

# **The Promise of *Olmstead*:**

## **Recommendations of the Olmstead Planning Committee**

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## PREFACE

The Olmstead Planning Committee (OPC) recommendations contained in this document are guided by a Vision and Principles Statement that the OPC intends for the State of Minnesota and the Department of Human Services (DHS) to use as a guide in the development of the Minnesota *Olmstead* Plan. The recommendations cover a wide array of *Olmstead* issues. There are, however, important topics and specific populations that the OPC could not adequately address because of the short amount of time it had to complete its work, the lack of expertise among OPC members in some areas and the composition of the OPC. For example, access to transportation is critically important if people with disabilities are to be fully integrated into their communities. However, the OPC did not address this issue as transportation funding and planning issues are complex, requiring special expertise which the OPC lacked.

Issues which the OPC did not have adequate time to address but which have been addressed in other states' Olmstead Plans include individuals with disabilities in the corrections system and strategies for addressing the need for additional direct support staff. The needs of children with disabilities and their families are addressed by some recommendations but the OPC recognizes that additional attention should be paid to children and family support needs. The elderly as a specific population group are not discussed because so many seniors do not have a disability covered under the Americans with Disabilities Act<sup>1</sup> (ADA). On the other hand, the recommendations address the Olmstead-related needs of individuals with disabilities of all ages. The OPC also did not address any recommendations regarding the Minnesota Sex Offender Program.

The State, as it prepares its Olmstead Plan, must look broadly across state executive agencies providing services to people with disabilities and do its own analysis of laws, policies and procedures that should be reviewed in light of the ADA and the Olmstead decision.

The OPC wishes to emphasize that its recommended reforms should not be implemented in a manner which causes harm to individuals with disabilities. Individual needs and desires should not be sacrificed in an effort to promote greater community integration. The OPC cautions against reducing existing resources for less integrated settings before sufficient resources supporting more integrated settings are available. An effective *Olmstead* Plan should involve redirecting public resources to more integrated settings but this must be done in an orderly and measured way to ensure that people with disabilities, collectively and individually, continue to benefit from public programs. If an individual with a disability desires to move from an institution or a less integrated setting to a more integrated setting, the move should not be carried out unless and until the services and supports the individual needs are available and in place.

It is important to acknowledge that the good faith efforts and hard work of fifteen individual OPC members resulted in recommendations by consensus rather than unanimity. It would be incorrect and unfair to the group process to assume that every member agreed with every recommendation because

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<sup>1</sup> Americans with Disabilities Act of 1990, 104 Stat. 337, 42 U.S.C. Section 12132

this is not the case. Finally, none of the conclusions in this report should be interpreted as agreement by state officials that the State of Minnesota is not in compliance with the integration provisions of the Americans with Disabilities Act.

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## THE PROMISE OF *OLMSTEAD*

### ***Olmstead v. L.C.***

In *Olmstead v. L.C.*,<sup>2</sup> the United States Supreme Court held that Title II<sup>3</sup> of the Americans with Disabilities Act of 1990 (ADA)<sup>4</sup> requires the placement of persons with mental disabilities in community settings, rather than in institutions, when:

- (1) the state's treatment professionals determine that such a placement is appropriate,
- (2) the transfer is not opposed by the individual, and
- (3) the placement can be reasonably accommodated given the resources available to the state and its obligation to provide for the needs of others with mental disabilities.<sup>5</sup>

A five justice majority held that a failure to provide care for individuals with mental disabilities in the most integrated setting appropriate to their needs is discrimination, in violation of the ADA, unless the state or other public entity can demonstrate an inability to provide for integration into the community without “fundamentally altering” the nature of its programs. The Supreme Court’s decision disfavors institutional placement, and looks positively on community living with needed services.

Institutional placement of persons who can benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.<sup>6</sup> The *Olmstead* decision applies to all individuals who have a “disability” as defined by the ADA. As amended in 2008, the ADA includes individuals who have a wide range of medical conditions<sup>7</sup> which substantially limit their major life activities or major bodily functions. A person’s ADA disability status is determined without regard to an individual’s use of medication, prostheses, mobility devices or other mitigating measures and without regard to the existence of intermittent periods of symptoms and remission.<sup>8</sup>

### **The Necessity for an *Olmstead* Plan**

*Olmstead* does not require a state plan, but compliance with the court’s decision is difficult to demonstrate without a formal *Olmstead* Plan.<sup>9</sup> The Supreme Court made it clear that the

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<sup>2</sup> *Olmstead v. L.C.*, (98-536) 527 U.S. 581 (1991).

<sup>3</sup> Title II of the ADA prohibits discrimination on the basis of disability in programs and activities of “public entities” i.e., state and local governments.

<sup>4</sup> 42 U.S.C. Section §12132

<sup>5</sup> 527 U.S. at 607.

<sup>6</sup> 527 U.S. at 600 (1999).

<sup>7</sup> The ADA protects people who have an actual disability, a record of an actual disability or who are regarded as having a disability regardless of the accuracy of that perception. In this document, the focus is on individuals who have an actual disability because it is this group who are in an institution.

<sup>8</sup> There are many individuals who may be protected by the ADA but who do not consider themselves as disabled. This is true for many individuals with a mental illness, among others. Regardless of a person’s self-identity, the ADA protects all individuals with substantially limiting physical, sensory or mental impairments.

<sup>9</sup> In addition, federal authorities anticipate development of *Olmstead* plans. See Letter from Timothy Westmoreland, Director, HCFA Center for Medicaid and State Operations and Thomas Perez, Director, Office of Civil Rights of the United States Department of Health and Human Services, to State Medicaid Directors, dated January 14, 2000 <http://www.hhs.gov/ocr/olms0114.htm>.

establishment and implementation of a “comprehensive, effectively working plan” is a vital criterion for evaluating a state’s compliance with the court’s decree.

If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.<sup>10</sup> States have recognized that such a plan affects the entire service system and have adopted plans of broad scope.

### **Federal Government Enforcement of *Olmstead***

As part of the New Freedom Initiative, in June 2001, President George W. Bush issued an Executive Order “Community-Based Alternatives for Individuals with Disabilities.”<sup>11</sup> The order directed six federal agencies to assist states to identify and remove barriers to *Olmstead* implementation. On the tenth anniversary of the *Olmstead* decision, President Obama launched the “Year of Community Living,”<sup>12</sup> a new effort requiring cooperation between executive branch agencies in the implementation of the *Olmstead* decision.

Primary guidance on the breadth of *Olmstead* comes from technical assistance guidance issued by the U.S. Department of Justice (DOJ) in June 2011.<sup>13</sup> Using a question and answer format, the DOJ makes clear that *Olmstead* applies to housing, home and community based services, and employment, among other areas. In addition, *Olmstead* is not limited by the parameters of a state’s Medicaid program and its remedies are broad. The DOJ’s expansive view of *Olmstead* was made clear in the testimony of Thomas E. Perez, Assistant Attorney General for Civil Rights, before the Senate Committee on Health, Education, Labor and Pensions.<sup>14</sup> Mr. Perez first noted that the “*Olmstead* decision was rightly called the Brown v. Board of Education of the disability rights movement.” He then noted *Olmstead* enforcement efforts have been driven by three goals: (1) people with disabilities should have opportunities to live life like people without disabilities; (2) people with disabilities should have opportunities for true integration, independence, recovery, choice and self-determination in all aspects of life including where they live, spend their days, work, or participate in their community; and (3) people with disabilities should receive quality services that meet their individual needs.

Finally, Assistant Attorney General Perez stated that *Olmstead* applies to situations in which individuals seek integrated supported employment services but are instead placed by the States in employment settings in which they have little or no opportunity to interact with non-disabled workers or to learn valuable skills that would assist them in working in competitive employment.

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<sup>10</sup> 527 U.S. at 605-606 (1999).

<sup>11</sup> Executive Order No. 13217, June 18, 2001.

<sup>12</sup> President Obama Commemorates Anniversary of *Olmstead* and Announces New Initiatives to Assist Americans with Disabilities, June 22, 2009.

<sup>13</sup> Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*, June 22, 2011.

<sup>14</sup> Assistant Attorney General Thomas E. Perez testifies before the U.S. Senate Committee on Health, Education, Labor and Pensions, Washington, D.C. on Thursday, June 21, 2012.

## **Jensen Settlement**

In July 2009, three former residents of the Minnesota Extended Treatment Options program (METO) in Cambridge, Minnesota, and their parents, brought a class action lawsuit (Class) against the State of Minnesota and the Minnesota Department of Human Services (DHS) in the United States District Court, District of Minnesota, on behalf of residents of METO with developmental disabilities who were subjected to the use of restraints and seclusion in alleged violation of the United States Constitution and other federal and state laws. In June 2011 the Plaintiffs, on behalf of the Class, and the State reached a comprehensive class action settlement agreement (Settlement Agreement), which was approved by court on December 5, 2011.

Among other things, the Settlement Agreement required the State to close METO by June 30, 2011, and mandated that any successor program comply with the U.S. Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999) and utilize person centered planning principles and positive behavioral supports. The Settlement Agreement also mandated that as part of system wide improvements, DHS establish an “Olmstead Planning Committee” (OPC) charged with making public recommendations as to the establishment of a State Plan by October 5, 2012. By June 5, 2013, the State and DHS are mandated to develop and implement a comprehensive *Olmstead* Plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the “most integrated setting,” consistent and in accord with the *Olmstead* decision.

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## VISION AND PRINCIPLES STATEMENT

### I. Vision Statement

The Minnesota *Olmstead* Plan (“Plan”) will empower and support people with disabilities of all ages and abilities to live with dignity and independence in the most integrated setting consistent with their own preferences and based upon their own choice. The intended outcome of the Plan is to expand, strengthen, and integrate high quality and effective systems of community-based services and supports that are person-centered, individually-directed, and adequately funded.

### II. Principles governing the content of the Plan

The primary principles governing the content of the Plan are as follows:

- Disability is a natural part of human experience. Disability does not mean “inability.”
- An individual with a disability is a human being equally as worthy of dignity and respect as all other human beings.
- “In enacting the ADA, Congress recognized that physical and mental disabilities in no way diminish a person’s right to fully participate in all aspects of society, but that people with physical or mental disabilities are frequently precluded from doing so because of prejudice, antiquated attitudes, or the failure to remove societal and institutional barriers.” 42 U.S.C. §12101(a)(2) Note.
- The ADA and the Supreme Court’s *Olmstead* decision requires state and local governments to administer services, programs, and activities in a manner that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.
- The State of Minnesota, like the Nation’s “proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.” 42 U.S.C. §12101(a)(7).
- The State of Minnesota (“State”) is committed to enabling individuals with disabilities to move from institutions to the most integrated setting appropriate, consistent with their desires. The State is equally committed to take steps necessary to avoid the risk of individuals with disabilities being unnecessarily institutionalized.
- The guiding principle in State disability policy development and funding decisions will be to support individuals with disabilities to have access to community living opportunities including employment opportunities, accessible and affordable housing, public

transportation, access to recovery and rehabilitation services, lifelong learning and educational opportunities, assistive technology, and health care, with access to the needed services and supports to make these opportunities a reality.

- Each individual with a disability will be empowered to make an informed decision, notwithstanding any myths, fears, or stereotypes that the individual may be experiencing regarding his or her capacity to live in the community with needed services and supports. The ability to make informed decisions will include the opportunity to speak with peers who are successfully living, learning, working and enjoying life in community-based integrated settings.
- Family members and significant others, as appropriate, may play an important role in supporting an individual with a disability to make informed choices.
- In order to support self-direction and to maximize independence, individuals with disabilities will be empowered to make choices for themselves on matters in their lives, just as non-disabled individuals do, including on issues which involve risks. Quality of life is enhanced when individuals with disabilities gain more control in their lives including deciding whether to take a risk.
- The goals when developing individual services and supports will include accessibility, quality, person-centered planning, and wherever possible, individually-controlled decision-making. An accurate ongoing and comprehensive system of assessment of an individual's abilities and functional limitations will be available to facilitate the individual in making choices about supports and services.
- A full array of services and supports are needed to address the broad range of individuals with disabilities including persons with stable, degenerative chronic medical conditions or multiple disabilities.
- Public and private mechanisms of financing programs and activities must be reexamined to enable federal, state, county, and individual funding to be used in the most creative, effective and efficient means available.
- All programs and activities developed or maintained under this Plan must be free of discrimination on all bases in accordance with applicable federal and state law and must address the diversity of individuals with disabilities in terms of race, ethnicity, national origin, age, gender, religion, language, ability to communicate, sexual orientation, geography, and ability to pay.

### III. Principles for Developing, Implementing and Evaluating the Plan

The primary principles that inform the development and implementation of the Plan are the following:

- Individuals with disabilities, their families, and advocates will play a significant role in the development, implementation and evaluation of the Plan. In addition, the State must engage other persons, entities and state councils who are or will be impacted by the Plan.
- All State agencies, not just the Department of Human Services, must collaborate in and be responsible for developing and implementing the Plan. This includes sharing costs and budget responsibilities as appropriate. The OPC strongly recommends that the Governor establish an *Olmstead* sub-cabinet to ensure the most efficient and effective inter-agency coordination, planning and implementation of the Plan. Key Minnesota State agencies identified by the OPC includes: Department of Human Services (DHS), Minnesota Housing, Minnesota Department of Education (MDE), Department of Corrections (DOC), Minnesota Department of Health (MDH), Department of Employment and Economic Development (DEED) and Department of Transportation (DOT).
- The Plan will take into account past and current reform efforts.
- The Plan will be developed and implemented with specific, measurable and achievable goals and timetables and in a manner that provides for transparency and accountability.
- The Plan will include a commitment by the State to the long-term effort necessary for its effective and efficient implementation regardless of changes in leadership.
- Any savings attributable to implementation of the Plan will be reinvested into expanding the availability of appropriate housing and services instead of using such funds for other purposes.
- Ongoing community engagement and training will be critical to implementation, evaluation, and revision as the Plan evolves to meet changing needs and resources.

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## CHANGING THE SERVICE SYSTEM TO EMPOWER INDIVIDUALS WITH DISABILITIES

Since the 1970's society's views of people with disabilities has been evolving to recognize the uniqueness of an individual's abilities and limitations. Despite forty years of improvement, lack of employment and resulting poverty frequently cause individuals with disabilities to enter into the social services system. While the requirement for an individualized assessment and response is a cornerstone of disability policy this is not always reflected in the service system. Although person-centered planning is considered a "best practice" often times individuals feel like their choices are not honored as authorization for services and supports comes from a "case manager."

There are certain assumptions that must be acknowledged if individuals with disabilities are to be empowered:

- Every individual should be presumed competent, unless declared otherwise by a court, to direct the planning process, make choices, achieve his or her goals and outcomes, and build a meaningful life in the community.
- Every individual has strengths, can express preferences, and can make choices.
- Every individual with a disability should have his or her choices and preferences accurately assessed and understood using a formal assessment process which is regularly updated. Currently, DHS is developing MnCHOICES as an assessment tool.
- Every individual with a disability should be provided a budget for housing and services which he or she can use to make choices with, as appropriate, the assistance of family and significant others.
- Every individual should be able to have the timely assistance of an advocate such as a certified peer specialist, peer integration specialist or self-advocate.
- Every individual contributes to his or her community, and has the ability to choose how supports and services enable him or her to meaningfully participate and contribute.
- Through the individualized planning process, an individual maximizes independence, creates community connections, and works towards achieving his or her chosen outcomes.
- An individual's cultural background is recognized and valued in the individualized planning process.

### Empowering Choice While Managing Risk

Empowering individuals to live their own lives in the community of their choosing, as mandated by *Olmstead*, raises complex challenges around the issues of risk of harm and potential liability. Few endeavors in life, if any, can be accomplished without some risk of harm. Moreover, taking a risk can have positive as well as potential negative consequences. However, the ability to make choices

enhances the quality of life of persons with disabilities. Most people weigh the potential benefits and the potential negatives when considering a course of action, whether or not this is done consciously or unconsciously.

When it comes to disability, however, risk taking is often viewed as having only potential negative consequences. Perceived or actual risk to the health and safety of people with disabilities or others in the community can undercut efforts at individual empowerment and community integration.

Continuing efforts to provide persons with disabilities real control over decisions affecting how they participate in all aspects of community life raises concerns in a variety of contexts. State and county officials,<sup>15</sup> providers of disability services, family members<sup>16</sup> and people in the community sometimes believe there is a potential for harm to people with disabilities and others resulting from unrestricted community integration of people with disabilities.

Many of these concerns arise from myths, fears and stereotypes about disability and disease. For this reason, disability rights advocates crafted the ADA to permit public and private disability programs to exclude only those persons whose disabilities posed a significant risk of substantial harm to others which could not be mitigated by some form of mandated accommodation which would not impose an undue burden or alter the nature of the program in question.<sup>17</sup> Risk to self is not a permitted statutory basis for exclusion of a person with a disability under the ADA.

However, perceived or actual fear about the health and safety of persons with disabilities and others in the community can and will torpedo efforts at integration unless they are dealt with effectively. There are many policy complexities to the appropriate management of risk in the context of community integration. Many persons with disabilities are perfectly able to accurately assess risks and rewards without assistance and without someone second-guessing their decisions. People with disabilities should not be subjected to risk management policies which are not applied to non-disabled adults in similar circumstances.

Moreover, every human being, including a person with a disability, has abilities and limitations. A valid risk management policy must be applied on a case-by-case basis to evaluate whether some form of accommodation, service, or support, which, if provided, would enable an individual to safely perform an activity or achieve a personal goal.

Finally, an effective risk management policy must be able to respond to systemic barriers created by fears of risk of harm to self or others. Fear about the possibility of litigation, bad publicity, or individual liability must be adequately addressed on a systemic as well as an individual basis.

The OPC recognizes that unique strategies have been developed by different disability populations regarding peer supports. Therefore, it is important to support multiple strategies to assist individuals

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<sup>15</sup> Hall-Lande, J.; Hewitt, A.; Bogenschutz, M.; Laliberte, T., "County Administrator Perspectives on the Implementation of Self-Directed Supports, *Journal of Disability Policy Studies*, Feb. 16, 2012.

<sup>16</sup> Assistant Attorney General Thomas E. Perez, Testimony Before the U.S. Senate Committee on Health, Education and Pensions, June 21, 2012.

<sup>17</sup> The ADA Title II (state and local governments) regulatory restriction permitting exclusion of a person with a disability only if the disability would pose a direct threat to others and not to self is found at 28 C.F.R. § 35.109. Similar ADA language applicable to private places of public accommodations, including social service agencies, may be found at 42 U.S.C. § 12182(d)(3) and 28 C.F.R. § 36.208.

with disabilities. For example, although self-advocates serving persons with developmental disabilities and certified peer specialists serving people experiencing mental illness are closely related in terms of outcomes achieved, they employ different successful practices. The OPC supports throughout its recommendations the expansion of peer supports for all disabilities. Thus, one of the recommendations below is to develop a new peer support called a Peer Integration Specialist. A certified peer specialist or a self-advocate could also be a Peer Integration Specialist. The key idea is to make peer support a critical component of the new service system.

### **Recommendations for Empowering Choice**

- The State should support the development of a position called a Peer Integration Specialist that helps train and support individuals with disabilities to learn to speak for themselves, understand their rights, and express their preferences. This will include funding to support the training and coordination of a network around the state, and payment to assist other individuals with disabilities in making choices and moving to the most integrated settings. Some funding will be dedicated to supporting Peer Integration Specialists to meaningfully participate in workgroups and task forces that affect services and quality evaluation.
- The State should support a self-advocacy network in Minnesota that helps train and support individuals with developmental disabilities to learn to speak for themselves, understand their rights, and express their preferences. This will include funding to support the training and coordination of a self-advocacy network around the state, and payment to self-advocates to assist other individuals with disabilities in making choices and moving to the most integrated settings. Some funding will be dedicated to supporting self-advocates to meaningfully participate in workgroups and task forces that affect services and quality evaluation.
- The State should involve persons with disabilities, their families and advocates in the implementation, evaluation and updating of MnCHOICES to ensure it accurately identifies the abilities and desires of all people with disabilities.
- The State should provide regular training on empowerment of individuals with disabilities and, their right to live, learn, work and participate in community living according to principles of the *Olmstead* decision. Such training should be offered on a statewide and systematic basis.
- The State should address risk management policies and standards in a consistent manner. Currently, the State Quality Council and several private entities are considering policies and standards for risk management. Best efforts should be made to ensure that existing and proposed risk management policies and standards are reviewed and do not conflict with applicable law including the ADA. In performing that review, the State should ensure that all laws and rules address the balance of choice versus risk and ensure that choice is given more weight than given to risk. The State should include in this review the Vulnerable Adult and Nurse Practices statutes to ensure they do not reduce individual choice.

- The State should develop a process to ensure that there is enforcement of consumer choice by all providers including but not limited to case managers as well as service providers.
- The State should provide ongoing training to stakeholders on applicable risk management policies and standards to ensure that concerns about empowering individuals with disabilities to be fully integrated into the community is not derailed by unwarranted health and safety concerns.

## **Goals**

- The State should, over the next five years, hire and train 1,000 Certified Peer Specialists to assist individuals in understanding, making and implementing their choices.
- The State should, over the next five years develop a network of 500 paid Peer Integration Specialists to perform the same functions as the Peer Specialists with individuals whose primary diagnosis is other than mental illness.
- The State should, over the next five years, develop a network of 500 paid or volunteer self-advocates to perform the same functions as the Peer Specialists with individuals whose primary diagnosis is other than mental illness.

## COMMUNITY-BASED SERVICES AND SUPPORTS

### Introduction

Currently, we have a system of community supports which are widespread, fragmented, and difficult to access. Any given support or service is probably dependent on diagnosis, age and level of care required. The new vision of the OPC for the future system is to begin with an assessment of the individual with a disability which is centered on the person. The assessment will help the system develop community support plans tailor-made to meet the strengths, goals, preferences and assessed needs that the individual will have to enter and/or live successfully in the community and offer the maximum possibility to interact with persons who do not have a disability. This applies to all ages across all disability types. To achieve this goal a functional assessment tool, MnCHOICES, is in development and will be rolled out statewide by the end of 2013.

Minnesota's current system lacks the flexibility to respond to the array of services that people with disabilities need to successfully live in the community. The waivers are complex and while they have an array of services from a menu, or combination of menus, the services offered by a specific waiver may still not match what the individual needs. New treatments and assistive technology rapidly evolve. Some of these services and supports may not be currently available through the existing menu of services. A new emphasis must be on asking the person with a disability what they would need in the community and then meet that critical need regardless of service menus.

Also, a strategy for moving away from waiver usage is to expand other non-waivered community-based services and supports. Medicaid State plan services would need to be enhanced and revamped to recognize this emphasis on community living.

Another problem with our current system of community supports is that it is expensive. Changes must be made that emphasize the goal is to do whatever is necessary to remain in or return to the community, so long as the provision of these services and supports is cost neutral with regard to Medicaid, including the costs of institutionalization of the person.

People with disabilities have continually faced a system that thinks it knows what the person needs. However, the system cannot imagine the full range of supports that might be important or necessary for the success of a person, and should not, because of that inability to imagine the service, deny funding it. People with disabilities envision a community-based system that emphasizes choice of housing options and services and gives more control to the individual.

### Home and Community-Based Waivers

The "What We Have" report prepared for the OPC by DHS with the help of Truven Analytics provides important background information on Home and Community-Based Waivers that will be referenced for this section of the report.<sup>18</sup>

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<sup>18</sup> MN DHS *What We Have Report*, Sept. 19, 2012, [http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16\\_171804.doc](http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_171804.doc).

Minnesota has five Medicaid Home and Community-Based Services (HCBS) waivers that provide the bulk of services and supports for people with disabilities living in the community. The five waivers are: the Elderly Waiver (EW), Developmental Disabilities (DD) Waiver, and Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC) and Brain Injury (BI) waivers. A brief description of these services is provided in Appendix A.

Table 12 from the “What We Have” report, provides important utilization and expenditure information for the waivers for state fiscal years 2008-2012 and is provided in Appendix A. The data shows that the majority of recipients in each waiver are using waiver services to live in community settings. However, with the DD waiver it is estimated that 60% of the waiver recipients are living in congregate settings including foster care homes, customized living, residential services, and out of home supportive living services.

Another table from the “What We Have” report is printed below. This table shows the number of persons on waiver services that are living in congregate settings.

**Table 5: Monthly Data for Number of People Receiving Publicly Funded Services in Congregate Settings, 2006 – 2010**

Program	2006	2007	2008	2009	2010	Avg Annual Increase
Nursing Facilities (NF)	21,011	20,233	19,468	18,783	18,219	-4%
Intermediate Care Facilities/DD (ICF/DD)	1,897	1,864	1,850	1,825	1,779	-2%
Children's Residential Treatment (Rule 5)	227	225	242	180	202	-3%
Alternative Care Services (AC)	531	472	363	210	71	-40%
Brain Injury Waiver (BI)	807	847	889	920	885	2%
Community Alternatives for Disabled Individuals Waiver (CADI)	3,542	4,055	4,582	4,876	5,136	10%
Community Alternative Care Waiver (CAC)	49	51	51	53	51	1%
DD Waiver – Corporate Foster Care	7,642	n/a	n/a	7,808	8,252	2%
DD Waiver – Family Foster Care	1,086	n/a	n/a	975	899	-5%
Elderly Waiver (EW)	6,416	6,696	6,780	6,780	6,479	0%

Notes:

- n/a means no information available for this report because data was not analyzed for these years.
- NF and ICF/DD data are based on the average monthly number of people receiving Medicaid services in a SFY
- Data for NF does not include individuals under age 65 at two facilities that are IMD. A private facility, Andrew Residence, served 221 people in 2011 according to Truven Health analysis of MDS data from DHS in May 2012.
- Data for AC, BI, CADI, CAC, and EW are based the number of people as of December of the year with a current living arrangement of "congregate setting" indicated in the most recent assessment
- Data for the DD Waiver is based on the number of people as of December 2006, July 2009, or December 2010 with a current support listed as “Foster Care – shift staff” i.e., corporate foster care, “Foster Care – family” or “Foster Care – live-in caregiver.” Family or live-in caregiver foster care arrangements are categorized as Family Foster Care.

Sources:

- NF and ICF/DD data from MN DHS, November 2011 Forecast.
- DD Waiver data for 2009 provided by the Minnesota DHS in July 2009.
- Other services data from Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012.

The “What We Have” report concludes “within Minnesota’s HCBS program, thousands of people receive residential services where the entity that owns the residence also furnishes services at the location. Some of these individuals may be better served in their own home or apartment, with the ability to change service providers without moving.”<sup>19</sup> The growth and cost of waiver spending on adult foster care also led to a moratorium on the building of adult foster care beds in 2009.

The growth of the waiver programs has been addressed by the legislature placing caps on waiver allocations. Thus, there are waiting lists for DD and CADI waivers. Currently, for fiscal year 2013, 72 new DD waiver allocations are allowed and 720 for CADI<sup>20</sup>. The other waivers do not have allocation limits and do not have current waiting lists. The waiting lists for these services must be addressed by the State in the Plan.

The HCBS waivers are managed by DHS, the counties and tribes through an annual waiver allocation process. DHS establishes an annual waiver budget for each county or tribe. Counties and tribes are required to manage their waiver budgets, which include:

- Adding new recipients;
- Managing waiting lists based on DHS established priorities; and
- Planning for the anticipated and unanticipated changes in needs of waiver recipients.

The management elements must be consistent with federal regulation requirements including the Centers for Medicare & Medicaid Services’ (CMS) approved waiver plan governing home and community-based waiver services and DHS priorities. Policies and procedures must be submitted to DHS for initial approval and for approval prior to any changes or revisions being implemented and available to the public upon request.

For the DD Waiver, each calendar year, DHS gives counties and tribes a DD Waiver budget from which to manage DD Waiver authorizations and spending. Home care costs for waiver participants are included in the county’s budget. The annual enrollment period runs from September 1 through November 30 each year. The initial allocation a county or tribe receives the following year is directly related to the number of people being served in that county during the enrollment period.

For the BI, CAC and CADI Waivers each state fiscal year (July 1 through June 30) DHS gives counties and tribes a CCT (CADI, CAC, BI) Waiver budget from which to manage CCT waiver authorizations. Home care costs for waiver participants are included in the county’s budgets. County budgets are based on daily resource amounts established for new conversions and diversions. The budget allocation methodology for each individual determines the daily resource amount.

For CCT Waivers, the county first screens a person for one of the CCT waivers then selects an available allocation. DHS takes information from the new waiver participant’s Long Term Care (LTC) screening document and applies the budget allocation methodology to establish the daily resource amount. DHS

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<sup>19</sup> MN DHS, *What We Have Report*, September 2012

<sup>20</sup> MN DHS Disability Services Division, *Annual Report on the Use and Availability of Home and Community-Based Services Waivers for Persons with Disabilities*, July 2012 found on <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6568-ENG>

contributes the daily amount to the county's or tribe's budget beginning when the person is opened and authorized for services.

While the waiver process has allowed for greater flexibility and local control to plan and meet the assessed needs of a person for supports and services, there are many concerns with the current system. The most recent DHS report<sup>21</sup> for fiscal year 2012 shows that counties and tribes spent \$163 million less than the total amount allocated.

DHS points out however, that this figure does not indicate significant under spending of the amount appropriated, because the allocation amount includes a factor to account for the counties' and tribes' need to manage spending within the allocation amount. In addition, the difference between actual spending and the appropriated funds was approximately \$9 million for all four waivers, and for the two waivers that had waiting lists – CADI and DD – the difference between actual spending and the appropriation was very close. It was 0.6% for CADI and 0.3% for DD. The OPC has concerns that under spending occurs while there are waiting lists for the DD and CADI waivers and individuals are in more restrictive settings because they cannot access the necessary waiver or other resources to allow them to return to the community.

Reform 2020<sup>22</sup> acknowledges that the current system is not sustainable. The OPC agrees with this assessment and makes the following recommendations.

### **Recommendations for Home and Community-Based Waiver Services**

- Establish and communicate to every individual with a disability his/her (monthly or annual) budget for housing and services. This budget amount will assist an individual to make informed choices on services and supports similar to a budget for a person without a disability. This individualized budget approach will require establishing a state-wide methodology for accurately assessing the cost per service/support. The current plan is for MnCHOICES to be the methodology for calculating individualized budgets.
- The waiting lists for the DD and CADI waivers must be tracked, monitored and the Plan must contain a plan to reduce waiting lists. The State should consider a systematic method of reducing waiting lists in keeping with the spirit and intent of the *Olmstead* decision.
- DHS should monitor access to services statewide across all disabilities (including transportation, cultural competency, and geographical disparities) and report the results to the public.
- The State should consider changes to the home and community based waivers to allow for the provision of “other supports necessary to enter, or successfully remain in the community.”

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<sup>21</sup> MN DHS Disability Services Division, *Annual Report on the Use and Availability of Home and Community-Based Services Waivers*, July 2012

<sup>22</sup> <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6535B-ENG>

- The State should continue to create a common waiver service menu so that people using waived services can get access to the complete array of services including Independent Living Skills that will enable living in the most integrated setting.
- The State should re-examine family supports and consider the entire family unit when doing assessment and planning for an individual with a disability. This support of families is particularly needed for families of children with disabilities and is also beneficial if a parent has a disability.

### **Medicaid State Plan Services**

Medicaid State plan services also provide important services and supports that assist people with living in the community. Important services as described in Appendix A include Personal Care Assistance (PCA), Private Duty Nursing, Home Health Services, Adult Rehabilitative Mental Health Services (ARMHS), Assertive Community Treatment (ACT) and Children’s Therapeutic Services and Supports (CTSS). Unlike the HCBS waivers, an individual with a disability does not need to meet an institutional level of care to be eligible for state plan services. To qualify for state plan services a person must be eligible for Medicaid and the services must be medically necessary. An individual can be on a waiver and also use state plan services. Also, an individual on a waiver waitlist can access state plan services. Thus, State plan services support individuals transitioning from institutional care.

The waivers were initially developed as alternatives to institutions for the elderly and specific disability populations. State plan services were also developed to assist individuals with mental illness to transition from institutional care. In 2001, ARMHS became a state plan service, followed in 2005 by the addition of ACT services.

However, several gaps in State plan services need to be addressed. Redesigning the PCA program through Reform 2020 is supported by the OPC. The redesigned PCA program called Community First Support Services (CFSS) proposes individualized service budgeting, flexible and improved services and participants have more choice. The OPC supports the direction the State is taking with CFSS.

While Reform 2020 is a positive step there are other problems with Medicaid State plan services that could be addressed by DHS. Several reports have highlighted that a population falling through the cracks in the current system of community supports are those individuals with complex, co-occurring disabilities. Additionally, they are often individuals who have had interactions with law enforcement and are deemed a public safety risk. Finally, they are frequent users of emergency rooms, detoxification services, hospitals and state run facilities. These individuals require multi-disciplinary teams with specialized expertise and extensive experience.

In order to keep individuals with complex disabilities in the community the State must build a better, more coordinated statewide crisis system that serves all disabilities. The use of crisis services must be a signal that individuals may need more intensive community services for some time period. Thus, a wraparound system must be designed so that individuals can have services delivered in the community which allows the individuals to remain in their own homes or apartments. Currently, people in crisis

often end up in an institution and may lose their homes. With the lack of affordable housing it becomes difficult to move back to the community once you have lost your home.

Many states have identified the need to enhance crisis services as a part of *Olmstead* settlements with the Department of Justice (DOJ). Virginia has agreed to develop a comprehensive crisis system that will help divert individuals from unnecessary institutionalization. Georgia is increasing its existing community services to 20 Assertive Community Treatment (ACT) teams, two intensive case management teams, two community support teams, maintains a crisis hotline, case management services, five crisis stabilization units, and peer support services. Over the next five years Delaware is seeking to prevent unnecessary hospitalization by expanding and deepening its crisis services, including a hotline, crisis walk-in centers, mobile crisis teams, crisis apartments and short term crisis stabilization programs. Delaware will also provide community treatment teams and case management to individuals living in the community who need intensive levels of support.

For people experiencing mental illness a barrier to receiving certain State plan services such as Assertive Community Treatment (ACT) is the lack of access to critical services until an individual meets the state definition of Serious and Persistent Mental Illness (SPMI). The SPMI definition in the Minnesota Comprehensive Mental Health Act has been viewed in the mental health community as too restrictive for a long time. It does not cover many individuals with severe anxiety related diagnoses who are unable to function without a high level of supports. Use of SPMI criteria makes many “first onset” individuals without extensive hospitalizations ineligible for very beneficial services which can prevent deterioration and functional limitations.

Another gap in State plan services is the lack of a robust Adult Rehabilitative Mental Health Services (ARMHS). ARMHS is critical to supporting persons with mental illnesses to remain as independent as possible in the community, but the State must upgrade it to meet its purpose: the service limits are too low and inflexible, the rates are very low, variable authorization of ARMHS’ services results in persons being treated inconsistently across the State, providers are either dropping or having to subsidize ARMHS, which is not a sound trajectory for an important mental health service which has been found effective in stabilizing individuals for successful living in the community.

Another identified gap is the need for comprehensive, early identification and intensive intervention services under 1915(i) for children and adults who have a first episode of serious mental illness, including crisis services, in-home supports, employment or education including Individualized Placement and Support (IPS), family-caregiver education and support and services to support stable housing. The lack of service intensity and flexibility is a serious gap in Minnesota’s service menu. This service is critical to meet the individual’s needs early in the onset of an illness and during recovery. The menu of services listed should be available to persons as needed during their first episode of mental illness. These services must be available to all who meet the criteria and provided without regard to other conditions including physical disabilities, intellectual and developmental disabilities and age.

In addition to Reform 2020, the State can also make changes to State plan services under a new provision of the Affordable Care Act. In the short term, with the new regulations regarding 1915 (i) the State can combine new services and target the services to specific populations. In addition, the State

can improve care management of individuals with multiple co-occurring disabilities by developing health homes.

Although the OPC did not include timelines or goals in this section of the report, it is believed that these recommendations require urgent attention. Timelines should reflect this urgency. The OPC recommends that DHS prioritize the recommendations and set ambitious, specific, realistic goals and timelines to accomplish each recommendation.

### **Recommendations for Medicaid State Plan Services**

- Evaluate and consider adding the following services to the Medicaid state plan:
  - An inter-agency employment initiative which should include a DHS state plan service under 1915(i) to add a broad employment supports service for all people with disabilities who need services to get and keep employment. This should include the aspects of IPS, autism specific employment supports, family stabilization services and other supported employment services that can be covered by Medicaid.
  - Expand and adequately fund the ARMHS service to better support individuals experiencing mental illness who are living in the community.
  - Caregiver-family education and supports, including respite services.
  - Supports to assure stability in housing.
  - Intensive early intervention for young children with autism.
- Develop regional crisis services to assure the provision of assessment, triage, and care coordination so that persons with disabilities receive the appropriate level of care in the most integrated setting.
  - Enhance care management/care coordination at the point when individuals experience contact with law enforcement, psychiatric hospitalization, or emergency room visits related to actions that present a risk of harm to themselves or others. These services will be available where the consumer lives, strengthening the capacity of the system to serve individuals with clinical complexities in their home community.
  - Include mobile wrap-around service response teams located across the state for proactive response to maintain living arrangements. The time for the crisis response should be as soon as possible with a maximum time of three hours from the time of request.
  - Crisis services will provide families, caregivers, and staff at community-based facilities and homes with state of the art training encompassing person-centered thinking, multi-modal assessment, positive behavior supports, consultation and facilitator skills, and creative

thinking. Training, mentoring and coaching as methodologies will result in increased community capacity to support individuals in their community.

- The crisis services will include short term respite capacity for planned respite. The services will also include crisis/short term bed capacity with the ability to provide assessment, evaluation, treatment and stabilization services that will avoid the inappropriate use of more restrictive settings, institutions, psychiatric hospitals, or jails. The crisis/short term treatment bed capacity could also support individuals transitioning to new living arrangements.
- Funding for these services needs to be sustainable and provide for flexibility in service delivery.
- Expand consultative services and make them available state-wide through the use of telepresence.
- Support workforce development for public and private providers. Development should include a short-term training component for existing professionals that achieves competency in the areas of positive behavioral supports and person-centered planning and thinking. It should also include a long-term strategy to develop a sufficient number of individuals with advanced training and competencies in treatment for individuals with developmental disabilities, people with mental illness and co-occurring chemical dependency issues and other clinical complexities.
- Support services should also be designed to provide technical assistance and support to families and other natural support caregivers regardless of setting.
- Develop comprehensive, early identification and intensive intervention services for children and adults who have a first episode of serious mental illness. Evaluate changing eligibility for services from SPMI to SMI thus enabling people experiencing mental illness to access more intensive community services at an earlier stage of the illness.

### **Non-Medicaid Funded Services and Supports**

There are also important services and supports that are funded by the state and counties. These services and supports as described in Appendix A. The services and supports include Day Training and Habilitation (DT&H), Alternative Care (AC), Consumer Support Grant (CSG), Semi-Independent Living Services (SILS) and Family Support Grant (FSG). Table 1 in Appendix A shows utilization trends for community-based services. Of the services listed, CSG has the highest average annual increase. CSG is a state-funded alternative to Medicaid-reimbursed home care. Individuals receive a monthly cash grant to pay for a variety of services and supports in lieu of other services including home health aide, PCA and/or PDN. The CSG is flexible and allows for consumer direction.

## Health Care Services

Comprehensive health care coverage, including but not limited to medical, mental health, chemical health, vision, audio and dental services, occupational and physical therapy including medications, assistive technology, medical equipment and preventative care are critical to living in the community. There are gaps and barriers to accessing health care services in the community. Some of these barriers include appropriate providers not available in all areas of the state, providers refuse to treat individuals with disabilities, and some providers do not accept Medicaid payment.

### Recommendations for Health Care Services

- Develop payment rates which are adequate to ensure access to health care services.
- Increase access to preventative health care services in the community by considering using state-employed health care professionals, mobile clinics using telemedicine and other technologies and the additional incentives to reach those who are underserved.

## Navigation, Referral and Coordination

The “What We Have” report describes Minnesota’s referral and coordination systems<sup>23</sup>. Minnesota Centers for Independent Living (CIL) and the Minnesota Board on Aging also provide important services that assist individuals to remain living in the community. Other important resources are Peer Support Specialists, Ombudsmen for Long-Term Care, Mental Health and Developmental Disabilities and State Managed Care Programs.

### Recommendations for Navigating the System

- The State should support and collaborate with Minnesota Centers for Independent Living (CIL) to improve statewide coverage. Additional centers will increase access to resources within the community to enable living in the most integrated setting.
- The State should work toward making the service system easier to understand and to access.

## Transportation

The OPC did not have time to adequately explore the issue of transportation for persons with disabilities; however, the lack of transportation was frequently mentioned as a barrier to community integration.

### Recommendation for Transportation

- The Plan must establish measurable transportation goals related to increasing community integration.

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<sup>23</sup> MN DHS, *What We Have*, September 2012

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## WHERE PEOPLE LIVE

### Introduction

Minnesota has undergone a massive transformation in the last several decades in moving persons from institutions to community-based settings. In the 1980s, Minnesota led the nation in the use of nursing homes and Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD). Policy changes at the state and federal level created opportunities to shift toward community-based care, most notably, the creation of the §1915(c) home and community-based waiver option under Medicaid. In addition, litigation in the late 1970s and early 1980s required the downsizing of state institutions and mandated the availability of home and community-based service options. Over time, moratoriums were placed on the development of nursing facilities and ICFs/DD and most recently adult foster care. In 2010, it is estimated that 87% of the public funds for long-term care services for people with disabilities is spent on home and community-based services.<sup>24</sup>

Yet, the definition of community setting continues to evolve as persons with disabilities have been moved out of institutions. No longer is it enough to move someone from an institution to a smaller facility in a community setting and claim community integration has been achieved. What is an institution? What is the most integrated setting? The vision of *Olmstead* requires new analysis.

The Department of Justice provides some guidance:

The “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible...”

Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings include, but are not limited to (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities<sup>25</sup>.

Other federal agencies such as the U.S. Department of Housing & Urban Development (HUD) and the U.S. Department of Health and Human Services (HHS) have recently issued guidance to the States on the implementation of *Olmstead*. In addition CMS is expected to issue the final rule regulating where 1915(c) home and community based services waivers can pay for services. The proposed rule released on April 14, 2011, was more descriptive of the types of settings that will qualify for waiver funding. The final rule is expected to be issued this fall.

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<sup>24</sup> Source: MN Department of Human Services Data Warehouse. [http://www.dhs.state.mn.us/main/dhs16\\_166837#](http://www.dhs.state.mn.us/main/dhs16_166837#)

<sup>25</sup> US DOJ Civil Rights Division *Statement of the DOJ on Enforcement of the Integration Mandate of Title II of the ADA and Olmstead v. L.C.*, [http://www.ada.gov/olmstead/q&a\\_olmstead.htm](http://www.ada.gov/olmstead/q&a_olmstead.htm)

## Background

People with disabilities currently live in many different settings which are regulated by DHS and MDH. See Appendix B for a brief background on each of the settings. The legislative report “*Evaluation of Current and Potential Housing Options for Persons with Disabilities*” prepared by the Disability Services Division in April 2011<sup>26</sup>, states: “Compared to other states, Minnesota traditionally has higher utilization rates of congregate settings to provide services and oversight to persons with disabilities and other groups, at higher costs per person” (page 13)<sup>27</sup>. In the table below, the State provided data to Senator Harkin in an August 28, 2012, letter that indicates that state funding for people with disabilities totals approximately 1.2 billion dollars. Out of the 1.2 billion dollars, 35% or approximately 413 million dollars is spent on people with disabilities to live in their own homes. The remaining 65% is spent on a range of settings from small adult foster care homes to large institutes for mental disease and nursing facilities.

**Table 1 - State Funding for People with Disabilities in SFY2011 (By Setting)**

Setting	State Funding	Percent
Group Homes	\$ 542,418,377	45.88%
Own Homes	\$ 413,859,087	35.01%
Supervised Living Facility	\$ 68,645,635	5.81%
ICF/DD	\$ 64,203,703	5.43%
Nursing Facilities	\$ 50,056,644	4.23%
Psychiatric Hospitals	\$ 32,854,227	2.78%
IMD	\$ 7,443,974	0.63%
Board and Care Homes	\$ 2,792,675	0.24%
Total	\$ 1,182,274,322	100%

Currently, Medicaid pays the room and board and services provided in nursing facilities, ICFs/DD and Children Rule 5 facilities. Minnesota has five Home and Community-based Waivers and important Medicaid State plan services such as Personal Care Assistance, Private Duty Nursing and Mental Health services that pay for services in the community (See Appendix A for a description of waiver services and State plan services). The waivers do not pay for room and board but pay for the services that support the individual with a disability to live in the setting.

The Group Residential Housing (GRH) program is an income supplement to assist people with disabilities to pay for room and board in *licensed or registered* settings. The current maximum income supplement for the GRH Housing Rate is \$867 per month per resident. Services might be provided by Medicaid waivers, the GRH Supplemental Service Rate, the Difficulty of Care (DOC) payment, private foundation grants, or private pay. (See Appendix B for the matrix of services provided).

<sup>26</sup> MN DHS Disability Services Division, *Evaluation of Current and Potential Housing Options for Persons with Disabilities*, April 2011

<sup>27</sup> MN DHS Disability Services Division, *Evaluation of Current and Potential Housing Options for Persons with Disabilities*, April 2011

The MSA Shelter Needy program is an income supplement to assist people with disabilities move into affordable housing. Services might be provided by the Medicaid self-directed supports option or Medicaid home and community-based waiver services, private foundation grants, or private pay.

The three waivers that serve the most people are the DD, CADI and EW waivers. The 2011 Legislative Report on Housing,<sup>28</sup> provides detail on persons using those three waivers by setting. In fiscal year 2009, the DD waiver served 14,000 individuals. Of those individuals, 55 percent (8,000) lived and received services in a corporate foster care setting. In contrast, in 2008, 71 percent of persons served by the CADI waiver lived in their own homes or with family and friends, 18 percent lived in corporate foster care and 11 percent lived in assisted living facilities.

The Elderly Waiver (EW) includes “customized living services,” which is a package of individualized services provided to EW individuals who live in a housing with services establishment that is licensed as an assisted living facility. Between 2001 and 2008 the percentage of EW participants using customized living services grew, from 7 percent to 35 percent. The 2011 Legislative Report on Housing concludes that “service costs could be reduced if more persons on the HCBS waivers were able to find suitable housing in the community, which is where they are increasingly seeking to reside.”

Recent housing reports<sup>29</sup> have documented barriers to living in the community for persons with disabilities. Below are some of the common barriers:

- The actual cost of market-rate housing is prohibitive to low-income individuals, including persons with disabilities.
- Consumers and service providers lack information about available funding, housing and service options.
- A lack of affordable and accessible housing options
- A lack of permanent supported housing
- A lack of housing in suitable locations near employment and accessible transportation
- Inadequate availability of accessible transportation options for people living in the community
- Individuals may not be able to access community settings based on: financial and credit history, eviction records, arrest records and/or unmet need for support services.
- There are inadequate community based services and supports on a statewide basis to permit persons with disabilities, including serious mental illness to live in market-rate housing.
- There is an inadequate focus of housing services and supports targeted to transition-aged youth.

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<sup>28</sup> MN DHS Disability Services Division *Evaluation of Current and Potential Housing Options for Persons with Disabilities*, April 2011

<sup>29</sup> *Options Too: Acting Together to Promote Community Alternatives for People with Disabilities*, February 2007 and MN DHS Disabilities Division, *Evaluation of Current and Potential Housing Options for People with Disabilities*, April 2011

DHS has several initiatives that currently support people moving from congregate settings to the community. In February, 2011, Minnesota was awarded a Money Follows the Person Rebalancing Demonstration Grant from the U.S. Department of Health and Human Services.<sup>30</sup> Minnesota will leverage an award of up to \$187.4 million over five years to improve community services and support people in their homes rather than institutions.

Minnesota's goals for Money Follows the Person are to:

- Simplify and improve the effectiveness of transition services that help people return to their homes after hospital or nursing facility stays;
- Advance promising practices to better serve individuals with complex needs in the community;
- Increase stability of individuals in the community by strengthening connections among healthcare, community support, employment, and housing systems; and
- Increase use of home and community-based services by setting priorities to address specific institutional needs for reform.

Throughout the demonstration, DHS will continue to increase the proportion of State Medicaid expenditures for HCBS relative to those spent on institutional long-term care.

The OPC recognizes Money Follows the Person Grant, Return to Community Living, and Return to Community Living for People with Mental Illness are important initiatives that are primarily aimed at moving people with disabilities from nursing facilities, ICFs/DD and hospitals from the facility to the community.

In addition, if approved by the federal government and state legislature, two housing proposals in the *Reform 2020 Section 1115 Waiver* the Housing Stability Services Demonstration and Project for Assistance in Transition from Homelessness and Critical Time Intervention Pilot support the goals of *Olmstead* and should be included in the *Olmstead* Plan.

Persons needing accessible housing may also benefit from the access to market rate housing using waiver-provided funding for home accessibility modifications. For these reasons, the OPC believes that it should be possible to significantly reduce the number of persons in more expensive housing over a five year period. The OPC recognizes that there will be significant system planning to be undertaken to attain the identified numerical percentage reductions in settings such as corporate foster care and nursing homes including the likely need of closing beds and even facilities when people with disabilities are enabled to move into the community. The Plan developed by the State must set numerical goals and periodically measure progress to assure the strategies are working as designed.

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<sup>30</sup> Money Follows the Person Rebalancing Demonstration webpage: [www.dhs.state.mn.us/main/dhs16\\_162194#](http://www.dhs.state.mn.us/main/dhs16_162194#)

## Recommendations for Housing in the Community

- The State must significantly increase the ability of persons with disabilities to afford and have access to market rate housing that the individual controls.
- Increase state funding for and access to rental assistance programs for persons with disabilities.
- Evaluate state funded housing and supports programs to determine if they are adequate, efficient, appropriately used or can be expanded based on the identified need. This includes Minnesota's income supplement programs, in particular Group Residential Housing and Minnesota Supplemental Assistance - Shelter Needy Option.
- Expand programs such as the Crisis Housing Fund that provide temporary rental, mortgage, and utility assistance for persons with disabilities to retain their housing while they are temporarily in less integrated settings or treatment facilities.
- Increase funding for a statewide rental housing vacancy referral system to provide information to people about available affordable and accessible housing units.
- The State shall use best efforts to form private/public partnerships to fund additional, affordable and accessible housing for people with disabilities. Such partnerships may include seeking grants from foundations or corporations.
- Annually, during the assessment process and subsequent reviews, individuals with disabilities should be asked if they want to move to a more integrated community setting or make other changes to their living situation. This currently occurs in nursing facilities and should be expanded across all settings.
- Those who express an interest in moving to a different setting should be informed of the resources available to them for housing and services.
  - A person-centered discharge plan and community support plan should be developed for people who choose to move to a new setting.
  - A Peer Integration Specialist will be available to assist the individual with a disability during the planning process to ensure their personal needs and preferences are considered.
- Evaluate the impact of the adult foster care moratorium on the increased utilization of more restrictive settings including nursing homes, ICF/DDs, Board and Lodge Facilities with and without Services, and Housing with Services Establishments, hospitals, Intensive Residential Treatment Services (IRTS), or other inpatient residential settings.
- Evaluate the populations residing in other settings including Board and Lodging establishments with and without services to determine if there is an *Olmstead* issue.

- The Plan should build upon the strategies identified in the Evaluation of Current and Potential Housing Option for Persons with Disabilities Report of April 2011 by:
  - Improving access to rent subsidies;
  - Creating and promoting accessible housing and accessible communities;
  - Making better use of existing housing stock to expand choice and access; and
  - Assisting persons with disabilities to become homeowners through the land trust program.
- The State must develop a plan to assist providers in transitioning their service array to a different model.
- Use existing data systems to better inventory and monitor the continuum of housing options and the movement toward integrated community settings in Minnesota and develop improvements as necessary. This includes data systems used by DHS, Department of Health, Minnesota Housing, HUD, Department of Corrections, Department of Public Safety, and Housing Authorities statewide.
- The State should convene a multi-agency collaborative Housing Task Force to work on the recommendations listed above, foster the development of new initiatives to address these identified issues, and help establish specific, measurable and achievable goals.

## Goals

- Increase the availability and access to integrated community settings in order to ensure that all people with disabilities have the ability to live in the most integrated setting possible.
- Reduce the number of persons with disabilities residing in nursing homes and ICFs/DD by 2,000 individuals over a five year time period through Money Follows the Person.
- A minimum reduction of 5% over the next five years in adult foster care beds and housing with services establishments. The money saved from reducing less integrated bed capacity should not be part of a budget reduction exercise but rather be reinvested into an array of existing or new and enhanced services.
  - Information about current use of family foster care and corporate foster care, and an analysis of capacity needed, will be available in the February 2013 foster care needs determination report to the Legislature.<sup>31</sup> The needs determination should inform the Plan.

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<sup>31</sup> 2012 Laws of Minnesota, Chapter 247, Article 4, Section 6.

## STATE OPERATED SERVICES

State Operated Services (SOS) is a division of the Minnesota Department of Human Services (DHS) that provides direct care services to people with mental illnesses, chemical dependency, intellectual disabilities, and traumatic brain injuries. These services range from short-term acute care in hospital settings to long-term residential support services. SOS typically serves people who have difficulty being served by other providers, including people committed to the Commissioner of DHS. See Appendix C for a description of all state operated services.

The *Olmstead* concept of “most integrated setting” poses three important challenges for SOS services:

- Residential services: Some SOS services are provided in congregate residential settings that are populated primarily by individuals with disabilities. To comply with *Olmstead*, the State and counties need to work with residents to develop plans to consider and/or implement moves to more integrated settings.
- Acute care services: It is often extremely difficult to discharge patients to more integrated settings when they no longer need a hospital level of care in SOS hospitals for individuals with complex, co-occurring conditions that require a unique array of services not available in most communities. This conflicts with the *Olmstead* standard of serving people with disabilities in the most integrated setting possible.
- Forensics services: The forensic population faces numerous barriers to discharge back to the community. With length of stays in the 10-25 year range it is clear the *Olmstead* standard of serving individuals is not always being met.

## Minnesota State Operated Community Services

Minnesota State Operated Community Services (MSOCs) provides community-based residential, vocational, and crisis respite services for about 450 people with disabilities annually. MSOCs have fifteen residential homes licensed as ICFs/DD that usually house six people for a total of about 90 residents at a time. MSOCs also operate 90 corporate foster care homes serving approximately 355 individuals annually. In addition, MSOCs provides a wide range of vocational training and supports for individuals in 19 Day Training and Habilitation (DT&H) sites serving about 863 individuals annually.

## Recommendations for Minnesota State Operated Community Services

- The State and counties should engage in a person centered planning process to offer individuals residing in MSOCs facilities a choice to move to a more integrated setting.
- Recommendations under the Where People Work section regarding DTHs and the Where People Live section regarding ICFs/DD and foster care recommendations apply to MSOCs.
- Review and study what role MSOCs can play to assist with transitioning an individual to another setting, providing crisis services, etc. This study would help determine what role MSOCs should

play in the safety net system to assist with the transition to non-state operated programs some of the most difficult to serve individuals.

### **State Operated Forensic Services (SOFS)**

The term “forensic” is used by SOS to refer to specialized statewide evaluation and treatment to individuals with disabilities who are involved with the legal system due to a crime. During fiscal year 2012 Minnesota spent \$68 million to provide forensic services to individuals residing on a campus in St. Peter, Minnesota. This includes the Minnesota Security Hospital (MSH). See Appendix C for a description of SOS forensic services. The MSH is a supervised living facility for individuals who have been committed as Mentally Ill and Dangerous (MI&D) by a court. The supervised living facility funding includes all costs paid by the state to serve individuals in this setting, including behavioral health treatment and other medical care. In 2011, Minnesota opened a forensic nursing home to serve individuals from the Minnesota Security Hospital, the Minnesota Sex Offender Program (MSOP), or persons who are on a medical release from the Department of Corrections (DOC).

As patients at MSH complete their treatment, they are moved to the Transition Readiness program and the Transition Services program, both of which prepare the individual to move back into their chosen local community. Upon completion of those programs, a Special Review Board and county representatives review each individual’s record and decide whether or not the individual should be released to the community (see next section for more detail). In a presentation to the *Olmstead* Planning Committee, SOS staff estimated that MSH has 50 people in the Transition Readiness program and 82 people in Transition Services, all of whom could move to the community if the move were supported by the county, recommended by the Special Review Board, and approved by the Commissioner. However, very few people overcome these hurdles. Only 11 people were provisionally discharged from Transition Services in 2011, and only 12 people were provisionally discharged in 2010. The two Transition programs support 35% of the Minnesota State Hospital population.

In addition, SOS’s St. Peter-based Competency Restoration Program has 26 beds. The purpose of this program is to provide treatment for people to restore their competence to stand trial. The average length of stay in this program is six months. SOS staff estimate that, at any one time, 40% of the beds in the program are occupied by people who have completed an evaluation and whose report has been submitted to the court. A major barrier to disposition and discharge is that criminal courts hold jurisdiction over these patients and have up to three years to take action.

The OPC requested information regarding the length of stay for individuals in forensic services. Data for patients served by forensic services on September 13, 2012, is included in Appendix C. The data provides a snapshot of the length of stay by current program, legal status and county of finance. The data shows that 108 of the Minnesota Security Hospital’s forensic patients have been in forensic services for 10-25 plus years. Of the 108 patients, the county of finance for half of the patients is Hennepin County. In addition, there were 147 patients in five transition programs; 55 of them had been in forensic services for 10-25 plus years.

## Civil Commitment and State Operated Forensic Services

Like most other states the inpatient forensic population of Minnesota consists of people who are being held according to Minnesota Rules of Criminal Procedure 20.01 (Incompetent to Stand Trial) and Minnesota Rules of Criminal Procedure 20.02 (Not Guilty by Reason of Mental Illness or Deficiency). However, Minnesota is unique and has a third large category of commitment status— Mentally Ill and Dangerous (MI&D)<sup>32</sup>—which is a civil commitment of indeterminate length (MN Statute 253B.18 subd.3). Other states do not have a population labeled MI&D through a civil process.

Currently, there are approximately 420 people committed as MI&D in Minnesota; this number is comprised of approximately 270 inpatient at State Operated Forensics Services (SOFS) and 150 residing in the community<sup>33</sup> in varying degrees of independence (such as Adult Foster Care, Institute for Mental Disease (IMD),<sup>34</sup> community nursing home, Intensive Residential Treatment Service (IRTS), Board and Lodge, or apartment). The inpatient population at SOFS increases at the rate of approximately 10 to 15 individuals per year. Indeterminate civil commitments means that individuals are committed through the civil court system and the provisional discharge is approved or denied<sup>35</sup> by the Special Review Board (SRB). The SRB is a quasi-judicial panel of mental health and legal experts which was “established to address the treatment needs of the patient and protect public safety.”<sup>36</sup> Thus, SOFS staff does not have the authority to discharge patients. The rate of admission via civil court proceedings, versus the rate of provisional discharges via the SRB, has resulted in an ever-increasing inpatient population at SOFS.

Another barrier to discharge for individuals at SOFS is that the resources necessary for supporting the individual’s return to the community are under the direct control of the county social services agency. Counties do not have targeted funding for people that raise public safety concerns. This creates an incentive for counties to give preference to individuals without histories of public safety concerns. All of these factors contribute to the limited numbers of people leaving SOFS, even though SOFS staff believes that a large number of people in the program could live safely and successfully in the community.

## Recommendations for State Operated Forensics Services

- The State in collaboration with the counties must develop an appropriate array of community based services, including Forensic Assertive Community Treatment Teams, to assist individuals to remain in the community and assist those returning to the community.

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<sup>32</sup> The MI and D civil commitment is an “indeterminate” civil commitment which means that the petitioning party does not have to re-prove that the client meets the statutory definition at the expiration of a pre-determined time period as is the case with “determinate” civil commitments such as the Mental Illness or Chemically Dependent civil commitment, which must be “re-proved” annually. Instead, the burden shifts and the MI and D client must prove that s/he is no longer MI and D and qualifies for what is referred to as a “full discharge.” These “full discharges” are granted to only a few people a year.

<sup>33</sup> Via the Provisional Discharge at a rate of approximately 10 to 15 per year.

<sup>34</sup> Most notably Andrew Residence in Minneapolis.

<sup>35</sup> Technically the SRB only makes a recommendation to the Commissioner of DHS, who has the final say, but the Commissioner rarely disagrees with the SRB’s recommendation.

<sup>36</sup> Per the DHS website: The next level of appeal is the quasi-judicial SCAP (Supreme Court Appeal Panel, formerly known [and still in statute] as the Judicial Appeal Panel), then the Minnesota Court of Appeals, and finally the Minnesota Supreme Court before federal courts are accessed. The factors that the SRB considers are found in Minnesota Statute 253B and State Operated Services Policy 10020 and are essentially a combination of the client’s clinical progress and public safety. Other relevant Policies are SOS 10030 and SOS 6050.

- The State should establish a committee made up of multiple stakeholders to review, analyze and recommend changes to the Minnesota Statute 253B.18 subd.3 regarding civil commitment of indeterminate length for persons who are mentally ill and dangerous to the public.
- The State should educate the Special Review Board and the Supreme Court Appeal Panel on the various community services and supports available to the individual to achieve a successful and safe return to community life.
- The State and counties should develop and implement a plan to move 132 individuals to a more integrated community-based setting within a maximum of 2 years, based on client preference and within the parameters of the identified community and client safety risk. To assist individuals returning to the community, a person-centered discharge process should be developed that includes sufficient Peer Integration Specialists with the capacity to work knowledgeably within specific disability groups and as part of the multidisciplinary treatment team to aid the individuals.
- Within one year, the State should develop an annual review process to assess all patients in forensic services to determine if the individual can move to a more integrated setting in the community given adequate supports and safeguards. The review should take place annually or at the time the individual is making significant progress in treatment. When the review process determines that a return to the community is warranted, sufficient community resources must be made available to support the individual's return to the community. The State must then initiate a petition supporting return to the community on behalf of the individual unless the individual objects. To assist individuals returning to the community, a person-centered discharge process must be developed that includes sufficient Peer Integration Specialists with the capacity to work knowledgeably within specific disability groups and as part of the multidisciplinary treatment team to aid the individuals.
- The State should seek technical assistance to address the treatment-related aspects contributing to extremely long length of stays to assure that the treatment program at the Minnesota Security Hospital is evidence-based and meets current treatment standards.
- The State must rebalance forensic financial resources from the institution to community-based services.

### **Anoka Metro Regional Treatment Center and Community Behavioral Health Hospitals**

Anoka Metro Regional Treatment Center (AMRTC) provides psychiatric services for patients who have acute mental illnesses requiring a hospital level of care and who are civilly committed. AMRTC has eight 25-bed units, and admitted 450 patients in 2011. SOS's Community Behavioral Health Hospitals (CBHH) also provide acute psychiatric care, but in small, 16-bed facilities that admitted a total of 1,488 patients in 2011. The average length of stay at AMRTC in 2011 was 88 days. At the CBHHs, the average length of stay is much lower, usually less than 20 days<sup>37</sup>.

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<sup>37</sup> SOS Utilization Presentation to OPC May 3, 2012 [http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/opc\\_docs\\_030.doc](http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/opc_docs_030.doc)

Like other hospitals, AMRTC and the CBHs have utilization management systems that monitor utilization of their hospital beds and determine when a patient no longer requires a hospital level of care. However, discharging patients when they no longer require hospital services is very challenging due to several factors, including the complexity of discharge planning for patients with complex chronic disabilities; the challenges of coordinating effectively among hospital social workers, counties and community providers; the difficulty of finding appropriate providers of services for people with aggressive histories; a lack of housing with services for patients with complex needs; and complicated funding streams that can make it difficult to fund appropriate placements.

As a result of these factors, AMRTC patients spent 10,670 days at AMRTC in 2011 when they did not meet criteria for a hospital level of care. Patients at the CBHs spent an additional 3,300 days not meeting criteria, for a total of over 14,000 bed days during which the patients did not meet a hospital level of care<sup>38</sup>. This represents about 15.4 million dollars of inappropriate care expenses, borne primarily by the state.

The fact that so many patients remain in SOS hospitals who no longer need inpatient hospitalization is of extreme concern, but concern is compounded by the fact that the CBHs are usually full and AMRTC has a waiting list that recently exceeded 100 people. When beds are filled by patients whose conditions don't require them to be in a hospital, those beds are not available for others who do require a hospital level of care. A significant amount of SOS staff time is spent managing the waiting list, which is typically reduced by diversions. Diversions include: contract bed referrals, hospitals writing their own provisional discharge, requesting a remote provisional discharge, IRTS referrals, nursing homes, assisted livings, and the use of ACT teams.

Each week AMRTC bed management staff and Hennepin, Ramsey, Dakota and Washington Counties case management staff review clients on the waiting list and hold meetings to plan for discharge of patients currently at AMRTC. AMRTC is starting to work with rural counties as well, so that discharge planning begins earlier in a patient's stay at AMRTC, thus reducing the number of days when patients don't meet a hospital level of care.

The AMRTC is licensed as a hospital but for Medicaid purposes is still considered an Institution for Mental Disease (IMD).<sup>39</sup> Because most people served in IMDs are not eligible for Medicaid coverage, AMRTC services are primarily funded through a state general fund appropriation, with counties paying a share. Under Reform 2020, Minnesota is requesting a waiver of the Institutions for Mental Diseases exclusion for AMRTC because it is operating as a tertiary hospital. This would allow Medicaid financing for the people aged 22-64 at AMRTC. If successful, Minnesota plans to use the state money that is saved to develop community-based, non-hospital services for individuals with more intensive and specialized needs to move from AMRTC to the community.

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<sup>38</sup> MN DHS SOS Admissions and Discharge Data Request to OPC May 3, 2012  
[http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/opc\\_docs\\_028.pdf](http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/opc_docs_028.pdf)

<sup>39</sup> IMDs are defined as facilities of 16 or more beds in which a majority of residents are age 22-64 and have diagnoses of mental illness. MA does not pay for services provided to residents in IMDs unless the resident is under age 21 or over age 65.

## **Recommendations for Anoka Metro Regional Treatment Center**

- The State and Counties should develop sufficiently robust community and housing services to improve the patient flow through the mental health treatment system, and within a maximum of two years eliminate the AMRTC wait list.
- Within a maximum of two years, AMRTC will ensure that patients who reach stability are discharged in 3-5 working days.
- SOS should evaluate how to make the AMRTC wait list more transparent and accountable. The waiting list data should be included in the annual AMRTC Utilization Data report.
- SOS should continue to work with the Counties to implement person centered discharge planning that includes a multidisciplinary approach, including Certified Peer Specialists and other Peer Integration Specialists with knowledge of the needs of the individual. This includes family and natural supports as appropriate.

## **Community Support Services**

Community Support Services (CSS) advances the SOS mission by strengthening the community living of people with clinically complex challenges. This is done through initiating and guiding innovative behavioral supports, building collaborative support networks and advocating for person-centered approaches. By facilitating activities that promote SOS as a leading partner in Minnesota's service systems, CSS involvement ensures that SOS has the capacity to meet targeted goals for providing state-of-the-art services.

## **Minnesota Specialty Health System - Cambridge**

In considering the values and expectations of the *Olmstead* decision it is the OPC's recommendation to develop a robust set of alternative services specifically designed to support individuals with developmental disabilities who exhibit severe behaviors which present a risk to public safety. These services, once implemented, will support people in the most integrated setting and eliminate the need for placement in the MSHS Cambridge program. The recommended services described in this section are also described in the section on Community-Based Supports and Services where the recommendation is to make them available for all persons with disabilities who are or may be at risk of crisis.

## **Recommendations for MSHS-Cambridge**

- Development of regional crisis services that consist of mobile teams of professionals and paraprofessional staff. This service will allow for the provision of assessment, triage, and care coordination to assure persons with developmental disabilities and those who exhibit severe

behaviors which present a risk to public safety receive the appropriate level of care in the most integrated setting in accordance with the *Olmstead* decision.

- This service will provide long term monitoring of individuals with clinical and situational complexities in order to help avert crisis reactions, provide strategies for changing needs, and prevent admissions to the MSHS Cambridge program, community jails and Minnesota Security Hospital.
- The long-term monitoring will be implemented at the point when individuals experience contact with law enforcement, psychiatric hospitalization, or emergency room visits related to actions that present a significant risk of harm to themselves or others or when school age youth experience truancy.
- These services will be provided where the person lives, strengthening the capacity of the system to serve individuals with clinical complexities in their home.
- Crisis services will include mobile wrap-around response teams located across the state for proactive response to maintain living arrangements. The time for the crisis response should be as soon as possible with a maximum time of three hours from the time of request.
- This service will provide families, caregivers, and staff at community-based facilities and homes with state of the art training encompassing person-centered thinking, multi-modal assessment, positive behavior supports, consultation and facilitator skills, and creative thinking. Training, mentoring and coaching as methodologies will result in increased community capacity to support individuals in their community.
- The service will include short-term respite capacity for planned respite. The service will also include crisis/short-term treatment bed capacity with the ability to provide assessment, evaluation, treatment, and stabilization services that will avoid the inappropriate use of more restrictive settings, institutions, psychiatric hospitals, or jails. The crisis/short-term treatment bed capacity could also support individuals transitioning to new living arrangements.
- Funding for these services needs to be stable and provide for flexibility in service delivery.
- Expand consultative services and make them available state-wide through the use of telepresence.
- Support work force development for public and private providers. It should include a short-term training component for existing professionals that achieves competency in the areas of positive behavioral supports and person-centered planning and thinking. It should also include a long-term strategy to develop a sufficient number of individuals with advanced training and competencies in treatment for individuals with developmental disabilities and other co-occurring clinical complexities.

- In order to secure this new work force and keep it stable, consideration should be given to the establishment of wage subsidies for specific professionals and paraprofessionals with the highly technical skill sets.
- Support services should also be designed to provide technical assistance and support to families and other natural support caregivers regardless of setting.
- The OPC is aware that there are a number of services that currently exist that provide portions of the services described targeted to specific disability population. It is recommended that the State, in developing the Plan, consider incorporating these services into a comprehensive crisis service network.

### **Goal**

- End the use of the MSHS-Cambridge through the development of a robust array of community services.

### **Child and Adolescent Behavioral Health Services (CABHS)**

- A priority of the Money Follows the Person grant is to move children from the Child and Adolescent Behavioral Health Services program in Willmar to their homes.
- The State must develop the capacity statewide to provide children with complex disabilities access to hospital or intensive residential treatment services in their communities.

### **Department of Corrections (DOC)**

- DHS and DOC should convene a workgroup with Community corrections and other stakeholders to review transition services from correctional institutions to the community, jails to SOS facilities, mental health courts and other issues as identified by the agencies.

## WHERE PEOPLE WORK

### Introduction

The OPC's vision is that Minnesota will make and carry out a plan that will tap the underused employment potential of the disability community. Consistent with the *Olmstead* decision, the OPC's goal is to increase the number of individuals with all types of disabilities working in integrated community settings and to increase their earnings. Planning and implementation will require sustained coordination across state agencies. The Plan must also ensure that people with disabilities who do not choose to work in the community continue to receive services that effectively meet their individual needs. Further, the Plan must acknowledge and address the lack of fluidity in access of services across an individual's lifetime. Fear of being unable to have timely access to more intensive (and less integrated) services- should they be needed in the future-prevents many from achieving the highest possible level of independence and integration. The Plan must move away from placing labels and limits on individuals with disabilities and move toward providing services based on individual choice with the supports needed to succeed.

The *Olmstead* planning process must play a key role in improving the employment situation of Minnesotans with disabilities. Despite the legal rights that flow from the ADA, the Individuals with Disabilities Education Act (IDEA), and the *Olmstead* decision, the rates of employment of people with disabilities have not improved. As of June 2012, according to the Bureau of Labor Statistics, only 32 percent of working age people with disabilities were in the labor force (those working plus those actively seeking employment), and only about 27.6 percent were actually working. As an employer, the State of Minnesota is even further behind, despite a project entitled "Minnesota as an Exemplary Employer," which was launched in 2007 to establish State government as a model employer of adults with disabilities.

With the convergence of President Obama's executive order directing the executive branch of the federal government to hire an additional 100,000 federal workers with disabilities by 2015; the National Governors Association "A Better Bottom Line";<sup>40</sup> Senator Tom Harkin's "Unfinished Business";<sup>41</sup> and the Oregon federal district court case to determine if *Olmstead's* community integration mandate applies to sheltered workshops, the state must make this the priority it needs to be and foster real change in employment outcomes for people with disabilities.

Employment levels among individuals with disabilities remain unacceptably low even though evidence suggests that the many myths associated with hiring people with disabilities are just that – the State needs to educate employers and the workforce about the benefits associated with an inclusive workforce that far outweigh perceived difficulties. In addition, to create the expectation of work, as opposed to dependency on services, the State needs to help young people with disabilities transition successfully from school to higher education and competitive, integrated employment that can lead to quality careers and economic security. People with disabilities, including those with complex disabilities, have the right to enjoy their lives as much as do people without disabilities. Working and

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<sup>40</sup> National Governor's Association "A Better Bottom Line: Employing People with Disabilities," [www.subnet.nga.org/ci/1213](http://www.subnet.nga.org/ci/1213)

<sup>41</sup> Senator Tom Harkin, "Unfinished Business: Making Employment of People with Disabilities a National Priority," July 2012.

earning money are basic aspects of typical adult life. To quote the late Justin Dart, a powerful advocate for people with disabilities, “Disabled does not mean ‘unable’.”

## **Employment Policy Leadership**

### **Background**

Inside state government several agencies work on employment. Accordingly, the Plan has to address more than DHS programs and will require ongoing collaboration and coordination across agencies. The OPC recommends that Governor Dayton establish an *Olmstead* sub-cabinet. One of the topics of focus should be employment of people with disabilities. There are several initiatives at the federal level that require a coordinated state response; and the goals in OPC’s recommendations cannot be reached without sustained collaborative leadership.

These federal initiatives include:

- The National Governor's Association has a new employment initiative “A Better Bottom Line”.
- Senator Harkin announced that an additional 1 million people with disabilities should be employed.
- President Obama announced that an additional 100,000 people with disabilities should be employed in federal government.
- The U.S. Department of Labor may promulgate rules for any federal contractor to do a 7 percent set aside for people with disabilities.
- The DOJ has taken a new interest in the *Olmstead* decision and day/employment services and filed an amicus brief in the Oregon lawsuit.
- The Government Accountability Office report on Transition-Age Students noted problems with lack of coordination.
- The Office of Special Education letter indicating that school work transition programs must also consider the least restrictive environment.
- The Office of Disability Employment Policy has selected lead states in teaching other states how to increase integrated employment .
- Centers for Medicare and Medicaid Services Bulletin dated September 16, 2011, limits the use of Medicaid waiver funding for center-based employment and clarifies that employment services must be provided in the most integrated setting.

In addition to these federal initiatives, the State of Minnesota lags in hiring people with disabilities based upon the Affirmative Action plans that have been approved by the Minnesota Management and Budget department. The issue of employment of people with disabilities should be addressed by the Governor established *Olmstead* sub-cabinet to coordinate and lead future efforts. This leadership team could pick up the recommendations of the OPC and move the issues forward.

## Recommendations for Employment Policy Leadership

- The *Olmstead* sub-cabinet must include a focus on employment. The sub-cabinet level work must involve representatives from Minnesota Department of Education (MDE), DHS including cross representation, Department of Employment and Economic Development (DEED), the business and higher education communities to lead efforts to increase employment of all persons with disabilities. It is further recommended that this sub-cabinet leverage the resources and work currently being done by the State Rehabilitation Council, the Governor's Workforce Development Council, and others as appropriate.
- Charge this sub-cabinet with the task of exploring the possibility of coordinating all employment service funding systems under one state unit.
- Charge this sub-cabinet with the task of improving employment-related policies and practices across all state agencies. Attention should be paid to reducing and not creating any new disincentives for individuals seeking competitive employment (i.e. not losing health care benefits if employed).

## Communication and Messaging

### Background

Among service areas (MDE, DHS, and DEED) terminology and definitions pertaining to work are varied and inconsistent. Unfortunately, the federal definition of disability as it pertains to Social Security benefits requires that a person be unable to participate in substantial gainful employment. For the purposes of this plan and in keeping with the intent of the ADA, this committee broadens this definition to include those people with disabilities who are able to participate in employment because of support services provided. Definitions should correspond to the recent CMS bulletin and get to the idea of "work" being competitive and integrated. The OPC recommends that all state websites be reviewed to understand what is being communicated about employment. This review could include all website sections dealing with day programs and other employment-related services. Feedback should be solicited from individuals and families as well as from businesses or employers.

**Core Service Definitions – Employment:** The following definitions of employment are based on the descriptions of employment services available under the Centers for Medicare and Medicaid Services<sup>42</sup> and the U.S. Department of Health and Human Services (HHS) Substance Abuse Mental Health Services Administration (SAMHSA).

- **Competitive Employment:** Sustained paid employment in the community at prevailing wages and independent of support services.
- **Supported Employment-Individualized Employment and Support:** Sustained paid employment at or above minimum wage in an integrated setting with ongoing support. The intended outcome of

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<sup>42</sup> CMCS Informational Bulletin, *Updates to the §1915 (c) Waiver Instructions and Technical Guide regarding employment and employment related services*, September 16, 2011

this service is sustained paid employment and work experience which leads to further career development and independent community-based employment.

- **Supported Employment- Small Group Employment Support:** Services and training activities provided in groups of 2-8 workers in businesses and community settings which promote integration into the workplace and interaction with non-disabled co-workers. The intended outcome of this service is sustained paid employment and work experience which leads to further career development and independent, integrated community-based employment paid at or above minimum wage. Note: while CMS defines small-group employment support services including groups as large as eight individuals, DHS allows as many as ten.
- **Center-Based Employment:** Pre-vocational services provided in facility-based work settings, such as “sheltered workshops.” Work may be paid by piece-rate or productivity rate below minimum wage according to Section 14(C) of the Fair Labor Standards Act. The intended outcome of this service is paid employment and work experience which leads to further career development and independent, integrated community-based employment paid at or above minimum wage.
- **Individual Placement and Support – Supported Employment (IPS-SE):** IPS-SE helps people with severe mental illness work at regular jobs of their choosing. Although variations of supported employment exist, IPS-SE refers to the evidence-based practice of supported employment. Refer to the Resources section at the end of this document for more information regarding IPS-SE.

## Recommendations for Communication and Messaging

- Across service areas, use consistent definitions of employment support services.
- Ensure that state websites and materials communicate a message that values integrated employment.
- Invest in messaging targeted to re-educate the business community on the value of employing people with disabilities as well as to invalidate current myths that serve as barriers to employment. Ensure that employers have access to current information and technical assistance to support hiring of persons with disabilities.

## Transition-Aged Students

### Background

Students with disabilities are considered to be “in transition” between educational services and adult services beginning at the age of 14. While special education programs define the end of transition as occurring at age 22, some students covered by their parents’ health plans are actually in transition until the age of 26. For the purpose of this report, “transition-aged students” refers to students between the ages of 14 years and 22 years.

OPC members attempted to collect employment data on transition-aged students from MDE. It appears that MDE has limited information on employment data for these students. MDE does have

information about dropout rates, graduation rates, and school inclusion. MDE might work with DHS and Vocational Rehabilitation Services (VRS) unit of DEED in gathering data. The information should be made available by disability type and by regions.

In writing the Plan, the State will need baseline information for the number of transition-aged students who are:

- on a waiting list for employment services
- entering Day Training & Habilitation (DTH) programs
  - participating in center-based employment
  - participating in community employment
  - participating in non-work activities
- entering post-secondary education
- employed including: self-employment, competitive employment, supported employment, customized employment, center based employment, and employment from one's own home

Of significant concern is in the area of Individualized Education Programs (IEPs) for transition-aged youth. The MDE's most recent Part B Annual Performance Report can be viewed at the following URL: <http://education.state.mn.us/MDE/SchSup/SpecEdComp/>. As referenced in the report, an unacceptably high percentage of audited IEPs for transition-aged students did not contain appropriate measurable post-secondary work or education goals.

### **Recommendations for Transition-Aged Students**

- Implement MDE initiatives to ensure that all transition-aged students have a current IEP that includes career/employment planning goals based on robust, current vocational assessments.
- Implement a data tracking system for the work experiences of transition-aged students (number of work experiences, length/hours, and level of integration).
- Ensure students and their families are receiving information, education, and training about integrated employment, work incentives, self-advocacy, and career planning.

### **Goals**

- Increase the number of transition-aged students who enter post-secondary education by a minimum of 5 percent each year for the next five years.
- Increase the number of transition-aged students who enter into integrated employment by a minimum of 5 percent each year for the next five years.

## **Adult Employment**

### **Background**

The overall goal is to increase the number of people in integrated employment and increase their employment earnings. DHS has published three goals on the topic of employment:

- Create and promote resources that help individuals plan for economic security.
- Create incentives and supports that increase individuals' opportunities to achieve their employment goals and result in increased income earnings.
- Implement policy and legislative changes to remove barriers to employment for individuals.

The OPC received a report from VRS/DEED that they utilize an individual tracking system and submit a detailed performance report to the federal government. This performance report includes placement type, hours worked, earnings, benefits, etc. DHS has periodically surveyed DTH programs for similar information. However, there is currently no tracking system capable of giving real-time data regarding level of integration of services being provided by DTH and Supported Employment service providers. DHS should consult with other states that are leading the nation in integrated employment practices to determine how they are tracking individuals.

Implementation of an improved employment outcome tracking system would set the stage for developing benchmarks for increased integrated employment outcomes. It would enable action steps such as ensuring that current and appropriate vocational assessments are completed. It would also ensure that a county or Vocational Rehabilitation plan is reviewed to ensure informed choice of a continuum of work opportunities (including competitive, integrated employment), and identification of available options and work experiences based on the assessment. Coming rate methodology changes include 15-minute unit service billing rather than per-diem billing which is currently standard for many services. This may afford opportunities to effectively tie information regarding service integration, wages, and hours to service authorization and billing.

Recommendations and goals focus on increased integrated employment in the community. As of this writing, there exist significant concerns in Minnesota and across the nation that center-based employment ("sheltered workshop") environments violate the spirit and intent of *Olmstead* and its integration mandate. The solution to these concerns is not an easy one. People with disabilities cannot lose services that effectively meet their individual needs and the employment aspects of the Plan must take into account the varied needs of individuals with different needs. For this reason, the OPC's recommendations focus on "positive" efforts to create integrated opportunities, rather than recommend that center-based services be eliminated without viable replacement services that meet those individual needs.

### **Recommendations for Adult Employment**

- Restructure funding mechanisms and contracts with providers to encourage investment in integrated community employment and incent innovative services which lead to integrated employment, including increased outreach to community-based employers.

- Implement a data tracking system to gather wage/hour/level of integration information for persons receiving DTH and other employment-related services.
- Invest in training and technical assistance for people with disabilities, their families, their support networks and employers with a focus on work and employment incentives.
- In future updates of the MnCHOICES assessment tool, add specific questions that evaluate whether the individual with a disability is satisfied with the level of integration, the number of hours of employment, earnings/benefits, and his/her career path.
- Increase access to Individual Placement and Support –Supported Employment (IPS-SE) Services for individuals with mental illness by expanding the number of IPS-SE providers statewide through training, technical assistance and increased service funding.

### **Goals**

- Increase integrated community employment by a minimum of 5 percent each year for the next five years. Integrated community employment includes both individual employment with supports and working in a small group with supports in the community.
- Increase the number of providers who offer IPS–SE services by 5 percent each year over the next five years.

## Employment Resources

Many resources are available to guide efforts to make integrated employment a reality for people with disabilities. The list below is not meant to be exhaustive. It represents a starting point for current effective practices in employment.

- [www.mnddc.org/asd-employment/index.html](http://www.mnddc.org/asd-employment/index.html)
- [www.communityinclusion.org/](http://www.communityinclusion.org/)
- [www.ntarcenter.org/home](http://www.ntarcenter.org/home)
- [www.dol.gov/odep/ietoolkit/](http://www.dol.gov/odep/ietoolkit/)
- [www.ncstac.org/](http://www.ncstac.org/)
- [www.dartmouth.edu/~ips/page56/page56.html](http://www.dartmouth.edu/~ips/page56/page56.html)
- <http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365>

Information regarding IPS-SE:

- [www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16\\_137895.pdf](http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_137895.pdf)
- [www.positivelyminnesota.com/Programs\\_Services/Pathways\\_to\\_Employment/IPS\\_SE\\_JJ\\_2009.pdf](http://www.positivelyminnesota.com/Programs_Services/Pathways_to_Employment/IPS_SE_JJ_2009.pdf)

## MEASURING COMMUNITY INTEGRATION

Measuring community integration is a critical component of a State's Olmstead Plan. The *Olmstead* vision and the subsequent DOJ guidance states "the most integrated setting is one that enables individuals with disabilities to interact with non-disabled persons to the fullest extent."<sup>43</sup>

### Measuring Community Integration at the Individual Level

The ultimate purpose of the *Olmstead* decision is that individuals experience more rich and varied opportunities to live, work, learn and recreate among all citizens in the mainstream of American life. Therefore, we must at some point track and measure the individual integration situations of the people supported by public funds. According to Dr. James Conroy, of the Center for Outcomes Analysis, there are three kinds of measures of integration. One is measures of the freedom to place oneself into situations and places with peer citizens who do not have disabilities ("choice" measures). The second is measures of the depth and intimacy of integrative activities ("intensity" measures). The third is measures of the actual frequency of such events ("frequency" measures).

"Choice" measures are about freedom, basic rights, and barriers. They include items such as "If you want to go out somewhere [where everyday citizens without disabilities might go] on the spur of the moment, can you?" and "Do you have to get permission to go out?" Items like these are available in dozens of scales and surveys, and can easily be reduced to 5 to 10 key questions. All of these will reflect the degree to which a person is free to choose to enter integrated situations. (People may choose not to take advantage of this freedom, of course.) This type of measurement is simple and brief, though there is no nationally recognized single tool.

"Intensity" measures about intimacy have been difficult to develop and validate. When properly designed, they would reflect the common observation that a person can be "in" the community without being "of" the community – one may live in an everyday neighborhood but still not participate in neighborhood life and activities. They also relate to the fact that for some people, one intimate friend is plenty, and for others, ten is just not enough. These measures have been the most difficult to develop and validate, and probably should not be considered for immediate application. They must await further research.

The third kind of measure, "frequency," is widely used, tested, and understood. The "gold standard" of measuring integration began in 1986: the Harris poll of Americans with (and without) disabilities.<sup>44</sup> This survey has been conducted at least every few years since then, and therefore offers not only a national database, but also a comparison with the integrative activity behavior of citizens without disabilities. The Harris scale measured how often people visited with friends, went shopping, went to a place of worship, engaged in recreation, and so on, in the presence of non-disabled citizens. The scale

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<sup>43</sup> US DOJ Civil Rights Division *Statement of the DOJ on Enforcement of the Integration Mandate of Title II of the ADA and Olmstead v. L.C.*, [http://www.ada.gov/olmstead/g&a\\_olmstead.htm](http://www.ada.gov/olmstead/g&a_olmstead.htm)

<sup>44</sup> Taylor, H., Kagay, M., & Leichenko, S. (1986). *The ICD Survey of Disabled Americans*. Conducted by Louis Harris and Associates. New York: The International Center for the Disabled, and Washington, DC: National Council for the Handicapped.

simply counted the number of “outings” to places where non-disabled citizens might be present. The scale was restricted to the month preceding the survey. It could be answered reliably by third parties who knew the focus individual well, including support workers and family members.

This scale was also used in the National Consumer Survey of 1990 with 13,075 Americans with developmental disabilities<sup>45</sup>. In addition, these authors tested the scale for reliability, and found it acceptable.<sup>46</sup> Thus there is a very rich national basis for comparison of individual and group experiences of integrative activities.

The decades of research conducted by the Center for Outcome Analysis on deinstitutionalization, employment, and self-determination also employed the “frequency” measure derived from the Harris poll approach.<sup>47</sup> Their version of the integration measures have been used in more than 50 projects, covering more than 180,000 face to face quality of life data collections over the years.

Most recently, the Harris and National Consumer Survey measures were adopted and adapted with minor revisions by the National Core Indicators project of the Human Services Research Institute.<sup>48</sup> The Core Indicators are now utilized for small samples of about 200 to 600 people every year in 36 states.

Because the “frequency” measures are the most concrete of the three kinds of measures, and because they have been developed, tested, and very widely utilized, thus offering “benchmark” comparative data, the recommended approach has to be an adaptation of the Harris, National Consumer Survey, Center for Outcome Analysis, and National Core Indicators instruments. Permission may or may not be granted by HSRI for the Core Indicators version, but the National Consumer Survey and the Center for Outcome Analysis versions are available for use at no cost.

Below are the dimensions included in the most recent version of the Core Indicators to give a sense of the dimensions and the breadth of this approach to an Integration Measure.

- Amount of Times Went on Vacation in the Past Year
- Amount of times went out for entertainment in past month
- Amount of times went out for exercise in past month
- Amount of times went out on errands/appointments in past month
- Amount of times went out to a restaurant/coffee shop in past month
- Amount of times went out to religious services in past month
- Amount of times went shopping in past month
- In the past month person went out for entertainment
- In the past month person went out for exercise
- In the past month person went out on errands/appointments
- In the past month person went shopping

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<sup>45</sup> Conroy, J., Feinstein, C., Lemanowicz, J., Devlin, S., & Metzler, C. (1990). *The report on the 1990 National Consumer Survey*. Washington DC: National Association of Developmental Disabilities Councils.

<sup>46</sup> The interrater reliability of this scale was reported to be low when the two interviews were separated by 8 weeks, during which genuine changes in the frequency of outings were likely, but very high when the time interval was corrected for (.97).

<sup>47</sup> <http://www.eoutcome.org>

<sup>48</sup> <http://www.nationalcoreindicators.org/indicators/domain/individual-outcomes/community-inclusion/>

- In the past month person went to religious services
- In the past month went out to a restaurant or coffee shop
- In the past year person went on vacation

To these standardized and well tested indicators, we suggest that several items on the right and freedom to move into the presence of citizens without disabilities (“choice” measures) should be added. This kind of measure is independent of how often it is utilized. Freedom is important, one would say, even if it is not taken advantage of.

### **Measuring Community Integration at the Systems Level**

Currently, there is not an agreed upon definition of community integration (it means different things to different people and to different agencies) and therefore there is not a standard to measure community integration. There is no common strategy used by states to measure system effectiveness in achieving community integration and inclusion for people with disabilities in Home and Community-Based Services (HCBS). A major impediment is finding agreement amongst stakeholders on what to measure. Since there is finite opportunity to assess each service user, the data sources must prioritize measures and survey items. As a result, the data sources have different strategies to measure the topic. A recent U.S. Department of Health and Human Services environmental scan of measures used in HCBS highlights the challenge (2010)<sup>49</sup>, where a number of complimentary outcomes directly intersect with the construct of integration and inclusion. Existing evaluative \measures have similar constructs that focus on the following themes: friends and family relationships, support needed for relationships, employment and school attendance, and social roles. In addition, at least 15 existing measures, from many data sources, seek information about community inclusion and integration explicitly.

There is also no common strategy on how to measure the many constructs and domains related to community integration and inclusion. To appropriately evaluate integration and inclusion, it is necessary for measures to adequately capture the diversity of the service delivery system. For example, employment is often times used as an associated measure to integration and inclusion. As pointed out in the environmental scan of measures used in HCBS, employment is measured in a number of different ways. It is often times measured dichotomous, where a person either has a job or is unemployed. Using such a measure to indicate more or less integration or inclusion can be misleading since employment in the HCBS system can be achieved in both integrated and segregated settings (U.S. Dept. of Health and Human Services, 2010).

The OPC has identified the need to develop a data system that tracks trends and outcomes of services and supports by population and over time. Currently the State has fragmented data systems within DHS and across other State agencies. These various systems have been mandated or developed to monitor services for a particular disability population, a specific program or service and therefore they are not integrated. Thus, they can be difficult to use to identify trends over time and across

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<sup>49</sup> U.S. Department of Health and Human Services. (2010). *Environmental Scan of Measures for Medicaid Title XIX Home and Community-Based Services*. AHRQ Publication No. 10-0042-EF, Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/research>

populations. Additionally, the data is often not easily understood by all stakeholders because terminology is not consistent and it is difficult to compare information across populations or groups within specific populations. In some instances, data is not collected. In consent decrees/settlements across the nation The Department of Justice is requiring specific data be collected to measure integration over time and across populations. It is important that the state of Minnesota develop a framework and indicators of community integration and implement a process to gather and trend this data over time.

There are several examples of measurement tools that have been developed and used by state's to measure community integration and the outcomes of community services long term services and supports. To assist state's in assessing community integration for a state's mental health system for adults with serious mental illness and children with serious emotional disturbances the Substance Abuse and Mental Health Services Administration (SAMHSA) recently developed "A Pilot Self-Assessment Tool For State Mental Health Agencies: An Effort to promote Community Integration of Persons with SMI and SED placed in Institutional Treatment Settings" available on the OPC website<sup>50</sup>. This provides an example of the type of measurement documentation that will need to be developed that includes community integration progress indicators across long term services and supports for the disability populations that fall within the scope of the Plan.

As evidenced in the recent measurement tools related to the outcomes and quality of life of people with disabilities have been developed as indicators of community integration. The National Core Indicators were developed by the Human Services Research Institute and the National Association of State Directors of Developmental Disability Services and are currently used in 36 states<sup>51</sup>. The Participant Experience Survey, which was originally developed by Thompson Reuter through a contract with CMS was developed for use with HCBS, and adapted by Minnesota for use with older adults and people with disabilities of all ages. Region 10, in Minnesota, developed a VOICE review process to focus on a person's life and inclusion in community activities that is used as an alternative licensing process. The DHS Continuing Care administration has been working on the development of measures of CHOICE outcomes, including work in developing dashboards and report cards, the HCBS Partner Panel, the State Quality Council, and the MnCHOICES assessment and support planning development. While many options exist to monitor and report outcomes and quality of life indicators related to community integration, currently in Minnesota this type of data is not collected consistently and across populations in a way that progress is trended and reported.

## **Recommendations for Measuring Community Integration**

- Review, develop if necessary, evaluate and implement a measurement rubric that tracks the movement of people with disabilities from specific types of congregate care facilities to community settings over time. In doing so, enhance the tools developed by SAMHSA to include measurement domains across financing/resources, movement to the community/recidivism, housing and community capacity/utilization that are appropriate to specific populations (e.g. developmental

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<sup>50</sup> [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc\\_documents#otherplans](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_documents#otherplans)

<sup>51</sup> <http://www.nationalcoreindicators.org/>

disability, mental health, brain injury, physical disability) and long term services and supports in Minnesota (e.g. HCBS, nursing home, psychiatric hospitals, sheltered work programs).

- Implement an outcome measurement process that gathers specific outcome indicators related to the populations included in the Plan about the quality of their lives in the community. This measurement process should gather data across several areas of life domains including health, safety, well-being, employment, social relationships, home, satisfaction with services and supports, choice and control, and inclusion/integration. It should provide comparative analyses opportunities across programs, populations and in comparison with other similar states.
- The data gathered to monitor community integration and the outcomes experienced by people who have been integrated should be easily accessible to the general population and should provide comparisons of the progress made in Minnesota over time and in comparison with other similar states. Annual progress should be reported.

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## APPENDIX A – Community-Based Services and Supports

All of the information in Appendix A is from the “What We Have”<sup>52</sup> report

### Medicaid services and supports

- **Elderly Waiver (EW):** HCBS Waiver that provides an array of services for people age 65 or older who qualify for nursing facility services. Almost all seniors—including EW participants—must receive services through managed care. People can enroll in Minnesota Senior Health Options (MSHO) or Minnesota Senior Care Plus (MSC+). MSHO includes traditional Medicare, Medicare Part D, and all Medicaid services. MSC+ is similar to MSHO but only includes Medicaid services.
- **Developmental Disabilities (DD) Waiver:** HCBS Waiver that provides an array of services to people with developmental disabilities as an alternative to ICF/DD.
- **Community Alternatives for Disabled Individuals (CADI) Waiver:** HCBS Waiver that provides services as an alternative to nursing facility care for people who are under age 65 at the time they enter the waiver.
- **Community Alternative Care (CAC) Waiver:** HCBS Waiver that serves people with complex medical needs who require a hospital level of care.
- **Brain Injury (BI) Waiver:** HCBS Waiver that serves people with brain injuries as an alternative to a nursing facility or a neurobehavioral hospital unit.
- **Medicaid State Plan services** provide LTSS or mental health rehabilitative services. Unlike an HCBS Waiver, a person does not need to meet institutional level of care criteria to qualify for these services, but the person must be eligible for Medicaid and the services must be medically necessary. These services often are able to meet the needs of an individual. If additional services are necessary, these services can be used in conjunction with an HCBS waiver services:
  - **Personal Care Assistance (PCA):** Assistance with activities of daily living and health-related tasks
  - **Private Duty Nursing (PDN):** In-home care by a licensed nurse
  - **Home Health services:** Medicaid home health services provide: (1) short-term care following an acute care episode such as a hospitalization, and (2) long-term care for people with ongoing needs related to medical care or daily living activities. Home

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<sup>52</sup> MN DHS, *What We Have*, September 2012

health includes skilled nursing, home health aide services, and physical, occupational, speech, and respiratory therapies

- **Adult Rehabilitative Mental Health Services (ARMHS):** Services to enable people to develop and enhance psychiatric stability, emotional adjustment, and independent living skills
- **Assertive Community Treatment (ACT):** An intensive, multidisciplinary rehabilitative service that includes case management; support and skills training for daily life skills and social and interpersonal skills; education regarding mental illness provided to the person and family members; medication management; and assistance in obtaining housing
- **Intensive Residential Treatment Services (IRTS):** Treatment in a residential setting that serves five to 16 adults with mental illness. Services are designed to last only a few months and are provided in adult mental health treatment facilities licensed under Rule 36, which previously provided long-term residential supports
- **Children’s Therapeutic Services and Supports (CTSS):** A rehabilitative service with a lower functional eligibility threshold than previous Medicaid services. This service is available to any Medicaid-eligible child with a mental health diagnosis to facilitate early intervention before symptoms become more severe.<sup>53</sup>

#### **Non-Medicaid funded services and supports:**

- **Day Training and Habilitation (DT&H):** Licensed services to help adults with developmental disabilities improve and maintain independence; enhance personal skills; empower choice making abilities; and improve integration into the community. Services include vocational supports, such as supported employment, as well as non-vocational supports. Medicaid pays for most day habilitation through the DD Waiver and ICFs/DD which can include DT&H. Counties may pay for DT&H for individuals who do not receive ICFs/DD or DD Waiver services.<sup>54</sup>
- **Alternative Care (AC):** a state-funded cost-sharing program that supports certain home and community-based services for eligible Minnesotans, age 65 and over. It provides home- and community-based services to prevent and delay transitions to nursing facility level of care. The program prevents the impoverishment of eligible seniors and shares the cost of care with clients by maximizing use of their own resources. It is administered by counties and tribal health agencies.
- **Consumer Support Grant (CSG):** a state-funded alternative to Medicaid-reimbursed home care. Eligible participants receive monthly cash grants to pay for a variety of goods and services in lieu of home health aide, personal care attendant and/or private duty nursing.

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<sup>53</sup> MN DHS *Uniform Application FY 2009 – State Plan: Community Mental Health Services Block Grant* Submitted to SAMHSA Center for Mental Health Services October 5, 2008

<sup>54</sup> MN DHS, Disability Services Division *Continuing Care Matrix of Services to People with Disabilities: FY 2007 Service Costs* April 2008

- **Semi-Independent Living Services (SILS):** training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene, and other activities needed to maintain and improve the capacity of an adult with an intellectual disability to live in the community. The state provides 70% of funding for SILS, with the county providing the remainder. Some counties also fund 100% of costs for some persons not served through the state supported allocations.
- **Family Support Grant (FSG):** provides state-funded cash assistance to prevent the out-of-home placement of children with disabilities and promote family health and social well-being. Approved categories of expenses include medications, education, day care, respite, special clothing, special diet, special equipment and transportation.

**Table 1: Average Monthly Number of People Receiving Publicly Funded Community-Based Services, 2006 – 2010**

Table 1 shows utilization trends for supports. Fewer people receive AC and PDN, and several types of support with double-digit annual growth (e.g., CADI, PCA, CSG, ACT, and CTSS).

Program	2006	2007	2008	2009	2010	Avg Annual Increase
Alternative Care Services (AC)	3,334	3,410	3,419	3,311	3,188	-1%
Brain Injury Waiver (BI)	1,263	1,341	1,394	1,424	1,420	3%
Community Alternatives for Disabled Individuals Waiver (CADI)	10,316	11,913	13,990	15,092	16,082	12%
Community Alternative Care Waiver (CAC)	247	282	314	326	342	8%
DD Waiver	14,273	14,094	14,126	14,443	14,994	1%
Elderly Waiver (EW)	16,808	18,553	19,859	21,063	22,081	7%
Personal Care Assistance Services (PCA)	14,231	15,516	18,477	23,076	24,926	15%
Private Duty Nursing Services (PDN)	1,264	1,011	816	724	716	-13%
Consumer Support Grants (CSG)	85	770	1,146	1,365	1,430	103%
Adult Rehabilitative Mental Health Services (ARMHS)	5,787	5,831	5,415	6,123	7,432	6%
Children's Therapeutic Services and Supports (CTSS)	3,850	4,056	3,959	4,986	6,940	16%
Assertive Community Treatment (ACT)	1,113	1,197	1,238	1,471	1,603	10%
Non-Medicaid Day Training and Habilitation (DT&H)	n/a	1,808	n/a	n/a	n/a	n/a
Semi-Independent Living Skills (SILS)	1,561	1,552	1,560	n/a	n/a	n/a
Family Support Grant (FSG)	1,628	1,628	1,810	n/a	n/a	n/a

**Notes:** Data may include duplicate participants. Some individuals may have received multiple services and/or services with multiple types of billing units e.g., 15 minute units and day units.

**Source:** Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012

**Table 12: Expenditures for MA Funded Waivers, State Fiscal Year 2008 – 2012**

<b>MA Funded Home and Community-Based Waiver Services</b>					
	<b>FY 08</b>	<b>FY 09</b>	<b>FY 10</b>	<b>FY 11</b>	<b>FY 12</b>
<b>BI Waiver</b>					
Avg # Recipients monthly	1,315	1,357	1,359	1,349	1,353
<i>Residential**</i>	904	934	934	925	915
<i>Non-residential**</i>	411	423	425	424	438
Avg Cost per Recipient monthly	5,588	5,883	5,913	5,969	6,184
Total Annual Cost Incurred	88,152,050	95,819,057	96,396,848	96,596,297	100,415,877
Federal Share	44,076,024	54,834,192	59,269,791	57,822,543	50,207,939
State Share	44,076,026	40,984,865	37,127,057	38,773,754	50,207,938.5
<i>Residential**</i>	40,162,725	37,486,365	33,723,723	35,073,161	45,406,631
<i>Non-residential**</i>	3,913,300	3,498,500	3,403,334	3,700,593	4,801,307
County Share	0	0	0	0	0
<i>DT&amp;H</i>	3,547,715	3,851,906	3,941,130	4,050,439	3,989,937
<i>Supported Employment</i>	1,368,507	1,456,250	1,591,456	1,536,431	
<b>CAC Waiver</b>					
Avg # Recipients monthly	279	300	313	314	332
<i>Residential**</i>	44	46	45	41	43
<i>Non-residential**</i>	235	254	268	273	289
Avg Cost per Recipient monthly	5,106	5,364	5,085	5,283	5,703
Total Annual Cost Incurred	17,064,201	19,303,360	19,115,670	19,931,351	22,684,585
Federal Share	8,532,101	11,046,698	11,753,307	11,930,907	11,342,293
State Share	8,532,101	8,256,662	7,362,363	8,000,444	11,342,293
<i>Residential**</i>	3,431,983	3,088,239	2,394,893	2,656,752	3,880,245
<i>Non-residential**</i>	5,100,117	5,168,424	4,967,470	5,343,692	7,462,048
County Share	-	-	-	-	-
<b>CADI Waiver</b>					
Avg # Recipients monthly	11,763	13,320	14,228	15,695	16,756
<i>Residential**</i>	3,778	4,542	5,014	5,484	5,975
<i>Non-residential**</i>	7,985	8,778	9,214	10,211	10,781
Avg Cost per Recipient monthly	2,070	2,294	2,417	2,516	2,566
Total Annual Cost Incurred	292,163,020	366,627,944	412,623,428	473,839,434	515,966,424
Federal Share	146,081,511	209,809,486	253,702,328	283,640,285	257,983,212
State Share	146,081,509	156,818,458	158,921,100	190,199,149	257,983,212
<i>Residential**</i>	105,314,357	114,563,836	116,691,957	138,920,749	187,811,734
<i>Non-residential**</i>	40,767,153	42,254,623	42,229,143	51,278,399	70,171,478
County Share	-	-	-	-	-
<i>Prevocational Services</i>	148,106,239	153,863,861	158,915,722	165,081,236	174,264,644
<i>Supported Employment</i>	4,260,076	4,581,523	4,951,420	5,637,606	

<b>DD Waiver</b>					
Avg # Recipients monthly	13,971	14,176	14,652	15,165	15,490
<i>Residential**</i>	9,193	9,312	9,506	9,753	10,020
<i>Non-residential**</i>	4,778	4,864	5,146	5,261	5,470
Avg Cost per Recipient monthly	5,537	5,673	5,595	5,596	5,628
Total Annual Cost Incurred	928,369,470	965,104,543	983,708,433	1,018,355,465	1,046,143,382
Federal Share	464,184,736	552,298,566	604,835,067	609,587,582	523,071,691
State Share	464,184,734	412,805,977	378,873,366	408,767,883	523,071,691
<i>Residential**</i>	383,349,418	340,893,188	310,132,453	331,489,416	422,899,710
<i>Non-residential**</i>	80,835,317	71,912,789	68,740,912	77,278,469	100,171,981
County Share	-	-	-	-	-
<i>DT&amp;H</i>	148,106,239	153,863,861	158,915,722	165,081,236	174,264,644
<i>Supported Employment</i>	4,260,076	4,581,523	4,951,420	5,637,606	
<b>EW – Fee for service</b>					
Avg # Recipients monthly	4,642	2,765	1,810	1,967	2,024
Avg Cost per Recipient monthly	1,399	1,521	1,619	1,578	1,512
Total Annual Cost Incurred	77,922,580	50,484,531	35,156,140	37,242,461	36,725,473
Federal Share	38,961,290	25,242,265	20,118,738	22,898,600	18,362,737
State Share	38,961,290	25,242,266	15,037,402	14,343,861	18,362,737
County Share	0	0	0	0	-
<b>EW – Managed care</b>					
Avg # Recipients monthly	13,724	16,889	19,012	19,816	20,601
Avg Cost per Recipient monthly	1,083	1,146	1,167	1,155	1,122.19
Total Annual Payments	178,323,902	232,174,777	266,291,405	274,756,876	277,419,588
Federal Share	89,161,951	116,087,387	152,390,083	168,934,805	138,709,794
State Share	89,161,951	116,087,390	113,901,322	105,822,071	138,709,794
County Share	0	0	0	0	0
<b>Total Waiver Spending*</b>	<b>1,581,995,223</b>	<b>1,729,514,212</b>	<b>1,813,291,924</b>	<b>1,920,721,884</b>	<b>1,999,355,329</b>

\*includes state, federal, and county shares

\*\* Residential includes foster care homes, customized living, residential services, out of home supportive living services

\*\* Non-residential includes individuals who receive waiver and home care services that may be delivered in their own home, a relative's home, or other home setting such as a friend's home. (There may be some duplication across the home care programs).

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## APPENDIX B – Where People Live

### Background Information and Descriptions of Settings

#### Nursing Facilities (NF)

Despite an aging population, the number of licensed nursing home beds decreased 30 percent between its peak in 1987 and 2009, from 48,307 to 33,878. (“What We Have” report, page 40). The decreased demand is expected to continue as people exercise their preference for smaller home-like settings or alternatives to traditional nursing homes. Nursing facilities have responded by increasingly moving toward short-term rehabilitative stays. For example, 82% of people admitted to a nursing facility in FY 2006 were discharged within 90 days. In 2012, the average number of monthly Medicaid recipients living in nursing facilities was 17,038. The average cost per recipient was \$3,831.

#### Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)

In 2012, the average number of monthly Medicaid recipients living in ICFs/DD was 1,749. The average cost per recipient was \$6,423. ICFs/DD range in size, serving anywhere from 4 to 64 individuals. SOS has 90 ICFs/DD beds. In state fiscal year 2012, 47.4% of recipient days were spent serving people in ICFs/DD with six or fewer beds. In 2011, 2% of people in ICFs/DD moved into their own home. The majority of ICFs/DD previously closed due to state policy efforts to convert funding to home and community based services.

#### Certified Boarding Care Homes

Certified Boarding Care Homes provide nursing services and personal or custodial care, such as assistance with eating and grooming and supervision of self-administered medication. These facilities serve five or more elderly, physically disabled or mentally ill persons. In 2009 there were 1,078 licensed beds in 21 facilities. These facilities are considered a nursing facility for MA certification and are licensed by the Minnesota Department of Health (MDH). MDH licensure standards for these facilities are less stringent than those for nursing homes and are not eligible to receive Medicare reimbursement.

#### Noncertified Boarding Care Homes

Noncertified Boarding Care Homes provide personal or custodial care, such as assistance with eating and grooming and supervision of self-administered medication. Nursing services are not required. These facilities serve five or more elderly, physically disabled or mentally ill persons. In 2009 there were 847 licensed beds in 13 facilities. These facilities are not certified for participation in the MA program. MDH classifies these as institutional or health care facilities so residents are not eligible for home and community-based waiver services and home care services. The group residential housing (GRH) program pays for room and board if the facility has GRH rate agreements with county agencies.

## **Board and Lodging Facilities**

Board and Lodging facilities provide room and board with no services. Board and Lodging facilities are licensed by MDH but **not** as a health care facility. Thus, they are licensed by the number of rooms, not beds. A Board and Lodge license covers board (provision of meals) and lodge (place to sleep). GRH pays for room and board for Board and Lodging facilities that are not Children's Residential Facilities.

Board and Lodging facilities licensure under DHS depends on the population served. A facility may be licensed under a Children's Residential Facility, Chemical Dependency rehabilitation program, residential program for adult mentally ill persons. For children a Board and Lodging facility may be certified under MA as a Children's Residential facility.

Facility and room and board can be paid by federal payments for foster care and adoption assistance. In 2009, there were 94 children's residential facilities (formerly Rule 5 or Rule 8) with a bed capacity of 1,856.

## **Board and Lodging Facilities with Special Services**

These facilities provide supportive or health supervision services such as assisting with preparation and administration of certain medications and assisting with dressing, grooming and bathing. They serve five or more regular boarders who need special services. Boarders may include frail elderly, mentally ill, developmentally disabled or chemically dependent. These facilities are licensed by either MDH or through a delegated agreement with local jurisdictions. In certain instances if the facility provides services to an elderly population it must also register as a housing with services establishment and obtain the appropriate home care provider license. No DHS program license is required. In 2009, there were 58 facilities licensed as Board and Lodging facilities with Special Services.

The room and board is paid for by GRH or private pay. Depending upon the population served, DHS program services may be funded under Rule 12, Residential services for mentally ill persons, Rule 25 chemical dependency care for public assistance recipients and if the person is MA eligible home health services. MA Home and Community-Based waivers including EW, CADI, TBI and the state funded Alternative Care program may also pay for services.

## **Housing with Services Establishments**

Most states license a facility that provides both housing and services. Minnesota and a few other states have separate regulatory structures for housing and for services.<sup>55</sup> Buildings in which a package of services is offered to residents must be registered with the Minnesota Department of Health (MDH) as housing with services establishments if 80% of the residents are age 55 or older. The separate housing registration and services licensure allows an establishment to contract with a service provider instead of furnishing services directly. Providers often have a separate licensure that authorizes their services. The most common licensure types are home care licensure and licensure as a board and lodging establishment.<sup>56</sup> The most common types of home care licensures are Class A, which authorizes

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<sup>55</sup> Mollica, Robert; Sims-Kastelein, Kristin; and O'Keeffe, Janet *Residential Care and Assisted Living Compendium: 2007* Nov 30, 2007

<sup>56</sup> Mollica, Robert; Sims-Kastelein, Kristin; and O'Keeffe, Janet *Residential Care and Assisted Living Compendium: 2007* Nov 30, 2007

provision of home care in any community residence and includes Medicare-certified home health agencies, and Class F, which is specific to housing with services establishments.

- **“Assisted Living” Services:** Since January 2007 housing with services establishments have been able to register with the Minnesota Department of Health as an “assisted living” provider if they meet additional criteria. Registration as an assisted living provider and services provided by a licensed Class A or Class F home care provider are required if an establishment or provider uses the term “assisted living” in marketing. The Elderly Waiver (EW), the Community Alternatives for Disabled Individuals (CADl) Waiver and the Brain Injury (BI) Waiver offer a service called Customized Living that is provided by assisted living providers in housing with services establishments. However, most people who receive assisted living do not receive publicly funded services.

## Foster Care

Foster care provides services in small-group residential settings. DHS distinguishes between *family foster care*, in which a family lives with the persons with a disability that reside there—and *corporate foster care*, in which an organization has the licensure and provides staffing. Information about current use of family foster care and corporate foster care, and an analysis of capacity needed, will be available in the February 2013 foster care needs determination report to the legislature. Approximately 60% of DD Waiver participants live in foster care settings,<sup>57</sup> and all other waivers have participants receiving foster care services. For waiver participants, the waiver pays for services. Room and board is often covered by Group Residential Housing and a portion of the resident’s income.

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<sup>57</sup> Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012.

## Matrix of Services Provided by Waivers and Alternative Care

Service Provided	CAC	CADI	BI	DD	EW	AC
24-Hour Emergency Assistance		X	X	X		
Adult Companion Services		X	X		X	X
Adult Day Care	FADS only	X	X	X	X	X
Adult Day Care Bath		X	X	X	X	X
Assistive Technology				X		
Behavioral Programming (being renamed to Behavioral Support) <ul style="list-style-type: none"> <li>Behavior Professional</li> <li>Behavior Analyst</li> <li>Behavior Specialist</li> <li>Behavior Aide (being eliminated)</li> </ul>		on hold	X			
Caregiver Living Expenses		X	X	X		
Caregiver Training & Education				X	X	X
Case Management	X	X	X	X	X	X
Case Management Aide	X	X	X		X	X
Chore Service		X	X	X	X	X
Consumer Directed Community Supports (CDCS)	X	X	X	X	X	X
Consumer Training and Education				X		
Crisis Respite				X		
Customized Living Services		X	X		X	
Customized Living Services, 24-Hour		X	X		X	
Day Training and Habilitation				X		
Environmental Accessibility Adaptations	X	X	X	X	X	X
Extended Home Health Care Services: <ul style="list-style-type: none"> <li>Extended home health aid</li> <li>Extended nursing services (LPN &amp; RN)</li> <li>Extended therapies (OT, PT, Speech and RT)</li> </ul>	X	X			X	
Extended Personal Care Assistance	X	X	X	X	X	
Extended Private Duty Nursing	X	X	X		X	
Family Adult Day Services (FADS)	Included in Adult Day Care				X	X
Family Training and Counseling	X	X	X	X		
Foster Care	X	X	X		X	
Home Delivered Meals	X	X	X	X	X	X
Home Health Services (AC Program only): <ul style="list-style-type: none"> <li>Home health aide</li> </ul>						

Service Provided	CAC	CADI	BI	DD	EW	AC
<ul style="list-style-type: none"> <li>Nursing services (LPN &amp; RN)</li> <li>Personal care assistance</li> <li>Skilled nurse visits</li> <li>Tele-homecare</li> </ul>						X
Homemaker	X	X	X	X	X	X
Housing Access Coordination		X	X	X		
ILS Therapies			X			
Independent Living Skills (ILS) Training		X	X			
Night Supervision Services			X			
Nutritional Services						X
Personal Support				X		
Prevocational Services		X	X	not yet		
Residential Care Services		X	X		X	
Residential Habilitation (In-Home Family Support, Supported Living Services)				X		
Respite	X	X	X	X	X	X
Specialist Services				X		
Specialized Supplies and Equipment	X	X	X		X	X
Structured Day Program			X			
Supported Employment Services		X	X	X		
Transitional Services	X	X	X	X	X	
Transportation	X	X	X	X	X	X

NOTE: Caregiver Training & Education and Consumer Training & Counseling are being consolidated into Family Training & Counseling. Once approved in the DD waiver, the 2 yellow highlighted services will be eliminated for DSD, but will still exist for EW and AC

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## APPENDIX C – State Operated Services

### Description of State Operated Services<sup>58</sup>

State Operated Services, a division of the Minnesota Department of Human Services (DHS), provides direct services to people with mental illness, chemical dependency, developmental disabilities, and traumatic brain injuries. State-operated services typically serve people who have difficulty being served by other providers, including people who have been committed to the Commissioner of DHS.

**Acute Adult Inpatient Psychiatric Services** provides specialized treatment and related supports to adults with mental illness, many of whom also have other complex conditions. Inpatient services are delivered at seven 16-bed Community Behavioral Health Hospitals (CBHH) and the Anoka Metro Regional Treatment Center (AMRTC). All sites deliver quality treatment by maximizing the prevailing clinical and organizational practice models.

**AMRTC** serves people who are mentally ill in a large campus-based setting. Many of these people have complex medical histories. AMRTC is a 200-bed psychiatric hospital consisting of eight 25-bed units. Services include units dedicated to the treatment of psychiatric patients with complex co-morbid medical conditions, treatment of individuals with mental illness who face a criminal trial and patients with high levels of behavioral issues.

**CBHHs** provide short-term, acute inpatient psychiatric services at seven 16-bed community-based sites located in Alexandria, Annandale, Baxter, Bemidji, Fergus Falls, Rochester and St. Peter. Natural support structures can be incorporated into treatment by serving patients as close as possible to their home communities. The hospitals provide a wide array of services.

**Community Clinic** services involve the operation of five community dental clinics that provide services to individuals with developmental disabilities, severe/persistent mental illness or traumatic brain injury who were unable to obtain care from other community providers. Clinics are located in Brainerd, Cambridge, Faribault, Fergus Falls and Willmar. The Faribault office also provides out-patient psychiatric services.

**Minnesota Specialty Health System (MSHS)** is to provide services in a safe and creative environment that assists adult individuals with varying levels of skills and abilities in identifying their strengths, needs and goals through skill training and acquisition. Each program works with adults in achieving their goals and transitioning them to a less structured, more stabilized setting. Programs provide rehabilitative and habilitative treatment that utilize evidence-based practices in helping individuals with their recovery, including Illness Management and Recovery, Integrated Dual Disorder Treatment, family psycho-education, behavioral expertise and 24/7 psychiatric on-call consultation, and coverage, and crisis prevention planning.

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<sup>58</sup>As described on DHS Public website

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_000087](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000087)

- **MSHS – Brainerd** provides individuals who are experiencing a serious mental illness and an acquired brain injury with evidenced-based treatment that encompasses an intensive clinical and cognitive rehabilitation in a residential community setting.
- **MSHS - Cambridge** provides services to individuals diagnosed with developmental disabilities or related conditions who may be highly complex with a history of legal problems, public safety and/or personal safety concerns due to significant behavioral disturbances and/or poorly managed medical conditions.
- **St. Paul Como Community Unit** provides individuals who are experiencing a serious mental illness with evidenced based treatment that encompasses an intensive clinical and rehabilitation approach in a safe and creative apartment environment.
- **MSHS – Willmar & Wadena** offer an individualized approach to treatment that includes, but is not limited to: Illness Management and Recovery, Integrated Dual Disorder Treatment, Family Psycho-education, individualized self-medication management program, community integration with an overarching goal of focusing on increasing an individual’s functioning capacity during their recovery. In addition, the areas of need for supports in the community for ongoing areas of deficit will be identified and the infrastructure to enlist these supports will be mapped out in a client’s plan for return to community (aka. discharge plan) for a more successful transition to the next phase in his or her recovery.

**Community Addiction Recovery Enterprise (C.A.R.E.)** provides inpatient and outpatient chemical dependency and substance abuse services statewide. Specialized treatment options are offered. All services are person-centered, building on the individual’s interests and capacity for growth, leading to a lifelong process of recovery. Programs are located in Anoka, Brainerd, Carlton (Liberalis), Fergus Falls, St. Peter and Willmar.

In partnership with Hennepin County, C.A.R.E. provides chemical health intensive day treatment services to Hennepin County residents at high risk for commitment or revocation of provisional discharges due to their chronic addiction to alcohol and other drugs.

**Child and Adolescent Behavioral Health Services (CABHS)** provides an array of person-centered mental health services statewide to children and adolescents with serious emotional disturbances whose needs exceed the resource capacities of their families and local communities. CABHS achieves this in part by partnering with other caregivers, families or guardians and private providers. Services range from in-home crisis intervention to hospital care. CABHS also provides mental health services to clients ages 18 to 21 who continue to require treatment.

**Minnesota Intensive Therapeutic Homes (MITH)** offers a unique alternative to institutionalization for children and adolescents with severe emotional disturbance and serious acting out behaviors. Services delivered in both inpatient and foster care are provided to youth with neurodevelopment disorders who also have a mental illness, youth whose needs may best be served through the application of

treatment with Dialectical Behavior Treatment (DBT), and youth who have suffered severe psychosocial trauma.

**Community Support Services** provide decentralized clinical consultation and technical assistance. Nine teams across Minnesota's 87 counties help clinically complex individuals remain in their communities and build support networks.

**Minnesota State Operated Community Services (MSOCS)** provides residential and vocational support services for people with disabilities. Vocational services include Day Training and Habilitation (DT & H) as well as support services that include evaluation, training and supported employment. Clients take advantage of and are integrated into the daily flow of the community. A state-of-the-art and highly specialized program called FACES (Friends and Community Experiencing Success) is used to plan individual support services that include community-based residential services typically provided in four-bed group homes. Supports focus on providing a wide range of individualized vocational training and support as well as whole life options for the individuals served.

**Forensic Services** provides specialized statewide evaluation and treatment to individuals involved with the legal system due to a crime. Forensic Services include the following:

- **Minnesota Security Hospital (MSH)** is a secure treatment facility that provides multi-disciplinary treatment services to individuals under civil commitment as Mentally Ill and Dangerous. MSH also provides comprehensive court-ordered evaluations, including competency to stand trial and pre-sentence mental health evaluations.
- **Forensic Network** conducts statewide examinations with experts for competency to proceed to trial and criminal responsibility evaluations, pre-sentence evaluations, repeat sex offender assessments and risk appraisals.
- **Special Needs Services** utilizes psychosocial rehabilitation techniques to emphasize relapse prevention for low-functioning, cognitively impaired individuals who demonstrate sexually aggressive behavior.
- **Young Adult and Adolescent Program** serves individuals ages 15 to 23 who have been committed by the courts and who are socially immature and/or demonstrate serious aggression.
- **Community Based Residential Support Services** provides residential placement for people committed Mentally Ill and Dangerous who have completed treatment in Transition Services and have been approved for a reduced level of custody.
- **Competency Restoration Program** provides treatment and evaluation of individuals who have been committed for competency restoration.

- **Transition Services** provides a supervised residential setting to people committed as Mentally Ill & Dangerous who have progressed through treatment and have been approved for a reduction of custody. The service provides psychosocial rehabilitation, skill enhancement, collaboration with community resources for patients' successful transition to/reintegration with the community. Also provided are ongoing crisis consultation and intervention to support clients in community settings.
- **Forensic Nursing Facility** provides services for people in need of a nursing home level of care who have been committed as Mentally Ill and Dangerous, a Sexual Psychopathic Personality, a Sexually Dangerous Person or who are on medical release from the Minnesota Department of Corrections.
- **Community Preparation Services** utilize multiple, redundant monitoring techniques to supervise an individual's progress and compliance with a reduced custody order in preparation for community reintegration and to enhance the likelihood of a successful community placement.
- **Centralized support services** are provided by personnel located in St. Paul, Anoka and various sites in greater Minnesota. All of these centralized services provide support to the entire system of care operated by DHS' State Operated Services.

Forensic Patients in St Peter Programs (Data for Patients In-house on 9/13/2012)

Patients by Years Since Admission and Current Program										
Current Program Location	Years Since Admission									Total
	00-01 yrs	02-03 yrs	04-05 yrs	06-07 yrs	08-09 yrs	10-14 yrs	15-19 yrs	20-24 yrs	25+ yrs	
7-FN01-FORENSIC NURSING HOME	10	3	5	0	2	5	2	0	1	28
7-FO37-TRANS-UNIT-1	3	6	8	6	8	16	5	2	1	55
7-FO38-TRANS UNIT-2	4	0	5	3	5	10	2	1	0	30
7-FO44-MSH EXTENDED CARE 2	0	0	0	1	0	0	0	0	0	1
7-FO74 MSH - YOUNG ADULT/ADOL	4	7	2	0	0	0	0	0	0	13
7-FO75 MSH - EXT CARE 3 - MED / PSYCH	2	1	3	0	1	6	4	2	4	23
7-FO76 MSH - EXTENDED CARE 1	0	0	0	0	0	0	0	0	2	2
7-FO77 MSH - SPECIAL NEEDS	3	1	5	4	1	2	1	0	1	18
7-FO78 MSH - LIFE SKILLS	4	5	2	1	1	5	0	0	1	19
7-FO79 MSH-REHAB + RECOVERY 1	13	4	3	4	1	2	1	0	0	28
7-FO80 MSH - REHAB + RECOVERY 2	10	5	3	1	1	1	1	1	1	24
7-FO81 MSH - ACE / ADMISSIONS	10	3	1	1	0	1	0	0	0	16
7-FO82 MSH - WOMENS NEW OUTLOOK	7	6	1	0	1	1	0	0	0	16
7-FO83 MSH - SOCIAL LEARNING	3	3	6	1	3	5	2	1	0	24
7-FO84 MSH - TRANSITION READINESS 1	3	4	5	4	6	4	2	3	1	32
7-FO85 MSH - TRANSITION READINESS 2	2	5	3	3	2	2	0	2	0	19
7-FO86 MSH - WOMEN'S TRANSITION READINES	1	2	2	2	0	4	0	0	0	11
7-FO87 COMPETENCY RESTORATION PROGRAM	27	0	0	0	0	0	0	0	0	27
<b>Total</b>	<b>106</b>	<b>55</b>	<b>54</b>	<b>31</b>	<b>32</b>	<b>64</b>	<b>20</b>	<b>12</b>	<b>12</b>	<b>386</b>

Patients by Legal Status and Years Since Admission										
Legal Status Group	Years Since Admission									Total
	00-01 yrs	02-03 yrs	04-05 yrs	06-07 yrs	08-09 yrs	10-14 yrs	15-19 yrs	20-24 yrs	25+ yrs	
MI&D Final	50	51	43	28	31	62	19	12	12	308
MI&D Initial	13	0	0	0	0	0	0	0	0	13
Other Legal Status	43	4	11	3	1	2	1	0	0	65
<b>Total</b>	<b>106</b>	<b>55</b>	<b>54</b>	<b>31</b>	<b>32</b>	<b>64</b>	<b>20</b>	<b>12</b>	<b>12</b>	<b>386</b>

Patients by County of Finance and Years Since Admission										
County of Finance	Years Since Admission									Total
	00-01 yrs	02-03 yrs	04-05 yrs	06-07 yrs	08-09 yrs	10-14 yrs	15-19 yrs	20-24 yrs	25+ yrs	
Aitkin	1	0	0	1	0	0	0	0	0	2
Anoka	2	7	1	1	0	2	2	1	1	17
Becker	1	0	0	0	0	0	0	0	0	1
Beltrami	3	1	1	0	1	1	0	0	2	9
Benton	2	0	0	0	1	0	0	0	1	4
Blue Earth	0	2	1	0	1	1	1	1	0	7
Brown	0	0	1	0	1	0	0	0	1	3
Carlton	3	0	0	0	0	0	0	0	0	3
Carver	0	0	0	0	0	2	0	0	0	2
Cass	2	0	0	0	0	0	0	0	0	2
Chisago	2	0	0	0	0	0	0	0	0	2
Clay	2	0	0	1	0	0	0	0	0	3
Cottonwood	0	1	0	0	0	0	0	0	0	1
Crow Wing	0	1	0	1	0	1	0	0	0	3
Dakota	1	2	1	1	0	0	1	0	0	6
Douglas	2	0	0	0	0	0	0	0	0	2
Faribault	1	0	0	0	0	1	0	0	0	2
Freeborn	0	0	1	0	2	0	0	0	0	3
Hennepin	34	20	32	17	9	33	10	7	4	166
Houston	1	0	0	0	1	0	0	0	0	2
Hubbard	0	0	0	1	0	0	0	0	0	1
Isanti	1	0	0	0	0	0	0	0	0	1
Itasca	0	1	1	1	0	1	0	0	0	4
Jackson	1	0	0	0	0	0	0	0	0	1
Koochiching	0	0	1	1	0	0	0	0	0	2
Lake	1	0	0	0	0	0	0	0	0	1
Le Sueur	0	0	1	0	0	0	0	0	0	1
Lincoln	0	0	1	0	0	0	0	0	0	1
Lyon	0	0	0	0	0	1	0	0	0	1
Marshall	0	1	0	0	0	0	0	0	0	1
Martin	1	1	0	0	1	1	0	0	0	4
McLeod	1	1	0	1	1	0	0	0	0	4
Meeker	0	0	0	0	0	1	0	0	0	1
Mille Lacs	1	0	0	0	0	0	0	0	0	1
Mower	1	1	0	2	0	0	0	0	0	4
Norman	0	0	0	0	0	0	0	0	1	1
Olmsted	4	2	0	1	0	1	1	0	0	9
Otter Tail	0	1	0	0	0	1	0	0	0	2

Pennington	0	0	0	1	0	0	0	0	0	1
Pine	0	1	0	0	0	0	1	0	0	2
Polk	1	0	0	0	0	0	0	0	0	1
Pope	0	1	0	0	0	1	0	0	0	2
Ramsey	14	3	4	0	9	7	2	2	0	41
RedWood	0	0	1	0	0	0	0	0	0	1
Renville	0	0	0	0	0	0	1	0	0	1
Roseau	0	0	0	0	0	1	0	0	0	1
Scott	1	0	0	0	0	0	0	0	0	1
Sherburne	0	0	0	0	0	0	0	1	1	2
Sibley	0	0	0	0	1	0	0	0	0	1
St Louis	8	2	3	0	3	2	1	0	0	19
Stearns	6	1	2	0	0	3	0	0	0	12
Steele	0	0	1	0	1	1	0	0	0	3
Todd	0	1	0	0	0	1	0	0	0	2
Waseca	0	1	0	0	0	0	0	0	0	1
Washington	5	3	0	1	0	1	0	0	0	10
Watsonwan	1	0	1	0	0	0	0	0	0	2
Wilkin	0	0	0	0	0	0	0	0	1	1
Wright	1	0	0	0	0	0	0	0	0	1
Yellow Medicine	1	0	0	0	0	0	0	0	0	1
<b>Total</b>	<b>106</b>	<b>55</b>	<b>54</b>	<b>31</b>	<b>32</b>	<b>64</b>	<b>20</b>	<b>12</b>	<b>12</b>	<b>386</b>