based waiver services, and adults with developmental disabilities receiving Vocational Rehabilitation Services. It also aligns to the Employment First policy, Executive Order 14-14 (increase in state employment of people with disabilities), to the implementation of WIOA, and the CMS Final Rule about HCBS.
4. This goal was written to supplement existing efforts and not supplant existing initiatives.

Self-Advocacy:

1. The Council conducted two input surveys in preparing this 5 Year Plan. Self-advocacy issues (know your rights, speak up for yourself, respect and dignity) were areas of concern to individuals with developmental disabilities and their families and/or allies. The providers answering the survey also ranked self-advocacy as a high priority. These results were used to prioritize the self-advocacy goal.
2. The CRA also provided background about:

- Peer support activities
 - Volunteering
 - Leadership activities
3. The self-advocacy goal is specifically mentioned in the Community Engagement goal of the Olmstead Plan.
 4. The self-advocacy goal aligns to the federal DD Act requirements.

Leadership Training:

1. The input survey of individuals and professionals revealed that leadership training is a key to IPSII. The areas of greatest concern continue to be the supports needed for people with developmental disabilities to be fully included in the community and treated with respect and dignity.
2. This goal is specifically mentioned as part of the Community Engagement Goal in the Olmstead Plan.
3. The highest return on investment of funding is leadership training and was a factor in selecting and prioritizing this goal.
4. The CRA describes major issues addressed by Leadership Training including:
 - LTSS, IL, SILS, CFSS, and family support
 - Waivers, 245D, crisis, residential habilitation, health care
 - Adequacy of the waiver, customer satisfaction and inclusion results

Cultural Outreach:

1. This goal fulfills the requirement for a targeted disparity goal (according to the 5 Year Planning guidance). The Council has worked on cultural outreach since the early 1990s when focus group results revealed that individuals from diverse backgrounds did not know their rights, how to access services and how to be an effective advocate. In the early 2000s, the Council received a Project of National Significance to support a Family Support hub in north Minneapolis.
2. The CRA cross-references to several topics relevant to cultural outreach including:
 - Racial and ethnicity demographics
 - LTSS, IL, SILS, CFSS and Family Support issues
 - Education topics
 - Criteria for eligibility
 - Waiting list
3. Because of the intersectionality of race, disability and inequities, this goal was prioritized.
4. Racial disparities are the subject of a Governor's Executive Order on Diversity and Inclusion in three areas of inequity—employment, state contracting and community engagement.
5. This goal aligns with all measurable goals included in the Olmstead Plan.

Training Conferences:

1. The results of the input surveys of individuals and providers pointed to the ongoing need for education across all the DD Act major areas of emphasis. These survey results helped in prioritizing the importance of co- sponsoring training events.
2. The CRA documents the ongoing need for promising and best practices information to be disseminated in training sessions in child care, transportation, housing, peer support, volunteering, Quality Assurance monitoring, Olmstead implementation, assistive technology and youth issues.
3. Training events must be flexible and respond to emerging issues during the next 5 Year planning period.
4. Education and training aligns with several measurable goals included in the Olmstead Plan including person centered planning, employment, positive supports, and community engagement.

E-government, Publications, Apps, and Online courses:

1. Previous surveys sponsored by the Council document the need for information, education and training to be available to end users 24/7/365 and at no cost. For those without Internet access, print publications must be available as an alternative format.
2. This goal aligns to the Community Engagement goals included in the Olmstead Plan.
3. This goal aligns with the Governor's initiative to "reduce, reuse, and recycle" by converting all Council products and services to digital formats and both the federal government's Plain Language Initiative and the Governor's Plain Language initiative.
4. The CRA documents the ongoing need for information, education and training especially the description of:
 - o Disability agency collaboration and the development of the MNDisability.Gov, Disability Justice and the Project SEARCH websites; and
 - o the need for ongoing presentation of Olmstead activities, person centered planning resources, legal and human rights, restraint and seclusion, and school issues.

Customer Research:

1. This goal supports the large scale input surveys of individuals and professionals in preparing the Council's 5 Year Plan and allows trend line comparisons of samples taken in 2000, 2005, 2010 and 2015.
2. Past survey results have been used in several public policy initiatives, public education campaigns, and in developing the Olmstead Plan.
3. This goal aligns to a comprehensive method of continuous improvement by measuring customer and market opinions as required by the Baldrige Criteria,

the Government Performance and Results Modernization Act of 2010 and the Governor's Results Based Accountability initiative.

4. The CRA illustrates the importance of documenting customer needs, requirements and expectations about delivery of services. The survey topics will be selected on a year to year basis.
5. This goal is meant to supplement and not supplant other data initiatives that are currently underway.

Continuous Quality Improvement:

1. The need for continuous improvement is illustrated by the input survey of individuals and professionals and helped in setting the priority of this goal by the Council. The State of Minnesota is implementing measurable goals defined in the Olmstead Plan under federal court supervision. New attention is now being paid to the State's progress toward the federally defined outcomes of integration and inclusion.
2. Level funding allocations under the DD Act require every effort be made to continuously improve products and services, and improve the ratings of independence, productivity, self-determination, integration and inclusion into the community. The Council Business Results documents the ongoing gains in market penetration, customer satisfaction, stakeholder satisfaction, productivity gains, efficiency, and return on investment.
3. This goal aligns to the Government Performance and Results Modernization Act (GPRMA) of 2010, AIDD performance indicators, and the Governor's Results Based Accountability (RBA) framework. Both GPRA and RBA focus on outputs, efficiency and outcomes. This goal also aligns with a framework for continuous improvement and use of the logic model for the 5 Year Plan goals.

D. Collaboration

In direct consultation with the Minnesota Disability Law Center (Minnesota's Protection & Advocacy System) and the Institute on Community Integration (UCEDD), **the employment goal has been selected as the collaboration goal.**

Employment first became a national priority in 1982 by the Commissioner of the Administration on Developmental Disabilities and the Assistant Secretary of OSERS. A goal of 25,000 supported employment placements was set and then that goal was doubled within a year. The 1984 DD Act (P.L. 98-527) added the definition of supported employment:

"Supported employment" means paid employment for persons for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive, ongoing support in a work setting, including settings in which non-handicapped persons are employed. The support includes any activity needed to sustain paid work including supervision, training and assistance with transportation.

For over 30 years, the Minnesota DD Network as a whole has placed a high priority on employment activities.

Most recently, attention was heightened because of federal DOJ actions in states related to employment, the growing Employment First initiatives, the reauthorization of WIOA, and the CMS Final Rule on HCBS waivers.

In Minnesota the Olmstead Plan contains several measurable goals related to employment. The Council participated in all mediation sessions leading to development of the employment goals.

The Council's role in this collaboration will be to provide funding for our employment goal that will offer customized employment, raise expectations of youth in transition and help educate employers.

ICI's role will match their mission:

Provide technical assistance and consultation to state and local agencies and service providers as well as public schools on effective employment practices. ICI has also been a primary sponsor of the Minnesota APSE chapter; a driving force behind the Employment Summits, and actively working with many providers on person centered planning, informed choice and training and technical assistance.

The Minnesota Disability Law Center has just completed their strategic plan and has two major priorities that touch on the same employment topic including:
Increase integration and decrease discrimination in areas such as employment:

MDLC seeks to maximize clients' opportunities to live, work and recreate in inclusive, integrated settings of their choice. MDLC helps clients obtain community-based services and supports.

Increase access to appropriate services including employment:

MDLC recognizes the challenges that people with disabilities can face in accessing necessary and appropriate services. MDLC's advocacy focuses: Maximizing clients' choice among appropriate services and supports; increasing opportunities for clients to self-direct their services and supports; Improving provider capacity to meet clients' needs; and Maintaining and increasing funding available to meet clients' services and support needs.

The Minnesota Disability Law Center has also filed amicus briefs in the Jensen case on employment issues and presented to the Olmstead Subcabinet on specific occasions related to employment.

In terms of activities, the DD network collaborated on the following employment activities during the past few years:

Star Tribune news series, "[A Matter of Dignity](#)", about Minnesota services and our lag in employment rates. This one week series was a runner-up for the Pulitzer Prize in investigative reporting;

Numerous Olmstead meetings about data base development, informed choice and person centered planning;

Extended Employment Rule revision leading to alignment of funding with competitive integrated employment outcomes;

CMS Transition Planning including all day input sessions held as part of the Council meeting schedule and involvement of both MDLC and ICI;

Exchange of information about federal lawsuits related to employment;

Employment First activities and conferences;

Providing comments about the WIOA state plan.

Implementation of the Disability Waiver Rate System.

Reviewing and commenting about the HCBS waiver amendments related to employment.

Executive Orders about increasing employment of people with disabilities and increasing the number of targeted vendors who are people with disabilities;

Direct participation in multiple versions of the Olmstead Plan, public input sessions; amicus briefs, and Olmstead Subcabinet meetings, etc.

Active participation in Employment Summits since 2007.

This work is conducted with the three major state agencies--Department of Human Services, Department of Employment and Economic Development and the Department of Education and their corresponding local agencies including counties, 200 day training and habilitation providers and community rehabilitation providers, school districts and others.

SECTION IV: FIVE YEAR GOALS

Goal #1: Employment

Employment Goal: Increase opportunities and the supports needed by individuals with developmental disabilities to be employed in integrated settings at or above minimum wage and benefits by:

- A. Educating and building the capacity of employers, and implementing employer incentives that contribute to workforce development.
- B. Providing individualized, person centered supports that may include technology and are necessary for a broad range of employment options including competitive, customized, or self-employment.
- C. Increasing and improving access to inclusive postsecondary education and other career focused training opportunities.
- D. Raising the expectations of individuals and families about the importance of having work experiences prior to and during high school (transition years) and increasing their involvement by using and building their relationships and personal networks to reach public and private sector employers, and identify job experiences in the community.
- E. Increasing long term sustained employment for adults with job opportunities and careers.

Expected Goal Outcome:

At the end of the 5 Year Plan, it is expected that there will be an increase in employment numbers; a higher expectation by individuals, families and businesses about employment; an increase in hours worked and wages earned, job choices, and IPSII. At a systems level it expected that the Olmstead measurable goals about employment will be met or exceeded; Employment First policies will be implemented and there will be a greater adoption of customized employment. This goal is the collaboration goal with the UCEDD and the P&A system as noted earlier.

Objectives:

Objective 1. By the end of each FFY, at least 10 adults with developmental disabilities will be employed in a broad range of inclusive employment settings.

Objective 2. By the end of each FFY, at least 10 transition-aged students with developmental disabilities will be enrolled in post-secondary education or employed in a broad range of inclusive employment settings.

Goal #2: Self-Advocacy

Self-Advocacy Goal: Develop a statewide network of well trained and informed self-advocates by fulfilling the federal Developmental Disabilities Act requirements - A. Establish or strengthen a program for the direct funding of a state self-advocacy organization led by individuals with developmental disabilities including identification of other funding opportunities; B. Support opportunities for individuals with developmental disabilities who are considered leaders to provide leadership training to individuals with developmental disabilities who may become leaders; C. Support and expand participation of individuals with developmental disabilities in cross disability and culturally diverse leadership coalitions (Public Law 106-402, Section 124(b)(4)(ii));

Expected Goal Outcome: At the end of the 5 Year Plan, it is expected that there will be an increased number of self-advocates who are better trained, become presenters and become actively involved in organizations. It is expected that IPSII will increase and there will be a greater unity of the self-advocacy movement. At the systems level, it is expected that the Olmstead goals about self-advocacy will be met or exceeded.

Objectives:

Objective 1. By the end of each FFY, establish or strengthen self-advocacy programs, led by individuals with developmental disabilities and assist in identifying alternative funding opportunities.

Objective 2. By the end of each FFY, at least 50 self-advocates will participate in training sessions each year and 90% will report customer satisfaction and improvement in IPSII.

Objective 3. By the end of each FFY, at least 10 individuals with developmental disabilities will provide leadership training.

Objective 4. By the end of each FFY, five individuals with developmental disabilities will participate in cross disability or culturally diverse coalitions.

Goal #3: Leadership Development:

Leadership Development Goal: Support and promote the development of leadership skills for families of children with developmental disabilities and adults with disabilities as advocates, spokespersons, and members of the larger disability rights movement. Educate people about rights, self-determination, engagement in public policy advocacy, and learning best practices in the areas of education, technology, housing, employment, and other aspects of community participation. Provide face to face training, online learning, blended learning, and graduate workshops as a means of reaching people and strengthening personal leadership skills.

Expected Goal Outcome: At the end of the 5 Year Plan it is expected that there will be a great number of individuals with developmental disabilities and family members who are actively engaged in advocacy and become leaders in public policy changes including policies, practices, statutes and rules. It is expected that IPSII will increase. At the systems level, it is expected that the Olmstead goals for community engagement and leadership will be met or exceeded. More individuals and family members will be engaged in the Olmstead Plan.

Objectives:

Objective 1. By the end of each FFY, 35 adults with disabilities and parents of young children with developmental disabilities will complete 128 hours of leadership training and graduate from the classroom program and 90% will report customer satisfaction and improvement in IPSII.

Objective 2. By the end of each FFY, at least 5 participants will complete one or more Council-sponsored online training courses.

Objective 3. By the end of each FFY, at least one graduate workshop will be offered to 40 graduates and 90% will report customer satisfaction and improvement in IPSII.

Objective 4. By the end of each FFY, longitudinal studies will be conducted to assess the long term effectiveness of the program; 40% of the graduates will participate in the study and 90% will report customer satisfaction and improvement in IPSII.

Goal #4: Training Conferences:

Training Conference Goal: Provide ongoing education and training that reflect and address the outcomes (independence, productivity, self-determination, integration and inclusion) as found in the Developmental Disabilities Act into programs and supports for people with developmental disabilities and their families. These conferences will lead to greater networking and partnering with others across the state through a variety of delivery modes.

Expected Goal Outcome: At the end of the 5 Year Plan, it is expected that there will be greater numbers of professionals and providers who are aware of promising and best practices across the areas of emphasis. At a systems level it is expected that there will be a greater awareness of the Olmstead Plan, WIOA and CMS Final Rules about HCBS waivers.

Objectives:

Objective 1. At least 10 training conferences will be held with at least 1,000 attendees including people with developmental disabilities, family members, professionals and students. At least 90% of attendees will report customer satisfaction and an overall quality rating of at least 8.5 on a 10 point scale for the conference.

Goal #5: Publications, Websites, & Online Learning Course

Publications, Website and Online Learning Goal: Provide information, education, and training that increases knowledge, skills and abilities of end users through a broad range of multiple media formats by:

- A. Promoting accurate historical archiving of resource materials;
- B. Investigating and using the latest technological advancements in communications that may include social networking;
- C. Showcasing the positive roles and contributions of people with developmental disabilities; and
- D. Increasing marketing efforts to ensure wide dissemination of Council products.

Expected Goal Outcome:

At the end of the 5 Year Plan, it is expected that there will an increase in the number of end users who access historical information about people with developmental disabilities as well as promising and best practices. It is expected that there will be an increase in the number of downloads of information and an increase in the number of people who use Apps and access the websites through smartphones. At a systems level, it is expected that there will be an increase in the number of people receiving information about the Olmstead Plan, its evolution, and the resource documents linked to the Olmstead Plan posted on the Council website.

Objectives:

Objective 1. At the end of each FFY, at least 40,000 unique visitors will review online Council resources including websites, online courses, Facebook page, YouTube channel, and Apps. These unique visitors will include people with developmental disabilities, family members, professionals and students. A sample of visitors will report 90% customer satisfaction and improvement in IPSII.

Goal #6: Customer and Market Research

Customer and Market Research: Conduct or commission statewide research studies to measure and assess quality outcomes (independence, productivity, self-determination, integration and inclusion) of the federal Developmental Disabilities Act through annual qualitative and quantitative surveys on new topics/issues or further research on topics/issues previously studied.

Expected Goal Outcome: At the end of the 5 Year Plan it is expected that there will be an increase in the number of people with developmental disabilities and family members who participate in customer research. It is expected that there will be an increase in the number of households that participate in research topics related to developmental disabilities. It is expected that the studies will show an improvement in public attitudes about people with developmental disabilities (the longitudinal study began in 1962 and was repeated in 2007, 2012 and 2017). At a systems level, the survey results will be used to verify results submitted to the US District Court through quarterly reports.

Objectives

Objective 1. By the end of each FFY, a statewide survey will be conducted of at least 100 individuals with developmental disabilities, family members and general households on topics current to the critical issues facing Minnesotans.

Goal #7: Continuous Quality Improvement

Continuous Quality Improvement Goal: Identify and implement an approach that promotes continuous quality improvement and apply the principles to all Council work.

Expected Goal Outcome: At the end of the 5 Year Plan, it is expected that there will be an increase in productivity of Council grants through application of continuous quality improvement techniques. It is expected that there will be confirmation and verification of results reported on the federal performance measures and logic models. At the systems level, it is expected that the Jensen and Olmstead reporting verification processes will be improved because of lessons learned through this sub-grantee.

Objectives:

Objective 1. At the end of each FFY, a quality improvement strategy will be applied to the Council products and services including the 5 Year Plan (logic models for each goal), the AIDD Performance Report, the Annual Work Plan, the Annual Report, and the Monthly Reports. The strategy includes annual verification of at least 200 customer satisfaction surveys completed by people with developmental disabilities and families and 75 stakeholder surveys completed by allies, partners, and professionals.

Goal #8: Cultural Outreach:

Cultural Outreach Goal: Support the development of leadership skills in culturally diverse communities through collaborative efforts with organizations in these communities to increase awareness and knowledge, and develop skills that will encourage participation in other leadership development programs and joining with the larger disability rights movement.

Expected Goal Outcome: This goal is the targeted disparity goal that will enable individuals in this program to have access and enroll in the home and community based waivers. In the past the Council has focused on the north side of Minneapolis because the State Demographer has identified the residents (who are primarily African American) unserved and underserved. According to DHS, there is disparity in enrollment in the DD waiver and other HCBS services. At the end of the 5 Year Plan, it is expected that enrollment of African Americans using the DD waiver will increase. It is expected that there will be an increase in the number of people from racially, ethnically, or culturally diverse backgrounds who learn their rights and take leadership positions that could influence changes in policy (procedures, practices, statutes, and rules). It is expected that IPSII scores will increase. At the systems level, it is expected that the Olmstead community engagement goals are met or exceeded especially the degree of diversity of the audience reached through community engagement activities.

Objectives

Objective 1. By the end of each FFY, 20 individuals with developmental disabilities and family members will complete 30 hours of introductory leadership training and 90% will report customer satisfaction and improvement in IPSII.

Objective 2. As a result of participation, at least 5 individuals with developmental disabilities and family members will have access to the home and community based waivers as a means of reducing disparities.

SECTION V: Evaluation Plan

1. Outline how the Council will examine the progress made in achieving the goals of the State Plan. Since 1997 the Council has applied the National Baldrige Criteria for Performance Excellence, which is aligned to the Government Performance and Results Modernization Act of 2010 (GPRMA). The Council's State Plan, Annual Work Plan, Monthly Activity Reports, and Logic Model for each goal are all aligned to Baldrige and GPRMA.

The Council spent a year developing the current State Plan and began with a thorough understanding of past performance of both qualitative and quantitative results at a full-day meeting of past sub-grantees. The Council then received and reviewed the results of both an individual and family survey (n=531) as well as a provider survey (n=286) to provide a state of the state review. The goals were crafted by the Council members and presented for a public review and comment period. The objectives, rationale, allocations and logic models for every goal were reviewed and approved by the Council.

Once the State Plan is approved then the Council will move into preparation of RFPs and selection of sub-grantees. Performance contracts grounded in the AIDD performance measures and Baldrige principles are developed. Continuous quality improvement is stressed at every step. The Grant Review Committee and the full Council are involved in reviewing progress toward goals.

2. Describe how the Council will assess the effectiveness of the strategies used that contributed to achieving the goals of the State Plan. According to the Baldrige Criteria, effectiveness is defined as how well a process or a measure addresses its intended purpose. Determining effectiveness requires evaluating how well the process is aligned with the organization's needs and evaluating the outcome of the measure.

Assessing the effectiveness of strategies begins with the performance results reported by sub-grantees. If results are missing the Individual and Family Advocacy and the Systems Change performance targets and measures, then strategy or work processes should be reviewed.

Monitoring effectiveness of strategy or work processes begins with the sub-grantee. If the monthly or quarterly reports show any trend of lagging, then Council staff must review and discuss with the sub-grantee to determine if it is a systemic issue or another type of barrier. Any deficiencies in performance come before the Grant Review Committee first. Every effort must be made to assist sub-grantees in meeting performance measures. The Council can offer assistance of experts on the topic for training and technical assistance. Additional information is contained below in answer to questions 5-8.

3. Describe how the Council will examine the progress made in achieving the outcomes of the self-advocacy goal. The Council has been funding various self-advocacy efforts since the mid-1970s with a public education and media campaign that

people with developmental disabilities are people first. Self-advocacy has grown over the years culminating in the reauthorization of the DD Act in 2000 mandating that Councils meet new federal requirements. The self-advocacy goal monitors progress of self-advocacy following the same processes outlined in questions 5-8 below.

The Council will follow its RFP process and supplier management system. Performance contracts will be executed that contain the federal performance measures. Tracking will be required of the number of people participating, customer satisfaction, training evaluation, and IPSII measurement. Reporting will occur on an ongoing basis and a mid-year face to face performance report will be required with the Grant Review Committee. At a systems level, self-advocacy is contained in the Olmstead measurable goal area of community engagement.

4. How will the annual review identify emerging trends and needs to update the CRA? In following the Baldrige Criteria, the Council undertakes ongoing and systematic environmental scanning which includes daily reviews of national listservs for news and updates (i.e. every Council member receives Inclusion Daily Express). As noted earlier, Council staff reviewed hundreds of Legislative reports, websites, and needs assessments to prepare the State Plan Comprehensive Review and Analysis. This process includes regular reviews of key state agency websites, the Legislative Reference Library acquisitions, and national PNS data collection websites.

The Council also sponsors customer and market surveys annually that enable in-depth study of a specific trends or needs such as employment, health care, IT, special education or public attitudes. The survey results are always presented to the full Council meeting, summarized in news releases and for the Council website. Copies are disseminated broadly through public media.

The Council receives regular updates at every meeting about the progress of the Jensen Agreement and the Olmstead Plan including: (1) progress toward the measurable goals; (2) the longitudinal study of Quality of Life outcomes; (3) the semi-annual Jensen reports to the Court and the quarterly Olmstead reports to the Court; (4) the semi-annual Status Conferences held with the US District Court; and (5) the in-depth reports submitted to the Olmstead Subcabinet. Reports to the Court provide information in three categories that are relevant for the Comprehensive Review and Analysis: (1) movement of people with developmental disabilities from segregated to integrated settings; (2) movement from the DD waiting list; and (3) any and all Quality of Life results. The Olmstead Plan has been another avenue to receive “real time” data from eight state agencies reporting about 39 measurable goals. The Court retains jurisdiction over the case until December 2019.

5 and 6. Explain the methodology (qualitative and quantitative) that will be used to determine if needs are being met and if Council results are being achieved. Include evaluation of consumer satisfaction. Since 1998, the Council has utilized quantitative and qualitative data to measure federal DD Act outcomes of independence, productivity, self-determination, integration and inclusion (IPSII).

In 2015, a qualitative study was conducted with 531 people with developmental disabilities and family members and 286 providers. The summarized results support the need for the federal lawsuit (Jensen Settlement Agreement) and court oversight of the Olmstead Plan, as a means to prompt statewide improvements in IPSII.

Every sub-grantee must report on applicable performance measures, use the federal customer satisfaction survey and the Council's IPSII pre- and post-evaluation forms where applicable. These results are submitted in program reports to the Council staff and summarized in reports to the Council (additional details in next section). Data is collected on an ongoing basis. Results are summarized in monthly activity reports, then mid-year supplier results, and then into annual Business Results, the federal Program Performance Report and the Council's Annual Report. The Baldrige Business Results present data in graphic format, showing trend lines for key business measures including IPSII results.

Customer satisfaction forms are reviewed for compliments or complaints that provide ideas for improvements or actionable items. Stakeholder Survey results are also reviewed to find opportunities for improvement. Continuous quality improvement experts often review all results to gain additional insights and objective verification. Return on Investment measures for Council results are also calculated in consultation with continuous quality improvement experts.

The Council can also monitor issues at a systems-level, not just Council results:

(1) The annual customer or market survey foster in-depth review of systems-level topics, providing the Council with both quantitative and qualitative feedback. For example, the Council experimented with a Narrative Research method to study education issues. Both quantitative and qualitative insights emerged from the stories and experiences of students and families. This initiative was a first for the Minnesota Department of Education.

(2) Finally, the Minnesota Department of Human Services adopted the National Core Indicators and the Olmstead Subcabinet has adopted a longitudinal survey approach to measure quality of life. These additional surveys will be important sources of information for identifying needs at a systems level.

7. and 8. Describe the Council's processes, procedures and role in reviewing and commenting on progress toward reaching the goals in the Plan. In following the Baldrige Criteria, the Council has aligned its approach to a "supplier management system" for all sub-grantees which begins with performance contracts that are aligned to the State Plan.

The Grant Review Committee is involved in the oversight of the supplier management system and the full Council can review results on an ongoing basis.

The Council expects that sub-grantees are in full compliance with all applicable state and federal laws, and other contract requirements. This is true regardless of the dollar amount involved, or the type or size of the business. These requirements include a record keeping system best suited to the business in order to monitor and track progress toward goals, monitor income and expenses, and other programmatic, financial and business transactions.

The Council maintains an online resource library of OMB Circulars, Federal Regulations, Questions and Answers about Sarbanes-Oxley, IRS publications, Minnesota statutes, small business development resources, and Minnesota nonprofit resources. This packet of information was converted to an online resource for quicker access.

Another part of the supplier management system is reporting based upon the contract terms including use of the AIDD customer satisfaction survey and federal outcomes of IPSII, and applicable performance measures. These reports accompany the financial reports. Performance reports are summarized and presented to the Grant Review Committee.

Each sub-grantee is expected to present results in-person to the Committee. This report includes updates, results achieved, process improvements and ideas or suggestions that could generate greater IPSII results. These in-performance reviews are summarized and presented to the full Council.

In preparing for this State Plan, all suppliers presented at an all-day meeting in October 2015 so that all Council members were briefed on both the quantitative and qualitative results.

The Grant Review Committee reviews results and allocations annually at two separate meetings, with a preliminary allocation process in June and final funding recommendations and Council approval at the August Council meeting. All performance results are summarized for the full Council to review prior to approval of final funding recommendations.

The above process is summarized in an Annual Work Plan approved by the Council at the Annual meeting held in October. The Annual Work Plan is aligned to the Baldrige Criteria category headings so that all aspects of the organization are addressed. The State Plan goals are embedded in the Annual Work Plan.

Monthly Activity Reports are distributed at each Council meeting; these Reports are aligned to the Baldrige Criteria and the Annual Work Plan. These Activity Reports summarize progress data on goals, objectives, evaluation data, customer satisfaction data and IPSII results. The Executive Director's report at every Council meeting allows time for discussion of all results presented in the Monthly Activity Reports.

The annual results of monthly reports and all sub-grantees are also summarized into Baldrige Business Results for the full Council in December. These Business Results are posted online and the Annual Report is also posted. The Business Results are fully discussed, especially any exceptional performance (either above or below goals).

SECTION VI: Projected Council Budget

Goal	Subtitle B \$	Other(s) \$	Total
Employment	\$80,000.00	\$39,145.00	\$119,145.00
Self-Advocacy	\$120,000.00	\$42,235.00	\$162,235.00
Leadership Development	\$210,000.00	\$35,967.00	\$245,967.00
Training Conferences	\$20,000.00	\$126,061.00	\$146,061.00
Publications, Websites, & Online Learning Course	\$177,959.00	\$1,000.00	\$178,959.00
Customer and Market Research	\$50,000.00	\$1,000.00	\$51,000.00
Continuous Quality Improvement	\$20,000.00	\$1,000.00	\$21,000.00
Cultural Outreach	\$50,000.00	\$25,332.00	\$75,332.00
General Management (Personnel, Budget, Finance, Reporting)	\$279,336.00	\$18,000.00	\$297,336.00

Goal	Subtitle B \$	Other(s) \$	Total
Functions of the DSA	\$18,000.00	\$56,000.00	\$74,000.00
Total	\$1,025,295.00	\$345,740.00	\$1,371,035.00

SECTION VII. ASSURANCES

Written and signed Assurances were submitted to the Administration on Developmental Disabilities, Administration for Children and Families, United States Department of Health and Human Services, regarding compliance with all requirements specified in Section 124 (C)(5)(A) – (N) in the Developmental Disabilities Assistance and Bill of Rights Act.

Lenora Madigan, Deputy Commissioner, signed Assurances for the Minnesota Department of Administration.

The Assurances were sent by USPS mail on August 8, 2016 and electronically.