MINNESOTA
OLMSTEAD
IMPLEMENTATION OFFICE

Agenda: Olmstead Subcabinet Meeting

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Date: Tuesday, September 15, 2026

Time: 10 a.m. – 12 p.m.

1. **Access check, call to order, and land acknowledgment**
2. **Approval of the agenda**
3. **Roll call**
4. **Approval of the June 24, 2026, meeting minutes**
5. **Compliance Report**
6. **Updates from OIO**
7. **Inclusion Consultant Presentation**
8. **Break**
9. **Discussion by Subcabinet for Approval of the New Olmstead Plan**
10. **Adjournment**

Land Acknowledgement

We collectively acknowledge that we are located on the traditional land of Indigenous people that once and still is occupied by the Ojibwe, Dakota and other Native peoples from the time immemorial. These lands hold great historical, spiritual, cultural and personal significance for these Native nations. We recognize, support and advocate for the sovereignty of these nations in this territory and beyond. By offering this land acknowledgement, we affirm tribal sovereignty and will hold ourselves accountable to the American Indian people and nations.

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Meeting Minutes: Olmstead Subcabinet (Unapproved)

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Date: June 24, 2026, 10:00 a.m.

Location: Department of Revenue Stassen building and Zoom Webinar online platform

Attendance

Subcabinet members and designees

- Jolene Rebertus, Minnesota Department of Corrections (DOC)
- Daron Korte, Minnesota Department of Education (MDE)
- Dee Torgerson, Minnesota Department of Employment and Economic Development (DEED)
- Colleen Wieck, Governor's Council on Developmental Disabilities (GCDD)
- Imee Cambronero, Minnesota Department of Health (MDH)
- Commissioner Jennifer Ho, Minnesota Housing Finance Agency (Minnesota Housing)
- Commissioner Rebecca Lucero, Minnesota Department of Human Rights (MDHR)
- Mor Vue, Minnesota Department of Human Services (DHS)
- Chair Robin Hutcheson, Metropolitan Council (MetC)
- Lisa Harrison-Hadler, Ombudsman for Mental Health and Developmental Disabilities (OMHDD)
- Commissioner Bob Jacobson, Minnesota Department of Public Safety (DPS)
- Commissioner Nancy Daubenberger, Minnesota Department of Transportation (MnDOT)
- Eric Meittenun, Minnesota Department of Veterans Affairs (MDVA)

Inclusion Consultants

- Mercedes Elder
- Angela Harper
- Adam Harrington
- Nikki Huelsman
- Sandy'Ci M.
- Rich Pennington
- Kevin Pone
- James Poteet
- Madam Robinson

- Ken Rodgers
- Abraham Tieman
- Mao Yang

Other state staff and guests

- Erik Adolphson, Direct Care and Treatment (DCT)
- Chloe Ahlf, Olmstead Implementation Office (OIO)
- Erica Alley, MDH
- Ryan Baumtrog, Minnesota Housing
- Scott Beutel, Minnesota Housing
- Commissioner Tikki Brown, Department of Children, Youth and Families (DCYF)
- Jonathan Bucki, Dendros Group
- Angela Carter, Dendros Group
- Yoshiko Chino, Dendros Group
- Nora Cronin, MDVA
- Tom Delaney, MDE
- Rilyn Eischens, OIO
- Maya Larson, Dendros Group
- Kari Martinka, DHS
- Natasha Merz, OIO
- John Patterson, Minnesota Housing
- Amy Petersen, DHS
- Jenn Purrington, OIO
- Gloria Smith, DHS
- Dez Sobiech, OIO
- Mike Tessneer, DHS
- Lauren Webber, DOC
- Madi Wegener, OIO
- Amanda Welliver, Minnesota Housing
- Leah Wilson, DHS

Call to order

Commissioner Ho (Minnesota Housing) called the meeting to order and welcomed attendees. Madi Wegener (OIO) gave an accessibility message, and Jenn Purrington (OIO) read a land acknowledgment.

Agenda review

Commissioner Ho reviewed the agenda. No changes were requested.

Approval of meeting minutes

Action: Approve the March 13, 2026, Subcabinet meeting minutes

Motion: Wieck Second: Jacobson

In favor: Voice vote was taken with 12 Ayes and 0 Nays. Motion carried.

- DOC: Aye
- MDE: Aye
- DEED: Aye
- GCDD: Aye
- MDH: Aye
- MHFA: Aye
- DHS: Aye
- MetC: Aye
- OOMHDD: Aye
- DPS: Aye
- MnDOT: Aye
- MDVA: Aye

Olmstead milestones and timeline review

Commissioner Ho responded to the recent Department of Justice memo on the *Olmstead* decision, highlighting the governor's Olmstead Day Proclamation and Minnesota's continuing commitment to promoting choice, dignity and true inclusion for people with disabilities. She read the full text of the proclamation.

Commissioner Ho also congratulated Mike Tessneer on his retirement at the end of the month, recognizing his forty-plus years of service as a state employee and his key role in developing, supporting and evaluating the state's Olmstead work from the beginning. Mike will be greatly missed by the OIO team and Subcabinet agencies.

Jenn Purrington reviewed the timeline for final revisions to and adoption of the new Olmstead Plan. Agency teams are currently reviewing and responding to public comment. Goal revisions are due to OIO in July, and we expect to have a revised draft for review at the August Leadership Forum meeting. The expectation is that the new Olmstead Plan will be ready for adoption by the Subcabinet at our next meeting on September 15, 2026.

OIO updates: public comment period summary

Rilyn Eischens (OIO) gave an overview of some themes from the draft plan public comment period. Public comment summaries and all redacted public comments can be found on the OIO website. Themes reviewed at this meeting are as follows:

Overall Themes

- Goal targets are not ambitious enough
- Important goal topics are missing
- Concerns about implementation and accountability

Crisis Services Themes

- The Olmstead Plan should address crisis prevention
- The staffing shortage affects crisis prevention and services

Education Themes

- The education goals should focus more on transition services
- Teachers and school staff need more resources to support students

Employment Themes

- People need sustained, quality employment built on person-centeredness
- Some populations experience increased barriers to employment

Health Themes

- The plan is missing goals about important health topics, including access to health care and services, health insurance, and dental care
- The goals rely too much on training, rather than accountability and enforcement

Housing Themes

- The plan should focus on housing choice
- Invest more in housing navigators who respect the culture of immigrant and underserved families

Transition Themes

- The Olmstead Plan needs to address the direct care workforce shortage
- There are too many data collection goals, and not enough focus on accountability and progress

Transit and Transportation Themes

- Greater Minnesota needs more transportation options
- People with disabilities need reliable transit and transportation options

The presentation was followed by a discussion period. Discussion topics included the need for robust interagency work and more intentional connections with city and county governments to optimize accessibility across programs and services, the need for concrete action steps to be named in the Olmstead Plan, and how commissioners can best prepare the next administration to continue working toward inclusion and choice for Minnesotans with disabilities. Ken Rodgers (Inclusion Consultant) shared that the public comments expressed the frustration felt by people with disabilities trying to navigate complicated systems that often fail to meet their needs. He also expressed concern that recent fraud investigations in state government would lead to less interagency collaboration and that the work of the agency teams in this process could be lost if there is no plan to record and continue working on issues that require state agencies to work with cities, counties or other organizations.

Discussion: systems change planning

Natasha Merz (OIO) introduced the topic of the proposed "Disability Systems Change Council" (DSCC) in the current draft of the new Olmstead Plan. The purpose of the DSCC would be to bring leaders together from various levels of government, along with community organizations and people with lived experience of disability, to tackle issues that require systemic change, legislation, and/or increased funding to improve the lives of people accessing disability services and programs. She opened the discussion by asking, "Is this the right solution to what we want to do? If not, do you have other suggestions or ideas?"

Responses included the important role of the federal government to make systemic changes and the need for a group like this to include a congressional delegation, concerns about whether the DSCC would have any authority or influence to enact change or would be making recommendations without follow-through, who would need to be part of the DSCC to make it effective, and who would convene the group and lead the work. Inclusion Consultants encouraged agencies to consider how they can work with community groups and center people with disabilities. Another idea offered was for OIO to hold summit events to bring leaders together to tackle specific issues.

Commissioner Ho wrapped up the discussion by noting that while there are issues outside the scope of state agencies, there is still accountability to increasing access and inclusion within state work and seeking ways to influence and collaborate across systems.

Adjournment

Commissioner Ho adjourned the meeting at 12:00 p.m.

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Compliance Update

Current and future Olmstead Plan reporting

- Current plan: Leadership Forum voted to accept the combined November 2025, February 2026, May 2026 quarterly report.
- OIO is still discussing details about compliance reporting for the updated plan, including:
  - When reporting will begin (likely mid-2027 at the earliest)
  - Which goals will be reported when
  - What compliance reports will look like

Plan highlights: Segregated to integrated settings

This table shows the number of people who moved from segregated to more integrated settings from July 2014 to September 2025. *(Transition Services Goal 1, DHS)*

Setting	Number of people
Intermediate Care Facilities for Persons with Developmental Disabilities	1,227
Nursing facilities (people under 65 in nursing facilities for more than 90 days)	8,352
Other segregated settings	13,071
Total	**22,650**

Plan highlights

- **1,018 people** moved from the Anoka Metro Regional Treatment Center to more integrated settings from July 2016 to September 2025. *(Transition Services Goal 2, DCT)*
- From 2014 to 2025, **10,593 people** moved from segregated settings to integrated housing where they signed a lease and received rent support. *(Housing and Services Goal 1, DHS and Minnesota Housing)*
- **94% reduction** in reports of the use of mechanical restraint from 2014 to 2025. *(Positive Supports Goal 3, DHS)*
  - In 2014, there were 2,038 reports. In 2025, there were 124.

Plan highlights (cont.)

- Employment: **26,427 people** achieved competitive, integrated employment through Vocational Rehabilitation Services and State Services for the Blind from 2015 to 2025. *(Employment Goal 1, DEED)*
- Health: The number of adults using the emergency department for non-traumatic dental services **dropped by 32%** from 2014 to 2024. *(Health Care Goal 2B, MDH and DHS)*
- Education: **24,131 more students** were learning in the most integrated setting in 2025 compared to 2013. *(Education Goal 1, MDE)*
- Transportation: Greater Minnesota on-time transit performance increased from 76% in 2014 to **88% in 2025**. *(Transportation Goal 4A, MnDOT)*

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Thank you!

Minnesota Olmstead Subcabinet

November 2025, February 2026, and May 2026 Quarterly Reports on Olmstead Plan Measurable Goals

REPORTING PERIOD:

Data acquired through May 2026

DATE REVIEWED BY LEADERSHIP FORUM:

August 14, 2026

Contents

PURPOSE OF REPORT

This quarterly report provides the status of work being completed by State agencies to implement the Olmstead Plan. The goals related to the number of people moving from segregated settings into more integrated settings and the quality of life measures will be reported in every quarterly report.

Reports are compiled on a quarterly basis. For the purpose of reporting, the measurable goals are grouped in three categories:

1. Movement of people with disabilities from segregated to integrated settings
2. Quality of life measurement results
3. Increasing system capacity and options for integration

This quarterly report includes data acquired through mid-2026 and covers three quarters. Progress on each measurable goal will be reported quarterly, semi-annually, or annually. This report will be reviewed by the Olmstead Leadership Forum for acceptance. After reports are accepted, they are made available to the public on the Olmstead Plan website at Mn.gov/Olmstead.[i]

EXECUTIVE SUMMARY

This report covers 33 measurable goals.[ii] As shown in the chart below, 10 goals met or are on track to meet the annual goal and 17 did meet or are not on track to meet the goals. Six goals are in process or expired in a prior year.

Status of Goals – May 2026 report	Number of Goals
Met annual goal	6
On track to meet annual goal	4
Not on track to meet annual goal	7
Did not meet annual goal	10
In process OR expired in a prior year and still monitored and reported	6
Goals Reported	**33**

Listed below is a performance summary of Plan goals in this report:
Progress on movement of people with disabilities from segregated to integrated settings

- During FY 2025, 65 individuals left ICF/DD programs to more integrated settings. The goal of 81 was not met. (Transition Services Goal One A)

- During FY 2025, 367 individuals with disabilities under age 65 in a nursing facility longer than 90 days moved to more integrated settings. The goal of 750 was not met. (Transition Services Goal One B)
- During FY 2025, 1,375 individuals moved from other segregated settings to more integrated settings. The goal of 1,200 was met. (Transition Services Goal One C)
- During FY 2025, 30% of people at AMRTC no longer meet hospital level of care and are awaiting discharge to the most integrated setting. The 2025 target to reduce to 25% or lower was not met. (Transition Services Goal Two)
- During CY 2025, the number of individuals at Forensic Services who moved to a less restrictive setting averaged 3.0 per month. The goal of 5 per month was not met. (Transition Services Goal Three)

Increasing system capacity and options for integration

- During FY 2025, 97.4% of cases utilized the Person-Centered Protocols. The goal is on track to meet the 2026 target of 95%. (Person-Centered Planning Goal One)
- During FY 2025, 380 individuals experienced a restrictive procedure. The 2025 goal to not exceed 451 was met. (Positive Supports Goal One).
- During FY 2025, there were 1,739 Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures. The 2025 goal to not exceed 2,680 reports was met. (Positive Supports Goal Two).
- During FY 2025, there were 124 reports of emergency use of mechanical restraints other than use of an auxiliary device with approved individuals. The 2025 goal to not exceed 88 reports was not met. (Positive Supports Goal Three).
- During FY 2025, there were 1,323 individuals moving into integrated housing. The goal is on track to meet the 2026 target. (Housing and Services Goal One)
- During FFY 25, the number of people with disabilities working in competitive integrated employment through Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) was 2,068. The goal to increase by 11,631 from 2020 to 2025 was met. (Employment Goal One).
- During FY2025, there were 12,901 MA recipients in competitive integrated employment. The goal is not on track to meet the 2026 target of 14,420. (Employment Goal Two)
- Using the 2024 Child Count, the percent of students receiving instruction in the most integrated setting was 64.2%. The goal is on track to meet the 2025 target of 64%. (Lifelong Learning and Education Goal One).
- During 2024, accessibility improvements were made to 1,100 curb ramps, bringing the total curb ramp improvements to 11,188. This goal expired in a prior year and was still monitored and reported in 2024. (Transportation Goal One A)
- During 2025, accessibility improvements were made to 15 accessible pedestrian signals, bringing the total improvements to 987. This goal expired in a prior year and was still monitored and reported in 2025. (Transportation Goal One B)

- During 2024, accessibility improvements were made to 17 miles of sidewalks, bringing the total to 171.37 miles. This goal expired in a prior year and was still monitored and reported in 2024. (Transportation Goal One C)
- During 2025, the annual number of service hours in Greater Minnesota was 1,379,752. The goal is not on track to meet the 2026 target of 1.71 million service hours. (Transportation Goal Two)
- In 2024, 80% of public transportation service areas met minimum service guidelines for access. The goal is in process, as it is too early to determine progress towards the 2026 target of 90%. (Transportation Goal Three)
- In 2025, Metro Transit's on-time performance was 78.6%. The 2025 goal to reach 90% or greater was not met. (Transportation Goal Four A)
- During the last six months of 2025, on-time performance for Greater Minnesota Transit was 88%. The 2025 goal of 90% was not met. (Transportation Goal Four B)
- As of March 2026, the percentage of target population served by regular route level of service for Market Areas 1, 2, and 3 was 92%, 89%, and 71%, respectively. This goal expired in a prior year and was still monitored and reported in 2026. (Transportation Goal Five)
- During 2024, the readmission rate of adults with disabilities was 20.87%. This is not on track to meet the 2025 target to reduce to 20% or less. (Health Care and Healthy Living Goal One)
- During 2024, the rate of children using an emergency department for non-traumatic dental care was 0.26%. This is not on track to meet the 2025 target to reduce to 0.20% or less. (Health Care and Healthy Living Goal Two A)
- During 2023, the rate of adults using an emergency department for non-traumatic dental care was 1.17%. This is not on track to meet the 2025 target to reduce to 1.0% or less. (Health Care and Healthy Living Goal Two B)
- During the 2024-25 school year, the number of students experiencing emergency use of restrictive procedures decreased by 28 from the previous year. The goal to decrease to 1.8% of students was met. (Positive Supports Goal Four).
- During the 2024-25 school year, the number of incidents of students experiencing an emergency use of restrictive procedure increased by 3,504 over the previous year. The goal to reduce by 3,615 or by 1.0 incidents per student was not met. (Positive Supports Goal Five).
- During FY 2025, 69.6% of children remained in their community after a crisis. This is not on track to meet the 2026 goal of 75%. (Crisis Services One)
- During FY 2025, 56.5% of adults remained in their community after a crisis. This is on track to meet the 2026 goal of 55%. (Crisis Services Goal Two)
- During FY 2024, 78.2% of individuals hospitalized due to a crisis were housed within five months of discharge. This is not on track to meet the 2026 goal of 82%. (Crisis Services Goal Four)
- As of July 2026, 267 individuals with disabilities participated in Governor appointed Boards and Commissions. This goal expired in a prior year and was still monitored and reported in 2026. (Community Engagement Goal One)

- During 2025, 500 people participated in public input opportunities related to the Olmstead Plan. The 2025 goal to increase by 25% over baseline was met. (Community Engagement Goal Two)
- During 2025, there were 48 emergency room visits and hospitalizations due to abuse and neglect, a 6% increase from baseline. The 2025 target to decrease by 15% from baseline was not met. (Preventing Abuse and Neglect Goal Two A)
- During 2024, 47 students with disabilities were determined to have been maltreated. The goal to decrease to 24 students was not met. (Preventing Abuse and Neglect Goal Four)

MOVEMENT FROM SEGREGATED TO INTEGRATED SETTINGS

This section reports on the progress of five separate Olmstead Plan goals that assess movement of individuals from segregated to integrated settings.

QUARTERLY SUMMARY OF MOVEMENT FROM SEGREGATED TO INTEGRATED

The table below indicates the cumulative net number of individuals who moved from various segregated settings to integrated settings for each of five goals included in this report. The reporting period for each goal is based on when the data collected can be considered reliable and valid.

Net number of individuals who moved from segregated to integrated settings during reporting period

Setting	Reporting period	Number moved
Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	July 2024 – June 2025	65
Nursing Facilities (individuals under age 65 in facility > 90 days)	July 2024 – June 2025	367
Other segregated settings	July 2024 – June 2025	1,375
Anoka Metro Regional Treatment Center (AMRTC)	July 2025 – December 2025	143

Setting	Reporting period	Number moved
Forensic Services[1]	January – December 2025	38
Total	--	**1,988**

More detailed information for each specific goal is included below. The information includes the overall goal, the annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance and the universe number when available. The universe number is the total number of individuals potentially affected by the goal. The universe number provides context as it relates to the measure.

[1] For the purposes of this report Forensic Services refers to individuals residing in the facility and committed as Mentally Ill and Dangerous and other civil commitment statuses. This goal measures moves to a less restrictive setting.

TRANSITION SERVICES GOAL ONE

By June 30, 2026, the annual number of people who have moved from segregated settings to more integrated settings[iii] will be 2,031. The segregated settings include: (A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD); (B) individuals with disabilities under age 65 receiving services in a nursing facility for longer than 90 days; and (C) other segregated housing. *(Updated in 2024)*

SETTING A: INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

By June 30, 2026, the annual number of people who have moved from Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD) to more integrated settings will be 81.

2025 Annual Goal

- By June 30, 2025, the number of people moving from ICFs/DD to more integrated settings will be **81**.

Baseline: During Calendar Year 2014, the number of people moving from ICFs/DD was 72.

RESULTS:

The 2025 goal to move 81 people annually from ICFs/DD to a more integrated setting was **not met.**

The 2026 goal to move 81 people annual from ICFs/DD to a more integrated setting is **not on track**.

Time period	Total number of individuals leaving	Transfers[iv] (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	138	18	62	**58**
2016 Annual (July 2015 – June 2016)	180	27	72	**81**
2017 Annual (July 2016 – June 2017)	263	25	56	**182**
2018 Annual (July 2017 – June 2018)	216	15	51	**150**
2019 Annual (July 2018 – June 2019)	298	20	58	**220**
2020 Annual (July 2019 – June 2020)	174	13	75	**86**
2021 Annual (July 2020 – June 2021)	194	13	62	**119**
2022 Annual (July 2021 – June 2022)	177	12	59	**106**

Time period	Total number of individuals leaving	Transfers[iv] (-)	Deaths (-)	Net moved to integrated setting
2023 Annual (July 2022 – June 2023)	151	9	43	**99**
2024 Annual (July 2023 – June 2024)	113	19	45	**49**
2025 Quarter 1 (July – September 2024)	30	1	5	**24**
2025 Quarter 2 (October – December 2024)	27	1	8	**18**
2025 Quarter 3 (January – March 2025)	28	3	11	**14**
2025 Quarter 4 (April – June 2025)	24	3	12	**9**
2025 Annual (July 2024 – June 2025)	109	8	30	**65**
2026 Quarter 1 (July 2025 – September 2025)	29	9	8	**12**

ANALYSIS OF DATA:

From January – March 2025, the number of people who moved from an ICF/DD to a more integrated setting was 0. This is 18 less than the quarter before.

From April - June 2025, the number of people who moved from an ICF/DD to a more integrated setting was 0. This was the same during previous quarter of 0 moves. After two quarters, the goal is not on track to meet the 2025 goal of 81.

From July 2024 – June 2025, the total number of people who moved from an ICF/DD to a more integrated setting was 42. This is 7 less than the year before. The annual goal of 81 was not met.

From July - September 2025, the number of people who moved from an ICF/DD to a more integrated setting was 12. This was 12 more than the previous two quarters combined. The goal is not on track to meet the target.

UNIVERSE NUMBER:

- In Fiscal Year 2024, there were 731 individuals receiving services in an ICF/DD on a monthly average.
- In September 2021, there were 779 individuals receiving services in an ICF/DD.
- In June 2017, there were 1,383 individuals receiving services in an ICF/DD.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

SETTING B: NURSING FACILITIES

By June 30, 2026, the annual number of people with a disability under age 65 in a nursing facility (for longer than 90 days) who have moved to a more integrated setting will be 750.

2025 Annual Goal

- By June 30, 2025, the number of people moving from nursing facilities to more integrated settings will be **750.**

Baseline: During Calendar Year 2014, the number of individuals moving from nursing facilities was 707.

RESULTS:

The 2025 goal to move 750 people under 65 in a nursing facility for more than 90 days to a more integrated setting was **not met**.

The 2026 goal to move 750 people under 65 in a nursing facility for more than 90 days to a more integrated setting is **on track**.

Time period	Total number of individuals leaving	Transfers (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	1,043	70	224	**749**
2016 Annual (July 2015 – June 2016)	1,018	91	198	**729**
2017 Annual (July 2016 – June 2017)	1,097	77	196	**824**
2018 Annual (July 2017 – June 2018)	1,114	87	197	**830**
2019 Annual (July 2018 – June 2019)	1,176	106	190	**880**

Time period	Total number of individuals leaving	Transfers (-)	Deaths (-)	Net moved to integrated setting
2020 Annual (July 2019 – June 2020)	1,241	86	240	**915**
2021 Annual (July 2020 – June 2021)	981	86	214	**681**
2022 Annual (July 2021 – June 2022)	1,058	61	198	**799**
2023 Annual (July 2022 – June 2023)	888	69	183	**636**
2024 Annual (July 2023 – June 2024)	997	81	179	**737**
2025 Quarter 1 (July – September 2024)	270	24	47	**199**
2025 Quarter 2 (October – December 2024)	232	13	51	**168**
2025 Quarter 3 (January – March 2025)	12	12	0	**0**
2025 Quarter 4 (April – June 2025)	20	20	0	**0**
2025 Annual (July 2024 – June 2025)	534	69	98	**367**
2026 Quarter 1 (July – September 2025)	259	9	45	**205**

ANALYSIS OF DATA:

From January - March 2025 the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 0. This was way less than in the previous quarter of 168. The goal is not on track.

From April - June 2025, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 0. This is the same as the previous quarter of 0. After two quarters, the total number is 0 of the annual goal of 750 and is not on track to meet the 2026 goal.

From July 2024 – June 2025, the number of people under age 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 367. This is a decrease of 370 from the previous year, the annual goal of 750 was not met.

From July – September 2025, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 205. This was way more than the previous two quarters of 0. The goal is on track.

UNIVERSE NUMBER:

- In Fiscal Year 2024, there were 2,459 individuals with disabilities under age 65 (including developmental disabilities) who received services in nursing facilities for longer than 90 days.
- In January 2020, there were 2,379 individuals with disabilities under age 65 (including developmental disabilities) who received services in nursing facilities for longer than 90 days.
- In June 2017, there were 1,502 individuals with disabilities under age 65 who received services in a nursing facility for longer than 90 days.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

SETTING C: OTHER SEGREGATED HOUSING

By June 30, 2026, the annual number of people who have moved from other segregated housing to a more integrated setting will be 1,200.

2025 Annual Goal

- By June 30, 2025, the number of people moving from other segregated housing to more integrated settings will be 1,200**.**

BASELINE: From July 2013 – June 2014, of the 5,694 individuals moving, 1,121 moved to an integrated setting.

RESULTS:

The 2025 goal to move 1,200 people from other segregated housing to more integrated settings **was met.**

The 2026 goal to move 1,200 people from other segregated housing to more integrated settings is **on track.**

		Receiving Medical Assistance (MA)			
Time Period	**Total moves**	**Moved to more integrated setting**	**Moved to congregate setting**	**Not receiving residential services**	**No longer on MA**
2015 Annual (July 14 – June 15)	5,703	1,137 (19.9%)	502 (8.8%)	3,805 (66.7%)	259 (4.6%)
2016 Annual (July 15 – June 16)	5,603	1,051 (18.8%)	437 (7.8%)	3,692 (65.9%)	423 (7.5%)
2017 Annual (July 16 – June 17)	5,504	1,102 (20%)	492 (8.9%)	3,466 (63%)	492 (8.9%)
2018 Annual (July 17 – June 18)	5,967	1,188 (19.9%)	516 (8.7%)	3,737(62.6%)	526 (8.8%)
2019 Annual (July 18 – June 19)	5,679	1,138 (20.0%)	484 (8.5%)	3,479 (61.3%)	578 (10.2%)
2020 Annual (July 19 – June 20)	5,967	1,190 (19.9%)	483 (8.1%)	3,796 (63.6%)	498 (8.4%)
2021 Annual (July 20 – June 21)	5,261	2,482 (47.2%)	364 (6.9%)	2,257 (42.9%)	158 (3.0%)
2022 Annual (July 21 – June 22)	5,971	2,127(35.6%)	349(5.8%)	3,273(54.8%)	222(3.7%)
2023 Annual (July 2022 – June 2023)	4,659	1,332 (28.6%)	284 (6.1%)	2,863 (61.5%)	180 (3.9%)
2024 Annual (July 23 – June 24)	5,442	1,471 (27%)	296 (5.4%)	3,322 (61%)	353 (6.5%)
2025 Quarter 1 (July – Sept 2024)	1,355	352 (25.9%)	73 (5.4%)	852 (62.9%)	78 (5.8%
2025 Quarter 2 (Oct – Dec 2024)	1,240	382 (30.8%)	59 (4.8%)	716 (57.7%)	83 (6.7%)
2025 Quarter 3 (January – March 2025)	1,285	297 (23.1%)	75 (5.8%)	847 (66.0%)	66 (5.1%)
2025 Quarter 4 (April – June 2025)	1,395	344 (24.7%)	64 (4.6%)	905 (64.8%)	82 (5.9%)
2025 Annual (July 2024 – June 2025)	5,275	1,375 (26%)	271 (5.1%)	3,320 (62.9%)	309 (5.8%)
2026 Quarter 1 (July 2025 – September 2025)	1,313	341 (26.0%)	83 (6.3%)	813 (61.9%)	76 (5.8%)

ANALYSIS OF DATA

From January - March 2025, of the 1,285 individuals moving from segregated housing, 297 individuals (23.1%) moved to a more integrated setting. This is a decrease of 85 people and a difference of 7.7% from the previous quarter.

From April - June 2025, of the 1,395 individuals moving from segregated housing, 734 individuals (28.3%) moved to a more integrated setting. This is an increase of 47 people and a difference of 1.6% from the previous quarter.

From July 2024 – June 2025, of the 5,275 individuals moving from segregated housing, 1,375 individuals (26.0%) moved to a more integrated setting. This is a decrease of 96 people from 1,471 the previous year. The annual goal of 1,200 was met.

From July – September 2025, of the 1,313 individuals moving from segregated housing, 341 individuals (26.0%) moved to a more integrated setting. This is a decrease of 3 people and a difference of 1.3% from the previous quarter.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

TRANSITION SERVICES GOAL TWO

By December 31, 2025, the percent of people who remain at Anoka Metro Regional Treatment Center (AMRTC) who are committed as persons with a mental illness, chemically dependent, and/or a developmental disability with a mental health commitment and no longer in need of hospital care will be reduced to 25% or lower (based on daily average). *(Updated in 2024)*

Baseline: In State Fiscal Year 2015, the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting was 36% on a daily average. In State Fiscal Year 2021, the percentage of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting was 27.6% on a daily average.[2]

[2] The baseline included individuals at AMRTC under mental health commitment and individuals committed after being found incompetent on a felony or gross misdemeanor charge (restore to competency).

RESULTS:

The 2025 goal to reduce the percent of people awaiting discharge from AMRTC to 25% or lower was **not met**.

Percent awaiting discharge (daily average)

Time period	Mental health commitment	Committed after finding of incompetency	Combined
2016 Annual (July 2015 – June 2016)	41.8%	44.7%	42.5%
2017 Annual (July 2016 – June 2017)	44.9%	29.3%	37.1%
2018 Annual (July 2017 – June 2018)	36.9%	23.8%	28.3%
2019 Annual (July 2018 – June 2019)	37.5%	28.2%	26.5%
2020 Annual (July 2019 – June 2020)	36.3%	22.7%	29.5%
2021 Annual (July 2020 – June 2021)	32.6%	24.9%	27.6%
2022 Annual (July 2021 – June 2022)	37.5%	20.6%	31.1%
2023 Annual (July 2022 – June 2023)	46.0%	45.1%	45.1%
2024 Annual (July 2023 – June 2024)	50.7%	46.1%	46.8%
2025 Annual (July 2024 – June 2025)	28.1%	31%	30.4%
2026 Quarter 1 (July 2025 – September 2025)	28.5%	26.2%	26.7%
2026 Quarter 2 (October 2025 to December 2025)	23.34%	28.3%	26.7%

ANALYSIS OF DATA:

July – September 2025

- The combined rate of all individuals at AMRTC who no longer met hospital level of care and were awaiting discharge was 26.7%, reflecting a decrease from the 2025 annual rate of 30.4%.

- For those under mental health commitment, 28.5% no longer met hospital level of care and were awaiting discharge to the most integrated setting, including individuals waiting for a bed at the Forensic Mental Health Program (FMHP).
- The percentage of individuals awaiting discharge who were civilly committed after being found incompetent was 26.2%.
- A total of 78 individuals moved to an integrated setting.

October – December 2025

- The combined rate of all individuals at AMRTC who no longer met hospital level of care and were awaiting discharge remained at 26.7%, unchanged from the previous quarter.
- For those under mental health commitment, 23.34% no longer met hospital level of care and were awaiting discharge to the most integrated setting, including those waiting for a bed at the FMHP.
- The percentage of individuals awaiting discharge who were civilly committed after being found incompetent was 28.3%, an increase from the previous quarter.
- A total of 65 individuals moved to an integrated setting.

The table below provides information about those individuals who left AMRTC. It includes the number of individuals under mental health commitment and those who were civilly committed after being found incompetent on a felony or gross misdemeanor charge who moved to integrated settings.

Time Period	Total number of individuals leaving	Transfers	Deaths	Net moved to integrated setting	Moved to integrated Mental health commitment	Moved to integrated Committed after finding of Incompetency
2017 Annual (July 16 – June 17)	267	155	2	110	54	56
2018 Annual (July 17 – June 18)	274	197	0	77	46	31
2019 Annual	317	235	1	81	47	34

Time Period	Total number of individuals leaving	Transfers	Deaths	Net moved to integrated setting	Moved to integrated Mental health commitment	Moved to integrated Committed after finding of Incompetency
(July 18 – June 19)						
2020 Annual (July 19 – June 20)	347	243	0	104	66	38
2021 Annual (July 20 – June 21)	383	259	0	124	66	58
2022 Annual (July 21 – June 22)	351	252	0	99	25	74
2023 Annual (July 22 – June 23)	274	184	1	89	16	73
2024 Annual (July 23 – June 24)	297	211	0	86	20	66
2025 Annual (July 2024 – June 2025)	320	150	0	170	51	119

Time Period	Total number of individuals leaving	Transfers	Deaths	Net moved to integrated setting	Moved to integrated Mental health commitment	Moved to integrated Committed after finding of Incompetency
2026 Quarter 1 (July 2025 – September 2025)	93	26	0	78	19	59
2026 Quarter 2 (October 2025 – December 2025)	91	26	0	65	20	45

UNIVERSE NUMBER:

- **(Fiscal Year 2025)**
- **Admissions:** 327
- **Discharges:** 297
- These totals may include individuals with multiple admissions during the year.
- **Average length of stay:** 107 days
-

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

TRANSITION SERVICES GOAL THREE

By December 31, 2025, the average monthly number of individuals at Forensic Services [3] moving to a less restrictive setting will increase to an average of 5 individuals per month. *(Updated in 2024)*

Baseline: During 2017-2020, for individuals committed under MI&D and other commitments, the average number of individuals moving to a less restrictive setting was approximately 3 per month.

RESULTS:

The 2025 goal to increase the average number of individuals moving out of Forensic Services to 5 per month was not met.

Time period	Total number of individuals leaving	Transfers [4] (-)	Deaths (-)	Net moved to less restrictive	Monthly average
2021 Annual (Jan – Dec 2021)	111	24	12	75	**6.3**
2022 Annual (Jan – Dec 2022)	75	24	8	43	**3.6**
2023 Annual (Jan – Dec 2023)	88	19	12	57	**4.8**
2024 Annual (Jan – Dec 2024)	97	44	5	48	**4.0**
2025 Quarter 1 (January – March 2025)	20	4	4	12	**4.0**
2025 Quarter 2 (April – June 2025)	14	3	0	11	**3.3**
2025 Quarter 3 (July – September 2025)	8	2	0	6	**2**
2025 Quarter 4 (October – December 2025)	16	7	0	9	**3**
2025 Annual (Jan – Dec 2025)	58	16	4	38	**3**
2026 Quarter 1 (January – March 2026)	23	7	3	13	**4**

[3] For the purpose of this goal, Forensic Services (formerly known as Minnesota Security Hospital) refers to individuals residing in the facility and committed as mentally ill and dangerous and other commitment statuses.

[4] Transfers reflect movement to other secure settings (i.e., Department of Corrections, jail, Minnesota Sex Offender Program, and/or between the Forensic Mental Health Program and Forensic Nursing Home).

ANALYSIS OF DATA:

From July to September 2025, six individuals moved to a less restrictive setting. This reflects a continued decrease from the previous quarter (Quarter 2, Calendar Year 2025), during which 10 individuals transitioned to less restrictive placements. The monthly average for this period was 2 discharges.

From October to December 2025, nine individuals moved to a less restrictive setting—an increase from Quarter 3 of Calendar Year 2025. The monthly average for this period was 3 discharges.

Overall, during Calendar Year 2025, 37 individuals moved to less restrictive settings—representing a diminished number of people discharging than in recent previous years with a monthly average of 3 discharges for the year.

From January to March 2026, 12 individuals moved to a less restrictive setting. This reflects an increase from Quarter 4 of Calendar Year 2025, during which nine individuals transitioned to less restrictive placements. The monthly average for this period was 4 discharges.

This goal measures moves out of the facility from the most restricted setting to less restrictive settings, even if the new setting isn't fully community integrated. For example, moving to treatment facilities in the community is counted as moving to a less restrictive setting. While those facilities aren't fully community-integrated, they are less restrictive than Forensic Services. It is believed that from a quality-of-life perspective, it is valid to track the people who move from the facility to a more integrated setting. Forensic Services is considered one of the most restrictive settings in the State. Therefore, transition to any other non-secure setting out of a Forensic Services facility is a move to a less restrictive setting. The definition of Transfer reflects movement to other secure settings (i.e. Department of Corrections, jail, Minnesota Sex Offender Program (MSOP), and/or between the Forensic Mental Health Program (FMHP) and Forensic Nursing Home (FNH).

Individuals committed to the facility are provided with services tailored to their individual needs. DHS efforts continue to expand community capacity and work towards the mission of the Olmstead Plan by identifying individuals who could be served in more integrated settings. Forensics meets with Hennepin County and other metro counties, as most individuals are committed from these counties. The meetings are focused on both individuals where there is a difference of opinion on readiness to discharge as well as identified discharge barriers.

MI&D committed, and Other committed

Persons committed as Mentally Ill and Dangerous (MI&D), are provided acute psychiatric care and stabilization, as well as psychosocial rehabilitation and treatment services. The MI&D commitment is indeterminate and requires a Special Review Board recommendation to the Commissioner of Human Services prior to approval for community-based placement (Minnesota Stat. 253B.18). Persons under other commitments receive services at the St Peter facility. Other

commitments include Mentally Ill (MI), Mentally Ill and Chemically Dependent (MI/CD), Mentally Ill and Developmentally Disabled (MI/DD).

An identified barrier to discharge is the limited number of providers with the capacity to serve:

- Individuals with Level 3 predatory offender designation;
- Individuals over age 65 who require adult foster care, skilled nursing, or nursing home level care;
- Individuals with DD/ID with high behavioral acuity;
- Individuals with undocumented citizenship status; and
- Individuals whose county case management staff has refused or failed to adequately participate in developing an appropriate provisional discharge plan for the individual.

Another identified barrier to discharge is the Special Review Board (SRB) process, which is required for individuals committed as MI&D. This process can take up to six months or longer from the time a petition is initiated and an order is received. The SRB process also impacts the ability of individuals committed as MI&D to expeditiously move from a secure unit to a nonsecure unit at FMHP.

Many residential community placements are unable or unwilling to work with this process because they need to fill their vacant beds more quickly than this process allows. Thus, further limiting the number of resources available for an already difficult to place population of people. As well, forecasted changes to waiver services and additional restrictions for exception rate approvals will further limit the community placements that can support Forensic patients.

The Forensic Review Panel serves to offer treatment recommendations that could assist the individual's growth or skill development, when necessary, to aid in preparing for community reintegration. A summary of the Forensic Review Panel efforts includes:

- From January through March 2026: Reviewed 32 cases and supported reductions for eight of those cases including six petitions for Provisional Discharge and two for Transfer; zero petitions were withdrawn. The SRB has supported eight reductions while denying 20 petitions. There are four cases pending SRB results. One case the FRP did not support a reduction while the SRB recommended a Provisional Discharge. The Order was ultimately denied.
- From April through June 2026: The FRP has reviewed 19 cases so far and supported reductions for three of those cases, including two petitions for Provisional Discharge and one for Transfer; one petition was withdrawn following FRP review. There are 17 results pending SRB results.

In the last two periods, FRP had an influx of patient-initiated petitions that were not supported. This led to longer wait times for report submissions and hearings.

- 24 patient-initiated petitions
- 11 team-initiated petitions

- 16 3-year reviews

Between January to now (6/2/2026), the FRP has reviewed 51 cases total, with an additional 21 consults for Track 2 consideration and treatment progression recommendations, which do not impact the SRB data.

Discharge data continues to be categorized into three areas to support analysis of potential barriers to discharge:

- Committed after being found incompetent on a felony or gross misdemeanor charge
- Committed as Mentally Ill and Dangerous (MI&D)
- Other committed

Time period	Type	Total moves	Transfers	Deaths	Moves to less restrictive settings
2021 Annual Jan – Dec 2021	Committed after finding of incompetency	37	6	1	30
Jan – Dec 2021	MI&D committed	53	16	10	27
Jan – Dec 2021	Other committed	21	2	1	18
Total	**N/A**	**111**	**24**	**12**	**(Avg. = 6.3) 75**
2022 Annual Jan – Dec 2022	Committed after finding of incompetency	3	2	0	1
Jan – Dec 2022	MI&D committed	62	22	8	32
Jan – Dec 2022	Other committed	10	0	0	10
Total	**N/A**	**75**	**24**	**8**	**(Avg. = 3.6) 43**
2023 Annual Jan – Dec 2023	Committed after finding of incompetency	**6**	**3**	**1**	**2**
Jan – Dec 2023	MI&D committed	**69**	**16**	**10**	**43**
Jan – Dec 2023	Other committed	**13**	**0**	**1**	**12**
Total	**N/A**	**88**	**19**	**12**	**(Avg. = 4.8) 57**
2024 Annual Jan – Dec 2024	Committed after finding of incompetency	8	3	0	5
Jan – Dec 2024	MI&D committed	79	39	5	35
Jan – Dec 2024	Other committed	10	2	0	8
Total	**N/A**	**97**	**44**	**5**	**(Avg. = 4) 48**

2025 Q1 Jan – March 2025	Committed after finding of incompetency	1	0	0	1
Jan – March 2025	MI&D committed	22	12	2	8
Jan – March 2025	Other committed	3	0	0	3
Total	**N/A**	**26**	**12**	**2**	**(Avg. = 4) 12**
2025 Q2 Apr – June 2025	Committed after finding of incompetency	0	0	0	0
Apr – June 2025	MI&D committed	11	3	1	7
Apr – June 2025	Other committed	3	0	0	3
Total	**N/A**	**14**	**3**	**1**	**(Avg. = 3.3) 10**
2025 Q3 July - Sept. 2025	Committed after finding of incompetency	0	0	0	0
July - Sept. 2025	MI&D committed	7	1	0	6
July - Sept. 2025	Other committed	1	1	0	0
Total	**N/A**	**8**	**2**	**0**	**6**
2025 Q4 Oct – Dec 2025	Committed after finding of incompetency	1	0	0	1
Oct – Dec 2025	MI&D committed	15	7	0	8
Oct – Dec 2025	Other committed	0	0	0	0
Total	**N/A**	**16**	**7**	**0**	**9**

2026 Q1 Jan – March 2026	Committed after finding of incompetency	0	0	0	0
Jan – March 2026	MI&D committed	20	6	1	13
Jan – March 2026	Other committed	3	1	2	0
Total	**N/A**	**23**	**7**	**3**	**13**

UNIVERSE NUMBER:

In calendar year 2025, 401 patients received services in the Forensic Mental Health Program. During that same timeframe 42 residents received services in the Forensic Nursing Home. This may include individuals who were admitted more than once during the year. The average daily census for the Forensic Mental Health Program was 341 and for the nursing home was 28.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

QUALITY OF LIFE MEASUREMENT RESULTS

This section includes report on the Olmstead Plan Quality of Life Survey.

OLMSTEAD PLAN QUALITY OF LIFE SURVEY

The Olmstead Subcabinet authorized this longitudinal survey to track progress of the quality of life (QOL) of Minnesotans with disabilities as the Olmstead Plan is being implemented. The Quality of Life Survey is a multi-year effort to assess the quality of life for people with disabilities who receive state services in potentially segregated settings. Minnesota Department of Human Services identified places such as group homes, nursing facilities and center-based employment as having the potential to be segregated settings.

The results of the QOL surveys are shared with state agencies implementing the Olmstead Plan so they can evaluate their efforts and better serve Minnesotans with disabilities.

In 2024, the Olmstead Implementation Office contracted with the Improve Group to conduct another survey. The process began in March and was completed in October. The survey report includes demographic information and findings compared to past years. For more information about the Quality of Life Survey visit: https://mn.gov/olmstead/documents/quality-of-life-surveys/.

INCREASING SYSTEM CAPACITY AND OPTIONS FOR INTEGRATION

This section reports on the progress of measurable goals related to increasing capacity of the system and options for integration that are being reported in each quarterly report. The information for each goal includes the overall goal, annual goal, baseline, results for the reporting period, analysis of the data and the universe number, when available. The universe number is the total number of individuals potentially affected by the goal. This number provides context as it relates to the measure.

PERSON-CENTERED PLANNING GOAL ONE

Plans for people using disability home and community-based waiver services will meet protocols based on the presence of eight required criteria. Protocols are based on principles of person-centered planning and informed choice. By June 30, 2026, the eight required criteria will be present at a combined rate of 95%. *(Updated in 2024)*

Baseline: In state Fiscal Year 2014, 38,550 people were served on the disability home and community-based services. From July 1, 2016 – June 30, 2017, there were 1,201 disability files reviewed during the Lead Agency Reviews. For the period from April – June 2017, in the 215 case files reviewed, the eight required criteria were present in the percentage of files shown below. The combined rate was 67%.

Element	Required criteria	Percent
1	The support plan describes goals or skills that are related to the person's **preferences**.	74%
2	The support plan includes a global statement about the person's **dreams and aspirations**.	17%
3	Opportunities for **choice** in the person's current environment are described.	79%
4	The person's current **rituals and routines** are described.	62%
5	**Social**, leisure, or religious **activities** the person wants to participate in are described.	83%
6	Action steps describing what needs to be done to assist the person in achieving his/her goals or skills are described.	70%
7	The person's preferred **living** setting is identified.	80%
8	The person's preferred **work** activities are identified.	71%
ALL	Combined average of all 8 elements	67%

RESULTS:

The goal is **on track** to meet the 2026 goal of 95% compliance rate.

Table amounts are percentages

Time period	(1) Preferences	(2) Dreams Aspirations	(3) Choice	(4) Rituals Routines	(5) Social Activities	(6) Goals	(7) Living	(8) Work	Avg of all 8
Baseline (Apr – June 17)	74	17	79	62	83	70	80	71	67
FY 18 (July 17 – June 18)	81.3	31.3	92.5	59.8	92.4	81.3	96.3	89.6	78.1
FY 19 (July 18 – June 19)	91.8	58.4	97.9	59.8	96.0	95.3	98.7	99.0	87.1
FY 20 (July 19 – June 20)	91.1	77.2	98.9	77.1	98.8	97.0	99.1	98.7	92.2
FY 21 (July 20 – June 21)	96.1	75.9	99.6	72.8	99.2	99.6	99.4	99.7	92.8
FY 22 (July 21 – June 22)	94.6	85.0	99.9	82.9	100	99.9	100	100	95.3
FY 23 (July 22 – June 23)	96.4	89.8	100	90.3	99.8	99.7	99.9	99.8	96.3
FY 24 (July 23 – June 24)	97.4	83.1	100	85.6	100	99.7	100	100	95.7
FY 25 (July 24 – June 25)	98.4	86.6	100	95.3	99.9	98.8	100	100	97.4

ANALYSIS OF DATA:

From July 2024 – June 2025, of the 1,634 case files reviewed, the eight required elements were present in the percentage of files shown above. The combined average of the eight elements was 97.4%, a decrease of 1.7% from the previous year. Three of the eight elements achieved 100%. Three elements showed an increase and two showed a decrease in their level of compliant performance compared to the previous year. All but one element surpassed 95% compliance. The combined compliance rate is on track to meet the 2026 goal of 95%.

Total number of cases and sample of cases reviewed

Time Period	Total number of cases (disability waivers)	Sample of cases reviewed (disability waivers)
Fiscal Year 18 (July 2017 – June 2018)	12,192	1,243
Fiscal Year 19 (July 2018 – June 2019)	4,240	515
Fiscal Year 20 (July 2019 – June 2020)	18,992	1,245
Fiscal Year 21 (July 2020 – June 2021)	7,900	812
Fiscal Year 22 (July 2021 – June 2022)	7,004	953
Fiscal Year 23 (July 2022 – June 2023)	16,562	1,214
Fiscal Year 24 (July 23 – June 24)	2,397	307
Fiscal Year 25 (July 24 – June 25)	28,054	1,634

Lead Agencies Participating in the Audit [5]

Time period	Lead agencies
Fiscal Year 2018 (July 2017 – June 2018)	(19) Pennington, Winona, Roseau, Marshall, Kittson, Lake of the Woods, Stearns, McLeod, Kandiyohi, Dakota, Scott, Ramsey, Big Stone, Des Moines Valley Alliance, Kanabec, Nicollet, Rice, Sibley, Wilkin
Fiscal Year 2019 (July 2018 – June 2019)	(15) Brown, Carlton, Pine, Watonwan, Benton, Blue Earth, Le Sueur, Meeker, Swift, Faribault, Itasca, Martin, Mille Lacs, Red Lake, Wadena
Fiscal Year 2020 (July 2019 – June 2020)	(20) Mahnomen, Koochiching, Wabasha, Goodhue, Traverse, Douglas, Pope, Grant, Stevens, Isanti, Olmsted, St. Louis,

[5] Agency visits are sequenced in a specific order approved by Centers for Medicare and Medicaid Services (CMS)

Time period	Lead agencies
Fiscal Year 2018 (July 2017 – June 2018)	(19) Pennington, Winona, Roseau, Marshall, Kittson, Lake of the Woods, Stearns, McLeod, Kandiyohi, Dakota, Scott, Ramsey, Big Stone, Des Moines Valley Alliance, Kanabec, Nicollet, Rice, Sibley, Wilkin
	Hennepin, Carver, Wright, Crow Wing, Renville, Lac Qui Parle, Chippewa, Otter Tail
Fiscal Year 2021 (July 2020 - June 2021)	(11) Mower, Norman, Houston, Freeborn, Nobles, SWHHS Alliance (Lincoln, Lyon, Murray, Pipestone, Redwood, Rock), Washington, Fillmore, Anoka, Clearwater, Sherburne
Fiscal Year 2022 (July 2021 – June 2022)	(24) Chisago, Hubbard, Aitkin, Beltrami, Cook, Becker, Polk, Yellow Medicine, Clay, Lake, MN Prairie Alliance (Dodge, Steele, Waseca), Cass, Lake of the Woods, Stearns, Todd, Kittson, Marshall, McLeod, Morrison, Pennington, Roseau, Winona
Fiscal Year 2023 (July 2022 – June 2023)	(21) Kanabec, Kandiyohi, Ramsey, Rice, Scott, Big Stone, Nicollet, Sibley, Wilkin, Benton, DVHHS Alliance (Cottonwood and Jackson), Meeker, Pine, Swift, Dakota, Leech Lake Tribe, Le Sueur, Red Lake Nation, Watonwan, White Earth Nation
Fiscal Year 2024 (July 2023 – June 2024)	(6) Blue Earth, Brown, Carlton, Isanti, Koochiching, Itasca
Fiscal Year 2025 (July 2024 – June 2025)	(25) Red Lake County, Mahnomen, Goodhue, Wadena, Faribault & Martin Counties, Mille Lacs, Olmsted, Horizon Public Health (Grant, Pope, Traverse, Douglas, and Stevens), St. Louis, Freeborn, Wabasha, Mower, Carver, Renville, Crow Wing, Hennepin, Chisago, Norman, Wright, Ottertail

UNIVERSE NUMBER:

In fiscal year 2025 (July 2024 – June 2025), there were 78,108 individuals receiving disability waiver services.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it will be reported three months after the end of the reporting period.

POSITIVE SUPPORTS GOAL ONE

By June 30, 2025, the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) who

experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will not exceed 451. *(Updated in 2024)*

4. **Baseline**: From July 2013 – June 2014 of the 35,668 people receiving services in licensed disability services, e.g., home and community-based services, there were 8,602 BIRF reports of restrictive procedures, involving 1,076 unique individuals.

RESULTS:

The 2025 goal to not exceed 451 individuals receiving restrictive procedures was met.

Time period	Individuals who experienced restrictive procedure	Reduction from previous year
Baseline (July 2013 – June 2014)	1,076 (unduplicated)	N/A
2015 Annual (July 2014 – June 2015)	867 (unduplicated)	209
2016 Annual (July 2015 – June 2016)	761 (unduplicated)	106
2017 Annual (July 2016 – June 2017)	692 (unduplicated)	69
2018 Annual (July 2017 - June 2018)	644 (unduplicated)	48
2019 Annual (July 2018 - June 2019)	642 (unduplicated)	2
2020 Annual (July 2019 - June 2020)	561 (unduplicated)	81
2021 Annual (July 2020 - June 2021)	456 (unduplicated)	105
2022 Annual (July 2021 - June 2022)	388 (unduplicated)	68
2023 Annual (July 2022 - June 2023)	406 (unduplicated)	+18
2024 Annual (July 2023 – June 2024)	396 (unduplicated)	10
2025 Annual (July 2024 – June 2025)	380(unduplicated)	16

ANALYSIS OF DATA:

From July 2024 – June 2025, the total number of people who experienced a restrictive procedure was 380. This was a decrease of 16 from the previous year and a decrease of 696 from baseline. The 2025 goal not to exceed 451 is met.

There were 380 individuals who experienced a restrictive procedure:

- 347 individuals were subjected to Emergency Use of Manual Restraint (EUMR) only. This was a decrease of 21 people from the previous year.
- 33 individuals experienced restrictive procedures other than EUMRs (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). This was an increase of 5 from the previous year.

The External Program Review Committee conducted EUMR-related assistance involving 69 people during this reporting period. This does not include people who are receiving similar support from other DHS groups.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

POSITIVE SUPPORTS GOAL TWO

By June 30, 2025, the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community-based services) will not exceed 2,680. *(Updated in 2024)*

Baseline: From July 2013 – June 2014 of the 35,668 people receiving services in licensed disability services, e.g., home and community-based services, there were 8,602 BIRF reports of restrictive procedures, involving 1,076 unique individuals.

RESULTS:

The 2025 goal to not exceed 2,680 restrictive procedures was met.

Time period	Number of BIRF reports	Reduction from previous year
2014 Baseline (July 2013 – June 2014)	8,602	N/A
2015 Annual (July 2014 – June 2015)	5,124	3,478
2016 Annual (July 2015 – June 2016)	4,008	1,116
2017 Annual (July 2016 - June 2017)	3,583	425
2018 Annual (July 2017 - June 2018)	3,739	+156
2019 Annual (July 2018 - June 2019)	3,223	516
2020 Annual (July 2019 - June 2020)	3,126	97
2021 Annual (July 2020 - June 2021)	2,636	490
2022 Annual (July 2021 - June 2022)	1,800	836
2023 Annual (July 2022 – June 2023)	1,916	+116
2024 Annual (July 2023 – June 2024)	1,866	50
2025 Annual (July 2024 – June 2025)	1,739	127

ANALYSIS OF DATA:

From July 2024—June 2025, the number of restrictive procedure reports was 1739. That is a decrease of 127 from the previous year and a decrease of 6,863 from baseline. The 2025 goal not to exceed 2,680 reports was met.

There were 1739 reports of restrictive procedures this year. Of those reports:

- 1531 reports were for emergency use of manual restraint (EUMR). This is a decrease of 126 reports of EUMR from the previous year.
- 208 reports involved restrictive procedures other than EUMR (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). This is a decrease of 1 from the previous year.
- 28 uses of seclusion involving 10 or fewer people were reported this year. This is an increase of 9 reports from last year.
- There were 3 reports of penalty consequences reported this year. This was no change from the previous year.
- There was 1 report of timeout this year. This was a decrease in 2 reports from last year.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

POSITIVE SUPPORTS GOAL THREE

Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544[v], with limited exceptions to protect the person from imminent risk of serious injury. (Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and safety clips for safe vehicle transport).

- **By June 30, 2025, the emergency use of mechanical restraints, other than the use of an auxiliary device[6] will be reduced to no more than 88 reports.** *(Updated in 2024)*

Baseline: From July 2013 - June 2014, there were 2,038 BIRF reports of mechanical restraints involving 85 unique individuals. In SFY 2019, of the 658 reports of mechanical restraints, 336 were for use of auxiliary devices to ensure a person does not unfasten a seatbelt in a vehicle. The number of reports other than use of auxiliary devices were 322.

RESULTS:

The 2025 goal to not exceed 88 reports was not met.

Time period	Total number of reports (includes auxiliary devices)	Number of individuals at end of time period
2014 Baseline (July 2013 – June 2014)	2,083	85
2015 Annual (July 2014 – June 2015)	912	21
2016 Annual (July 2015 – June 2016)	691	13
2017 Annual (July 2016 – June 2017)	664	16
2018 Annual (July 2017 – June 2018)	671	13

[6] Auxiliary devices ensure a person does not unfasten a seat belt in a vehicle and includes seatbelt guards, harnesses, and clips.

Time period	Reports (other than seat belt devices)	Reports on use of auxiliary devices	Total number of reports (includes auxiliary devices)	Number of individuals at end of time period
2019 Annual Baseline (July 2018 – June 2019)	332	336	658	12
FY 2020 (July '19 – June '20)	273	257	530	10
FY 2021 (July '20 – June '21)	153	220	373	8
FY 2022 (July '21 – June '22)	138	120	258	6
FY 2023 (July '22 – June '23)	151	49	200	6
FY 2024 (July '23 – June '24)	133	51	184	10 or fewer
FY 2025 (July 2024 – June 2025)	124	52	176	10 or fewer

ANALYSIS OF DATA:

From July 2024 – June 2025, the number of reports of mechanical restraints other than auxiliary devices was 124. This was a decrease of 9 reports from the previous year. At the end of the reporting period, the number of individuals for whom the use of mechanical restraint use was approved was 10 or fewer people. During this year the total number of reports on mechanical restraints (including auxiliary devices), was 176. This is a decrease of 8 from the previous year. This is a decrease of 1907 reports from baseline.

The number of individuals who had approval from the commissioner to use restraints to protect against serious self-injury remained at 10 or fewer throughout the year so further detailed information and categorization of restraints cannot be provided.

Of the 176 BIRFs reporting use of mechanical restraint this year:

- 52 reports involved auxiliary devices to prevent a person from unbuckling their seatbelt during travel. Compared to the previous year, there was 1 increased use.
- 124 reports involved use of another type of mechanical restraint. This is a decrease of 9 reports from the previous year.

TIMELINESS OF DATA: In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

SEMI-ANNUAL AND ANNUAL GOALS

This section includes reports on the progress of measurable goals related to increasing capacity of the system and options for integration that are being reported semi-annually or annually. Each goal includes the overall goal, the annual goal, baseline, results for the reporting period, and analysis of data.

HOUSING AND SERVICES GOAL ONE

By June 30, 2026, the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing will increase by 3,797 (from 2021 through 2026). *(Updated in 2024)*

Baseline: In State Fiscal Year 2014, there were an estimated 38,079 people living in segregated settings. Over the last 10 years, 5,995 individuals with disabilities moved from segregated settings into integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing. From July 2014 – June 2020, an additional 5,388 individuals moved into integrated housing of their choice (an annual average of 898).

RESULTS:

The 2026 goal of 665 individuals moving into integrated housing is on track.

Time period	People in integrated housing	Increase from previous year	Increase over baseline	Percent change over baseline
2014 Baseline (July 2013 – June 2014)	5,995	--	--	--
2015 Annual (July 2014 – June 2015)	6,910	915	915	15.3
2016 Annual (July 2015 – June 2016)	7,605	695	1,610	26.8
2017 Annual (July 2016 – June 2017)	8,745	1,140	2,750	45.8
2018 Annual (July 2017 – June 2018)	9,869	1,263	3,852	64.2

Time period	People in integrated housing	Increase from previous year	Increase over baseline	Percent change over baseline
2019 Annual (July 2018 – June 2019)	10,251	382	4,256	70.4
2020 Annual (July 2019 – June 2020)	11,383	1,132	5,388	89.9
2021 Annual (July 2020 – June 2021)	12,478	1,095	6,483	108.1
2022 Annual (July 2021 – June 2022)	12,897	419	6,902	115.1
2023 Annual (July 2022 – June 2023)	13,735	838	7,740	129
2024 Annual (July 2023 – June 2024)	15,265	1,530	9,270	155
2025 Annual (July 2024 – June 2025)	16,588	1,323	10,593	177%

ANALYSIS OF DATA:

From July 2024 – June 2025 the number of people living in integrated housing increased by 1,323 from the previous year and an increase of 10,593 over the baseline. The 2025 goal to increase by 665 was met.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

EMPLOYMENT GOAL ONE

By September 30, 2025, the number of individuals[7] who are in competitive integrated employment as a result of receiving Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) will increase by 11,631 (from 2020 through 2025). *(Updated in 2024)*

Baseline: In 2014, Vocational Rehabilitation Services and State Services for the Blind helped 2,738 people with significant disabilities find competitive integrated employment. In 2019, VRS and SSB helped 2,670 people find competitive integrated employment.

RESULTS:

The 2025 goal to increase the number of individuals in competitive integrated employment by 11,631 from 2020 to 2025 was **met**.

Number of Individuals Achieving Employment Outcomes

Time period Federal Fiscal Year (FFY)	Vocational Rehabilitation Services (VRS)	State Services for the Blind (SSB)	Annual Total
2015 Annual (FFY 15) October 2014 – September 2015	3,104	132	3,236
2016 Annual (FFY 16) October 2015 – September 2016	3,115	133	3,248
2017 Annual (FFY 17) October 2016 – September 2017	2,713	94	2,807

[7] This includes individuals who were closed successfully from the Vocational Rehabilitation program. This is an unduplicated count of people working successfully in competitive, integrated jobs. These numbers are based on historical trends for annual successful employment outcomes.

Time period Federal Fiscal Year (FFY)	Vocational Rehabilitation Services (VRS)	State Services for the Blind (SSB)	Annual Total
2018 Annual (FFY 18) October 2017 – September 2018	2,577	105	2,682
Reset Baseline and Goals			
Baseline 2019 Annual (FFY 19) October 2018 – September 2019	2,578	92	2,670
2020 Annual (FFY 20) October 2019 – September 2020	2,005	66	2,071
2021 Annual (FFY 21) October 2020 – September 2021	1,591	69	1,660
2022 Annual (FFY 22) October 2021 – September 2022	1,925	81	2,006
2023 Annual (FFY 23) October 2022 – September 2023	1,856	75	1,931
2024 Annual (FFY 24) October 2023 – September 2024	1,991	57	2,048
2025 Annual (FFY 25) October 2024 – September 2025	1,986	82	2,068

ANALYSIS OF DATA:

Demographics of Individuals Achieving Employment Outcomes

In general, the racial and ethnic demographics of individuals achieving employment outcomes are similar to participants and the overall population of Minnesotans with disabilities. The percentage of individuals who identify as Hispanic/Latinx achieving employment outcomes has increased since 2022, while the percentage of individuals who identify as white achieving employment outcomes has decreased over the same period. Consistent with data from 2022 through 2024, nearly half of the individuals who found employment through SSB and VRS services in 2025 were under the age of 25. The age group with the largest increase in the share of employment outcomes achieved from 2022 to 2025 is the 31-40 age group, with an increase of 5 percentage points.

The tables below provide demographic information of the individuals achieving employment outcomes in this reporting period.

Percentage of All Individuals Achieving Employment Outcomes by Race/Ethnicity

Race/Ethnicity	2022 (FFY 23) Oct 2021 – Sept 2022	2023 (FFY 23) Oct 2022 – Sept 2023	2024 (FFY 24) Oct 2023 – Sept 2024	2025 (FFY 25) Oct 2024 – Sept 2025
More than 1 Race	4%	5%	4%	4%
American Indian/Native American	1%	2%	1%	2%
Asian/Pacific Islander	4%	3%	4%	3%
Black/African American	8%	7%	7%	8%
Did not report	1%	2%	2%	1%
Hispanic/Latinx	5%	7%	7%	8%
White	76%	74%	75%	74%

Age of Individuals Achieving Employment Outcomes by Age Group

Age Group	2022 (FFY 23)	2023 (FFY 23)	2024 (FFY 24)	2025 (FFY 25)

	Oct 2021 – Sept 2022	Oct 2022 – Sept 2023	Oct 2023 – Sept 2024	Oct 2024 – Sept 2025
18 and under	25%	25%	24%	24%
19-24	23%	22%	22%	21%
25-30	11%	11%	11%	11%
31-40	12%	14%	17%	17%
41-50	12%	13%	11%	12%
51-60	13%	11%	11%	11%
61 and older	4%	4%	4%	4%

Additional information

The Workforce Innovation and Opportunity Act (WIOA) impact on Vocational Rehabilitation Services

The Workforce Innovation and Opportunity Act (WIOA) has significantly broadened the scope of services that VRS is required to provide to people with disabilities. Two categories of service required by WIOA have the greatest impact on VRS administered programs: Pre-Employment Transition Services (Pre-ETS) and Limitations on the Use of Subminimum Wage (WIOA Section 511).

Pre-Employment Transition Services (Pre-ETS)

WIOA requires VRS to have Pre-ETS available statewide to all students with disabilities, ages 14 through 21. The five required Pre-Employment Transition Services are: (1) job exploration counseling; (2) work-based learning experiences; (3) post-secondary education counseling; (4) workplace readiness experiences; and (5) instruction in self-advocacy.

In the 2024-2025 school year, this statewide mandate for services covers more than 48,681 students, ages 14 through 21 in Minnesota who are eligible for and receiving special education and related services based on information from the Minnesota Automated Reporting Student System (MARSS) and reported by the Minnesota Department of Education.

From October 1, 2024 to September 30, 2025 a total of 4,810 students received VRS Pre-Employment Transition Services. About $3.1 million in pre-ETS services were provided through community providers. VR staff provided 10,305 services to 4,264 students.

In comparison, from October 1, 2020 to September 30, 2021 a total of 3,394 students received VRS Pre-Employment Transition Services. About $3.1 million in pre-ETS services were provided through community providers and VR staff provided over 6,000 services to 3,063 students.

From October 1, 2019 to September 30, 2020 a total of 3,270 students received VRS Pre-Employment Transition Services. It's important to note that many students received more than just one of the required services.

Limitations on the Use of Subminimum Wage (WIOA Section 511)

Section 511 of WIOA addresses the subject of subminimum wage jobs, usually in segregated work settings such as sheltered workshops.

In September 2022, VRS learned that their proposal for a Disability Innovation Fund (DIF) grant from the U.S. Department of Education was successful. The five-year $13 million DIF grant award, named Go MN!, affords an opportunity for Minnesota to move the dial on opportunities for persons with disabilities who currently earn, or are contemplating, subminimum wages. To date, 46 adults and 130 youth have enrolled in Go MN!

Young people who historically have been placed into subminimum wage employment – typically youth with developmental disabilities – are required to apply for VRS before they can be hired into a job that pays less than minimum wage. As a result, the number of youth with developmental disabilities referred to VRS increased significantly when WIOA Section 511 took effect in July 2016. In Federal Fiscal Year 2022, the number of youth referred increased to near pre-COVID-19 pandemic levels. Nearly half of youth referred have a developmental disability.

Youth Aged 24 and Younger Referred for VR Services by Federal Fiscal Year (FFY)

FFY	All Youth Referrals	Youth with Autism	Youth with Intellectual Disabilities	Total	% of Total Referrals for Youth with DD
2015	2,833	581	367	948	33.5%
2016	3,064	680	517	1,197	39.1%
2017	3,425	873	826	1,699	49.6%
2018	3,192	888	594	1,482	46.4%
2019	3,029	852	543	1,395	46.1%
2020	2,465	732	411	1,143	46.4%

2021	2,261	712	398	1,110	49.1%
2022	2,755	883	492	1,375	49.9%
2023	2,797	894	461	1,355	48.4%
2024	3,334	1,027	462	1,489	44.7%
2025	2,671	781	391	1,172	43.9%

Adults currently working in jobs below the federal minimum wage in segregated settings must receive career counseling, information, and referral services, and discuss opportunities to pursue competitive, integrated employment in the community. These services are to be offered at six-month intervals during the first year and annually thereafter. Minnesota's eight Centers for Independent Living (CILs) are the VRS designated representatives to provide the initial career counseling and information and referral (CC&I&R) services to adults working at minimum wage for 14(c) employers.

CIL staff provide career counseling and information and referral services to adults working at sub-minimum wage, as listed in the table below. Due to the pandemic, many individuals were not working due to 14 (c) employers closing. This had a significant impact on the CILs being able to conduct CCI&R interviews with individuals. CCI&R conversations were held virtually starting in March 2020 in order to continue the work during the COVID-19 pandemic. The decline in individuals participating in the CCI&R conversations is due primarily to providers moving away from offering subminimum wage.

Career Counseling and Information and Referral Services (CC&I&R)

Time Period	Participants in CC&I&R	Number Interested in CIE	Percent Interested in CIE
Year 1 (July 23, 2016 – July 22, 2017)	11,991	2,010	17%
Year 2 (July 23, 2017 – July 22, 2018)	10,237	1,452	14%
Year 3 (July 23, 2018 – July 22, 2019)	9,901	1,635	17%
Year 4 (July 23, 2019 – July 22, 2020)	8,265	999	12%
Year 5 (July 23, 2020 – July 22, 2021)	5,716	562	10%
Year 6 (July 23, 2021 – July 22, 2022)	4,800	521	11%
Year 7 (July 23, 2022 – July 22, 2023)	4,500	609	14%
Year 8 (July 23, 2023 – July 22, 2024)	3,445	445	13%

Year 9 (July 23, 2024 – July 22, 2025)	3,331	576	17%

WIOA impact on State Services for the Blind (SSB)

WIOA has significantly broadened the scope of services that SSB is required to provide to people with disabilities. Pre-Employment Transition Services, as required by WIOA, continues to have the greatest impact on SSB administered programs. WIOA requires SSB to have Pre-ETS available statewide to all students with disabilities, ages 14 through 21. The five required Pre-Employment Transition Services are: (1) job exploration counseling; (2) work-based learning experiences; (3) post-secondary education counseling; (4) workplace readiness experiences; and (5) instruction in self-advocacy.

SSB considers a student with a disability to be between the ages of 14 and 21; is in an educational program; and is eligible for and receiving special education or related services under Individuals with Disabilities Education Act or is an individual with a disability for purposes of section 504 of the act.

MDE has indicated in their "Unduplicated Child Count" report that there are approximately 212 students in secondary education who are blind, visually impaired, or DeafBlind. This number only includes those students whose primary disability is blindness or DeafBlindness. Additionally, we serve some Pre-ETS students enrolled in post-secondary options. Based on our current numbers, we estimate there to be 45 additional students in post-secondary, for a total of 257 students, 198 of whom are connected to SSB.

MDE can provide SSB information about the 212 students except for their names. The report includes the school district and contact information for the district special education director. The SSB Pre-ETS Transition Coordinator reaches out by email to ask the special education directors to share information with the students about SSB and our services. Historically, we have found teachers to be the critical linking point for students accessing SSB services and have high expectations for success with this effort. Based on this year's numbers, there are 62 students in secondary education who are not yet receiving services from SSB.

SSB has a small student population but is required to spend approximately 1.65 million dollars on Pre-ETS this Federal Fiscal Year. A concerted effort is made to provide outreach to every student statewide. SSB's Pre-ETS Blueprint lays out the yearly plan to provide those services.

For the time period of this report (October 1, 2024 through September 30, 2025) a total of 193 students received Pre-ETS. It's important to note that some students received more than just one of the five required services.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

EMPLOYMENT GOAL TWO

By June 30, 2026, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 8,283 over baseline to 14,420 in competitive integrated employment. *(Updated in 2024)*

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

RESULTS:

The goal is **not on track** to meet the 2026 goal to increase the number of individuals in competitive integrated employment by 8,283 over baseline.

MA Recipients (18 -64) in Competitive Integrated Employment (CIE)

Time period	Total MA recipients	Number in CIE ($600+/month)	Percent of MA recipients in CIE	Change from previous year	Increase over baseline
Baseline (July 2013 – June 2014)	50,157	6,137	12.2%	--	--
July 2014 – June 2015	49,922	6,596	13.2%	459	459
2017 Annual Goal (July 2015 – June 2016)	52,383	8,203	15.7%	1,607	2,066
2018 Annual Goal (July 2016 – June 2017)	54,923	9,017	16.4%	814	2,880
2019 Annual Goal (July 2017 – June 2018)	58,711	9,751	16.6%	734	3,614
2020 Annual Goal (July 2018 – June 2019)	57,640	10,420	18.1%	669	4,283
2021 Annual (July 2019 – June 2020)	59,080	10,488	17.8%	68	4,351
2022 Annual	58,513	8,851	15.1%	<1,637>	2,714

Time period	Total MA recipients	Number in CIE ($600+/month)	Percent of MA recipients in CIE	Change from previous year	Increase over baseline
(July 2020 – June 2021)					
2023 Annual (July 2021 – June 2022)	60,303	10,141	16.8%	1,290	4,004
2024 (July 2022 – June 2023)	62,413	10,922	17.5%	781	4,785
2025 (July 2023 – June 2024)	67,067	12,901	19.2%	1,979	6,764
2026 (July 2024 – June 2025)	68,818	12,848	18.7%	<53>	6,711

ANALYSIS OF DATA:

During July 2023 – June 2024 there were 12,901 people in competitive integrated employment earning at least $600 a month. This is an increase of 1979 from the previous year and 6,764 above baseline. The goal is not on track to increase by 8,283 over baseline to 14,420 by 2026.

From July 2024 – June 2025 there were 12,848 people in competitive integrated employment earning at least $600 a month. This is a decrease of 53 from the previous year and 6,711 above baseline. The goal is not on track to increase by 8,283 over baseline to 14,420 by 2026.

The data reported is a proxy measure to track the number of individuals in competitive integrated employment from certain Medicaid programs and includes the number of people who have monthly earnings of over $600 a month. This is calculated by dividing the annual earnings of an individual (as reported by financial eligibility workers during re-qualification for Medicaid) by the number of months they have worked in a given fiscal year.

During development of the employment data dashboard in 2015, DHS tested the use of $600 a month as a proxy measure for competitive integrated employment. This was done by reviewing a random sample of files across the state. DHS staff verified that information from the data system matched county files and determined that when people were working and making $600 or more, the likelihood was they were in competitive integrated employment.

Following 2023 legislation, DHS now has, for the first time, a list of all people who are paid subminimum wages in Minnesota. DHS will be retiring the proxy measure and will update reporting measures, dashboards, etc. to reflect the actual number of people paid subminimum wages, which will in turn provide more accurate data on those who have competitive integrated employment.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported twelve months after the end of the reporting period.

LIFELONG LEARNING AND EDUCATION GOAL ONE

By March 1, 2025, the percent of students with disabilities[vi], receiving instruction in the general education setting, will increase to 64%. *(Updated in 2024)*

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

RESULTS:

The goal is **on track** to meet the 2025 goal to increase the percent of students with disabilities receiving instruction in the general education setting to 64%.

Time Period	Total number of students with disabilities (ages 6 – 21)	Number of students with disabilities in most integrated setting	Percent of students with disabilities in most integrated setting
Baseline (Jan – Dec 2013)	109,332	67,917	62.11%
January – December 2014 (Dec 2014 Child Count)	110,141	68,434	62.13%
January – December 2015 (Dec 2015 Child Count)	112,375	69,749	62.07%
January – December 2016 (Dec 2016 Child Count)	115,279	71,810	62.29%
January – December 2017 (Dec 2017 Child Count)	118,800	74,274	62.52%
January – December 2018 (Dec 2018 Child Count)	123,101	77,291	62.79%
January – December 2019 (Dec 2019 Child Count)	126,693	79,595	62.83%

Time Period	Total number of students with disabilities (ages 6 – 21)	Number of students with disabilities in most integrated setting	Percent of students with disabilities in most integrated setting
January – December 2020 (Dec 2020 Child Count)	127,314	80,688	63.38%
January – December 2021 (Dec 2021 Child Count)	128,980	82,476	63.94%
January – December 2022 (Dec 2022 Child Count)	133,048	85,186	64.03%
January – December 2023 (Dec 2023 Child Count)	138,304	89,093	64.42%
January – December 2024 (Dec 2024 Child Count)	143,375	92,048	64.2%

ANALYSIS OF DATA:

The overall goal to increase the percentage of students with disabilities receiving instruction in the most integrated setting to 64% was met. The goal was met even with a 31% increase in the number of students with disabilities served in Minnesota public schools since the baseline year (2013), and especially including significant increases in the number of students with Autism Spectrum Disorders, the fastest growing category of special education eligibility in Minnesota (80.1% increase from 2015 to 2025).

During 2024, the number of students with disabilities receiving instruction in the most integrated setting was 2.09% over baseline at 64.20%. While this was a decrease of 0.22% from the previous year, it was also an increase of 2,955 students from the previous year. Under federal law IDEA Section 1414 and Minnesota Statute §125A.08, the extent to which a student can be included in the least restrictive environment is determined by their individualized education program team, including parents, as well as the student when possible. The goal will continue to be reported without a target. Progress on this goal will continue to be reported as in process.

Beginning in 2021, additional data is provided to the Olmstead Subcabinet by student race and ethnicity. This information includes the percentage of students with disabilities within seven racial or ethnic groups receiving education in the most integrated setting. MDE uses the most recent publicly available published by the Office of Special Education Programs (OSEP).

Percentage of Students with Disabilities Receiving Education in the Most Integrated Setting by Racial or Ethnic Group

Racial or Ethnic Group	2019	2020	2021	2022	2023
American Indian or Alaskan Native	59.44%	59.71%	59.20%	58.87%	59.03%
Asian or Pacific Islander	61.05%	62.46%	60.83%	59.42%	58.76%
Black or African American	43.95%	45.24%	45.88%	44.82%	44.89%
Hispanic or Latino	58.67%	59.73%	59.88%	59.50%	59.86%
Native Hawaiian or Other Pacific Islander	50.52%	52.73%	54.92%	51.97%	54.29%
Two or More Races	60.18%	61.65%	61.83%	61.29%	61.27%
White	65.36%	66.36%	66.92%	67.57%	68.30%

*IDEA Section 618 Data Products

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one year after the end of the reporting period.

TRANSPORTATION GOAL ONE

By December 31, 2023, accessibility improvements will be made to (A) 10,299 curb ramps (increase from base of 19% to 79%); (B) 490 Accessible Pedestrian Signals (increase from base of 10% to 79%). (C) By December 31, 2023, improvements will made to 113 miles of sidewalks

A) Curb Ramps

By December 31, 2023, accessibility improvements will be made to 10,299 curb ramps bringing the percentage of compliant ramps to approximately 79%.

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

RESULTS:

This goal expired in a prior year and continues to be monitored and reported.

Time Period	Curb Ramp Improvements	Total curb ramp Improvements	PROW Compliance Rate
Baseline - Calendar Year 2012	--		19%
Calendar Year 2014	1,139	1,139	24.5%
Calendar Year 2015	1,594	2,733	28.5%
Calendar Year 2016	1,015	3,748	35.0%
Calendar Year 2017	1,658	5,406	42.0%
Calendar Year 2018	1,188	6,594	51.7%
Calendar Year 2019	358	6,952	52.2%
Calendar Year 2020	327	7,279	57.0%
Calendar Year 2021	509	7,788	61.0%
Calendar Year 2022	1,100	8,888	45.6%
Calendar Year 2023	1,200	10,088	41%

Time Period	Curb Ramp Improvements	Total curb ramp Improvements	PROW Compliance Rate
Calendar Year 2024	1,100	11,188	46%

ANALYSIS OF DATA:

In 2024, the total number of curb ramps improved was 1,400, bringing the total improvements to 11,188 and a 46% compliance under PROW. The goal of 10,299 has been met. From 2020 – 2022 MnDOT conducted a reassessment of the baseline for ADA assets which includes assets not been previously counted in the baseline. This resulted in the decrease in the PROW compliance rate.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one year after the end of the reporting period.

B) Accessible Pedestrian Signals

2023 Goal:

- By December 31, 2023, an additional 490 Accessible Pedestrian Signals (APS) installations will be provided on MnDOT owned and operated signals bringing the number to 935 and the percentage to 79%.

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

RESULTS:

This goal expired in a prior year and continues to be monitored and reported.

Time Period	Total APS in place	Increase over previous year	Increase over baseline
Baseline Calendar Year 2009	118 of 1,179 APS (10% of system)	N/A	N/A
Calendar Year 2014	454 of 1,179 APS (38% of system)	40	336
Calendar Year 2015	523 of 1,179 APS (44% of system)	69	405
Calendar Year 2016	595 of 1,179 APS (50% of system)	72	477
Calendar Year 2017	695 of 1,179 APS (59% of system)	100	577
Calendar Year 2018	770 of 1,179 APS (65% of system)	86	652
Calendar Year 2019	824 of 1,179 APS (70% of system)	43	706
Calendar Year 2020	840 of 1,179 APS (71% of system)	16	722
Calendar Year 2021	892 of 1,179 APS (76% of system)	52	774
Calendar Year 2022	905 of 1,179 APS (76% of system)	13	787
Calendar Year 2023	920 of 1,179 APS (78% of system)	15	802
Calendar Year 2024	972 of 1174 APS (82% of system)	52	854
Calendar Year 2025	987 of 1,174 APS (84% of system)	15	864

ANALYSIS OF DATA:

In Calendar Year 2025, MnDOT constructed 15 signals with APS, bringing the number of APS signals to 987 and the percentage to 84% of the system. Using Calendar Yer 2025 data, the 2023 goal to bring the number of APS to 935 (79% of system) was met and exceeded.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one year after the end of the reporting period.

(C) Sidewalks

5. By December 31, 2023, improvements will be made to an additional 113 miles of sidewalks bringing total system compliance to 64%.

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

RESULTS:

This goal expired in a prior year and continues to be monitored and reported.

Time Period	Sidewalk Improvements	Cumulative sidewalk improvements	PROW Compliance Rate
Baseline - Calendar Year 2012	N/A		46%
Calendar Year 2015	12.41 miles	12.41 miles	47.3%
Calendar Year 2016	18.80 miles	31.21 miles	49%
Calendar Year 2017	28.34 miles	59.55 miles	56%
Calendar Year 2018	33.24 miles	92.79 miles	60%
Calendar Year 2019	5.6 miles	98.3 miles	62%
Calendar Year 2020	11.5 miles	109.8 miles	63%
Calendar Year 2021	17.57 miles	127.37 miles	66%
Calendar Year 2022	12 miles	139.37 miles	56%
Calendar Year 2023	15 miles	154.37 miles	54%
Calendar Year 2024	17 miles	171.37 miles	58%

ANALYSIS OF DATA:

In Calendar Year 2023, improvements were made to an additional 15 miles of sidewalks. This brings the PROW compliance rate to 54%. From 2020 – 2022 MnDOT conducted a reassessment of the baseline for ADA assets which includes assets not been previously counted in the baseline. This resulted in the decrease in the PROW compliance rate.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one year after the end of the reporting period.

TRANSPORTATION GOAL TWO

By 2026, the annual number of service hours will increase to 1.71 million in Greater Minnesota (approximately 50% increase).

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

RESULTS:

The goal is not on track to meet the 2026 target.

Time Period	Service Hours	Change from baseline
Baseline – Calendar Year 2014	1,200,000	N/A
Calendar Year 2015	1,218,787	18,787
Calendar Year 2016	1,418,908	218,908
Calendar Year 2017	1,369,316	169,316
Calendar Year 2018	1,442,652	242,652
Calendar Year 2019	1,451,000	251,000
Calendar Year 2020	1,164,758	<35,242>
Calendar Year 2021	1,283,546	83,546
Calendar Year 2022	1,289,576	89,576
Calendar Year 2023	1,334,241	134,241
Calendar Year 2024	1,355,618	155,618
Calendar Year 2025	1,379,752	179,752

ANALYSIS OF DATA:

We are continuing to see growth with hours being added and exceeding the goal, but we have not returned to pre pandemic levels.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one year after the end of the reporting period.

TRANSPORTATION GOAL THREE

By 2026, expand transit coverage so that 90% of the public transportation service areas in Minnesota will meet minimum service guidelines for access. *(Updated in 2024)*

Greater Minnesota transit access is measured against industry recognized standards for the minimal level of transit availability needed by population size. Availability is tracked as span of service, which is the number of hours during the day when transit service is available in a particular area. The measure is based on industry recognized standards and is incorporated into both the Metropolitan Council Transportation Policy Plan and the MnDOT "Greater Minnesota Transit Investment Plan."[8]

BASELINE:

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

RESULTS:

This goal is **in process** as it is too early to determine progress towards the 2026 target.

Percentage of public transportation meeting minimum service guidelines for access

	Weekday	Saturday	Sunday
2016 Baseline	47%	12%	3%
2017	47%	16%	5%
2018	53.3%	13.3%	8.5%
2019	53.3%	16%	8%
2020	62.5%	23.3%	18.8%
2021	72.2%	20.0%	22.9%
2022	76.9%	29.2%	13.7%
2023	73.8%	28.5%	13.7%

[8] Greater Minnesota Transit Investment Plan is available at http://minnesotago.org/index.php?cID=435.

	Weekday	Saturday	Sunday
2024	80%	26.2%	13.7%

ANALYSIS OF DATA:

An increase of 6.2% has occurred in weekday services as driver shortages have diminished and increased service. Saturday service has had a minimal decline due to staffing and reallocating resources. Sunday service remains unchanged from the previous reporting period.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported seven months after the end of the reporting period.

TRANSPORTATION GOAL FOUR

6. By December 31, 2025, transit systems' on-time performance will be 90% or greater statewide.

(A) Metro Transit System

Ten-year goals to improve on-time performance:

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

Baseline for on-time performance in 2014 was:

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

RESULTS:

The 2025 goal to have on-time performance at 90% or greater was not met.

On time performance percentage by transit system[9]

Time Period	Transit Link	Metro Mobility	Metro Transit[10]
Baseline - Calendar Year 2014	97%	96.3%	86%
Calendar Year 2016	98%	95.3%	85.1%
Calendar Year 2017	98.5%	96.8%	86.4%
Calendar Year 2018	98%	95.3%	84.8%
Calendar Year 2019	97%	93.0%	82.7%
Calendar Year 2020	96%	96.4%	87.8%
Calendar Year 2021	98%	94.8%	84.8%
Calendar Year 2022	99%	91.9%	81.3%
Calendar Year 2023	99%	90.1%	78.8%
Calendar Year 2024	98.4%	91.8%	77.9%
Calendar Year 2025	98.1%	93.6%	78.6%

ANALYSIS OF DATA:

During 2025 of the three measures, two measures did not meet the performance standards, and the goal was not met. During 2024, the on-time performances for Transit Link of 98.4% is above the 95% goal. The Metro Transit system is made up of three types of services: bus, light rail (Blue and Green lines) and the Northstar commuter rail. The on-time performance for each service type is shown below.

[9] Beginning in 2017, on-time performance for the Metro Transit system was defined as up to 1 minute early and 5 minutes late (-1/+5 minutes). This is the preferred methodology when on-time performance is reported for the entire system. The 2016 results were updated to use the same methodology.

[10] Metro transit (weighted) represents on-time performance for the Metro transit modes combined. The percentage is weighted based on ridership and is not an average of the three modes.

On-time performance percentage for Metro Transit system

Time Period	Bus	Light Rail (Blue/Green line)	Northstar Commuter Rail	Metro Transit System[11]
Baseline - Calendar Year 2014	--	--	--	86%
Calendar Year 2016	85.8%	82.9%	93.2%	85.1%
Calendar Year 2017	85.1%	89.5%	93.2%	86.4%
Calendar Year 2018	83.7%	86.7%	94.7%	84.8%
Calendar Year 2019	82.2%	83.4%	93.3%	82.7%
Calendar Year 2020	87.5%	88.3%	96.8%	87.8%
Calendar Year 2021	86.2%	81.7%	95.3%	84.8%
Calendar Year 2022	84.0%	75.4%	94.8%	81.3%
Calendar Year 2023	81.2%	74.1%	94.1%	78.8%
Calendar Year 2024	79.0%	75.5%	93.2%	77.9%
Calendar Year 2025	78.2%	79.7%	95.7%	78.6%

TIMELINESS OF DATA:

In order for this data to be reliable and valid, the data is reported three months after collection.

[11] Metro transit (weighted) represents on-time performance for the Metro transit modes combined. The percentage is weighted based on ridership and is not an average of the three modes.

A) Greater Minnesota Transit

Ten-year goals to improve on time performance:

- Greater Minnesota – improve to a 90% within a 45-minute timeframe.

Baseline for on time performance in 2014 was:

- Greater Minnesota – 76% within a 45-minute timeframe.

RESULTS:

The goal is **on track** to meet the 2025 goal to improve Greater Minnesota transit system on time performance to 90% or greater.

Greater Minnesota on-time performance percentage

Time Period	On-Time Performance (Within a 45-Minute Timeframe)
Baseline - Calendar Year 2014	76%
Calendar Year 2016	76%
Calendar Year 2017	78%
Calendar Year 2018	Not available
Calendar Year 2019	Not available
January – February 2020*	91.3%
July – December 2020	92.6%
January – June 2021	95.1%
July – December 2021	95.3%
January – June 2022	94%
July – December 2022	90%
January – June 2023	92%
July – December 2023	89.4%

Time Period	On-Time Performance (Within a 45-Minute Timeframe)
January – June 2024	94%
July – December 2024	90%
January – June 2025	90%
July – December 2025	88%

*A new data collection methodology began in January of 2020 with providers reporting monthly. However, due to the COVID-19 pandemic, shifts in funding sources and reporting requirements, reporting was put on hold. Reporting resumed in July 2020.

ANALYSIS OF DATA:

The data is consistent with the performance of previous years. Change in performance will likely be static until there are enough drivers available for transit providers.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported two months after it is collected.

TRANSPORTATION GOAL FIVE

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

2025 Goal

By 2025, the percentage of target population served by regular route level of service for each market area will be:

- Market Area 1 will be 100%
- Market Area 2 will be 95%
- Market Area 3 will be 70%

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

RESULTS:

This goal expired in a prior year and was still monitored and reported in 2026.

Percent of target population served by regular route service per Market Area

Time Period	Transit Market Area 1	Transit Market Area 2	Transit Market Area 3
Baseline (June 2017)	95%	91%	67%
As of March 2019	94%	93%	70%
As of March 2020	98%	94%	72%
As of March 2021	93%	92%	69%
As of March 2022	92%	87%	69%
As of March 2023	93%	96%	80%
As of March 2024	93%	97%	76%
As of March 2025	85%	85%	69%
As of March 2026	92%	89%	71%

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

ANALYSIS OF DATA:

New data is based on March 2025 and March 2026 service levels combined with most recent available population data as well as updates to the Transit Market Areas made as part of the Imagine 2050 plan, adopted by the Met Council in February, 2025. The percent of population covered by the Market Area service levels appears to drop due to the updates in the extent of Transit Market Areas 1, 2 and 3 included in Imagine 2050. However, the geographic area coverage stayed relatively flat from 2024 with service frequency improved on some routes not reflected in this measure. Metro Transit began implementing the *Network Now* plan in 2025 and 2026; which lead to the increase of coverage meeting service levels for Transit Market Areas 1, 2, and 3.

TIMELINESS OF DATA:

Data will be collected in January of each year. In order for this data to be reliable and valid, it will be reported four months after the end of the reporting period.

HEALTH CARE AND HEALTHY LIVING GOAL ONE

By December 31, 2025, the rate of adult public enrollees (with disabilities) who had an acute inpatient hospital stay that was followed by an unplanned acute readmission to a hospital within 30 days will be 20% or less. *(Updated in 2024)*

Baseline: In Calendar Year 2014, of the 28,773 adults with disabilities with an acute inpatient hospital stay, 5,887 (20.46%) had an unplanned acute readmission within 30 days. During the same time period, of the 3,735 adults without disabilities with an acute inpatient hospital stay, 295 (7.90%) had an unplanned acute readmission within 30 days.

RESULTS:

The 2025 goal to reduce to 20% or less readmission rate of adults with disabilities is not on track.

Adults with disabilities

Time period	Acute inpatient hospital stay	Unplanned acute readmission within 30 days	Readmission rate
January – December 2014 (Baseline)	28,773	5,887	20.5%
January – December 2015	31,628	6,369	20.1%
January – December 2016	25,294	5,142	20.3%
January – December 2017	26,126	5,053	19.3%
January – December 2018	30,896	6,376	20.6%
January – December 2019	31,965	6,654	20.8%
January – December 2020	27,857	4,929	17.7%
January – December 2021	37,319	7,664	20.5%
January – December 2022	33,810	6,883	20.4%
January – December 2023	35,599	7,332	20.6%
January – December 2024	32,934	6,873	20.87%

ANALYSIS OF DATA:

From January – December 2024, of the 32,934 acute inpatient hospital stays for adults with disabilities, 6,873 individuals had an unplanned acute readmission within 30 days, for a rate of 20.8%. The goal is above baseline and is not on track to meet the 2025 goal of a 20% readmission rate of adults with disabilities.

During the same time period, of the 5,087 acute inpatient hospital stays for adults without disabilities, 343 individuals had unplanned acute readmission, for a rate of 6.7%.

For further analysis the tables below provide the information separated into three categories: adults with disabilities with serious mental illness; adults with disabilities without serious mental illness; and adults without disabilities.

Adults with disabilities with serious mental illness (SMI)

Time period	Acute inpatient hospital stay	Unplanned acute readmission within 30 days	Readmission rate
January – December 2014	14,796	3,107	21.0%
January – December 2015	16,511	3,438	20.8%
January – December 2016	12,701	2,673	21.1%
January – December 2017	12,659	2,504	19.8%
January – December 2018	15,353	3,156	20.6%
January – December 2019	16,211	3,358	20.7%
January – December 2020	15,240	3,027	19.9%
January – December 2021	19,465	3,996	20.5%
January – December 2022	17,995	3,566	19.8%
January – December 2023	19,042	3,661	19.2%
January – December 2024	17,173	3,445	20.06%

Adults with disabilities without serious mental illness (SMI)

Time period	Acute inpatient hospital stay	Unplanned acute readmission within 30 days	Readmission rate
January – December 2014	13,977	2,780	19.9%
January – December 2015	15,117	2,931	19.4%
January – December 2016	12,593	2,469	19.6%
January – December 2017	13,467	2,549	18.9%
January – December 2018	15,543	3,220	20.7%
January – December 2019	15,754	3,296	20.9%
January – December 2020	9,617	1,902	19.8%
January – December 2021	17,854	3,668	20.5%
January – December 2022	15,815	3,317	21.0%
January – December 2023	16,557	3,671	22.2%
January – December 2024	15,761	3,428	21.75%

Adults without disabilities

Time period	Acute inpatient hospital stay	Unplanned acute readmission within 30 days	Readmission rate
January – December 2014	3,735	295	7.9%
January – December 2015	5,351	386	7.2%
January – December 2016	2,522	159	6.3%
January – December 2017	3,109	239	7.7%
January – December 2018	4,469	311	7.0%
January – December 2019	4,885	734	6.4%
January – December 2020	10,318	1,620	15.7%
January – December 2021	7,905	596	7.2%
January – December 2022	7,147	524	7.3%
January – December 2023	8,372	620	7.4%
January – December 2024	5,087	343	6.74%

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it will be reported 8 months after the end of the reporting period.

HEALTH CARE AND HEALTHY LIVING GOAL TWO

By December 31, 2025, the rate of enrollees with disabilities who used an emergency department for non-traumatic dental services will be (A) 0.20% or less for children with disabilities and (B) 1% or less for adults with disabilities. *(Updated in 2024)*

A) CHILDREN USING EMERGENCY DEPARTMENT FOR DENTAL SERVICES

Baseline: In Calendar year 2014, of the 75,774 children with disabilities, 314 (0.41%) used an emergency department for non-traumatic dental services. During the same timeframe, of the 468,631 children without disabilities, 1,216 (0.26%) used an emergency department for non-traumatic dental services.

2025 Goal

- By December 31, 2025, the rate for children with disabilities using an ED for non-traumatic dental services will be 0.20% or less

RESULTS:

The 2025 goal to reduce to a 0.20% rate of children with disabilities using an ED for dental care is not on track.

Time period	Total number of children with disabilities	Number of children with ED visit for non-traumatic dental care	Rate of children using ED for dental care
January – December 2014 (Baseline)	75,774	314	0.41%
January – December 2015	81,954	330	0.40%
January – December 2016	84,141	324	0.38%
January – December 2017	87,724	185	0.21%
January – December 2018	91,126	188	0.21%
January – December 2019	93,701	199	0.21%
January – December 2020	88,748	174	0.20%
January – December 2021	93,796	198	0.21%
January – December 2022	99,132	232	0.23%
January – December 2023	106,166	258	0.24%
January – December 2024	108,586	284	0.26%

ANALYSIS OF DATA:

During January – December 2024, of the 108,586 children with disabilities, the number with emergency department visits for non-traumatic dental care was 284 (0.26%). The goal is not on track to meet the 2025 goal to reduce to 0.20% or less.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it will be reported 8 months after the end of the reporting period.

B) ADULTS USING EMERGENCY DEPARTMENT FOR DENTAL SERVICES

Baseline: In Calendar year 2014, of the 166,852 adults with disabilities, 3,884 (2.33%) used an emergency department for non-traumatic dental services. During the same timeframe, of the 377,482 adults without disabilities, 6,594 (1.75%) used an emergency department for non-traumatic dental services.

2025 Goal

- By December 31, 2025, the rate for adults with disabilities using an ED for non-traumatic dental services will be 1.0% or less

RESULTS:

The 2025 goal to reduce to a 1.0% rate of adults with disabilities using an ED for dental care was not met

Time period	Total number of adults with disabilities	Number of adults with ED visit for non-traumatic dental care	Rate of adults using ED for dental care
January – December 2014 (Baseline)	166,852	3,884	2.33%
January – December 2015	174,215	4,233	2.43%
January – December 2016	185,701	4,110	2.21%
January – December 2017	187,750	2,685	1.43%
January – December 2018	191,650	2,455	1.28%
January – December 2019	192,352	2,415	1.26%
January – December 2020	164,096	1,725	1.05%
January – December 2021	201,933	2,231	1.10%
January – December 2022	213,993	2,334	1.09%
January – December 2023	226,693	2,539	1.12%
January – December 2024	226,620	2,642	1.17%

ANALYSIS OF DATA:

During January – December 2024, of the 226,620 adults with disabilities, the number with emergency department visits for non-traumatic dental care was 2,642 (1.17%). If progress continues at the same pace, the goal is not on track to meet the 2025 goal to reduce to 1.0% or less.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it will be reported 8 months after the end of the reporting period.

POSITIVE SUPPORTS GOAL FOUR

By June 30, 2025, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 882 students or decrease to 1.8% of the total number of students receiving special education services. *(Updated in 2024)*

Baseline: During school year 2018-2019, school districts (which include charter schools and intermediate districts) reported to MDE that 3,603 students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting. In 2018-2019, the number of reported students receiving special education services was 147,605 students. Accordingly, during school year 2018-2019, 2.4% of students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting.

RESULTS:

The 2025 goal to reduce the number of students with disabilities who experienced a restrictive procedure by 882 students or to reduce the percentage of such students to 1.8% was **met.**

Time period	Students receiving special education services	Students who experienced restrictive procedure	Change from previous year
2019 Annual (Baseline) 2018-19 school year	147,605	3,603 (2.4%)	+57 (-0.1%)
2020 Annual 2019-20 school year	152,012	3,052 (2.0%)	<551> (-15.3%)
2021 Annual 2020-21 school year	149,382	1,689 (1.1%)	<1,363> (-44.8)
2022 Annual 2021-22 school year1	151,532	2,341 (1.5%)	+652 (+38.6%)
2023 Annual 2022-23 school year	158,057	2,956 (1.9%)	+615 (+26%)
2024 Annual	165,285	2,932 (1.8%)	<24> (-0.8%)

2023-24 school year			
2025 Annual 2024-25 school year	166,982	2,904 (1.7%)	<28> (1.0%)

ANALYSIS OF DATA:

The overall goal to reduce the number of students with disabilities who experienced a restrictive procedure by 882 students or to reduce the percentage of such students to 1.8% of the total number of students receiving special education services was met. The goal was met even with a 36% increase in the number of students with disabilities served in Minnesota public schools since the baseline year.

School districts reported that of the 166,982 students receiving special education services, restrictive procedures were used with 2,904 of those students (1.7%). This was a decrease of 28 students from the previous year and a percentage decrease of 1%. Overall, this was a decrease of 699 students from the baseline and a percentage decrease of 19% from the baseline.

The restrictive procedures summary data is self-reported by school districts and the deadline for reporting the data to MDE is July 15 for the prior school year. The data included for the 2015-16 through the 2024-25 school years has been reviewed as needed. The data is described in more detail for the respective years in MDE's legislative report, *A Report on School Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools*. The 2026 report to the legislature will include more detailed reporting of data for the 2024-25 school year. The data includes all public schools, including intermediate districts, charter schools, and special education cooperatives. In the 2024-25 school year:

- Physical holds were used with 2,810 students, an increase of 33 students from the 2023-24 school year.
- Seclusion was used with 359 students, a decrease of 194 students from the 2023-24 school year.
- Compared to the 2023-2024 school year, the average number of physical holds per physically held student is 6.8, up by 1.8; the average number of uses of seclusion per secluded student was 5.2, down by 1.0.

The table below shows this information over the last several school years.

School year	Number of students experiencing physical holds	Average number of holds per held student	Number of students experiencing seclusions	Average number of seclusions per secluded student
2015-16	2,743	5.7	848	7.6
2016-17	3,127	5.5	976	7.3
2017-18	3,465	5.4	824	7.6
2018-19	3,357	5.1	861	6.5
2019-20	2,828	4.5	753	5.3
2020-21	1,576	4.2	463	4.0
2021-22	2,001	5.0	716	6.4
2022-23	2,750	4.5	730	5.4
2023-24	2,777	5.0	553	6.2
2024-25	2,810	6.8	359	5.2

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported seven months after the end of the reporting period.

POSITIVE SUPPORTS GOAL FIVE

By June 30, 2025, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 3,615 or by 1.0 incidents of restrictive procedures per student who experienced the use of restrictive procedures in the school setting. *(Updated in 2024)*

Baseline: During school year 2018-2019, school districts (which include charter schools and intermediate districts) reported 22,772 incidents of emergency use of a restrictive procedure in the school setting. In school year 2018-2019, the number of reported students who had one or more emergency use of restrictive procedure incidents in the school setting was 3,603 students receiving special education services. Accordingly, during school year 2018-2019, there were 6.3 incidents of restrictive procedures per student who experienced the use of a restrictive procedures in the school setting.

RESULTS:

The 2025 goal to reduce the number of incidents of emergency use by 3,615, or by 1.0 incidents of restrictive procedures per student was not met.

Time period	Incidents of emergency use of restrictive procedures	Students who experienced use of restrictive procedure	Rate of incidents per student	Change from previous year
2019 Annual (Baseline) 2018-19 school year	22,772	3,603	6.3	<2,280> incidents <0.8> rate
2020 Annual 2019-20 school year[12]	16,656	3,052	5.5	<5,872> incidents <0.8> rate
2021 Annual 2020-21 school year[13]	8,537	1,689	5.1	<8,119> incidents <0.4> rate

[12] Data from 2019-20 was substantially affected by Covid-19-related school closures.

[13] Data from 2020-21 was substantially affected by Covid-19-related school closures during the spring of 2020.

Time period	Incidents of emergency use of restrictive procedures	Students who experienced use of restrictive procedure	Rate of incidents per student	Change from previous year
2022 Annual 2021-22 school year[14]	14,684	2,341	6.2	+6,147 incidents +1.1 rate
2023 Annual 2022-23 school year	16,343	2,956	5.5	+1,659 incidents <0.7> rate
2024 Annual 2023-24 school year	17,464	2,932	6.0	+1,121 incidents +0.5 rate
2025 Annual 2024-25 school year	20,968	2,904	7.2	+3,504 incidents +1.2 rate

ANALYSIS OF DATA:

During the 2024-25 school year, there were 20,968 incidents of emergency use of restrictive procedures. This is an increase of 3,504 incidents from the previous year. There were 7.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure. This was an increase of 1.2 incidents per student. Compared to the 2018-2019 baseline, the number of incidents of restrictive procedures reduced by 1,804 incidents and increased by 0.9 incidents per student, during the same years in which there was a 36% increase in the number of students with disabilities served in Minnesota public schools. The overall goal to reduce the number of incidents of emergency use by 3,615, or by 1.0 incidents of restrictive procedures per student was partially met.

The restrictive procedures summary data is self-reported by school districts and the deadline for reporting the data to the MDE is July 15 for the prior school year. The data included for the 2015-16 through the 2024-25 school years has been reviewed as needed. The data is described in more detail for the respective years in MDE' legislative report, A Report on School Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools. The 2026 report to the legislature will include more detailed reporting of data for the 2024-25 school year. The data includes all public schools, including intermediate districts, charter schools, and special education cooperatives.

[14] Data from 2021-22 continues to be impacted by the Covid-19 pandemic.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported seven months after the end of the reporting period (February of each year).

CRISIS SERVICES GOAL ONE

By June 30, 2026, the percent of children who receive children's mental health crisis services and remain in their community will increase to 75% or more. *(Updated in 2024)*

Baseline: In State Fiscal Year 2014 of 3,793 episodes, the child remained in their community 79% of the time.

RESULTS:

The goal is **not on track** to meet the 2026 goal to increase the percent of children who remain in their community after a crisis to 75%.

Time period	Total Episodes	Community	Treatment	Other
2016 Annual (6 months data) January – June 2016	1,318	1,100 (83.5%)	172 (13.2%)	46 (3.5%)
2017 Annual (July 2016 – June 2017)	2,653	2,120 (79.9%)	407 (15.3%)	(4.8%)
2018 Annual (July 2017 – June 2018)	2,736	2,006 (73.3%)	491 (18.0%)	239 (8.7%)
2019 Annual (July 2018 – June 2019)	3,809	2,742 (72.0%)	847 (22.2%)	220 (5.8%)
2020 Annual (July 2019 – June 2020)	3,639	2,643 (72.6%)	832 (22.9%)	164 (4.5%)
2021 Annual (July 2020 – June 2021)	3,318	2,439 (73.5%)	651 (19.6%)	228 (6.9%)
2022 Annual (July 2021 – June 2022)	3,431	2,483 (72.4%)	797 (23.2%)	151 (4.4%)

Time period	Total Episodes	Community	Treatment	Other
2023 Annual (July 2022 – June 2023)	3,181	2,189 (68.8%)	754 (23.7%)	238 (7.5%)
2024 Annual (July 2023 – June 2024)	3,832	2,567 (67.0%)	855 (23.3%)	410 (10.7%)
2025 Annual (July 2024 – June 2025)	3,629	2,526 (69.6%	709 (19.5%)	394 (10.9%)

- Community = emergency foster care, remained in current residence (foster care, self or family), remained in school, temporary residence with relatives/friends.
- Treatment = chemical health residential treatment, emergency department, inpatient psychiatric unit, residential crisis stabilization, residential treatment (Children's Residential Treatment).
- Other = children's shelter placement, domestic abuse shelter, homeless shelter, jail or corrections, other.

ANALYSIS OF DATA:

From July 2024 – June 2025, of the 3,629 crisis episodes, the child remained in their community after the crisis 2,526 times or 69.6% of the time. This was an increase of 2.6% from the previous year and 9.4% below baseline. The goal is not on track to meet the 2026 goal of 75%.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

CRISIS SERVICES GOAL TWO

By June 30, 2026, the percent of adults who receive adult mental health crises services and remain in their community (e.g., home or other setting) will increase to 55% or more. *(Updated in 2024)*

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

RESULTS:

The goal is **on track** to meet the 2026 goal to increase the percent of adults who remain in their community after a crisis to 55%.

Time period	Total Episodes	Community	Treatment	Other
2016 Annual (6 months data) January – June 2016	5,436	3,136 (57.7%)	1,492 (27.4%)	808 (14.9%)
2017 Annual (July 2016 - June 2017)	10,825	5,848 (54.0%)	3,444 (31.8%)	1,533(14.2%)
2018 Annual (July 2017 – June 2018)	11,023	5,619 (51.0%)	3,510 (31.8%)	1,894 (17.2%)
2019 Annual (July 2018 – June 2019)	12,599	6,143 (48.8%)	4,421 (35.1%)	2,035 (16.2%)
2020 Annual (July 2019 – June 2020)	11,247	6,019 (53.5%)	3,864 (34.2%)	1,364 (12.1%)
2021 Annual (July 2020 – June 2021)	11,911	6,805 (57.1%)	3,392 (28.5%)	1,714 (14.4%)
2022 Annual (July 2021 – June 2022)	10,138	5,504 (54.3%)	3,253 (32.1%)	1,381 (13.6%)
2023 Annual (July 2022 – June 2023)	10,193	5,318 (52.2%)	3,912 (38.4%)	963 (9.4%)
2024 Annual (July 2023 – June 2024)	14,253	7,647 (53.7%)	4,856 (34.1%)	1,750 (12.2%)
2025 Annual (July 2024 – June 2025)	14,631	8,260 (56.5%)	4,525 (30.9%)	1,846 (12.6%)

- Community: remained in current residence (foster care, self or family), temporary residence with relatives/friends.
- Treatment: chemical health residential treatment, emergency department, inpatient psychiatric unit, residential crisis stabilization, residential treatment (IRTS)
- Other: homeless shelter, jail or corrections, other.

ANALYSIS OF DATA:

From July 2024 – June 2025, of the 14,631 crisis episodes, the adult remained in their community after the crisis 8,260 times or 56.5% of the time. This was an increase of 2.8% from the previous year and 1.3% below the baseline. The goal is on track to meet the 2026 goal of 55% or more.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

CRISIS SERVICES GOAL FOUR

By June 30, 2026, 82% of people in community hospital settings due to a crisis will have a stable, permanent home within 5 months after leaving the hospital. *(Updated in 2024)*

Baseline: From July 2014 – June 2015, 81.9% of people discharged from the hospital due to a crisis were housed five months after the date of discharge compared to 80.9% in the previous year. From July 2017 - June 2018, 77.8% were housed five months after the date of discharge.

RESULTS:

The goal is **not on track** to meet the 2026 goal to increase to 82%.

Status five months after discharge from hospital

Time period	Discharged from hospital	Housed	Not housed	Treatment facility	Not using public programs	Deceased	Unable to determine type of housing
2016 Baseline July 2014 – June 2015	13,786	11,290 81.9%	893 6.5%	672 4.9%	517 3.7%	99 0.7%	315 2.3%
2017 Annual Goal July 2015 – June 2016	15,027	11,809 78.6%	1,155 7.7%	1,177 7.8%	468 3.1%	110 0.7%	308 2.1%
2018 Annual Goal July 2016 – June 2017	15,237	12,017 78.8%	1,015 6.9%	1,158 7.6%	559 3.7%	115 0.8%	338 2.2%
2019 Annual Goal July 2017 – June 2018	15,405	11,995 77.8%	1,043 6.8%	1,226 8%	652 4.2%	118 0.8%	371 2.4%
2020 Annual Goal July 2018 – June 2019	15,258	11,814 77.4%	999 6.6%	1,116 7.3%	820 5.4%	113 0.7%	396 2.6%
2021 Annual Goal	13,924	11,214	820	958	428	115	389

Time period	Discharged from hospital	Housed	Not housed	Treatment facility	Not using public programs	Deceased	Unable to determine type of housing
July 2019 – June 2020		80.5%	5.9%	6.9%	3.1%	0.8%	2.8%
2022 Annual Goal July 2020 – June 2021	13,392	10,955 81.8%	739 5.5%	951 7.1%	189 1.4%	137 1.0%	421 3.1%
2023 Annual Goal July 2021 – June 2022	12,577	10,326 82.1%	749 0%	821 6.5%	172 1.4%	104 0.8%	405 3.2%
2024 Annual July 2022 – June 2023	12,470	10,132 81.3%	769 6.2%	814 6.5%	230 1.8%	120 1.0%	405 3.2%
2025 Annual July 2023 – June 2024	12,303	9,621 78.2%	852 6.9%	830 6.7%	518 4.2%	127 1%	355 2.9%

- "Housed" is defined as a setting in the community where DHS pays for services including ICFs/DD, Single Family homes, town homes, apartments, or mobile homes.
- [NOTE: For this measure, settings were not considered as integrated or segregated.]
- "Not housed" is defined as homeless, correction facilities, halfway house or shelter.
- "Treatment facility" is defined as institutions, hospitals, mental and chemical health treatment facilities, except for ICFs/DD.

ANALYSIS OF DATA:

From July 2023 – June 2024, of the 12,303 individuals hospitalized due to a crisis, 9,621 (78.2%) were housed within five months of discharge. This was a decrease of 3.1% from the previous year and 1.8% below the overall goal of 80%.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported 16 months after the end of the reporting period.

PREVENTING ABUSE AND NEGLECT GOAL TWO

By December 31, 2025, the number of cases of vulnerable individuals being treated due to abuse and neglect will decrease by 15% compared to baseline. *(Updated in 2024)*

There are two measures for this goal:

(A) Decrease the number of emergency room visits and hospitalizations due to abuse and neglect

Baseline: During Calendar Year 2019, there were 39 cases of vulnerable individuals who were treated in an emergency room or hospital due to abuse or neglect. After the baseline was established, an additional case was found bringing the baseline to 45.

RESULTS:

The 2025 goal to reduce the number of emergency room visits and hospitalizations due to abuse and neglect by 15% compared to baseline was **not met**.

Time Period	(A) Number of emergency room visits and hospitalizations	Change from baseline	Percentage change from baseline
Calendar Year 2019 (Baseline)	45	N/A	N/A
Calendar Year 2020	38	7	16%
Calendar Year 2021	41	4	9%
Calendar Year 2022	44	1	2%
Calendar Year 2023	34	11	24%
Calendar Year 2024	15	30	66%
Calendar Year 2025	48	+3	+6%

ANALYSIS OF DATA:

During calendar year 2025, there were 48 cases of emergency room visits and hospitalizations due to abuse and neglect. This was an increase of 33 from the previous year and an increase of 3 from the baseline. The 2025 goal to reduce by 15% from baseline was not met.

Cases by age group:

Time Period	Total	Birth – 17	18 – 64	65 and over
Calendar Year 2019	45	8	35	2
Calendar Year 2020	38	13	24	1
Calendar Year 2021	41	10	30	1
Calendar Year 2022	44	6	36	2
Calendar Year 2023	34	8	25	1
Calendar Year 2024	15	3	11	1
Calendar Year 2025	48	11	36	1

Cases by geography (Metro vs. Greater MN):

Time Period	Total	Metro	Greater Minnesota
Calendar Year 2019	45	23	22
Calendar Year 2020	38	13	25
Calendar Year 2021	41	12	29
Calendar Year 2022	44	20	24
Calendar Year 2023	34	17	17
Calendar Year 2024	15	9	6
Calendar Year 2025	48	15	33

PREVENTING ABUSE AND NEGLECT GOAL FOUR

By July 31, 2026, the number of students with disabilities statewide identified as victims in determinations of maltreatment will decrease by 30% compared to baseline.

Baseline: From July 2017 to June 2018, there were 32 students with a disability statewide identified as victims in determinations of maltreatment.

RESULTS:

The 2026 goal to decrease by 25% from baseline to 24 was **not met**.

Time Period	Number of students with disabilities determined to have been maltreated	Change from baseline	Percent of change
Baseline (July 2017 – June 2018)	32	N/A	N/A
2021 Annual (July 2018 – June 2019)	28	<4>	<12.5%>
2022 Annual (July 2019 – June 2020)	21	<11>	<34.4%>
2023 Annual (July 2020 – June 2021)	7	<25>	<78.1%>
2024 Annual (July 2021 – June 2022)	22	<10>	<31.3%>
2025 Annual (July 2022 – June 2023)	28	<4>	<12.5%>
2026 Annual (July 2023 – June 2024)	47	+15	+46.9%

ANALYSIS OF DATA:

During the 2023-2024 school year a total of 243 students were identified as alleged victims of abuse and neglect in Minnesota public schools with 144 students identified as having disabilities. Of the students with disabilities, 47 were determined to have been maltreated.

The July 2023 to June 2024 school year data indicates 47 students with disabilities were identified as a victim of maltreatment as compared to 32 students identified in MDE's baseline data from July 2017 to

June 2018. This was 46.9% increase from the baseline data which did not meet MDE's goal of reducing the number of students with a disability who have been maltreated by 30% from the baseline data. The data also shows an increase in the number of students with a disability who were determined to have been maltreated from the prior year (July 2022- June 2023). This increase
from 28 to 47 students represents a 67.9% increase in the number of victims with a disability who have been maltreated from the previous school year.

During the 2023-2024 school year, the MDE Student Maltreatment Team received
and assessed 1,057 reports of alleged maltreatment. Of those reports, the Student Maltreatment Team opened 223 cases for onsite investigations.

The goal of reducing maltreatment determinations involving students with disabilities by 30 percent from the baseline was not achieved. During the 2023-24 school year, 47 students with disabilities were determined to have been maltreated, representing an increase of 15 students (46.9 percent) compared to the baseline of 32 students and an increase of 19 students (67.9 percent) from the previous year.

The increase occurred during a period of elevated reporting activity. During the 2023-24 school year, the Student Maltreatment Team received 1,057 reports of alleged maltreatment and opened 223 investigations. While the data indicate an increase in confirmed maltreatment determinations involving students with disabilities, the underlying causes cannot be determined from these data alone. Potential contributing factors may include increased reporting, heightened awareness of maltreatment indicators, growth in the number of students receiving special education services, and ongoing challenges associated with the long-term effects of the COVID-19 pandemic. Many schools continue to address behavioral, social-emotional, and educational impacts resulting from extended disruptions to in-person instruction, while simultaneously re-establishing structured learning environments and behavioral expectations. In addition, many districts continue to experience staffing shortages among teachers, paraprofessionals, special education providers, and other student support personnel. These workforce challenges may reduce the availability of individualized supports and increase demands on existing staff, particularly when serving students with complex behavioral, emotional, or disability-related needs. Collectively, these factors may contribute to situations that increase the risk of inappropriate staff responses or interventions.

Given the relatively small number of annual determinations and the fact that reports are externally generated and not controlled by MDE, year-to-year fluctuations should be interpreted with caution. MDE will continue to prioritize prevention efforts through training, technical assistance, collaboration with partner agencies and advocacy organizations, and education regarding mandatory reporting requirements to help reduce incidents of abuse and neglect involving students with disabilities.

TIMELINESS OF DATA:

Cases involved in criminal proceedings sometimes require additional time to reach a resolution. Therefore, this data is reported 24 months after the conclusion of the applicable school year to ensure that all cases have reached a resolution and to confirm that the data is accurate.

COMMUNITY ENGAGEMENT GOAL ONE

By December 31, 2025, the number of individuals with disabilities who participate in Governor appointed Boards and Commissions and other Workgroups and Committees established by the Olmstead Subcabinet will increase to 278 members. *(Updated in 2024)*

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

RESULTS:

This goal expired in a prior year and was still monitored and reported in 2026.

Time Period	Number of individuals with a disability on Boards / Commissions	Number of individuals with a disability on Olmstead Subcabinet workgroups	Total number
Baseline (June 30, 2017)	159	16	**175**
2018 Annual (as of July 31, 2018)	171	26	**197**
2019 Annual (as of July 31, 2019)	167	20	**187**
2020 Annual (as of July 31, 2020)	182	10	**192**
2021 Annual (as of July 15, 2021)	199	12	**211**
2022 Annual (as of July 15, 2022)	224	7	**231**
2023 Annual (as of July 15, 2023)	252	21	**273**
2024 Annual (as of December)	284	NA	**284**
As of July 2026	267	NA	**267**

ANALYSIS OF DATA:

Of the 3,972 members listed on the Secretary of State's Boards and Commissions website, 267 (approximately 6.7%) self-identified as an individual with a disability.

Olmstead Subcabinet Workgroups were not active in 2025 or 2026. Instead, the Olmstead Implementation Office (OIO) focused on outreach efforts that can be found on OIO's website.

The total number of individuals may include duplicates if a member participated in more than one group throughout the year. In addition, the totals may be undercounted if individuals chose not to self-identify as a person with a disability.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one month after the end of the reporting period. Data is accessed through the Secretary of State's website.

COMMUNITY ENGAGEMENT GOAL TWO

By December 31, 2025, the (A) annual number of individuals with disabilities to participate in public input opportunities related to the Olmstead Plan, and (B) the annual number of comments received by individuals with disabilities (including comments submitted on behalf of individuals with disabilities) will increase by 25% over baseline. *(Updated in 2024)*

Baseline: From December 20, 2018 – March 11, 2019, there were 192 individuals who participated in public input opportunities related to Olmstead Plan. The number of comments received was 249.

RESULTS:

The 2025 goal to increase by 25% over baseline was met.

Participation in public input opportunities related to Olmstead Plan

Time Period	Number of individuals	Change from baseline		Number of comments	Change from baseline	
Baseline Dec 20, 2018 – Mar 11, 2019	192	N/A		249	N/A	
Oct 14, 2019 – Jan 31, 2020	214	22	11.5%	680	431	173%
Feb 10, 2021 – Apr 6, 2021	27	<165>	<85.9%>	70	<179>	<71.9%>
Nov 22, 2021 – Mar 8, 2022	233	41	21.4%	346	97	38.9%
March 2022 – Oct 31, 2023	107	<85>	<44.3%>	180	<69>	<27.7%>
January – December 2024	1,279	1,087	566.1%	2,251	2,002	804%
January – December 2025	500	308	160%	NA		NA
January – July 2026	201	9	4.6%	NA		NA

ANALYSIS OF DATA:

In calendar year 2025, 500 people participated in public input opportunities related to the Olmstead Plan. This number includes People who participated in community conversations hosted in partnership with the Dendros Group. In the first half of 2026, 201 people participated in the 2026 Olmstead Plan public comment period.

The number of comments received was not available because the number of specific comments was not tallied.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported two months after the end of the reporting period.

ENDNOTES

[i] Olmstead Implementation Office website address is www.MN.gov/Olmstead.

[ii] Some Olmstead Plan goals have multiple subparts or components that are measured and evaluated separately. Each subpart or component is treated as a measurable goal in this report.

[iii] This goal measures the number of people exiting institutional and other segregated settings. Some of these individuals may be accessing integrated housing options also reported under Housing Goal One.

[iv] Transfers reflect movement to other secure settings (i.e. Department of Corrections, jail, Minnesota Sex Offender Program, and/or between the Forensic Mental Health Program and Forensic Nursing Home).

[v] The Forensic Mental Health Program is governed by the Positive Supports Rule when serving people with a developmental disability.

[vi] "Students with disabilities" are defined as students with an Individualized Education Program age 6 to 21 years.

Inclusion Consultants' End of the Project Reflections

Angela Harper, Adam Harrington, Rich Pennington, Ken Rogers, Mao Yang

September 15, 2026

DENDROS GROUP

Introductions

We're Most Proud Of...

1. Representing our communities
2. Facilitating the 2025 community conversations
3. Advocating for better data practices
4. Speaking our truths

We Suggest Agencies…

1. Keep learning from disabled people
2. Continue working with consultants with lived experience!
3. Be creative within this moment
4. Think bigger long term

Why is it important to work with people with lived experience?

Nothing About Us Without Us!

Image Credit: Disabled And Here This photo was taken by Gritchelle Fallesgon. The background mural's artist is Lliam Werproc.

DENDROS GROUP

Thank you!

MINNESOTA
OLMSTEAD
IMPLEMENTATION OFFICE

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

For approval by Subcabinet

Reviewed by Leadership Forum August 14, 2026

Feedback

The Olmstead Subcabinet welcomes feedback to inform the implementation of Minnesota's Olmstead Plan.

There are several ways to provide your comments and thoughts:

- Send an email to MNOlmsteadPlan@state.mn.us
- Send a letter to: Olmstead Implementation Office 400 Wabasha Street N, Suite 400, St. Paul, MN 55102
- Call the Olmstead Implementation Office at 651-296-8081 to speak to a staff member at the or leave your comment through voicemail.

Accessibility

This document is available in alternative formats to people with disabilities by calling the Olmstead Implementation Office at 651-296-8081, or by emailing MNOlmsteadPlan@state.mn.us

For translations of this publication write to MNOlmsteadPlan@state.mn.us or call 651-296-8081.

Disability language

This plan is written with an intentional emphasis on using both identity-first language and person-first language. Identity-first language places the individual's disability at the forefront; for example, "disabled person." Person-first language uses the word "person" before the disability, like "person with autism." Members of the disability community use both approaches, including Inclusion Consultants who worked on this plan. The choice to use both person-first and identity-first language in the Olmstead Plan reflects our commitment to respecting individual preference.

Table of Contents

Executive summary

Minnesota's Olmstead Plan is a commitment by state agencies to improve the lives of people with disabilities. The plan focuses on integration and inclusion and includes: a vision statement, guiding values, measurable goals, strategies, and plans for collecting data so that future goals can be measured.

The Olmstead Plan vision statement is:

People with disabilities are living, learning, working, and enjoying life in the most integrated setting and community of their choice. People with disabilities will thrive, enjoying full lives with dignity and belonging.

The plan is named after a United States Supreme Court decision, *Olmstead v. L.C.* This decision affirmed the rights of people with disabilities to live and receive services in the communities of their choice. Minnesota's first Olmstead Plan was finalized in 2015.

The plan has been updated several times since 2015. However, the 2026 Olmstead Plan represents the first comprehensive plan update in a decade. A diverse and intersectional group of contributors created and influenced this plan. This approach aimed to make the plan more representative and transparent for the communities it is meant to serve. Contributors included state staff, community members with lived experience of disability, and national policy consultants.

This plan includes measurable goals for 13 state entities across eight topic areas. Those topics are:

- Crisis services
- Education
- Employment
- Health and safety
- Housing
- Preventing abuse and neglect
- Transportation and transit
- Transition

The goals follow a five-year timeline. Agencies will report at least quarterly to the public on progress toward their goals. Throughout the next five years, community engagement opportunities will inform plan updates.

Plan updates will happen annually. However, the changes necessary to truly meet the needs of disabled Minnesotans will take more than five years of work. This plan also calls for the creation of a Disability Systems Change Workgroup to help design a plan to work on transformative, systemic changes to Minnesota's disability services systems.

This plan calls for continued work by state agencies alongside people with lived experience of disability, which supports the disability community's motto of "nothing about us without us." It is essential that disabled Minnesotans continue to influence the plan.

This plan represents years of work by many people. Thank you to the individuals and groups who contributed. This plan would not be possible without their energy and insight. Their efforts will help us create a more inclusive, integrated Minnesota.

Introduction

“Freedom means having control over your own life. That includes choosing where to live, what kind of work to do, how to spend your time, and who you spend it with. These choices are deeply connected to identity, dignity, and the ability to belong.”

This is how the Minnesotans with disabilities who helped create this document describe what they need to thrive. These truths are shared by all of us. Yet people with disabilities still face barriers to informed choice, freedom, and belonging. This is why, over 25 years later, the U.S. Supreme Court’s *Olmstead* decision is as important as ever.

The ruling stated that segregating people with disabilities without reason is discrimination. Under the *Olmstead* decision, states are required to ensure people with disabilities can enjoy life in the most integrated setting appropriate. This plan is our state’s roadmap to meet these requirements.

Minnesota is committed to going beyond the minimum requirements. Fulfilling the spirit of the *Olmstead* decision is our North Star. This means communities are not only integrated, but also fully inclusive. It means people with disabilities have true freedom and informed choice.

This Olmstead Plan is guided by the following vision statement:

People with disabilities are living, learning, working, and enjoying life in the most integrated setting and community of their choice. People with disabilities will thrive, enjoying full lives with dignity and belonging.

This plan wouldn’t be possible without the advocacy of disabled people and allies. They shaped this plan’s vision, goals, and strategies alongside state agency staff. This was an effort towards co-creation. Co-creation is grounded in the disability community’s motto, “Nothing about us without us.”

During this process, people with disabilities were clear that incremental progress isn’t enough. Fulfilling the spirit of Olmstead will require large-scale transformation. This plan includes achievable, measurable goals for the next five years, data collection projects, and a framework to implement systemic change beyond that.

Minnesota's Olmstead Plan is a culmination of years of progress, strategy, and advocacy. Each future plan will build on the insights and co-creation efforts that shaped this one. This work must bring us closer to reaching our North Star for present and future generations of disabled Minnesotans.

History of the *Olmstead* decision

An Olmstead plan is a state’s plan for fulfilling its obligation to provide people with disabilities the opportunity to live, work, and enjoy life in the most integrated setting appropriate. It is named after a United States Supreme Court decision, *Olmstead v. L.C.*

The plaintiffs of the *Olmstead* decision were Lois Curtis and Elaine Wilson. They were two women with diagnoses of mental health conditions and intellectual disabilities who were institutionalized in Georgia. The state claimed that they did not have the resources to move them into the community. Lois Curtis and Elaine Wilson fought for their right to live in safe, accessible housing of their choice. These civil rights are guaranteed by the Americans with Disabilities Act (ADA), which passed in 1990. Lois Curtis and Elaine Wilson sued under the ADA.

On June 22, 1999, the Supreme Court issued its landmark decision, *Olmstead v. L.C.* The ruling stated that segregating people with disabilities without a legal reason is discrimination. It also said that public entities must provide services in the most integrated setting that is appropriate. Public entities include state and local governments and their programs. This decision applies to people with all types of disabilities.

At the heart of the Olmstead Plan is the determination of Lois Curtis and Elaine Wilson. Their power cannot be overstated. When they fought for their own civil rights, they also unlocked freedom for millions of Americans for decades to come.

History of Minnesota's plan

All states, including Minnesota, have a history of institutionalizing people with disabilities. Many institutions have closed since the mid-20th century. However, segregation and other forms of institutionalization as defined by the ADA still continue.

The state's first Olmstead Plan was created as part of the *Jensen* Settlement Agreement. The *Jensen* Settlement Agreement is the result of a lawsuit against the Minnesota Department of Human Services (DHS) in 2009.

The lawsuit was about the use of restraint and seclusion in a DHS program called Minnesota Extended Treatment Options. It alleged the program broke the law and violated the civil rights of disabled people. The *Jensen* Settlement Agreement improved treatment and care for people with disabilities in Minnesota.

The first Minnesota Olmstead Plan was adopted in 2015. A federal court oversaw the plan through October 2020. In 2023, the Olmstead Subcabinet decided it was time for a more comprehensive update. State agencies continued reporting on their goals through the update process.

A more comprehensive history of Minnesota's Olmstead Plan is on the Olmstead Implementation Office's website.

Creation of the 2026 Olmstead Plan

The 2026 Olmstead Plan was created in partnership with:

- State agency leaders and staff
- Consultants with lived experience of disability, called Inclusion Consultants
- National policy consultants
- People across Minnesota

Who was involved

Olmstead Subcabinet and Leadership Forum

The Olmstead Subcabinet exists through Executive Order (19-13). It is made up of 12 state agencies and entities, plus the Metropolitan Council. Subcabinet members include agency commissioners and leaders. They work together to develop and implement the Olmstead Plan.

The Leadership Forum is a Subcabinet-created workgroup. It includes agency leaders and assistant commissioners. They make recommendations to the Subcabinet.

The Olmstead Subcabinet includes:

- Department of Corrections (DOC)
- Department of Education (MDE)
- Department of Employment and Economic Development (DEED)
- The Governor's Council on Developmental Disabilities (GCDD)
- Department of Health (MDH)
- Department of Human Rights (MDHR)
- Department of Human Services (DHS)
- The Metropolitan Council (Met Council, MetC)
- Minnesota Housing Finance Agency (Minnesota Housing)
- The Office of the Ombudsman for Mental Health and Developmental Disabilities (OMHDD)
- Department of Public Safety (DPS)
- Department of Transportation (MnDOT)
- Department of Veterans Affairs (MDVA)

Direct Care and Treatment (DCT) and the Department of Children, Youth, and Families (DCYF) are newer state agencies. They are not officially included in Executive Order 19-13 as Subcabinet members. Recognizing the important roles both agencies play for Minnesotans with disabilities, including children, DCYF and DCT contributed goals and strategies to this plan.

The Executive Order, Subcabinet Procedures, and Leadership Forum Charter describe the duties of the Subcabinet and Leadership Forum in more detail. [These documents are on the Olmstead Implementation Office's website.]

Olmstead Implementation Office

The Minnesota Olmstead Implementation Office (OIO) works at the intersection of the Olmstead Subcabinet and the disability community. OIO was created in 2013. Its work includes:

- Supporting people with disabilities and state agency leaders in efforts to co-create the Olmstead Plan.
- Creating opportunities for public input about the plan.
- Educating people about the Olmstead Plan and progress on its goals.
- Sharing data about the Olmstead Plan and integration of people with disabilities.
- Overseeing plan updates and compliance.

The Executive Order, Subcabinet Procedures, and Leadership Forum Charter also describe OIO's duties.

Inclusion Consultants

Inclusion Consultants are people with lived experience of disability. Lived experience includes people with disabilities and their supporters. Inclusion Consultants started work in 2025 in an effort to co-create the Olmstead Plan with state agency staff. OIO worked with a contractor, the Dendros Group, to support these paid consultants.

The Inclusion Consultants brought a diversity of perspectives. These perspectives include:

- People of color, including Indigenous people and members of Tribal Nations
- People from the metro area and Greater Minnesota
- Members of the LGBTQIA2S+ community
- Veterans
- People with a variety of disabilities
- People with experience in segregated settings
- Parents of children with disabilities

The consultants and state staff considered community perspectives while writing goals. Community members shared perspectives in community conversations, surveys, and interviews.

Inclusion Consultants include:

- Abraham Tieman
- Adam Harrington
- Alesha Alexcee
- Angela Harper
- Bob Wagner
- Dee Martineau

- Ivory Taylor
- James Poteet
- Ken Rodgers
- Kevin Pone
- Madam Robinson
- Mao Yang
- Mercedes Elder
- Nikki Huelsman
- Rich Pennington
- Riss Leitzke
- Sandy'Ci M
- Taylor O'Shea

Policy Consultants

The Technical Assistance Collaborative (TAC) also supported the plan update. TAC chose Policy Consultants for specific disability topics. These consultants were a resource for agency teams. They shared information about what other states were doing well.

TAC works with governments to improve community-based services for people with disabilities. They have also helped other states create their Olmstead plans.

For a full list of Policy Consultants, please see the appendix.

Community feedback

2024 community feedback

In 2024, OIO engaged Minnesotans about the plan update. About 2,000 people shared feedback. This included people with disabilities, supporters, service providers, and state staff. This round of feedback focused on broad themes to create the foundation of the plan. Community members shared about disabled life in Minnesota, including what inclusion and integration meant to them.

Engagement efforts included:

- A statewide Disability Inclusion and Choice survey
- Small community conversations
- The Quality of Life Survey
- One-on-one meetings
- Attending community events

Overarching themes from 2024 community feedback

Some community feedback focused on specific topics, like transportation and employment. Feedback themes are available in the appendix.

Additionally, community members made clear that the plan won't be successful without true inclusion, anti-ableism, and an intersectional lens.

- Inclusion: Community members stressed that integration alone isn't enough. Communities and services must be fully inclusive and foster belonging.
- Anti-ableism: Community members shared that ableism is a major barrier to integration, inclusion, and choice.
- Intersectionality: Community members said the state must address disparities based on other identities held by people with disabilities. These identities can include race, ethnicity, gender, sexuality, socioeconomic status, language, and more.

You can find more details about these terms in the appendix.

2025 community feedback

In summer 2025, the Dendros Group held more than 20 community conversations statewide. Most conversations were co-hosted with community partners. They took place both in person and online. Conversations were held in multiple languages.

These conversations focused on specific Olmstead Plan topics. They were intended to inform agency teams' measurable goals and strategies. Agency teams helped develop discussion questions. Conversation topics included:

- Education
- Employment
- Health
- Housing
- Safety
- Services and systems
- Transportation

2026 community feedback

OIO held a public comment period about the draft plan in spring 2026. This was an opportunity for people to give direct feedback about the plan and measurable goals. For more details about the public comment period, please refer to the section in this document titled "plan update timeline."

Across all public comment opportunities, 186 people and organizations shared input. Overarching themes included:

- Draft goals were not ambitious enough.
- The plan needed more accountability and enforcement mechanisms.
- Important topics were missing from the plan, such as intersectionality, assistive technology, and representation of all disability types.

More information about the 2026 public comment period is available on the Olmstead Implementation Office's website.

Vision statement and guiding values

This Olmstead Plan is grounded in the vision and aspirations of disabled people. The following vision is based on:

- Engagement with more than 2,000 people in 2024 and 2025, which involved over 50 community conversations around the state and two surveys.
- The Inclusion Consultants' Focus Area Report, written in spring 2025.

The Olmstead Plan vision statement is:

People with disabilities are living, learning, working, and enjoying life in the most integrated setting and community of their choice. People with disabilities will thrive, enjoying full lives with dignity and belonging.

In their Focus Area Report, the Inclusion Consultants wrote: "We imagine a world where all Minnesota state agencies care about our perspectives, listen to us, and make decisions with us in authentic collaboration so we can live, learn, work, and enjoy life with everyone else."

As expressed in the Inclusion Consultants' Focus Area Report, people with disabilities need:

- "More real choice."
- "More control over their lives."
- "Less red tape."
- "Services that respect all parts of who they are."
- "Leadership that listens — and acts."

Physical, social, attitudinal, and systemic barriers stand in the way of full inclusion. The "barriers aren't just about inaccessible buildings or broken systems—they are about attitudes, about being seen as 'less than,' about facing bias that limits opportunity before the conversation even begins," according to the Focus Area Report. Ableism and stigma drive the social and attitudinal barriers.

Inclusion and integration benefit everyone, whether they have disabilities or not. In schools, non-disabled students who learn alongside their disabled peers experience social, emotional, and cognitive gains. Accessible features, such as sidewalks with curb cuts, create safer conditions for everyone. Inclusive communities are stronger, more vibrant, and more equitable for everyone.

Minnesota has achieved notable progress under the current Olmstead Plan, but the state has a long way to go to achieve true inclusion and integration. Community members have shared urgent needs in housing, transportation, employment, services, and other key areas of life. Minnesota must commit to this work, even with varying political and financial realities.

Guiding values

Minnesota will achieve the vision when we reach the following guiding values. These guiding values include people of all identities, backgrounds, disability types, and stages of life, including children.

- Disabled people who experience segregation or institutionalization have what they need to transition into the community and thrive.
- People with disabilities receive person-centered services that support choice and self-determination.
- People with disabilities live in the communities and settings of their choice without barriers.
- Disabled adults and youth fully participate, find belonging, and thrive in high-quality and inclusive education.
- People with disabilities engage in meaningful work to thrive, without fear of losing benefits and supports.
- Disabled Minnesotans authentically participate in community life, belong, and are safe.
- People with disabilities have the resources they need for optimal health and well-being.

Disabled people who experience segregation or institutionalization have what they need to transition into the community and thrive

At its core, the *Olmstead* decision mandates that people with disabilities transition from institutional and segregated settings to community settings when appropriate. It also means people at risk of entering segregated settings are provided the services and supports they need to remain in the communities of their choice. This requires preparation and ongoing, comprehensive, and coordinated support in the community. As the first paragraph of the *Olmstead* decision states:

> … the "integration regulation" requires a "public entity shall administer … services, programs, and activities … in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR § 35.130(d).

People with disabilities receive person-centered services that support choice and self-determination.

As the Inclusion Consultants expressed, “One of the most explicit messages we heard from Minnesotans with disabilities is this: freedom means having control over your own life. That includes choosing where to live, what kind of work to do, how to spend your time, and who you spend it with.”

Inclusions Consultants also said:

- “Trust in people’s ability to make their own decisions.”
- “Services are siloed.”
- “People have to fight way too hard for basic access."

Overall, “it’s not about tweaking policies. It’s about rethinking how systems work – and who gets to shape them.” It is important for state staff to recognize that ableism is widespread, and that people with disabilities know their own needs best.

People with disabilities live in the communities and settings of their choice without barriers

As the Inclusion Consultants expressed, “When we asked Minnesotans with disabilities about access, many talked about the basics—getting into buildings, having qualified interpreters, finding housing, using transportation, or safely crossing the street. These are not luxuries; they are the foundation of a full life. But too often, the spaces, systems, and services meant to support access are inconsistent, incomplete, or entirely missing, especially in rural areas, small towns, and low-income neighborhoods.”

Disabled people fully participate, find belonging, and thrive in high-quality and inclusive education

Students with disabilities who learn in inclusive, integrated settings have improved academic performance, social development, communication skills, and higher graduation rates compared to those in segregated settings. Creating supportive and inclusive environments where everyone belongs is critical.

Some respondents from the 2024 Olmstead Disability Inclusion and Choice survey shared:

- “I would like to see less segregation of children receiving special education services in schools. Children without disabilities or special education services learn that it is okay to exclude people because that is what they experience throughout school. My experience has been that my son's classmates are the best problem-solvers for how he can be included. We need to stop creating systemic barriers.”
- “Schools should go through inclusion training – staff and students alike. You can't just integrate without managing the integration. Bullying just forces students with disabilities back into ‘self-selected’ segregation."

People with disabilities engage in meaningful work to thrive, without fear of losing benefits and supports

As the Inclusion Consultants expressed, “Minnesotans with disabilities want more than survival—they want to thrive. That means having access to meaningful work, fair pay, and the freedom to make their own choices about how they live, learn, and contribute. But too many people are still locked out of the workforce, stuck in poverty, or pushed into jobs that don’t reflect their strengths or goals. People also shared their fear: if they try to work, they could lose health care or housing. And if they can’t work due to their disability, they feel punished by a system that makes them prove they’re ‘disabled enough’ just to receive support. This isn’t equity—it’s a trap.”

Disabled Minnesotans authentically participate in community life, belong, and are safe

As the Inclusion Consultants identified:

Accessible social networks are “the networks, relationships, communication methods, and social systems that allow people to fully participate in community life. Accessible social infrastructure means not just getting into the building, but also being able to build relationships, get information, and feel connected.”

“Belonging is not just about being included; it’s about being wanted and supported … it means being fully accepted and valued for who you are, without having to hide or change yourself to fit in. It’s about being seen, respected, and included in community life—not just allowed to participate, but wanted and needed.”

Safe(r) spaces are “environments where people feel physically, emotionally, and socially safe—where they can show up as their full selves without fear of harm, dismissal, or punishment. The ‘(r)’ acknowledges that no space can guarantee complete safety, but intentional efforts must be made.”

People with disabilities have the resources they need for optimal health and well-being

As the Inclusion Consultants expressed, “Minnesotans with disabilities told us that health is more than access to doctors—it's about feeling safe in your body, being treated with dignity, and having the resources to heal from trauma. Safety includes protection from abuse and neglect, while healing means access to physical and mental health supports that are culturally responsive, trauma-informed, and rooted in trust. For many, it also means being believed.”

Conclusion

These guiding values overlap and intersect. Strong social networks and community inclusion are crucial for a sense of belonging, healing and overall well-being. Yet, ableism and a lack of inclusive spaces can lead to social isolation for people with disabilities. This is why integration alone is not enough.

Reaching our North Star: True inclusion

Achievable goals are the foundation of an effective Olmstead Plan. Minnesota state agencies wrote goals with Inclusion Consultants to promote progress and transparency. They are specific, measurable, achievable, relevant, and time-bound (SMART). This plan's goals represent five-year commitments for state agencies.

Inclusion Consultants also advocated for transforming systems that serve people with disabilities. SMART goals alone will not ensure Minnesota fulfills the spirit of Olmstead. Reaching our North Star — full inclusion — requires long-term innovation and investment. The state needs to consider fundamental shifts in how it supports and serves disabled Minnesotans.

This plan recommends the formation of a long-term planning body, with the ultimate purpose of transforming Minnesota's disability services system to foster true and authentic community membership for Minnesotans with disabilities. This body will focus on issues raised by Inclusion Consultants and the disability community; for example:

- Disability services are incomplete, fractured, and uncoordinated. This leaves people struggling to find and maintain support, making it difficult to plan for the future.
- People with disabilities often have to choose between employment and keeping their benefits. Many benefits and services include income limits. Once people start earning a living wage, they may lose their benefits.
- Government and society at large often view and treat disabled people as "less than" or an afterthought. Systems and structures must transform to combat these harmful stereotypes, foster authenticity, belonging, and full community participation.
- The direct care workforce shortage is a complex issue facing the disability community, providers, and others. As a result, people with disabilities may struggle to find and maintain the services and supports they need.

No one state agency is empowered to solve these issues alone. Rather, transformation requires engagement and commitment across all sectors and regions of Minnesota. Achieving change on this scale will require fundamental shifts in service models, deep engagement with people with lived experience, new resources, and long-term planning.

Minnesota already has similar entities. The Children's Cabinet and the Opioid Epidemic Response Advisory Council serve as models that could be adapted.

As a first step, the Olmstead Subcabinet will authorize the formation of a Disability Systems Change Workgroup. This workgroup will be formed by March 1, 2027. The workgroup's focus will be developing the structure, mission, and membership of a transformational change planning body. It will include both internal and external partners.

The workgroup will provide a written report to the Subcabinet no later than October 1, 2027. The report will make recommendations to the Subcabinet on:

- Membership, including who should be involved in the long-term planning body. Examples could include counties, local government, providers, advocacy organizations, people with expertise in areas like assistive technology, and more.
- Key issues and areas of focus, as described earlier in this section.
- Legal authority and funding to operate the planning body, which may involve questions about legislative authority or who the long-term body will report to.
- Mechanisms for aligning to state legislative and budgeting processes, including how recommendations could be implemented and funded by policymakers.

The Subcabinet will review and discuss all recommendations from the workgroup.

Measurable goals and strategies

Measurable goals are the foundation of an effective Olmstead plan. These are goals that are specific, measurable, achievable, relevant, and time-bound (SMART). They are key to holding state agencies accountable for integration and inclusion of people with disabilities. The following measurable goals are organized by topic. These topics are organized alphabetically for ease of review:

- Crisis services
- Education
- Employment
- Health and safety
- Housing
- Preventing abuse and neglect
- Transit and transportation
- Transition

The goals include:

- A one-sentence summary of the goal.
- The lead agency or lead agencies that are responsible for the goal.
- A section titled “What is this goal about?” with more details about the goal.
- A section titled “Why does this goal matter?” that explains why the goal is important.
- A section titled “How we track our progress” with information about measurable targets
- Strategies explaining how the agency will reach the goal.

Crisis services

Crisis Services Goal 1: Fewer children and teens in foster care who may have a disability will experience institutional placements.

Lead agency: Department of Children, Youth, and Families (DCYF)

What is this goal about?

This goal is about children and teens who experience out-of-home care. Out-of-home care includes care in family homes and institutions. Children with disabilities who are in foster care are more likely to be placed in institutions. The goal is for fewer children 17 and under to be placed in institutions.

Definition of institutional for this goal: non-family setting including children's residential facilities, group homes, and correctional settings.

Children and families navigate a complex statewide system of services and supports. DCYF oversees the Child Safety and Permanency system through policy, guidance, workforce training, and data collection. DCYF works in partnership with counties, Tribes, and providers to strengthen coordination in the implementation of the programs.

DCYF's responsibilities and roles include:

- Oversight of the child welfare and child protection system.
- Partnership with county, courts, Tribes and providers regarding foster care placement guidance and policy.
- Workforce training and provision of technical assistance in the areas of child welfare and child protection.
- Partnership with federal partners on compliance and foster care reporting through the Adoption and Foster Care Analysis and Reporting System (AFCARS)
- Upkeep of Information Technology (IT) systems that support the child welfare and protection system and related data through the Social Services Information System (SSIS)

Why does this goal matter?

Out-of-home care is stressful for anyone. These experiences can harm children's well-being in the short and long term. Being placed in an institution can be especially distressing. Children placed in institutional settings are more likely to be identified as having a disability, as group homes and residential programs provide treatment of mental health conditions or developmental disabilities.

It is best for children to stay connected to their communities. Meeting children's needs in the community can prevent the use of out-of-home care and help children remain safely with families whenever possible.

This goal is also important for addressing racial inequity, disproportionality, and intersectionality. Children with disabilities may experience inequities based on disability and other parts of their identity or life experiences. Children of color are more likely than white children to experience out-of-home care. This goal aligns with the Minnesota African American Family Preservation and Child Welfare Disproportionality Act and the federal Family First Prevention Services Act. It supports prevention, early intervention, and family preservation efforts that reduce unnecessary family separation and improve permanency outcomes.

How we track our progress

Our starting point (baseline): In 2024, there were 8,904 total out-of-home placements of children. Of these, 2,368 were institutional placements. 71% of institutional placements involved disabled children. In contrast, 30% of family home placements involved children with disabilities.

Measurable goal:

- By 2027, the number of new placements in institutional settings will decrease by 3% from baseline (or to 2,296 institutional placements).
- By 2028, the number of new placements in institutional settings will decrease by 3% from the prior year.
- By 2029, the number of new placements in institutional settings will decrease by 4% from the prior year.
- By 2030, the number of new placements in institutional settings will decrease by 4% from the prior year.
- By 2031, the number of new placements in institutional settings will decrease by 5% from the prior year.

Data context:

Most institutional placements are in residential programs or group homes.

- 30% of the children placed in institutions were African American/Black children.
- 35% of the children placed in institutions were American Indian/Alaskan Native children.

About this target: This target reflects changes that DCYF can realistically make. Institutional placements are influenced by many factors, including the availability of community-based services, workforce shortages, provider capacity, and broader system conditions. DCYF's strategies focus on areas the agency can directly influence and include collaboration with other state agencies, counties, and Tribal Nations to strengthen supports for children and families. These strategies will take time to make a difference and also lay groundwork for more reductions in institutional placement going forward.

About the data: This data comes from DCYF's Social Services Information System (SSIS). Foster care data is also reported to the federal government. It tracks the number of placements, not the number of children who receive placements. The same child might receive multiple institutional placements in the same year.

Strategies

DCYF will reach this goal by focusing on prevention. This includes cross-training the workforce to know all the supports available for children. These supports can prevent a child from being placed in an institution. Families of children placed in institutional settings often share that they could not get the right supports early enough.

Crisis intervention for youth involved in the juvenile justice system

DCYF will partner with the Minnesota Department of Health (MDH) on these strategies. DCYF and MDH will:

- Create a coordinated support system called a Juvenile Justice Mental Health Continuum of Care. This will help identify gaps in training and services to support juvenile justice facilities and frontline staff responding to mental health crises.
- Lead statewide training initiatives about mental health. One initiative is about trauma-informed care. Another is about suicide prevention. These trainings will be available for juvenile justice facilities, child welfare partners, school staff, and others who work with youth.

Cross-training for the workforce

DCYF will partner with the Minnesota Department of Human Services (DHS) on these strategies. They will:

- Create cross-training for child welfare, children's mental health, and children's waiver case workers and residential service providers. These trainings will focus on serving children with complex needs. They will emphasize early intervention and compassion for children and families.
- Develop best practices for collaboration and coordination across services.
- Develop supports for counties and Tribes around early intervention and in-home supports.

Community prevention

DCYF will partner with the Minnesota Department of Education (MDE) and MDH on these strategies to increase referrals for early intervention services. Connecting children and families to support earlier can help build on family strengths, support children's development, and prevent the need for more intensive services later.

They will:

- Educate counties and community organizations about early and ongoing developmental screenings.
- Invite and listen to Tribal Nations through dialogue and representation. Learn American Indian lifeways for early and ongoing developmental screenings for our youngest relatives. Co-create mutually beneficial supports for American Indian children and families.
- Create best practice guides for referrals for children who experience abuse and neglect. They will ensure these guides are culturally competent.

Crisis Services Goal 2: More people will stay in the community after a crisis.

Lead agency: DHS

What is this goal about?

This goal is about how many people stay in their community after using mobile crisis services. This means they avoid more segregated settings like hospitals when appropriate.

For this goal, staying in the community means:

- Remaining in an individual's current living environment,
- Transitioning to an appropriate community-based setting, or
- Receiving services in a non-locked residential placement that supports continued community integration.

This goal has two parts. Crisis Services Goal 2A is about adults. Crisis Services Goal 2B is about children.

Why does this goal matter?

Mobile crisis teams are an invaluable mental health service. They promote dignity, choice, and community connection for people experiencing crises. Mobile crisis services reduce unnecessary hospitalizations and institutionalizations. These experiences can cause extra stress and disrupt people's lives. Helping people with behavioral health needs stay in their communities supports the spirit of *Olmstead*. Crisis services can also help people:

- Stabilize
- Access other mental health services
- Develop action plans
- And more

This goal will help measure how effective mobile crisis services are in helping people remain safely in the community.

How we track our progress

Crisis Services Goal 2A: Adults who receive adult mental health crises services

Our starting point (baseline): About 18,000 mobile crisis encounters happened across Minnesota in state fiscal year 2025. Of those, 14,631 involved adults. Of those adults:

- 56.5% remained in community.
- 30.9% were in treatment.
- 12.6% were in other settings at the end of a mobile crisis encounter.

Measurable goal:

- By June 30, 2027, at least 58% of adults who receive adult mental health crises services will remain in their community.
- By June 30, 2028, at least 59% of adults who receive adult mental health crises services will remain in their community.
- By June 30, 2029, at least 60% of adults who receive adult mental health crises services will remain in their community.
- By June 30, 2030, at least 61% of adults who receive adult mental health crises services will remain in their community.
- By June 30, 2031, at least 62% of adults who receive adult mental health crises services will remain in their community.

Crisis Services Goal 2B: Children who receive mental health crises services

Our starting point (baseline): About 18,000 mobile crisis encounters happened across Minnesota in state fiscal year 2025. Of those, 3,269 involved children. Of those children:

- 69.6% remained in community.
- 19.5% were in treatment.10.9% were in other settings at the end of a mobile crisis encounter.

Measurable goal:

- By June 30, 2027, at least 70% of children who receive mental health crises services will remain in their community.
- By June 30, 2028, at least 71% of children who receive mental health crises services will remain in their community.
- By June 30, 2029, at least 72% of children who receive mental health crises services will remain in their community.
- By June 30, 2030, at least 73% of children who receive mental health crises services will remain in their community.

- By June 30, 2031, at least 74% of children who receive mental health crises services will remain in their community.

Crisis Services Goal 2A and 2B

About the data: This data comes from the Mental Health Information System (MHIS). MHIS tracks each person's outcome at the end of a crisis episode. Anyone in Minnesota can access mobile crisis services, regardless of disability status, insurance status, or ability to pay for services.

Strategies

From 2026 to 2029, DHS will:

- Review and refine MHIS data points, including data about service referrals through mobile crisis response.
- Identify people with repeat mobile crisis responses and their outcomes. DHS will use this information to:
    - Provide referrals to additional services
    - Inform future crisis prevention efforts
    - Support community stability
    - Improve mobile crisis response services
- Review MHIS outcome categories. This will ensure the outcomes are accurately counted as community-based, treatment-related, correctional, or other. DHS will also create a clearer definition of community-based outcomes.
- Improve MHIS data collection, data accuracy, and analysis.
- Monitor outcomes by population and services. This will help DHS understand if mobile crisis services effectively support different demographic groups and service settings. DHS will use that information to improve mobile crisis services.

Education

Education Goal 1: More students with disabilities will learn in integrated classrooms.

Lead agency: Minnesota Department of Education (MDE)

What is this goal about?

This goal is about students with Individualized Education Programs (IEPs). The goal is for more students with IEPs to learn in the most integrated setting of their choice.

Why does this goal matter?

Inclusive classrooms benefit all learners. In general, students with disabilities experience better outcomes in:

- Academics
- Social skills
- Peer relationships
- Lifelong community integration

Students without disabilities also benefit from inclusion of students with disabilities in their classrooms.

How we track our progress

Our starting point (baseline): In 2024, 63.14% of students with disabilities were taught in the most integrated setting. That means 91,377 of Minnesota's 144,720 students with disabilities were in the most integrated setting.

Measurable goal:

- By January 1, 2027, at least 65.3% of students with disabilities will be taught in the most integrated setting.
- By January 1, 2028, at least 65.8% of students with disabilities will be taught in the most integrated setting.
- By January 1, 2029, at least 66.3% of students with disabilities will be taught in the most integrated setting.
- By January 1, 2030, at least 66.8% of students with disabilities will be taught in the most integrated setting.

- By January 1, 2031, at least 67.3% of students with disabilities will be taught in the most integrated setting.

About this target: The target is developed with stakeholder input. It is part of the Minnesota State Performance Plan for special education. This plan is required by federal special education law.

About the data: This goal includes students with IEPs. Students' IEP teams decide how students will learn in the most integrated setting of their choice. IEP teams include parents and caregivers. Schools share this information with MDE. Minnesota is required to report this data to the federal government. Students with disabilities age 18 to 22 that are served in transition programs are not counted as being educated in the most integrated setting, even though these programs usually include work-based learning and employment in the community.

Strategies

To reach this goal, MDE will:

- Develop professional development and resources for school principals on effective practices for inclusive education, including cultural competence.
- Develop professional development and resources for teachers on tailoring instruction to meet student needs. Topics will include differentiated instruction, co-teaching, cultural competence, and universal design for learning.
- Develop professional development and resources for paraprofessionals on supporting students to learn in the most integrated setting, including cultural competence.
- Support schools in using best practices for inclusive education, including cultural competence.
- Develop guidance for IEP teams on how to consider the communication needs of the child, and in the case of a child who is deaf or hard of hearing, consider the child's language and communication needs, opportunities for direct communications with peers and professional personnel in the child's language and communication mode, academic level, and full range of needs, including opportunities for direct instruction in the child's language and communication mode.
- Develop resources for students and school staff about disability and inclusivity, including cultural competence.
    - This includes emphasizing that including and accommodating students with disabilities is everyone's responsibility.
- Continue supporting the federal and state parent training and technical assistance center (PTIC). These provide parents with information about education in the most integrated setting, including:
    - Special Education Placement Settings
    - Least Restrictive Environment
    - Free Appropriate Public Education and the Least Restrictive Environment

    - Guide to the IEP for Parents
    - Assistive Technology
- Develop resources for parents and caregivers about how assistive technology can be used as part of the IEP process. Assistive Technology can help students with disabilities be in more integrated settings. These resources will also include information on where parents and caregivers can go for live real-time assistance.
- Develop professional development opportunities for school staff and parents and caregivers of students with disabilities to learn about person-centered planning. This will include Charting the LifeCourse at Disability Hub.
- Provide guidance to school districts and charter schools on available and federal and state funding to implement greater inclusion of students with disabilities in more integrated settings of their choice.
- Disaggregate special education setting data by race/ethnicity and category of special education eligibility. Analyze this data for opportunities to improve the continuum of alternative placements available for students with disabilities to increase education in more integrated settings.

Education Goal 2: Schools will better engage families of students with disabilities.

Lead agency: MDE

What is this goal about?

This goal is about families of children who have IEPs. The goal is for more families to report that schools facilitate family engagement.

Why does this goal matter?

Family engagement is essential for students with disabilities to thrive. Meaningful family engagement can help students get appropriate services and supports. These supports promote inclusion and self-determination. Students with disabilities whose families are engaged are also more likely to achieve their goals. They are also more likely to have a successful transition to adult life. Students whose families are engaged have a better sense of community knowing that their parents and caregivers are working with the school for the success of the student.

How we track our progress

Our starting point (baseline): In 2022-23, about 69.8% of families reported that schools facilitated family engagement. That means 127 of the 182 survey respondents reported schools facilitated family engagement.

Measurable goal:

- By February 1, 2027, at least 72% of families of children with IEPs will report that schools facilitate engagement.
- By February 1, 2028, at least 72.5% of families of children with IEPs will report that schools facilitate engagement.
- By February 1, 2029, at least 73% of families of children with IEPs will report that schools facilitate engagement.
- By February 1, 2030, at least 73.5% of families of children with IEPs will report that schools facilitate engagement.
- By February 1, 2031, at least 74% of families of children with IEPs will report that schools facilitate engagement.

About this target: The target is developed with stakeholder input. It is part of the Minnesota State Performance Plan for special education. This plan is required by federal special education law.

About the data: This data comes from MDE's annual Family Engagement Survey, developed and validated by the National Center on Special Education Accountability and Monitoring. Each year, a different sample of families across the state take the survey. Families of children and youth with IEPs can participate. MDE reports the results to the federal Office of Special Education Programs.

Strategies

To reach this goal, MDE will:

- Improve outreach to families from underrepresented and culturally and linguistically diverse communities.
    - This includes families who speak languages other than English, Hmong, Somali, and Spanish.
- Develop professional development and resources for school staff on culturally responsive family engagement practices.
- Give the survey in multiple ways, including online, on paper, and over the phone.
- Help schools better engage families through regional coordinators of family engagement in school districts and charter schools, as well as American Indian Home School.
- Use survey results to inform local and statewide school improvement planning.
- Continue supporting the federal and state parent training and technical assistance center.
- Provide parents with information about special education, including the "Guide to the IEP for Parents," as well as materials and guidance available to parents in languages other than English, for example Spanish, Somali, and more.
- Develop professional development opportunities for school staff to learn about person-centered planning and how it improved engagement with families, including Charting the LifeCourse at Disability Hub.

- Provide guidance to school districts and charter schools on available and federal and state funding to implement improved family engagement.
- Provide guidance to school districts and charter schools on how to use federal and state funding for engaging with families in culturally specific community settings.
- Scale up individual mentoring and school/family connection for American Indian and Black students with disabilities through expanding Check & Connect implementation in schools.

Education Goal 3: Fewer students with disabilities will be suspended and expelled based on systemic bias.

Lead agency: MDE

What is this goal about?

This goal is about school districts that disproportionately discipline students with disabilities.

- "Students with disabilities" means students with IEPs.
- "Discipline" means suspension longer than 10 days, or expulsion.
- "Disproportionately" means at a rate higher than the state average.

Why does this goal matter?

Students with disabilities tend to be suspended and expelled more often than students without disabilities. Using positive supports can help keep students in the classroom and engaged with effective instruction. Students who experience a lot of exclusionary discipline are at higher risk for removal from instruction and learning supports, as well as long-term life consequences.

This goal is also important for addressing racial inequity. Students of color with disabilities are more likely than white students with disabilities to experience exclusionary discipline.

How we track our progress

Our starting point (baseline): In the 2022-2023 school year, 5.99% of school districts and charter schools were identified as disproportionately disciplining students with disabilities. That is 29 out of 484 school districts and charter schools.

Measurable goal:

- By February 1, 2027, 3.55% of school districts and charter schools will be identified as disproportionately disciplining students with disabilities. That is about 17 school districts and charter schools.

- By February 1, 2028, 3.35% of school districts and charter schools will be identified as disproportionately disciplining students with disabilities. That is about 16 school districts and charter schools.
- By February 1, 2029, 3.15% of school districts and charter schools will be identified as disproportionately disciplining students with disabilities. That is about 15 school districts and charter schools.
- By February 1, 2030, 2.95% of school districts and charter schools will be identified as disproportionately disciplining students with disabilities. That is about 14 school districts and charter schools.
- By February 1, 2031, 2.75% of school districts and charter schools will be identified as disproportionately disciplining students with disabilities. That is about 13 school districts and charter schools.

About the data: All school districts and charter schools report discipline data to MDE.

Strategies

To reach this goal, MDE will:

- Expand use of Positive Behavioral Interventions and Supports (PBIS) statewide.
- Provide training on trauma-informed practices, de-escalation techniques, and culturally responsive classroom management.
- Require schools to finish self-reviews and corrective action plans if they have high rates of suspension and expulsion, or statistical overrepresentation of student demographic groups in suspension and expulsion.
- Proactively support schools that approach high rates of suspension and expulsion for students with disabilities.
- Expand school-based behavioral health services, including coordination with county-based services and supports and behavioral health providers in communities.
- Provide guidance to school districts and charter schools on available and federal and state funding to implement prevention of suspensions and expulsions and implement alternatives to suspension and expulsion.

Education Goal 4: More staff will be equipped to support children with disabilities in early care and education (ECE).

Lead agency: Department of Children, Youth, and Families (DCYF)

Supporting agencies: MDE, Minnesota Department of Health (MDH), Department of Human Services (DHS)

What is this goal about?

This goal is about training for the early care and education (ECE) workforce. This type of training will help staff better support children with disabilities. In early childhood, supporting the adults who care for and teach children is the main way to support children. The goal aims to make ECE programs more inclusive for children with disabilities.

Children and families navigate a complex statewide system of services and supports. DCYF oversees the Early Childhood system through policy, program guidance and technical assistance, workforce and provider support, and data collection. DCYF works in partnership with counties, Tribes, schools, and providers to strengthen coordination in the implementation of the programs.

DCYF's oversees programs including:

- Child Care and Development Fund (CCDF)
- Preschool Development Grant (PDG)
- Child Care Assistance Program (CCAP)
- Early Learning Scholarships Program
- Parent Aware
- Public Pre-Kindergarten Programs
- Early Childhood Family Education (ECFE)
- Health and Developmental Screening
- Co-leadership of Part C Early Intervention (birth-age 2) with the MN Department of Education

For a comprehensive list of oversight programs, see the Programs Directory on the DCYF website.

- Partnership with counties, schools, Tribes and providers regarding guidance, policy, and program implementation
- Workforce and provider support with training, quality rating, and provision of technical assistance in the areas of early childhood care and education
- Partnership with State and Federal partners on compliance and program implementation including CCDF, PDG, and Head Start
- Upkeep of IT systems that support child care access and provider support including MEC2 and the Provider Hub

Why does this goal matter?

Inclusive ECE is beneficial for children with and without disabilities. Benefits include better education and social outcomes. Disabled children in inclusive ECE programs are also less likely to experience segregation later in life.

Families with disabled children often struggle to find inclusive ECE programs. Children with disabilities are also suspended and expelled from these programs at higher rates than non-disabled children. In Minnesota, it is illegal to suspend or expel children from preschool and pre-K programs, except in certain cases outlined in statute. However, informal suspensions and expulsions still happen. ECE programs may say things like:

- “Please pick up your child early today.”
- “Let’s try half days for the next few weeks.”
- “The program isn’t a good fit for your child.”

How we track our progress

Our starting point (baseline): In 2023, 48% of early care and education staff reported in Minnesota’s Early Childhood Workforce Study that they need additional support or training around behavior management.

Measurable goal: By 2029, 40% or fewer of early care and education staff will report in Minnesota’s Early Childhood Workforce Study that they need additional support or training around behavior management.

About this target: DCYF wants to measure attendance and inclusion of disabled children in ECE programs. However, DCYF doesn't have that data right now. The agency will work to get that data and may use it for a future Olmstead Plan goal.

About the data: This data comes from Minnesota’s Early Childhood Workforce Study. The study happens every three years. It was conducted in 2023 and will be conducted again in 2026. Progress toward the target will be reported after each study. The study is only conducted every three years because meaningful changes in the workforce would likely not be visible if it were conducted more frequently. This cadence is appropriate because training and coaching take time to influence staff practices. Therefore, the goal does not include annual targets.

In 2023, 1,050 educators responded to the survey. This is a large sample of educators. There are an estimated 40,000 early childhood educators in Minnesota.

Strategies

To reach this goal, DCYF:

- Hired a researcher to study attendance in ECE programs. This will include disaggregation by disability. This will help DCYF understand if children with disabilities are regularly attending and included.
- Is investing in expansion of the Center for Inclusive Child Care's (CICC) Early Childhood Leadership Development Program. This will allow more ECE staff statewide to enroll in the

program. The program will also offer more resources. Anti-ableism and disability training are core components of the CICC's overall work. These topics will be a focus of the training and resources.

- Will create a framework to align training and support for staff across different ECE programs. The framework will reduce duplicate efforts and give staff more access to high-quality coaching and other resources. These supports will help staff respond to the different ways children learn, communicate, manage emotions, build relationships, and participate. They also recognize intersectionality and how children's needs may be shaped by disability and other parts of their identity, family context, culture, language, and life experiences.
- Will explore better systems for ECE programs to access and track trainings. The new system will offer and track data for courses about inclusion of children with disabilities.
- Will review programming and coaching approaches to focus on *supporting behaviors* NOT pathologizing or correcting.

DCYF will need support from other agencies to reach this goal. DCYF will partner with:

- MDE, to increase the leadership skills of ECE staff through learning modules, trainings, and webinars. This includes coordinated support of the Collaborative Minnesota Partnerships to Advance Student Success (COMPASS) system.
- DHS, to increase ECE staff access to trauma-informed training and coaching.
- DHS, to support infant and child mental health services.
- MDH, to increase ECE staff access to training on supporting the health needs of children with disabilities.

Education Goal 5: Fewer students with disabilities will experience restrictive procedures.

Lead agency: MDE

What is this goal about?

This goal is about students with IEPs who experience emergency use of restrictive procedures.

Why does this goal matter?

Being treated with dignity and respect is an important part of quality of life. Experiencing restrictive procedures can be traumatizing for students. Positive supports are more effective than restrictive procedures to reduce harmful behaviors.

How we track our progress

Our starting point (baseline): In 2024, 1.8% of students with disabilities or fewer experienced emergency use of restrictive procedures at school. That means 2,932 students with disabilities out of 144,720 experienced restrictive procedures.

Measurable goal:

- By June 30, 2027, 1.7% of students with disabilities or fewer will experience emergency use of restrictive procedures at school.
- By June 30, 2028, 1.6% of students with disabilities or fewer will experience emergency use of restrictive procedures at school.
- By June 30, 2029, 1.5% of students with disabilities or fewer will experience emergency use of restrictive procedures at school.
- By June 30, 2030, 1.4% of students with disabilities or fewer will experience emergency use of restrictive procedures at school.
- By June 30, 2031, 1.3% of students with disabilities or fewer will experience emergency use of restrictive procedures at school.

About this target: The target is developed as part of the state's "Standards for Restrictive Procedures" statute.

About the data: All school districts and charter schools report data about restrictive procedures to MDE.

Strategies

To reach this goal, MDE will:

- Develop information for school districts and charter schools on effective practices for preventing and using alternatives to restrictive procedures.
- Publicly share information about reducing the use of restrictive procedures.
- Expand school-based behavioral health services, including coordination with county-based services and supports and behavioral health providers in communities.
- Expand use of Positive Behavioral Interventions and Supports (PBIS) statewide.
- Provide training on trauma-informed practices, de-escalation techniques, and culturally responsive classroom management.
- Proactively support schools that approach high rates of restrictive procedures for students with disabilities.
- Develop and deliver educator wellness information to schools and their staff as a strategy to lower restrictive procedure use.

- Provide guidance to school districts and charter schools on available federal and state funding to implement prevention of student crises and implement alternatives to restrictive procedures.
- Develop professional development opportunities for school staff to learn about person-centered planning and how it improved engagement with families and caregivers, including Charting the LifeCourse at Disability Hub.
- Develop professional development opportunities for special education teachers to facilitate students sharing their support needs with school staff through one-page profiles. Examples of profile prompts include: “I feel best supported when my teachers [blank]” and “When I need help with my feelings, [blank] is what helps me.” Students who need help with writing or need support with communication will be assisted by their school staff in sharing their needs and what helps them.

Employment

Employment Goal 1: More people with disabilities will have jobs in the community.

Lead agencies: Department of Employment and Economic Development (DEED), Minnesota Department of Education (MDE), Department of Human Services (DHS)

What is this goal about?

This goal is about more people with disabilities having competitive, integrated employment (CIE). This goal has three different parts. Those parts are:

- Goal 1A: People who receive services from Vocational Rehabilitation Services or State Services for the Blind (VRS/SSB)
- Goal 1B: People who receive both Medicaid waiver services and VRS/SSB services
- Goal 1C: Students ages 16 and up who have Individualized Education Programs (IEPs) with complete secondary transition planning.

Why does this goal matter?

Employment is a way for all people to earn money and be self-sufficient. For many people, jobs can be a source of meaning and fulfillment. Jobs can also help people:

- Socialize and make friends.
- Share knowledge and talents with others.
- Engage in the community.
- Learn new skills.

People with disabilities tend to have higher unemployment rates than people without disabilities. That is because people with disabilities experience more barriers to employment. Barriers include:

- Lack of services and supports, like job coaches.
- Discrimination and ableism from employers and coworkers.
- Challenges getting accommodations.
- Lack of transportation.
- Fear of losing necessary benefits.

How we track our progress

Employment Goal 1A: VRS/SSB

Our starting point (baseline): In state fiscal year 2025, 41.5% of people served by VRS/SSB who exited from the programs had CIE. That means 2,098 of the 5,052 people served by VRS/SSB had jobs in the community.

Measurable goal*:*

- By December 31, 2027, 42% of people served by VRS/SSB will have CIE.
- By December 31, 2028, 43% of people served by VRS/SSB will have CIE.
- By December 31, 2029, 44% of people served by VRS/SSB will have CIE.
- By December 31, 2030, 45% of people served by VRS/SSB will have CIE.
- By December 31, 2031, 45% of people served by VRS/SSB will have CIE.

About this target: Finding CIE can take a long time. Getting a community job through VRS/SSB means that someone:

- Applied for services,
- Was found to be eligible for services, and
- Completed an individualized employment plan.
- Received personalized services such as counseling, training, job search and supports.
- Completed services and/or left the VRS/SSB program prior to fully carrying out their plan for employment.

This process usually takes about two years or longer. That limits how fast VRS/SSB can increase the rate of people who get jobs. Some people who leave the programs are counted as not having a job in this measure, but are working soon after they leave VRS/SSB. Around 55% of people are working six months after leaving VRS/SSB services.

About the data: This data comes from DEED's case management database.

Employment Goal 1B: VRS/SSB and Medicaid waiver services

Our starting point (baseline): In state fiscal year 2025, 39% of people who received both Medicaid waiver services and VRS/SSB services had CIE. That means 670 of the 1,716 people served through both programs had CIE.

Measurable goal:

- By December 31, 2027, 41% of people who receive both Medicaid waiver services and VRS/SSB services will have CIE.

- By December 31, 2028, 42% of people who receive both Medicaid waiver services and VRS/SSB services will have CIE.
- By December 31, 2029,43% of people who receive both Medicaid waiver services and VRS/SSB services will have CIE.
- By December 31, 2030, 44% of people who receive both Medicaid waiver services and VRS/SSB services will have CIE.
- By December 31, 2031, 45% of people who receive both Medicaid waiver services and VRS/SSB services will have CIE.

About this target: Finding CIE can take a long time. Getting a community job through VRS/SSB means that someone:

- Applied for services,
- Was found to be eligible for services, and
- Completed an individualized employment plan.
- Received personalized services such as counseling, training, job search and supports.

Completed services and/or left the VRS/SSB program prior to fully carrying out their plan for employment.

This process usually takes about two years or longer. That limits how fast VRS/SSB can increase the rate of people who get jobs. Some people who leave the programs are counted as not having a job in this measure, but are working soon after they leave VRS/SSB. Around 55% of people are working six months after leaving VRS/SSB services.

About the data: This data comes from DEED's case management database.

Employment Goal 1C: Students ages 16 and up who have IEPs with complete Secondary Transition Planning

Our starting point (baseline): In the 2023-2024 school year, there were 158,574 students with IEPs and 34.9% of those students were age 16 and above. In that same year, 70.73% of students with IEPs had complete postsecondary transition planning in their IEPs.

Measurable goal:

- By June 30, 2027, 100% of students age 16 and above with an IEP will have complete postsecondary transition planning in their IEPs.
- By June 30, 2028, 100% of students age 16 and above with an IEP will have complete postsecondary transition planning in their IEPs.
- By June 30, 2029, 100% of students age 16 and above with an IEP will have complete postsecondary transition planning in their IEPs.
- By June 30, 2030, 100% of students age 16 and above with an IEP will have complete postsecondary transition planning in their IEPs.

- By June 30, 2031, 100% of students age 16 and above with an IEP will have complete postsecondary transition planning in their IEPs.

About this target: This target is a federal and state special education compliance indicator that measures the percentage of students with disabilities ages 16 and above with an IEP. It includes appropriate, measurable postsecondary goals that are: a) updated annually, b) based on age-appropriate transition assessment and services, c) include courses of study that will reasonably enable the student to meet their postsecondary goals, and d) related to the student's transition service needs.

Strategies

Employment Goal 1A: VRS/SSB

To reach this goal, DEED will:

- Increase employment outcomes by using evidence-based and promising practices.
- Support MDE and local education agencies in ensuring high quality secondary transition planning is reflected in IEPs. This includes attending IEP meetings to plan together when students are enrolled in VR and ensuring the VR Employment Plans are coordinated with IEPs.
- Support students enrolled in VR services in collaboration with MDE, local education agencies, and DHS lead agencies. Support will include students receiving all needed Pre-Employment Transition Services (Pre-EST), including experience with competitive integrated employment before high school graduation.
- Support existing Individualized Placement and Support (IPS) projects and Minnesota Customized Employment training.
- Evaluate feasibility and effectiveness of Progressive Employment via the Disability Innovation Fund (DIF) grant.
- Train employment services providers on delivering high-quality, person-centered services through ongoing professional development and technical assistance. This includes expanding access to partner training through the Learning Management System (LMS) and promoting quality standards such as the CARF accreditation.
- Support businesses by:
    - Creating partnerships with businesses to increase hiring people with disabilities.
    - Promoting recruitment, hiring, and retention of people with disabilities throughout the state.
    - Working with local partners like chambers of commerce and other entities about hiring people with disabilities.
    - Providing disability awareness training and information on accommodations and other existing resources.
- Promote services like assistive technology, benefits planning, and other resources to support employment.

- DEED-VRS will provide the Workforce Innovation and Opportunity Act Limitations on the Use of Subminimum Wage: Section 511 required Career Counseling, Information, and Referral process for Youth Ages 24 and under and for those currently earning a subminimum wage to promote informed choice about competitive integrated employment options.

Employment Goal 1B: VRS/SSB and Medicaid waiver services

To meet this goal, DEED, MDE, and DHS will work together to:

- Streamline the informed choice process for people earning subminimum wages and youth who are considering subminimum wage jobs.
- Ensure more youth get CIE experience before graduation.
- Increase the percentage of students whose IEPs have goals for life after high school.
- Carry out an interagency alignment study to make it easier to get employment services by:
    - Identifying ways to address barriers that make it harder to get and move between different employment services.
    - Learning more about the specific experiences of Black people on waivers getting employment services and what is causing racial disparities in employment outcomes.
    - Forming an advisory group of Black people with disabilities who will help plan the study and recommend how to make services more equitable.
    - Using the recommendations from the study to make changes to the system.
- Use the Disability Hub and other resources to promote benefits planning to help people understand how work will impact benefits and how work and benefits can go together to support employment goals.
- Add more information in benefits planning resources for people, families, and professionals about how work affects benefits when multiple people in a household have low income and get benefits.
- Make a plain-language guide to give to people on waivers and their families at MnCHOICES assessments that explains competitive integrated employment options and employment services.

Employment Goal 1C: Students ages 16 and up who have IEPs with complete Secondary Transition Planning

To meet this goal for students with disabilities age 14 and above, MDE will:

- Implement improved secondary transition planning in schools statewide through the Employment Capacity Building Cohort and an MDE-hosted community of practice for school districts and charter schools.
- Ensure and expand families' access to information about secondary transition planning and services, including planning for assistive technology, through MDE support of the federal and

state Parent Training and Information Center (PACER Center, Simon Technology Center, National Parent Center on Transition and Employment).

- Collaborate with DEED to give guidance to school district and charter school special education staff and their partnering Vocational Rehabilitation (VR) counselors. This includes guidance on implementation of work-based learning opportunities for students with disabilities as a component of secondary transition planning.
- Reinforce partnership between the MDE Special Education Division and the MDE Career and College Success Division to support school districts and charter schools in implementing secondary credits toward graduation through work-based learning as an option in secondary transition planning.
- Continue Project SEARCH implementation at sites statewide and as an opportunity in secondary transition planning for students with disabilities.
- Provide guidance and technical assistance for school district and charter school coordination with local CareerForce centers to expand options in secondary transition planning for job placement, work-based learning, and career preparation.
- Provide guidance and technical assistance for school districts and charter schools to coordinate education and opportunities for employment through the statewide network of community transition interagency committees (CTIC's).
- Expand implementation of Charting the LifeCourse and other systematic person-centered planning in school districts and charter schools.
- Ensure secondary transition planning guidance and technical assistance includes planning for assistive technology as part of secondary transition planning. Including collaboration with Vocational Rehabilitation assistive technology resources and support, focusing on early employment and job retention skills.
- Promote the Minnesota Career Information System and ensure access for special education staff in school districts and charter schools for their secondary transition planning with students with disabilities and their families.
- Improve consistency in school district and charter school compliance with federal and state standards for secondary transition planning. This includes ensuring all school districts have access to compliance standards used by the Program Monitoring Unit in MDE's Special Education Division, and supportive guidance and technical assistance materials specific to compliance with federal and state standards for secondary transition planning.

Health and safety

Health and Safety Goal 1: More Veterans with disabilities will receive disability compensation.

Lead agency: Minnesota Department of Veterans Affairs (MDVA)

What is this goal about?

This goal is about increasing the number of Veterans with service-related disabilities who:

- File service-related disability claims through their local County Veterans Services Office (CVSO)
- Receive compensation from their claims

Why does this goal matter?

Benefits are an important resource for Veterans. But some Veterans face barriers to getting benefits. Barriers can include:

- Lack of awareness about available benefits and services
- Long and/or confusing application processes
- Lack of trust in government services

Working to address these barriers will help more Veterans receive benefits and services. Increasing income through disability compensation allows Veterans with disabilities to have more choice in where they live and increases their access to the services and supports they may benefit from, including access to VA healthcare.

How we track our progress

Our starting point (baseline): In 2025, 107,465 Veterans in Minnesota received disability compensation. That represents 39% of Minnesota's total Veteran population.

Measurable goal:

- By June 30, 2027, 109,824 Veterans with disabilities will receive disability compensation. That would be about 42% of the estimated total Minnesota Veteran population (261,488 Veterans.)
- By June 30, 2028, 111,603 Veterans with disabilities will receive disability compensation. That would be about 44% of the estimated total Minnesota Veteran population (253,644 Veterans.)
- By June 30, 2029, 115,636 Veterans with disabilities will receive disability compensation. That would be about 47% of the estimated total Minnesota Veteran population (246,035 Veterans.)
- By June 30, 2030, 114,553 Veterans with disabilities will receive disability compensation. That would be about 48% of the estimated total Minnesota Veteran population (238,654 Veterans.)
- By June 30, 2031, 113,432 Veterans with disabilities will receive disability compensation. That would be about 49% of the estimated total Minnesota Veteran population (231,495 Veterans.)

About the data: The federal Veteran Benefits Administration (VBA) has data about disability compensation claims. MDVA and CVSOs help Veterans file claims for disability compensation when appropriate. The VBA reviews and approves claims. MDVA has little impact on whether a claim is approved or not, though supports Veterans and their advocates through the process of filing.

Strategies

To reach this goal, MDVA will:

- Partner with healthcare systems across the state to improve Veteran identification. This will increase outreach to Veterans who do not access care through the federal Veterans Affairs (VA) system.
- Use the Veteran Health Navigator initiative to help disabled Veterans find and access services. This may include services related to VA disability compensation and CVSOs.
- Partner with the federal VA's VetResources Community Network Digital Outreach project. This project increases awareness of Veteran resources. It emphasizes resources for those who are seeking compensation for a service-connected disability or want to increase their disability compensation.
- Provide training for County Veteran Service Officers who work with Veterans seeking assistance with their VA disability compensation claims. Training will be specific to person centered planning and engagement.
- Support community capacity for Veteran suicide prevention strategies. Lead efforts in identifying risks for suicide among Veterans and promoting methods to assist Veterans transitioning back into civilian life. This may include connecting to CVSOs to navigate the claims process.
- Increase efforts through community partnerships for Veterans with disabilities in accessing Veteran specific resources. Resources may include education benefits, disability compensation, legal aid, healthcare, transportation, and housing.
- Ensure all Veterans with disabilities who are in MDVA's Homes or Domiciliary programs are evaluated for service connection. This includes Veterans on the waitlist for these programs, as necessary and appropriate.

Health and Safety Goal 2: Improve access to Medicaid and waiver services by simplifying information, standardizing guidance, and modernizing application processes.

Lead agency: Minnesota Department of Human Services (DHS)

What is this goal about?

This goal is about reducing avoidable delays in reviewing applications for Medicaid and waiver services. The State Medical Review Team (SMRT) reviews these applications. Reasons for avoidable delays in the SMRT process include:

- Incomplete referrals
- Missing documentation
- Confusion about eligibility requirements
- Incomplete, outdated, or incorrectly submitted forms

Why does this goal matter?

Medicaid and waiver services help people live full lives in the community. They support health, independence, and community integration. Administrative delays cause people to wait longer for needed services. This can be frustrating for applicants and staff.

Confusion about Medicaid and waiver services and the SMRT process contribute to these delays. Recipients, advocates, providers, counties, and Tribes often have different levels of understanding about this process. That can result in submitting incomplete or incorrect paperwork, which causes delays. That is why DHS wants to help people better understand Medicaid and waiver services, as well as the SMRT process. DHS will do that by improving the application process and guidance and information for Minnesotans seeking services.

How we track our progress

For this goal, “avoidable delays” means delays due to:

- Incomplete submissions
- Missing documentation
- Incorrect routing

Our starting point (baseline): About 16,000 people are referred to SMRT each year. Of those, about 55% of cases (or 8,800 cases) are completed without avoidable delays. About 45% of cases (or 7,200 cases) do experience delays.

Measurable goal:

- By June 30, 2027, 59% of Medicaid disability determinations and Medicaid waiver eligibility processes will be completed without avoidable delays. That is about 9,400 disability determinations and waiver processes.
- By June 30, 2028, 63% of Medicaid disability determinations and Medicaid waiver eligibility processes will be completed without avoidable delays. That is about 10,080 disability determinations and waiver processes.
- By June 30, 2029, 67% of Medicaid disability determinations and Medicaid waiver eligibility processes will be completed without avoidable delays. That is about 10,720 disability determinations and waiver processes.

- By June 30, 2030, 71% of Medicaid disability determinations and Medicaid waiver eligibility processes will be completed without avoidable delays. That is about 11,360 disability determinations and waiver processes.
- By June 30, 2031, 75% of Medicaid disability determinations and Medicaid waiver eligibility processes will be completed without avoidable delays. That is about 12,000 disability determinations and waiver processes.

About the data: This data comes from the SMRT case management system.

Strategies

To reach this goal, DHS will:

- Make Medicaid information more accessible. DHS will do this by launching a digital transformation pilot. The pilot will update outdated form submission methods. It will also include multilingual support and mobile-friendly formats.
- Create better guidance about the Medicaid application process. DHS will first identify pain points and gaps in the assessment pathways. DHS will then create a standardized, plain-language step-by-step guide for applicants and providers.
- Use electronic forms and signatures for applications. This will make it easier for people to submit information and communicate with SMRT. DHS will also provide education and support about electronic forms and signatures. The agency will track outcomes and collect feedback to improve the tools.

DHS developed these strategies based on:

- Reviewing common barriers in Medicaid eligibility and disability determination processes.
- Best practices in administering public benefits.
- SMRT workflow data.

Housing

State programs that help people with disabilities with housing are spread across several agencies. These agencies have different responsibilities.

Minnesota Housing provides financing to developers and housing providers. Developers and providers use this financing to build new housing units and update existing units. These include Permanent Supportive Housing (PSH) units and units designed for people with disabilities. When a project receives state or federal funds, there are requirements for design, affordability and operation. This typically affects some of or all the housing units in the project. The funding that Minnesota Housing awards represents about 5% of new multifamily units built in Minnesota in a typical year.

Minnesota Housing also administers some project-based rental subsidies and operating subsidies for supportive housing. People do not come directly to Minnesota Housing for help with housing expenses or finding housing.

The agency also works through a network of lending partners and nonprofit providers to provide the following:

- Home improvement financing
- Homebuyer education
- Down payment assistance
- Home purchase financing

The **Department of Human Services (DHS)** has several housing programs. These programs help people afford housing and provide services to help people live independently.

The **Department of Corrections (DOC)** and **Direct Care and Treatment (DCT)** help people find housing when they are transitioning back to community living or on community supervision.

The **Metropolitan Council (Met Council, MetC)** operates federal and state rent assistance. They do this through the Housing and Redevelopment Authority (Metro HRA). These programs serve approximately 8,000 low-income households. Metro HRA helps people afford housing in the private rental market. Some programs specifically help people living with disabilities. The Metro HRA also operates a project-based voucher program. In this program, rent assistance is tied to specific units. Some of these voucher programs serve people living with disabilities.

Housing Goal 1: People with disabilities will have access to more accessible housing that meets their personal preferences, as well as housing with deeply affordable rents paired with supportive services.

Lead agency: Minnesota Housing

What is this goal about?

This goal is about increasing the number of accessible housing units in Minnesota. The goal focuses on housing development financed by Minnesota Housing. The goal has two parts.

Housing Goal 1A: Universal design

This goal is about increasing availability of housing units that meet universal design standards.

Housing Goal 1B: Permanent supportive housing

This goal is about increasing the number of permanent supportive housing (PSH) units developed to primarily serve people with disabilities. This type of housing has deeply affordable rents paired with supportive services.

Why does this goal matter?

Ensuring disabled people can live in the most integrated setting that meets their personal preferences is key to Olmstead. Integrated housing is a required first step for living and enjoying life in the community. However, affordable, accessible housing can be hard for disabled people to find. People with disabilities should have equal access to housing compared to a person without a disability.

How we track our progress

Housing Goal 1A: Universal design

Our starting point (baseline): Minnesota Housing can fund approximately 500 units with universal design per year. This number is based on current development costs and available funding. This selection happens through the agency's request for proposals. The number of units each year depends on funding availability, as well as on how many proposals are for new housing versus fixing up existing housing.

Measurable goal: Between 2027 and 2031, Minnesota Housing will select for funding at least 2,500 new rental units that meet universal design standards, adding on average 500 units each year.

About the data: This data comes from Minnesota Housing’s summary of units selected for financing.

Housing Goal 1B: Permanent supportive housing

Our starting point (baseline): Currently, developing permanent supportive housing is one of Minnesota Housing’s top funding priorities. Based on current development costs and availability of funding, Minnesota Housing can finance construction of about 200 units of permanent supportive housing each year. This selection happens through the agency's request for proposals. The number of units of permanent supportive housing varies each year based on the availability and type of funding

and on the amount of PSH in the proposals submitted each year. At the end of 2025, Minnesota Housing's portfolio totaled about 7,000 units of PSH.

Measurable goal: Between 2027 and 2031, Minnesota Housing will select for funding at least 1,000 units of PSH primarily for people with disabilities, adding an average of 200 units each year.

About the data: This data comes from Minnesota Housing's summary of units selected for financing. It includes PSH serving two populations: (1) exclusively for people with disabilities and (2) people experiencing homelessness (typically having a disability and experiencing long-term homelessness).

Strategies

To reach these goals, Minnesota Housing will:

- Incentivize universal design in the selection process that Minnesota Housing uses in funding new, affordable housing.
- Incentivize the construction and rehabilitation of permanent supportive housing.
- Advocate for additional funding for affordable, accessible housing. This will make sure funding is more aligned with the level of need in the state.
- Use inclusive and trauma-informed practices when developing materials for housing providers. These materials include trainings and tenant selection plan guidelines.
- Continue to regularly review design requirements related to accessibility for properties applying for new funding.
- Engage with people with lived experience to improve processes and programs.
- Provide training for staff about Assistive Technology and how it can help people live independently. Accessible housing, home modifications, and AT/smart-home technology are complementary strategies for independent living.
- Each year, announce the number of PSH units and units with universal design, and the percentage of all new units that are universal design.
- Include more images of housing with accessibility features in communications and feature best practices for accessible housing.

Housing Goal 2: More people with disabilities who own their homes will receive affordable financing for accessibility updates to their homes.

Lead agency: Minnesota Housing

What is this goal about?

This goal is about homeownership and Minnesota Housing's home improvement loan programs. The goal is for more loans to go to people with disabilities to make accessibility updates. Minnesota Housing has two home improvement loan programs:

- The Rehabilitation Loan Program provides interest-free loans to extremely low-income homeowners where the loan amount can eventually be forgiven.
- Fix Up Loans are more traditional home improvement loans for more moderate-income homeowners, where the borrower pays back the loan with interest.

Why does this goal matter?

Homeownership is an important housing option. However, lack of accessibility can be a major challenge for disabled homeowners, including people who become disabled later in life. Making accessibility changes can be expensive. Receiving affordable financing to make these changes can help people move into a home they own or stay in their homes instead of moving to a less integrated setting. It can also help people return home from an institution.

Current funding for home improvement repairs is not enough to meet the level of need in the community. Minnesota Housing does not have resources to make accessibility updates to rented living spaces. (People who access Home and Community Based Services through DHS may be able to make accessibility updates to rental housing.) There are also challenges for people whose incomes are too high to qualify for the Rehabilitation Loan Program, yet not high enough to afford a monthly loan payment. Policies from the federal and state government, like caps on financial assets, can make it harder for people with disabilities to buy a home.

How we track our progress

Our starting point (baseline): In 2025, 57.6% of households who receive home improvement financing through the Rehabilitation Loan Program self-identified as having at least one disabled household member. That means 174 of the 302 households receiving a loan had at least one disabled household member.

Measurable goal: By 2031, 60% of households who receive financing under Minnesota Housing's Rehabilitation Loan Program self-identify as a household having at least one person with a disability.

- By March 2028, 58.2% of households who receive financing under Minnesota Housing's Rehabilitation Loan Program self-identify as a household having at least one person with a disability.
- By March 2029, 58.8% of households who receive financing under Minnesota Housing's Rehabilitation Loan Program self-identify as a household having at least one person with a disability.
- By March 2030, 59.4% of households who receive financing under Minnesota Housing's Rehabilitation Loan Program self-identify as a household having at least one person with a disability.

- By March 2031, 60% of households who receive financing under Minnesota Housing's Rehabilitation Loan Program self-identify as a household having at least one person with a disability.

Data development plan: Minnesota Housing will also start tracking and reporting data on the number and share of Rehabilitation Loans used specifically for accessibility improvements. Once that baseline data is available, Minnesota Housing will create a target for increasing the share of loans used for accessibility improvements.

In addition, Minnesota Housing will improve its collection of disability-related data for the Fix Up Loan program and create targets for this program.

About the data: This data comes from Minnesota Housing's administrative records for the Rehabilitation Loan program. They rely on lenders and borrowers to provide the information.

Strategies

To meet this goal, Minnesota Housing will:

- Include people with lived experience of disability in evaluating and improving the Rehabilitation Loan Program so that the program is accessible to them and better meets their needs.
- Explore additional funding for the Rehabilitation Loan Program and policy changes to make programs work better for people with disabilities.
- Ensure communications and marketing about Minnesota Housing's home improvement programs are accessible and reaching people with disabilities.
- Explore additional loan products to make homes accessible, including products that combine a home purchase and improvement financing, so accessibility modifications can start being made at the time of purchase.
- Explore strategies for increasing the number of people with disabilities who are homeowners. For example, having a disability is currently one of the eligibility criteria to receive a larger amount of downpayment assistance from Minnesota Housing.
- Provide training opportunities for staff to learn more about Assistive Technology and how it can help people live independently and explore ways to make training available to lending partners.

Preventing abuse and neglect

Preventing Abuse and Neglect Goal 1: Fewer students with disabilities will experience maltreatment at school.

Lead agency: Minnesota Department of Education (MDE)

What is this goal about?

This goal is about students with Individualized Education Programs (IEPs) who experienced confirmed maltreatment.

Maltreatment could include neglect, physical abuse, or sexual abuse that happens at school.

Why does this goal matter?

Everyone deserves to feel safe, respected, and supported at school. Students with disabilities may be at higher risk of maltreatment than students without disabilities.

How we track our progress

Our starting point (baseline): In 2023, 28 students with disabilities were identified and confirmed as victims of maltreatment. They represent 0.018% of the total number of students with disabilities.

Measurable goal:

- By June 30, 2027, the number of students with disabilities who experienced confirmed maltreatment will be zero.
- By June 30, 2028, the number of students with disabilities who experienced confirmed maltreatment will be zero.
- By June 30, 2029, the number of students with disabilities who experienced confirmed maltreatment will be zero.
- By June 30, 2030, the number of students with disabilities who experienced confirmed maltreatment will be zero.
- By June 30, 2031, the number of students with disabilities who experienced confirmed maltreatment will be zero.

About this target: This target number is based on the number of reported, investigated and confirmed cases of student maltreatment, not solely reported cases.

About the data: All school staff must report suspected abuse or neglect to MDE. Data for this goal is reported 24 months after the school year ends. That is because some cases take a long time to resolve, especially if they involve criminal proceedings.

MDE will include additional data when reporting on goal progress. This data will include:

- The total number of reports of alleged maltreatment
- How many of those reports involved students with disabilities
- How many reports were opened for investigations.

Strategies

To meet this goal, MDE will:

- Identify schools with multiple cases of maltreatment of students with disabilities. Follow-up will include training and technical assistance.
- Continue and expand training for school staff about:
    - Child maltreatment
    - Mandated reporting requirements
    - Positive Behavioral Interventions and Supports
    - Alternatives to restrictive procedures
    - Effective conflict and crisis prevention, and deescalation
    - Evidence-based practices for effective student discipline
    - Anti-retaliation policies for staff who make reports

Preventing Abuse and Neglect Goal 2: Fewer people with disabilities will experience sexual violence, abuse, and neglect.

Lead agency: Minnesota Department of Health (MDH)

What is this goal about?

This goal has two parts.

Preventing Abuse and Neglect Goal 2A: Reducing the number of adults with disabilities who experience sexual violence

This goal is about reducing the number of adults with disabilities who experience sexual violence.

Preventing Abuse and Neglect Goal 2B: Reducing the number of children with disabilities who experience abuse and neglect

This goal is about reducing the number of children with disabilities who experience abuse and neglect.

Why does this goal matter?

Everyone should be free from abuse and neglect. People with disabilities are more likely than people without disabilities to experience abuse and neglect. These experiences can cause lasting harm to physical and mental health.

How we track our progress

Preventing Abuse and Neglect Goal 2A: Reducing the number of adults with disabilities who experience sexual violence

Our starting point (baseline): In 2024, 19% of adults with disabilities reported experiencing sexual violence. In contrast, 8.8% of adults without disabilities reported experiencing sexual violence (MN BRFSS, 2024).

Measurable goal:

- By January 1, 2029, if question is included on 2027 Behavioral Risk Factor Surveillance System (BRFSS), data will be updated with 2027 BRFSS results.
- By January 1, 2031, the percentage of adults with disabilities who experience sexual violence will decrease to 17% (data from the 2029 BRFSS; dependent on question being included in the survey tool).

About the data:

We will use data from the Behavioral Risk Factor Surveillance System (BRFSS), based on the percentage of Minnesota adults with disabilities who answered “yes” to a question about sexual coercion or force. The CDC conducts the BRFSS, and while states can add questions, their inclusion depends on funding and approval from the federal government. Therefore, ability to report on this goal depends on inclusion of the question about sexual violence in BRFSS. Sexual violence victimization questions are expected to be included on the:

- 2027 survey, results available by Jan. 1, 2029
- 2029 survey, results available by Jan. 1, 2031

Preventing Abuse and Neglect Goal 2B: Reducing the number of children with disabilities who experience abuse and neglect

Our starting point (baseline): In 2025, 44.8% of ninth and 11th graders with disabilities reported experiencing abuse or neglect. In contrast, 17.4% of students without disabilities reported experiencing abuse and neglect.

Measurable goal: By January 1, 2029, the percentage of students with disabilities who report experiencing abuse and neglect will decrease to 42% (measured through data collected from 2028 Minnesota Student Survey [MSS]).

About the data: This data comes from the Minnesota Student Survey, a voluntary survey given to fifth, eighth, ninth, and 11th graders. Data from the next MSS (administered in 2028) will become available by Jan. 1, 2029 and will create a baseline. When data from the 2031 MSS becomes available in 2032, data trends will be established. Please refer to the appendix for the full list of survey questions used for this goal.

Strategies

Preventing Abuse and Neglect Goal 2A: Reducing the number of adults with disabilities who experience sexual violence

To reach this goal, MDH will:

- Continue to train healthcare and other service providers to identify and report abuse and neglect.
- Continue to collaborate with communities with disabilities to advance primary prevention resources, funding, and prevention strategies.
- Continue to gather and analyze data about sexual violence with attention to intersections between disability and other identities that face health inequities.
- Ensure that human trafficking prevention and response are supportive of people with disabilities. This includes labor and sex trafficking and exploitation.

Preventing Abuse and Neglect Goal 2B: Reducing the number of children with disabilities who experience abuse and neglect

To reach this goal, MDH will:

- Continue to collaborate with communities with disabilities to advance primary prevention resources, funding, and prevention strategies.
- Publish data every three years on Adverse Childhood Experiences (ACEs) experienced by youth with disabilities. This will include information on traumatic stressors that uniquely affect the disability community.
- Continue to gather and analyze data about sexual violence with attention to connections between disability and other identities that are impacted by health inequities.
- Ensure that human trafficking prevention and response are supportive of people with disabilities. This includes labor and sex trafficking and exploitation.
- Continue to train healthcare and other service providers to identify and report abuse and neglect. This includes care coordinators and local public health providers.

- Build knowledge and awareness for community-based nonprofits, like family support organizations, on identifying and reporting abuse and neglect.

Transit and transportation

Transportation is a shared responsibility among several agencies. Each has different roles.

The Metropolitan Council (Met Council, MetC) plans, funds, and operates many public transit services. This includes Metro Transit buses, light rail, and Metro Mobility.

The Minnesota Department of Transportation (MnDOT) manages the state highway system. MnDOT also supports 34 transit systems operating in all 80 counties of Greater Minnesota through technical assistance, federal and state capital and operating grants, and oversight. Statewide, MnDOT supports public transportation services focused on serving seniors and people with disabilities through mobility management and grants for buses to qualifying organizations providing rides.

Cities and counties own most local streets and sidewalks however MnDOT's roads provide critical connections to local streets and sidewalks. More complete and connected sidewalk systems make using transit and being in the community easier.

State, regional, county, city, and transit partners must work together to address concerns and improve systems.

Transit and Transportation Goal 1: Public transit will run on time.

Lead agency: Met Council

What is this goal about?

This goal is about on-time performance for different Met Council transit services. The services are:

- Metro Mobility
- Metro Move
- Transit Link
- Light Rail
- Fixed route buses

Metro Mobility must meet federal requirements for on-time pickups. The federal requirement is that at least 90% of pickups are on time. Proposed goals exceed this requirement in many months of the year. The other transit services do not have federal requirements for on-time performance.

The Met Council aspires to provide on-time performance at 100%. This would help riders reach their destinations at any time and in any weather. For Metro Mobility, even a small performance increase requires significant additional financial resources. Increasing on-time performance without additional resources would mean fewer people can use Metro Mobility. The chosen on-time performance goal balances system performance and customer access.

Knowing where a transit vehicle is and when it will arrive can be helpful for riders. This can also help drivers stay on time by reducing delays.

How we track our progress

Metro Mobility, Metro Move, and Transit Link

Metro Mobility (trips to appointments)

- On-time performance definition: The customer arrives no more than one hour early and zero minutes late.
- In 2026/2027, the definition will change to no more than 30 minutes early and zero minutes late.
- Baseline: In 2024, on-time performance was met at least 90% of the time for four months. It was not met for any months at 92% of the time.
- Goal: On-time performance is achieved at least 90% of the time each month. It is also achieved at least 92% of the time for at least six months of the year.

Metro Mobility (on-time pickups)

- On-time performance definition: The driver arrives at the customer pickup address within 30 minutes of the negotiated time.
- Baseline: In 2024, on-time performance was met at least 90% of the time for one month. It was met at least 92% of the time for three months.
- Goal: On-time performance is achieved at least 90% of the time each month. It is also achieved at least 92% of the time for at least eight months of the year.

Metro Move (trips to appointments)

- On-time performance definition: The customer arrives no more than 45 minutes early and zero minutes late.
- Baseline: In 2025, 82% of trips arrived less than five minutes late, and 90% arrived less than 15 minutes late.
- Goal: At least 90% of trips arrive no more than five minutes late, and at least 93% arrive no more than 15 minutes late.

Metro Move (on-time pickups)

- On-time performance definition: The driver arrives for pickup within 30 minutes of the negotiated time.
- Baseline: In 2025, on-time performance was met at least 90% of the time for 12 months, and at least 92% for 12 months.

- Goal: On-time performance is met at least 92% of the time each month. It is also met at least 92% of the time for at least eight months of the year.

Transit Link (trips to appointments)

- On-time performance definition: The customer arrives at the drop-off address no more than one hour early and zero minutes late.
- Baseline: In 2024, on-time performance was met at least 90% of the time for 12 months.
- Goal: On-time performance is met at least 92% of the time each month.

Transit Link (pickups)

- On-time performance definition: The driver arrives no more than 30 minutes after the negotiated pickup time.
- Baseline: In 2024, on-time performance was met at least 93% of the time for 12 months.
- Goal: On-time performance is met at least 93% of the time each month.

About these targets

Metro Mobility and Metro Move drivers come across many potential slowdowns each day. A slowdown is an event that might delay travel. Drivers do their best to anticipate slowdowns, but some are unavoidable. Slowdowns can include:

- Traffic from construction, car accidents, and more
- Construction detours
- Delays at drop-off and pick-up zones
- Staff not being ready for drop-off

On-time performance is enforced through service contracts and reports. Met Council regularly reports Metro Mobility performance to its Transportation Accessibility Advisory Committee. This typically happens on a monthly basis. Met Council can give financial bonuses or damages to contractors based on performance.

About the data

This data comes from Met Council's performance tracking database.

Metro Transit services

Regular route bus

- On-time performance definition: A Metro Transit bus may be up to one minute early and five minutes late.
- Baseline: In 2024, Metro Transit buses were on-time for 79% of the year.

- Goal: Meet on-time performance for at least 79% for the calendar year.

Light Rail

- On-time performance definition: The light rail may be up to one minute early and five minutes late.
- Baseline: In 2024, the light rail was on-time for 75.5% of the year.
- Goal: Meet on-time performance for at least 75% of the calendar year.

About these targets

Regular route bus performance is affected by:

- Traffic
- Construction detours
- Increased number of passengers

Light Rail performance is affected by:

- Speed limits to avoid rail damage
- Delays at stations, caused by passenger behavior such as door holding or from onboard incidents requiring train holds
- Delays at traffic lights, caused by motorists and other roadway users

Strategies

To reach these goals, Met Council will:

- Help riders be aware of actual arrival times. This is done by improving technology for real-time information.
- Work with medical providers to create accommodations for Metro Mobility riders. The accommodations would allow for riders who arrive late to still see their providers.

Transit and Transportation Goal 2: People with disabilities will use fixed route public transit more often.

Lead agency: Met Council

What is this goal about?

This goal is about people who use Metro Mobility services. The goal is for Metro Mobility riders to use fixed route services, like bus lines and the light rail, more often.

A new state law makes it possible for Metro Mobility riders to use fixed route public transit for free. Fixed route transit includes buses and light rail. The law came after a pilot program in 2023 through 2024.

Metro Transit is responsible for snow and ice removal at transit platforms. This helps maintain safe access. Sidewalks to and from the transit platforms are typically the responsibility of property owners, the city, or the county. Because of this, it may be challenging to get to and from transit platforms.

Why does this goal matter?

Fixed route public transit is an affordable option, since rides are now free for certified Metro Mobility users. It also allows people to be more spontaneous, compared to Metro Mobility. That's because Metro Mobility requires people to schedule rides in advance. However, public transit isn't accessible for some people with disabilities. Making public transit more accessible will allow more people to use it.

How we track our progress

Our starting point (baseline): Between October 2024 and September 2025, Metro Mobility users took about 106,600 trips on public transit.

Measurable goal:

- In 2027, Metro Mobility users will take at least 113,092 rides on public transit. That would be at least 3,294 more rides, or at least a 3% increase from the 2026 goal.
- In 2028, Metro Mobility users will take at least 115,354 rides on public transit. That would be at least 2,262 more rides, or at least a 2% increase from the 2027 goal.
- In 2029, Metro Mobility users will take at least 117,661 rides on public transit. That would be at least 2,307 more rides, or at least a 2% increase from the 2028 goal.
- In 2030, Metro Mobility users will take at least 120,014 rides on public transit. That would be at least 2,353 more rides, or at least a 2% increase from the 2029 goal.
- In 2031, Metro Mobility users will take at least 122,414 rides on public transit. That would be at least 2,400 more rides, or at least a 2% increase from the 2030 goal.

About the data: This data comes from Metro Transit's boarding data. Recent law changes make fixed route transit free for Metro Mobility certified riders and the Council expects this will result in early initial growth followed by continued growth at a slower pace as the program reaches maturity.

Strategies

To achieve this goal, Met Council will:

- Install accessible boarding pads in at least 60 Metro Transit bus stops each year through 2030.

- Install more visual and audible real-time bus arrival signs at bus stops.
- Improve real-time transit information through mobile apps, website, and digital signs, with a focus on supporting riders with disabilities.
- Explore enhanced travel training for Metro Mobility riders using fixed route transit services. This might include financial support for travel trainers that specialize in certain types of disabilities.

Transit and Transportation Goal 3: The Minnesota Department of Transportation will remove barriers on their sidewalks and curb ramps throughout the state by 2037.

Lead agency: Minnesota Department of Transportation (MnDOT)

What is this goal about?

This goal is to ensure that MnDOT owned pedestrian sidewalks and curb ramps will meet or exceed accessibility requirements by 2037.

Why does this goal matter?

Pedestrians need accessible sidewalks and curbs to fully access community. When sidewalks and curb ramps are not accessible, people with disabilities have barriers to pedestrian and transit travel. These barriers reduce opportunities to live independently and participate in community. Transportation barriers are especially impactful in Greater Minnesota.

How we track our progress

Our starting point (baseline): MnDOT has been working on accessibility issues on its sidewalks and curb ramps since 2013. At the time of Olmstead Plan development, the percentage of curb ramps and sidewalks that met or exceeded accessibility standards were:

- Curb ramps – 67% complete
- Sidewalks – 49.4% complete

Measurable targets:

2027

- Curb ramps – 70% complete
- Sidewalks – 53.9% complete

2028

- Curb ramps – 73% complete
- Sidewalks – 58.4% complete

2029

- Curb ramps – 76% complete
- Sidewalks – 62.9% complete

2030

- Curb ramps – 79% complete
- Sidewalks – 67.4% complete

2031

- Curb ramps – 82% complete
- Sidewalks – 71.9% complete

Strategies

To reach these goals, MnDOT will:

- Include sidewalk and curb ramp improvements as a part of pavement projects that reach the alteration threshold.
- Identify sidewalk and curb ramp-only projects where feasible.
- Include the revised goal and measure in MnDOT's Transition Plan.

Transit and Transportation Goal 4: Greater Minnesota public transit will run on time.

Lead agency: MnDOT

What is this goal about?

This goal is about on-time performance for public transit services in Greater Minnesota that receive state or federal funding from MnDOT. These public transit services include:

- Demand Response / Dial-a-Ride: A flexible, call-ahead transit service that comes to you instead of you going to a bus stop.
- Deviated Fixed-Route: A bus route that follows a set path and schedule but can go off the route within a certain area if the rider requests it.
- Fixed-Route: Operates on a set path with published stops and schedules
- Paratransit: ADA-required transportation for individuals with disabilities who cannot use regular fixed-route transit service. It provides origin-to-destination or on-call service within ¾ mile of bus routes ensuring access comparable to fixed-route service.

For this goal public transit is defined as shared transportation services open to the public, including bus, demand-response, and coordinated services.

Why does this goal matter?

On-time performance supports people living with disabilities in getting reliably to and from destinations. It is important for all riders to be able to rely on transit in getting to time sensitive activities such as medical appointments or social events and spending less time waiting for transportation.

How we track our progress

Our starting point (baseline): On-time performance has been measured and reported since 2014. On-time performance measures the percentage of trips within a specific timeframe of the scheduled time. MnDOT's on-time performance target for Greater Minnesota's transit systems is for 90% of trips to be within 45 minutes of scheduled times.

Historic trends in annual percent of trips within 45 minutes of the scheduled time include:

- 2014: 76% - original base line
- 2020: 92% average
- 2021: 95% average
- 2022: 92% average
- 2023: 90% average
- 2024: 92% average
- 2025: 89% average

Measurable goal:

- In 2026, 90% of the public transit trips taken in Greater Minnesota will be within 45 minutes of scheduled times.
- In 2027-2030, 92% or more of the public transit trips taken in Greater Minnesota will be within 45 minutes of scheduled times.

Strategies

To reach these goals, MnDOT will:

- Create and provide technical assistance and training for Greater Minnesota public transit systems. This will happen through MnDOT's in-house service planning program.
- Use trip purpose data, onboard surveys, and performance metrics to adjust and improve transit service.

- Complete a statewide study of future Bus Rapid Transit (BRT) and high-frequency corridors. Results will be used to identify funding needs for development.
- Publish a digital statewide trip navigation platform. The platform will provide information on what public transit is available and for trip planning.
- Track the progress for this goal in two locations for transparency and accountability.
    - The percent of "On-Time Performance" will be incorporated into MnDOT's "Transit System Scorecards" for individual systems. These are reported in the annual Transit Report to the legislature and available to the public: Plans and Reports - Transit - MnDOT
    - The statewide performance measure is reported annually on MnDOT's Performance Measure Dashboard:
    - Transit On-time Performance - Performance Measure Dashboard - MnDOT

Transition

Transition Goal 1: Fewer people will stay at Anoka Metro Regional Treatment Center (AMRTC) when they don't need hospital-level care.

Lead agency: Direct Care and Treatment (DCT)

What is this goal about?

This goal is about people who stay at Anoka Metro Regional Treatment Center (AMRTC) after staff deem them ready to return to the community. This can happen for many reasons. Some reasons are outside DCT's control. Examples of reasons outside DCT's control include:

- A criminal court needs to approve someone's release. DCT may be waiting for the court to rule, or the court may have ruled against release.
- The person can go to a community program, but first that program needs to hire staff to safely care for the person.
- There are no available beds in settings that meet the person's needs.
- And more.

Why does this goal matter?

It is important that people don't stay at a psychiatric hospital longer than clinically needed. Staying at the hospital longer than needed can harm people's well-being and make it harder to return to the community. Additionally, there is high demand for services at AMRTC. When someone leaves the hospital, then AMRTC can treat another person. When a bed is used for someone who does not have a clinical need, this denies others in need access to AMRTC services.

Public comment reinforced the importance of strengthening implementation of DCT's existing transition strategies. DCT will continue to deepen collaboration with Tribes, counties, DHS, providers, and community partners; strengthen discharge planning and diversion efforts; use performance data to identify barriers; and advocate for expanded community capacity that supports timely, person-centered transitions.

How we track our progress

Our starting point (baseline): As of December 2025, about 27% of patients are people who no longer need to be in the hospital.

Measurable goal:

- By June 30, 2027, 22.5% or fewer AMRTC patients will be people who no longer need to be in the hospital.

- By June 30, 2028, 20% or fewer AMRTC patients will be people who no longer need to be in the hospital.
- By June 30, 2029, 20% or fewer AMRTC patients will be people who no longer need to be in the hospital.
- By June 30, 2030, 19% or fewer AMRTC patients will be people who no longer need to be in the hospital.
- By June 30, 2031, 18% or fewer AMRTC patients will be people who no longer need to be in the hospital.

About this target: There are many reasons that someone may stay at AMRTC when they no longer need to be in the hospital. Some of these reasons are outside DCT's control. DCT can work on things like improving identification, planning, and coordination. However, making sustained progress will require work outside DCT's direct control. Examples include:

- Increasing system capacity for mental health treatment
- County actions
- Aligning work across state agencies

About the data: This data comes from AMRTC's admissions and discharge database. AMRTC is increasing capacity in 2028. While the addition of 50 beds in 2028 introduces variables that may affect future performance, DCT is amenable to establishing goals through 2031. Given the uncertainty associated with the additional capacity and the time needed to assess its operational impact, DCT recommends maintaining the goal at 20% for 2029, followed by incremental reductions thereafter. This approach establishes a clear trajectory for continued improvement while allowing sufficient time to evaluate the impact of the additional beds and adjust operational strategies as needed.

Strategies

To reach this goal, DCT will improve coordination by:

- Continuing strategies to improve early and close alignment with Tribes, counties, and state partners on treatment and discharge planning.
- Establishing regular case reviews with the Department of Human Services (DHS). This will resolve state-related barriers to move people to appropriate placements faster.
- Improving coordination across DCT programs to support smooth transitions into the community.
- Engaging communities to reduce stigma and build support for integrated services.

DCT will also use data to drive decisions by:

- Developing and routinely reviewing shared internal performance dashboards. This will increase transparency and accountability, identify barriers, and help improve DCT services.

- Exploring options, barriers and resource needs for tracking post-discharge outcomes.
- Improving data sharing to better identify gaps and disparities.
- Continuing to implement person-centered services. These services are responsive to individuals' cultural, linguistic, disability-related, and other unique needs. DCT will also monitor disparities in outcomes.

Additionally, DCT will strengthen community capacity by:

- Supporting community providers through training and technical assistance.
- Identifying service gaps and developing solutions so people can access the right level of care.
- Simplifying and modernizing referral processes.
- Strengthening collaboration with Tribes, DHS, counties, providers, and community partners. This will help identify and address system-level barriers that delay successful community transitions.

DCT will also increase access to peer support across all service areas.

Transition Goal 2: Participants in the Forensic Mental Health Program (FMHP) are assessed consistently and routinely to determine when their mental health needs have been met, and they are safe and ready for discharge.

Lead agency: DCT

The assessment will:

- determine when their mental health needs have been met
- identify when they are safe and ready for discharge
- minimize unnecessary time in the FMHP (or locked facility).

What is this goal about?

This goal is about the amount of time from when someone is admitted to FMHP to when they are ready for discharge. For this goal, “discharge readiness” means the Forensic Review Panel has determined someone is ready for provisional discharge.

Why does this goal matter?

FMHP is a segregated, institutional setting. *Olmstead’s* mission is for people to live life in the most integrated setting possible. Being ready for discharge faster will help people return to their communities sooner. Additionally, there is high demand for services at FMHP. When someone leaves the program, then FMHP can treat another person.

Public feedback reinforced the importance of:

- Individualized treatment pathways,
- Earlier identification of complex needs, and
- Stronger coordination across systems.

DCT will strengthen implementation of these existing strategies by monitoring performance, collaboration, and refining treatment and discharge planning processes.

How we track our progress

Our starting point (baseline): In 2025, the average time from FMHP admission to discharge readiness is 84 months.

Measurable goal:

- By June 30, 2027, the average time from FMHP admission to discharge readiness will be 83 months.
- By June 30, 2028, the average time from FMHP admission to discharge readiness will be 81 months.
- By June 30, 2029, the average time from FMHP admission to discharge readiness will be 79 months.
- By June 30, 2030, the average time from FMHP admission to discharge readiness will be 77 months.
- By June 30, 2031, the average time from FMHP admission to discharge readiness will be 75 months.

About this target: DCT helps people get the treatment they need to be ready to leave FMHP. However, DCT cannot decide independently to discharge a client. The Special Review Board (SRB) must approve any provisional discharge or discharge. The SRB is independent from DCT. The county also plays a key role in that decision. Even when a person is ready to leave FMHP, they must stay until the SRB approves their discharge. Even after provisional discharge is recommended, successful transition also depends on the availability of community services. These include appropriate community housing, providers, and supports. Many of these factors are outside DCT's direct control.

About the data: This data comes from FMHP's admissions and discharge database.

Strategies

DCT will improve coordination by:

- Strengthening collaboration with counties, community providers, and other partners. This collaboration will help begin discharge planning early. It will also support timely transitions following provisional discharge.

- Improving interdisciplinary treatment planning. This will ensure assessments, treatment recommendations, and discharge planning remain person-centered.
- Continuing to refine specialized treatment pathways for individuals with complex needs. These can include people with developmental disabilities, neurocognitive disorders, traumatic brain injuries, autism spectrum disorders, and other complex needs.
- Improving communication with stakeholders about the treatment progress, discharge readiness, and barriers to successful transition.

DCT will use data to drive decisions by:

- Developing and routinely reviewing shared internal performance dashboards. This will increase transparency and accountability, identify barriers, and help improve DCT services. Using performance data to improve assessment timelines, treatment pathways, and discharge planning processes.
- Improving data collection and reporting. This will help DCT better understand outcomes for people with complex treatment needs. It will also help DCT identify disparities.

DCT will strengthen individualized treatment by:

- Continuing to implement person-centered treatment pathways beginning at admission. This will promote consistent progress toward discharge readiness.
- Identifying people with complex treatment needs earlier in the admission process. Then DCT can begin specialized services and supports sooner.
- Continuing to implement person-centered services. These services are responsive to individuals' cultural, linguistic, disability-related, and other unique needs. DCT will also monitor disparities in outcomes.

DCT will strengthen transition readiness by:

- Collaborating with DHS, counties, providers, and community partners. This will help identify and address system-level barriers to successful transitions from FMHP.
- Identifying community service gaps. DCT will also support efforts to expand capacity for individuals with complex behavioral health, developmental disability, and neurocognitive support needs.
- Continuing to evaluate opportunities to expand diversion and community-based treatment options when clinically appropriate.

Transition Goal 3A: More people will receive supportive services in DCT-operated community-based settings.

Lead agency: DCT

What is this goal about?

This goal is about people who are:

- In a hospital, jail, or withdrawal management facilities,
- On a waitlist for a locked DCT facility, and
- Eligible for services in a residential Community-Based Services (CBS) program operated by DCT which include:
    - Residential Services
    - Vocational Services
    - Community Support Services
    - Minnesota Intensive Therapeutic Homes
    - Minnesota Life Bridge

The goal is for people who might receive services in a locked facility to receive them in a community setting operated by DCT instead. This is called being "diverted" from a locked setting.

Why does this goal matter?

This goal will help prevent unnecessary institutionalization. It is also easier to reintegrate in the community from a CBS program than from a locked facility. This aligns with Olmstead's mission: for people to receive services in the most integrated setting possible. Additionally, there is high demand for services at locked DCT facilities. This goal will help reduce demand.

Public comment affirmed the importance of expanding community-based opportunities. DCT will strengthen implementation of existing diversion and transition strategies by:

- Identifying service gaps,
- Enhancing coordination with partners, and
- Continuing to advocate for expanded community capacity that supports integrated community living.

How we track our progress

Our starting point (baseline): In 2025, three people were diverted from locked DCT facilities.

Measurable goal:

- By June 30, 2027, four people per fiscal year will be diverted from locked DCT facilities.
- By June 30, 2028, five people per fiscal year will be diverted from locked DCT facilities.
- By June 30, 2029, six people per fiscal year will be diverted from locked DCT facilities.
- By June 30, 2030, seven people per fiscal year will be diverted from locked DCT facilities.
- By June 30, 2031, eight people per fiscal year will be diverted from locked DCT facilities.

About this target: Making progress on this goal requires work that is both within and outside of DCT's direct control. Increasing diversions requires action from DCT and other partners, like counties, state entities, and community organizations. DCT has direct control over:

- CBS program operations
- CBS admissions processes
- Internal coordination
- Tracking of diversion and transition outcomes

However, progress also depends on factors outside DCT's control, including:

- Availability of community housing and staffing
- County funding and service authorizations
- Referrals from hospitals and jails
- Coordination with law enforcement and community providers
- Individual clinical readiness

About the data: This data comes from:

- CBS admissions and discharge database
- DCT services
- Diversion tracking reports

Strategies

To reach this goal, DCT will improve coordination by:

- Continuing strategies to improve early and close alignment with Tribes, counties, and state partners on treatment and discharge planning.
- Establishing regular case reviews with the Department of Human Services. This will resolve state-related barriers to move people to appropriate placements faster.
- Improving coordination across DCT programs to support smooth transitions into the community.
- Engaging communities to reduce stigma and build support for integrated services.

DCT will also use data to drive decisions by:

- Developing and routinely reviewing shared internal performance dashboards. This will increase transparency and accountability, identify barriers, and help improve DCT services.
- Exploring options, barriers and resource needs for tracking post-discharge outcomes.
- Improving data sharing to better identify gaps and disparities.

- Continuing to implement person-centered services. These services are responsive to individuals' cultural, linguistic, disability-related, and other unique needs. DCT will also monitor disparities in outcomes.

Additionally, DCT will strengthen community capacity by:

- Supporting community providers through training and technical assistance.
- Identifying service gaps and developing solutions so people can access the right level of care.
- Simplifying and modernizing referral processes.
- Strengthening collaboration with Tribes, DHS, counties, providers, and community partners. This will help identify and address system-level barriers that delay successful community transitions.

Transition Goal 3B: More people will move from segregated mental health treatment facilities to more integrated facilities.

Lead agency: DCT

What is this goal about?

This goal is about people who are currently receiving services in a locked DCT facility. The goal is for more people to move from these facilities to DCT-operated CBS programs. These programs are less restrictive.

Why does this goal matter?

This goal will help reduce institutionalization. It is also easier to reintegrate in the community from a CBS program than from a locked facility. This aligns with Olmstead's mission: for people to receive services in the most integrated setting possible. Additionally, there is high demand for services in locked DCT facilities. When someone leaves a locked facility, that facility can treat another person.

Public comment affirmed the importance of expanding community-based opportunities. DCT will strengthen implementation of existing diversion and transition strategies by:

- Identifying service gaps,
- Enhancing coordination with partners, and
- Continuing to advocate for expanded community capacity that supports integrated community living.

How we track our progress

Our starting point (baseline): In fiscal year 2025, eight people moved from locked DCT facilities to a CBS site.

Measurable goal:

- By June 30, 2027, 10 people per fiscal year will move from a locked DCT facility to a CBS site.
- By June 30, 2028, 12 people per fiscal year will move from a locked DCT facility to a CBS site.
- By June 30, 2029, 14 people per fiscal year will move from a locked DCT facility to a CBS site.
- By June 30, 2030, 16 people per fiscal year will move from a locked DCT facility to a CBS site.
- By June 30, 2031, 18 people per fiscal year will move from a locked DCT facility to a CBS site.

About the data: This data comes from:

- CBS admissions and discharge database
- DCT services
- Diversion tracking reports

Strategies

To reach this goal, DCT will improve coordination by:

- Continuing strategies to improve early and close alignment with Tribes, counties, and state partners on treatment and discharge planning.
- Establishing regular case reviews with the Department of Human Services. This will resolve state-related barriers to move people to appropriate placements faster.
- Improving coordination across DCT programs to support smooth transitions into the community.
- Engaging communities to reduce stigma and build support for integrated services.

DCT will also use data to drive decisions by:

- Developing and routinely reviewing shared internal performance dashboards. This will increase transparency and accountability, identify barriers, and help improve DCT services.
- Exploring options, barriers and resource needs for tracking post-discharge outcomes.
- Improving data sharing to better identify gaps and disparities.
- Continuing to implement person-centered services. These services are responsive to individuals' cultural, linguistic, disability-related, and other unique needs. DCT will also monitor disparities in outcomes.

Additionally, DCT will strengthen community capacity by:

- Supporting community providers through training and technical assistance.
- Identifying service gaps and developing solutions so people can access the right level of care.
- Simplifying and modernizing referral processes.

- Strengthening collaboration with Tribes, DHS, counties, providers, and community partners. This will help identify and address system-level barriers that delay successful community transitions.

Transition Goal 4: More people with disabilities will move from segregated settings to integrated housing of their choice, where they sign a lease and receive rent support.

Lead agencies: Minnesota Housing, Department of Human Services (DHS)

Supporting agency: Department of Corrections (DOC), DCT

What is this goal about?

This goal is about supporting people with disabilities who live in segregated settings to move into integrated community housing. This goal is for more people to:

- Choose where they want to live
- Sign a lease for their own home
- Receive rental assistance through programs such as Bridges, Bridges RTC, Section 811, or other eligible rental assistance programs

Why does this goal matter?

Providing disabled people with housing assistance to live in the community is fundamental to achieving the integration mandate. Integrated housing is often the first step toward community inclusion, self-determination, employment, and improved quality of life.

Affordable and accessible housing is difficult to find for many people with disabilities. It can be especially challenging for people leaving institutional or congregate settings. Rental assistance and coordinated transition supports reduce barriers to community living. They also increase housing stability.

How we track our progress

Our starting point (baseline): In 2025, 16,588 people with disabilities, who had previously been in segregated settings, including homelessness, were living in integrated housing where they had a signed lease and received rental assistance through eligible housing programs.

Measurable goal:

- By June 2027, the number of people with disabilities living in integrated housing, where they have a signed lease and receive rent support, will increase by at least 1,000 people from baseline.

- By June 2028, the number of people with disabilities living in integrated housing, where they have a signed lease and receive rent support, will increase by at least 1,000 people from the previous year.
- By June 2029, the number of people with disabilities living in integrated housing, where they have a signed lease and receive rent support, will increase by at least 1,000 people from the previous year.
- By June 2030, the number of people with disabilities living in integrated housing, where they have a signed lease and receive rent support, will increase by at least 1,000 people from the previous year.
- By June 2031, the number of people with disabilities living in integrated housing, where they have a signed lease and receive rent support, will increase by at least 1,000 people from the previous year.

The measurement will also monitor changes to the baseline to understand what progress is being made to reduce the number of people living in segregated settings.

About the data: Data about individuals living in integrated housing with a signed lease and rental assistance will come from DHS and Minnesota Housing administrative data. This includes data from programs such as Bridges, Section 811, Housing Support, and other eligible housing programs. Applicable Housing Support non-segregated settings include Metro Demo, and Supportive Housing and Assisted Living. The DOC will contribute data related to individuals transitioning from correctional settings into community housing.

Minnesota Housing, DHS, and DOC will continue improving interagency data sharing and data quality to strengthen measurement and reporting.

Strategies

To reach this goal, Minnesota Housing, DHS, and DOC will:

- Explore creating a consolidated application process for housing programs. This will ensure people with disabilities do not need to apply separately to multiple programs.
- Improve data sharing across agencies. This will better align the housing resources with the needs of people leaving segregated settings
- Evaluate and redesign rental assistance programs with human-centered design principles. That will make application processes and services more accessible and responsive to people with disabilities.
- Advocate for additional federal and state funding for rental assistance, supportive housing, and transition services when resources become available.
- Identify barriers that prevent people from leaving segregated settings and develop recommendations to address policy, service, and funding gaps.

- Increase coordination between housing providers, behavioral health providers, corrections staff, case managers, and transition coordinators to support successful community transitions.
- Minnesota Housing and DHS will work collaboratively to improve access to and retention of housing. They will also resolve barriers between housing, homelessness, human service, and corrections systems.
- Include people with lived experience to drive policy, implementation, and evaluation efforts.

Housing Data Goal 2B, which will measure choice and satisfaction with housing, is intended to support the strategies identified here.

Transition Goal 5: People who receive home- and community-based services will experience less use of restrictive procedures.

Lead agency: DHS

What is this goal about?

This goal is about reducing the emergency use of manual restraint (EUMR) for people who receive waiver services and other disability services, regardless of diagnosis. For this goal, these are services licensed under Minnesota Statute 245D or in the scope of Minnesota Rule Part 9544. They include:

- Services provided in group homes and other community residential settings
- Services provided in someone's own home
- Homemaker services
- Crisis respite services
- Day services
- Some employment services

This goal counts the number of reports of EUMR, not the number of people. Some people may experience EUMR multiple times. State law only allows EUMR in certain circumstances. These circumstances are when:

- Immediate action is needed to prevent someone from harming themselves or others,
- The type of manual restraint used is the least restrictive intervention to prevent harm and achieve safety, and
- The manual restraint ends when the threat of harm ends.

Why does this goal matter?

Being treated with dignity and respect is an important part of quality of life. Experiencing restraint and seclusion can be traumatizing. Positive supports are more effective than restrictive procedures at:

- Reducing harmful behaviors

- Keeping people safe
- Helping people build life skills

Reducing the use of restrictive procedures is foundational to Minnesota's Olmstead Plan. The plan was created as part of a settlement from a lawsuit against DHS, called *Jensen*. This lawsuit was about the use of restraint and seclusion in a DHS program. It alleged the program broke the law and violated the civil rights of disabled people.

The *Jensen* Settlement Agreement improved treatment and care for people with disabilities in Minnesota. Goals about restrictive procedures help us continue to make progress.

How do we track our progress?

Our starting point (baseline): During fiscal year 2025, there were 1,739 reports of the use of restrictive procedures.

Measurable goal:

- By June 30, 2027, reports of the use of restrictive procedures will be 1,652 or less. That would be a decrease of 5% from current baseline.
- By June 30, 2028, reports of the use of restrictive procedures will be 1,569 or less. That would be a decrease of 5% from the previous year.
- By June 30, 2029, reports of the use of restrictive procedures will be 1,490 or less. That would be a decrease of 5% from the previous year.
- By June 30, 2030, reports of the use of restrictive procedures will be 1,416 or less. That would be a decrease of 5% from the previous year.
- By June 30, 2031, reports of the use of restrictive procedures will be 1,345 or less. That would be a decrease of 5% from the previous year.

About the data: This goal tracks the number of reports made through Behavior Intervention Report Forms (BIRFs). Law requires service providers licensed under Statute 245D to submit BIRFs to DHS when they use restrictive procedures, regardless of a person's diagnosis. Providers licensed under Statute 245A must submit BIRFs for people with a developmental disability or related conditions.

Since BIRFs are self-reported by providers, data may be missing or have occasional errors. However, DHS Licensing, counties, Tribes, and guardians work together to hold these providers accountable and monitor reporting. All these groups must receive notification of and data on restraint use. Providers who fail to report may face legal and financial consequences.

Strategies

To reach this goal, DHS staff and the External Program Review Committee (EPRC) will continue to provide one on one technical assistance to service providers who report using EUMR. Technical

assistance from the EPRC and DHS includes helping service providers, in partnership with many other providers, clinicians, schools, counties, and more. Technical assistance covers a variety of needs such as:

- Supporting mental health needs
- Addressing physical health care needs
- Helping people improve their quality of life
- Helping people resolve their social conflicts with others
- Helping people learn new skills
- Any many other needs that might impact a person's life.

Additionally, DHS will launch the new Minnesota Incident Reporting System (MIRS). This system will collect more and better information about restrictive procedures. DHS will:

- Use MIRS data to identify patterns and trends in the use of restrictive procedures by providers.
- Share reports about restrictive procedures to identify patterns and help investigations.
- Auto-summarize restrictive procedure data to help service providers reduce their use.
- Increase access to information about trauma-informed positive support practices.

Transition Goal 6: More people with disabilities will move from segregated settings to integrated settings.

Lead agency: DHS

What is this goal about?

This goal is about people moving from certain segregated settings to more integrated settings. This goal focuses on ensuring people have support and resources to be housed, stable, and included in their communities.

This goal has three parts:

- Transition Goal 6A: People receiving services in ICF/DDs
- Transition Goal 6B: People with disabilities under age 65 receiving services in a nursing facility longer than 60 days
- Transition Goal 6C: People receiving services in other segregated settings. For this goal, "other segregated settings" are:
    - Child and Adolescent Behavioral Health Services (CABHS)
    - Psychiatric Residential Treatment Facility (PRTF)
    - Institutions for Mental Disease (IMD), for people under age 21 and over age 64
    - Institutions for Mental Diseases/Substance Use Disorder (SUD) that meets the following requirements (Moving Home Minnesota only):

- Licensed under Minnesota Statute Chapter 245G as a residential SUD treatment program
- Provide a specified American Society of Addiction (ASAM) level of care and meet ASAM criteria standards under the 1115 Substance Use Disorder System Reform Demonstration, as required by state statute
- Regional Treatment Center (RTC) that provides inpatient services to people on Medical Assistance (Relocation Service Coordination only)

Provider-controlled settings in the community can have isolating effects and the characteristics of Institutional settings, making it segregated. A setting is segregated when it doesn't provide people with privacy, lockable doors, choice of roommates, freedom to have visitors or control over their daily schedules. Settings that are located on the grounds or close by a public institution are presumed to be segregated.

Community residential settings, sometimes known as "group homes" may have characteristics that segregate and isolate people, depending on how the services are delivered. Some people with disabilities report that living in a group home has been isolating and that they have felt segregated from their communities in these settings. DHS works with community residential settings providers to ensure people are not isolated from the broader community and have opportunities to be fully included and engaged in the community. DHS is collaborating with Minnesota Housing to increase the number of people that transition from segregated settings to their own homes (see Transition Goal 4).

Why does this goal matter?

This goal is foundational to Minnesota's Olmstead Plan. People with disabilities must be able to live in the most integrated setting of their choice that meets their needs. Compared to segregated settings, integrated settings allow people to have more:

- Choice about their day-to-day lives
- Self-determination
- Community integration
- Connection to family and friends
- And other benefits.

We recognize that many people remain in hospitals, correctional facilities, and other institutional settings due to gaps in available services and supports. These experiences are important and can have significant impacts on individuals and families. Baseline data for transitions from hospitals are not currently available and would need to be developed in collaboration with other state agencies. For the purposes of this goal, the focus is on transitions from the segregated settings defined in this measure.

Successful transitions from segregated to integrated settings require more than just finding housing. They require:

- Coordinated planning
- Timely access to services
- Communication across systems
- Ongoing supports

This goal strengthens the transition process by promoting person-centered practices, planning, informed choice, and coordination with the person and their care team, which could include institutional providers, lead agencies, Tribal Nations, housing partners, and community service providers.

It emphasizes providing the ongoing supports people need to remain stable and housed in their preferred communities

How do we track our progress?

Transition Goal 6A: People receiving services in ICFs/DD

Our starting point (baseline):

During fiscal year 2025, 42 people moved from ICFs/DD to more integrated settings.

Measurable goal:

- From July 1, 2026 to June 30, 2027, 42 people will move from ICFs/DD to more integrated settings.
- From July 1, 2027 to June 30, 2028, 45 people will move from ICFs/DD to more integrated settings.
- From July 1, 2028 to June 30, 2029, 48 people will move from ICFs/DD to more integrated settings.
- From July 1, 2029 to June 30, 2030, 50 people will move from ICFs/DD to more integrated settings.
- From July 1, 2030 to June 30, 2031, 53 people will move from ICFs/DD to more integrated settings.

About this target:

Some ICFs/DD in Minnesota have closed over the past five years. That means there are fewer people receiving services in ICFs/DD. As a result, there are fewer people transitioning from ICFs/DD.

Transition Goal 6B: People with disabilities under age 65 receiving services in a nursing facility longer than 60 days

Our starting point (baseline):

During fiscal year 2024, 737 people under 65 in a nursing facility for more than 90 days moved to a more integrated setting.

Measurable goal:

- From July 1, 2026 to June 30, 2027, 775 people will move from nursing facilities to more integrated settings.
- From July 1, 2027 to June 30, 2028, 785 people will move from nursing facilities to more integrated settings.
- From July 1, 2028 to June 30, 2029, 795 people will move from nursing facilities to more integrated settings.
- From July 1, 2029 to June 30, 2030, 805 people will move from nursing facilities to more integrated settings.
- From July 1, 2030 to June 30, 2031, 815 people will move from nursing facilities to more integrated settings.

Transition Goal 6C: Other segregated settings

Our starting point (baseline):

During fiscal year 2025, 1,375 people moved from other segregated settings to more integrated settings.

Measurable goal:

- From July 1, 2026 to June 30, 2027, 1,300 people will move from other segregated settings to more integrated settings.
- From July 1, 2027 to June 30, 2028, 1,365 people will move from other segregated settings to more integrated settings.
- From July 1, 2028 to June 30, 2029, 1,433 people will move from other segregated settings to more integrated settings.
- From July 1, 2029 to June 30, 2030, 1,505 people will move from other segregated settings to more integrated settings.
- From July 1, 2030 to June 30, 2031, 1,580 people will move from other segregated settings to more integrated settings.

Transition Goals 6A, 6B, 6C

About these targets: Minnesota has made progress helping people move from institutional settings into the community over the years. However, opportunities and outcomes vary depending on the setting and available community supports. People continue to experience barriers to community transitions. These can make it difficult to find and remain stable in community settings. These barriers

include housing availability, workforce shortages, service capacity, and inconsistent transition planning and coordination.

About the data: This data comes from National Core Indicator Surveys and the DHS Transitions, Tribal & Transformation Division (TT&T). The TT&T data includes Moving Home Minnesota and Relocation Service Coordination–Targeted Case Management (RSC-TCM). In order for a person to qualify for Moving Home MN, the person has to be in an institution for 60 days prior to allowing services to begin. For RSC-TCM, services can begin the first day a person enters an institution. Due to closures of ICFs/DD, the target number may decrease for that population. With MHM, data shows how many people used the program and moved to a qualified community residence. With RSC-TCM, data shows how many people used the program. It does not show whether a move successfully occurred.

Strategies

To increase service options for people making transitions, DHS will:

- Improve coordination among institutional settings, lead agencies, Tribal Nations, housing partners, and community providers.
- Standardize statewide guidance, communication, and transition planning expectations. This will promote consistent practice across counties and Tribal Nations.
- Provide technical assistance and routine consideration of assistive technology as part of a person-centered planning to lead agencies and providers. This includes examples of innovative uses of assistive technology to support successful transitions to more integrated settings.
- Strengthen person-centered transition planning that begins early and reflects each person's housing goals, informed choice, support needs, and identified barriers.
- Align transition planning with Waiver Reimagine implementation. This will improve access to community-based supports before, during, and after transition.

To monitor and audit the effectiveness of transitions, DHS will:

- Develop materials to help people with disabilities, families and guardians understand transitions. These materials will explain options, answer questions, and connect with people who can help make an informed choice and plan for a transition.
- Provide education and increase awareness to lead agencies, providers, community partners, and the public. The information will be about available transition services and supportive housing resources, including RSC-TCM, Moving Home Minnesota, and Housing Benefits 101 (HB101).
- Use data to identify barriers, monitor outcomes, and improve long-term housing stability, community integration, and continuity of supports after transition.

Data collection projects

This section includes state agency data collection projects. These data projects lay the groundwork for future measurable goals. Data projects represent issues that agencies want to write measurable goals about, but don't have the necessary data to create a measurable goal yet or where they have not created a mechanism to collect the data needed to focus on important issues that require future goals. They describe how an agency will gather the information it needs to write a measurable goal. Data projects will be monitored and reported on quarterly along with measurable goals.

Data projects are organized by topic:

- Education
- Employment
- Health and safety
- Housing
- Preventing abuse and neglect
- Transition

The projects include:

- A one-sentence summary of the project.
- The lead agency or lead agencies that are responsible for the project.
- A section titled "What are we working toward?" with more details about the project.
- A section titled "Where are we now?" that explains where the agency(ies) are at with the data project at this time.
- A section titled "Why does this project matter?" with information about why the data project is important.
- A section titled "How will we collect the data?" with information about strategies to get the data needed in order to work toward writing a measurable goal.

Education

Education Data Project 1: Adolescent students with disabilities released from correctional facilities will be prepared to transition to the educational or vocational setting of their choice.

Lead agency: Department of Corrections (DOC)

Supporting agency: Department of Education (MDE)

What are we working toward?

The DOC proposes collecting data for a goal that will focus on students with disabilities' progress in high school after they leave correctional facilities. The goal will be about:

- School attendance
- Behavioral incidents
- Progress toward graduation by passing classes

The tracked outcomes were chosen because they are signs of success and inclusion. A student who attends school regularly, is not cited for misbehavior in school, and makes progress towards graduation is experiencing success. This data is collected by schools throughout Minnesota. The data signals if adolescents are being successful or if they continue to experience barriers to their education. Past problems with attendance, behavior, and obtaining school credit are very common for adolescents with the DOC. Tracking these post-release outcomes is very relevant.

Where are we now?

Right now, the DOC does not track students' progress in school after release.

Why does this project matter?

For students with disabilities who are released from correctional facilities, benefits of school include:

- Lower risk of becoming incarcerated again
- Better job opportunities
- Community connections

Tracking student progress can help the DOC and MDE better support students.

How will we collect the data?

To collect this data, the DOC will:

- Collect data regarding education outcomes for high school students with a disability after they leave a correctional facility. This will be done by the end of 2027.
- Set a target for improvement.

Education Data Project 2: Incarcerated adults with disabilities released from correctional facilities will be prepared to enter the workforce or continue their education following release.

Lead agency: DOC

Supporting agency: MDE

What are we working toward?

The DOC proposes collecting data for a goal about incarcerated individuals with disabilities and education. The goal will focus on coordinated education and reintegration planning before release.

Where are we now?

Right now, the DOC does not track information about coordinated education and reintegration planning.

Why does this project matter?

Education is important for everyone. For individuals with disabilities who are released from correctional facilities, benefits of continued education include:

- Lower risk of becoming incarcerated again
- Better job opportunities
- Community connections

How will we collect the data?

To collect this data, the DOC will:

- Collect data regarding education outcomes for incarcerated adults with disabilities after they leave a correctional facility. This will be done by the end of 2027.
- Discuss education, employment, and training options based on the individual's goals, strengths, and support needs.
- Set a target for improvement.

Employment

Employment Data Project 1: More people with disabilities will have jobs in the community.

Lead agencies: Department of Employment and Economic Development (DEED), Minnesota Department of Education (MDE), Department of Human Service (DHS)

What are we working toward?

DEED, DHS, and MDE want to write a goal about competitive, integrated employment (CIE) for people who use certain DHS services. Those services are:

- Medicaid waiver services
- Mental health targeted case management
- Adult mental health rehabilitation
- Assertive community treatment services, and/or
- Medical Assistance for Employed Persons with Disabilities (MA-EPD)

The goal will be for more people who use these programs to have community jobs.

Where are we now?

Right now, DHS does not have a way to measure how many people have CIE. Instead, DHS estimates the number by measuring how much money people earn. If someone makes $600 or more per month, they are counted as having CIE. If someone makes $599 or less per month, they are counted as having non-competitive employment. This estimate is not always accurate. Some people in CIE make less than $600 a month, and some people in non-competitive employment make more than $600 a month. Non-competitive employment can pay either minimum wage or higher, or subminimum wages.

In fiscal year 2024, 81,852 people received these Medicaid services. 20% of those people earned $600 or more per month.

Why does this project matter?

Employment is a way for all people to earn money and be self-sufficient. For many people, jobs can be a source of meaning and fulfillment. Jobs can also help people:

- Socialize and make friends
- Share knowledge and talents with others
- Engage in the community
- Learn new skills

People with disabilities tend to have higher unemployment rates than people without disabilities. That is because people with disabilities experience more barriers to employment. Barriers include:

- Lack of services and supports, like job coaches
- Discrimination and ableism from employers and coworkers
- Challenges getting accommodations
- Lack of transportation
- Fear of losing necessary benefits

How will we collect the data?

DHS is working on getting data that will show the number of people who have CIE. This will let them report how many people actually have CIE instead of just estimating. DHS will also be able to report who has non-competitive earned income paid at minimum wage or higher, and who is paid subminimum wages. DHS hopes to have access to this data by late-2026. Once they have access, DHS will determine the baseline number of people who have CIE. This baseline will replace the baseline about who makes $600 a month or more. After DHS knows the baseline, they will be able to set a goal. DHS anticipates that the data will come from the following:

- DEED's unemployment insurance database
- DHS subminimum wage data reports

To increase the number of people with CIE for this goal, DHS will:

- Improve access to and use of employment services by people with disabilities, especially people who earn subminimum wages or are exclusively in day services.
- Promote Employment First principles through training, grants, sharing best practices, peer learning opportunities, and identifying and addressing employment barriers.
- Increase awareness and understanding of how work affects disability benefits through:
    - Expanding access to benefits planning services
    - Informing case managers
    - Raising awareness among disabled job-seekers and their supporters
- Strengthen and expand Minnesota's employment services provider network.
- Collect more accurate and useful employment outcome data.

Employment Data Project 2: More Veterans with disabilities will have jobs in the community.

Lead agency: Minnesota Department of Veterans Affairs (MDVA)

What are we working toward?

This data project is about Veterans with disabilities or health conditions who:

- Are identified within non-VA healthcare systems
- Are employment seeking

Where are we now?

MDVA is improving employment engagement efforts in non-Veterans Affairs (VA) health care systems. Around half of American Veterans do not use the VA for care. This could be because of where they live, personal preference, or long wait times. Many of these Veterans may be seeking employment. However, they lack the connection to Veteran-specific employment resources.

MDVA aims to partner with nine healthcare systems. The partnership will help ensure that Veterans response models and services are appropriate. It is vital that Veterans are not missing out on employment resources that can help them.

MDVA is in the beginning stages of this work. The agency is working to build connections with healthcare systems across the state. MDVA's Veteran Health Navigators are essential in this. They work with healthcare systems to identify Veterans and connect them to services. The services available to Veterans will range. Services include care coordination, education services, and employment services such as Veteran Readiness and Employment. Services will also include non-profit, state, and federal employment resources.

Once fully embedded across the state, MDVA will begin tracking the number of disabled Veterans who were connected to employment services. This will create baseline data. A goal will be created to increase the number of disabled Veterans who are referred to employment services.

Why does this project matter?

Employment is a key source of income and community connection. Veterans tend to have a harder time finding jobs than non-veterans. One reason is that military experience doesn't always align with non-military job requirements. Disabled Veterans experience unemployment at even higher rates. Many Veterans who use non-VA healthcare systems are job seeking but lack connections to Veteran specific employment resources. Job services can help Veterans find meaningful work.

How will we collect this data?

This data will come from non-VA healthcare systems that are partnering with MDVA in this initiative. To collect the data, MDVA will:

- Partner with healthcare systems across the state. Together they will improve outreach efforts to Veterans who do not engage with Veteran specific services and resources.
- Collaboratively assist healthcare systems to use person centered practices. This will help address the needs of Veterans with disabilities or health conditions that are employment seeking.

- Engage with healthcare systems to develop data reporting requirements. This includes gathering data that speaks to a variety of Veteran identities and backgrounds that receive care in these systems.

Health and safety

Health and Safety Data Project 1: Department of Public Safety will ensure its communications, programs, and services are designed and delivered to be accessible to people with disabilities by collaborating with people with lived experience.

Lead agencies: Department of Public Safety (DPS)

What are we working toward?

DPS wants to make sure its communications about safety and service delivery are accessible. DPS also wants to make sure its programs and services are inclusive and accessible.

Where are we now?

Right now, DPS collects data related to service delivery and communications. DPS has also made accessibility improvements to its website and various programs and services. However, DPS does not have a centralized platform that uses data to improve service delivery and communications. Having a centralized platform would help the agency do a full evaluation of programs and services.

Why does this project matter?

The information DPS shares is important for Minnesotans' well-being. DPS also operates many essential programs and services. People with disabilities must have equal access to DPS information to stay safe, as well as equal access to the agency's programs and services.

How will we collect the data?

To collect the data, DPS will:

- Analyze the data it collects from different programs, such as:
    - State Fire Marshal
    - Office of Justice Programs
    - Homeland Security Emergency Management
    - Driver Vehicle Services
- Gather community input about potential gaps in data and accessibility.
- Publish a report about gaps in data and accessibility.
- Create mandatory disability awareness training for DPS staff.
- Partner with people with lived experience to inform agency work.
- Conduct an accessibility audit of public materials.
- Improve accessibility based on audit results.
- Develop a sustainable plan to improve accessibility by 2031.

- DPS will review and update implementation timelines at least biennially to reflect available resources, findings from earlier activities, and progress toward the 2031 outcome.

Health and Safety Data Project 2: Minnesota Department of Health staff trained to support people with disabilities in public health emergencies

Lead agency: Minnesota Department of Health (MDH)

What are we working toward?

MDH Emergency Preparedness and Response (EPR) staff and Response Sections staff receive training on the access and functional needs of people with disabilities and the unique needs of this population during public health emergencies.

Where are we now?

MDH staff involved in preparing for, or responding to, public health emergencies have different levels of experience and training in the access and functional needs of people with disabilities. MDH coordinates the preparedness activities of the organization's staff using an equity lens. This includes incorporating access and functional needs actions into emergency planning and training.

Why does this project matter?

Emergency preparedness is vital to make sure people stay safe during emergencies like tornados, fires, disease outbreaks, and more. People with disabilities are at higher risk of negative outcomes during emergencies. It is important for public health staff to understand the needs of people with disabilities when they plan and respond to public health emergencies.

How will we collect the data?

- By December 31, 2026, MDH will establish a baseline percentage of EPR and Response Section staff who have completed training on the access and functional needs of people with disabilities. Then, MDH will set a target for improvement.
- By December 31, 2026, MDH will establish a baseline percentage of Response Section staff who have training on the access and functional needs of people with disabilities.
- Both EPR and MDH Response Sections staff will be directed to complete the training: "HHS/ASPR: Access and Functional Needs"

A training plan will be created or added to existing Response Ready training plans in MN.TRAIN. Biannual reports will be generated from MN.TRAIN to determine progress in meeting goal measures.

Housing

Housing Data Project 1: Incarcerated individuals with disabilities will have accessible housing upon release.

Lead agency: Department of Corrections (DOC)

Supporting agencies: Department of Human Services (DHS) and Minnesota Housing

What are we working toward?

The DOC proposes collecting data for a goal about housing for incarcerated individuals with Americans with Disabilities Act (ADA) plans. An ADA plan is a written plan created by DOC. It explains what supports a person with disabilities needs to access programs and services related to daily living. The goal will be for more individuals to have accessible housing and supports after release. The incarcerated individual will determine whether the housing meets their identified accessibility and disability related support needs.

Where are we now?

Right now, the DOC does not track information about housing for individuals with disabilities after release.

Why does this project matter?

Housing is vital for everyone's well-being. Safe and accessible housing can be hard to find. Formerly incarcerated individuals face even more barriers to finding housing. This puts people at risk of homelessness, health problems, and becoming incarcerated again.

How will we collect the data?

To collect this data, the DOC will:

- Create a system to track how many incarcerated individuals have ADA plans. This will be done in 2027.
- Create a system to track whether individuals with ADA plans have housing that meets their needs related to their disability. This will be done in 2027.
- Set targets for improvement by 2029.
- Create measurable goals in 2029. This will be done after data is analyzed.
- Continue to track the accessibility of transitional housing options utilized by the DOC.

Housing Data Project 2: More people with disabilities will have safe housing, affordable housing that meets their personal preferences.

Lead agencies: Metropolitan Council (Met Council), Minnesota Housing, DHS

What are we working toward?

This project will have two parts:

Housing Data Project 2A: Met Council wants to collect data about disabled people's experiences with housing services. Met Council will explore what safe, accessible, affordable housing means to people living with disabilities. This will help Met Council identify program strengths, areas for improvement, and ideas to make services better.

Housing Data Project 2B: Minnesota Housing and DHS want to measure the share of people with disabilities who have safe and affordable housing. They will measure how many people are satisfied that their housing meets their personal preferences and reflects their choices.

Where are we now?

Housing Data Project 2A: A total of 3,654 households that receive Met Council housing services self-identified as being headed by someone who is an older adult and/or has a disability.

Right now, Met Council does not collect information specifically about disabled people's experiences with housing services. In 2024, the council conducted a survey about housing for low-income people. They were able to collect some information about needs of people with disabilities through the survey, but that was not the focus.

Housing Data Project 2B: The state of Minnesota has a new data source, MnCHOICES, that measures housing choice for people with disabilities. Minnesota also participates in the National Core Indicators, a survey that measures housing choice and satisfaction.

DHS will use existing data as proxy measures to monitor available outcomes and inform the development of measures of housing choice and satisfaction. For example, the Mental Health Information System uses a proxy measure for housing satisfaction by identifying "housing informed choice." Which is defined as people, "Not wanting or planning to move from their current environment." In 2024 a total of 535 people (81%) in the Housing with Support for Adults with Serious Mental Illness grant program identified that they were not wanting or planning to move.

Why does this project matter?

Many people with disabilities struggle to find and retain housing that is safe, affordable, and accessible. People frequently have to move away from their communities and support networks to get

housing. Having only one housing option with limited affordability and marginal accessibility is not sustainable or a real choice. It is at best an option of last resort.

How will we collect the data?

Housing Data Project 2A: The Met Council will reach out to voucher holders that identify as being elderly or living with a disability. They will offer engagement around housing services. Met Council will explore additional follow-up with voucher holders that do not use their voucher. The follow-up would seek to learn the reasons why. For example, the voucher holder might not have been able to find:

- An appropriate unit with necessary features,
- A property owner who would accept the voucher, or
- A unit in their chosen community.

The Met Council will use the information to develop at least two actionable strategies to improve housing services.

Housing Data Project 2B:

To collect this data, Minnesota Housing and DHS will launch an interagency team that includes people with lived experience. The team will explore ways to measure housing choice and satisfaction for people with disabilities. They may use data from the National Core Indicators In-Person Survey. This is a face-to-face survey of a representative sample of people with disabilities living in the community. They may also use MnCHOICES data.

Minnesota Housing and DHS will also:

- Develop ways to measure and track individuals' opportunities to choose their housing. They will also find ways to measure and track people's satisfaction with their living situation. DHS and Minnesota Housing will do this using National Core Indicators and MnCHOICES data.
- Establish a baseline using three years of initial data, then set measurable targets. They will also create strategies for the goal.
- Share available housing data and updates on the data development process on a public website.
- Prioritize face-to-face interaction with people impacted when collecting data about satisfaction and choice.
- Consider intersectionality when reviewing data to discover and address disparities in outcomes.
- Identify strengths and areas for improvement. The data will show where there are gaps in program effectiveness. That can highlight where programs need to be changed.
- Use data to recommend action steps. DHS will use data to inform targeted strategies. For example, if the data shows that people have housing but feel limited in their choices, DHS will work to broaden available options, not just increase the number of units.

DHS will measure the percentage of people receiving services who report that:

- Safety is a barrier to housing.
- Affordability is a barrier to housing.
- They are satisfied that their housing meets their personal preferences.

What will we do while we develop this project?

DHS will replace and strengthen Housing Stabilization (HSS) services through community engagement, including:

- Supporting equitable, culturally specific implementation of the HSS replacement.
- Using lived experience advisory groups to guide implementation and promote accountability.
- Engaging people with lived experience as data advisors.

DHS will also:

- Develop DHS strategies and objectives for implementing and tracking housing outcome measures.
- Identify agency, service, and program specific housing outcome measure implementation strategies.
- Publish and regularly update public data dashboards about housing outcomes.

Preventing abuse and neglect

Preventing abuse and neglect Data Project 1: Medicaid-funded case managers for adults will be informed of maltreatment reports.

Lead agencies: Department of Human Services (DHS), Minnesota Department of Health (MDH)

What are we working toward?

DHS wants to improve supports, service coordination, and safety for people who may have experienced maltreatment. DHS is proposing a policy to require that Lead Investigative Agencies (LIAs) notify case managers about all reports of suspected maltreatment. This policy would be about:

- Lead investigative agencies (LIAs), which are the entities responsible for investigating potential maltreatment. DHS, MDH, and counties are LIAs.
- Case managers funded by Medical Assistance. These are case managers for adults receiving waiver services or Targeted Case Management.
- Reports of suspected maltreatment made to the Minnesota Adult Abuse Reporting Center (MAARC).

Where are we now?

There are several reasons that caseworkers might not be aware of reports of alleged maltreatment:

- The Vulnerable Adults Act requires LIAs to communicate with case managers as part of maltreatment investigations. However, many cases do not reach the investigation stage. This risks a gap in the case managers' awareness of a potential risk to the adult's health and safety.
- The Vulnerable Adults Act allows LIAs to coordinate with and share information with case managers for the adult's safety. However, the law does not require them to do so.
- LIAs might not know that the person experiencing alleged abuse has a case manager. This information is not consistently available in the adult maltreatment case management system.

As a result, case managers might miss vital information about their clients' health and safety.

Why does this project matter?

All people with disabilities should be free from abuse and neglect. Ensuring case managers know about reports of maltreatment will help promote clients' health and safety. Case managers use the information to:

- Provide support
- Prevent further harm
- Coordinate services to ensure continuity of care

- Monitor safety
- Respond to needs and challenges

How will we collect the data?

To collect this data, DHS and MDH will develop a legislative proposal by 2027. The proposal will include requests for data sharing authority and administrative resources, including for systems changes.

If the Legislature passes the proposal, DHS and MDH will implement the policy by July 1, 2029. This will include providing policy and practice guidance for counties. Another component of implementation will be the establishment of metrics for case manager notification to track compliance or progress toward statewide implementation. DHS and MDH will then explore possible metrics to establish a baseline and measurable targets.

Preventing Abuse and neglect Data Project 2: Fewer cases of abuse and neglect will go unreported to the state.

Lead agencies: DHS

What are we working toward?

DHS proposes collecting data for a goal about identifying unreported cases of abuse and neglect. The federal Centers for Medicare and Medicaid Services (CMS) require Minnesota to do so by July 2029. DHS will check whether Medicaid claims relating to abuse and neglect match reports made to the Minnesota Adult Abuse Reporting Center (MAARC). This will allow DHS to identify if mandated reporters failed to report incidents of abuse and neglect.

Where are we now?

Right now, DHS is not able to identify unreported cases of abuse and neglect. DHS can only identify cases of abuse and neglect that are reported through MAARC. Completing this project will require more funding and upgrades to MAARC systems.

Why does this project matter?

People with disabilities experience higher rates of abuse and neglect compared to non-disabled people. Some people with disabilities might experience barriers to reporting abuse and neglect on their own. Being able to identify unreported incidents will promote safety and well-being for people at highest risk of abuse and neglect. When cases are not reported, DHS cannot:

- Investigate providers who may be responsible for maltreatment.
- Support the health and safety of the person who experienced maltreatment.
- Prevent maltreatment from happening again.

How will we collect the data?

To collect the data, DHS will:

- Complete a plan for data collection and analysis by July 2027.
- Secure funding for the program and technology upgrades by July 2027.
- Complete program and technology upgrades by July 2029.
- Collect baseline data starting July 2029.
- Use baseline data to identify gaps in the abuse and neglect reporting system and create goals for improvement.

Preventing abuse and neglect Data Project 3: Decrease staff-to-resident abuse in MDH-licensed facilities

Lead agencies: MDH

What are we working toward?

Adults with disabilities are more likely than people without disabilities to experience abuse. These experiences can cause lasting harm to physical and mental health. Adults with disabilities who live in settings where care is received can be dependent on staff for services and are more vulnerable* to experiencing staff-to-resident abuse. To address this challenge, MDH will begin collecting data specifically associated with confirmed cases of staff-to-resident abuse within MDH-licensed facilities. From this baseline, MDH will be able to inform next steps to reduce instances of staff-to-resident abuse each year.

*Definition: A vulnerable adult is any person 18 years of age or older who is a resident of a facility such as those listed below. A vulnerable adult receives services and possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction. Because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment (definition from MN statute 626.5572 subd. 21).

Examples of MDH-licensed facilities include:

- Nursing Homes
- Assisted Living Facilities
- Home Care
- Hospice
- Intermediate Care Facilities for Individuals with Intellectual Disabilities

Where are we now?

MDH Health Regulation Division can retrieve staff-to-resident abuse data from maltreatment reports.

Why does this project matter?

This level of data has not yet been reported in detail or disaggregated in a way that can lead to meaningful change. Because MDH licenses and regulates these providers, MDH has the enforcement authority if the facility is found responsible and can refer to licensing boards if individuals are found to be responsible.

How will we collect the data?

- Each month, MDH will review reports from the previous three months and send facilities a bulletin summarizing allegation types and offering prevention recommendations.
- MDH will conduct follow-up visits for every substantiated maltreatment case to confirm the facility has taken steps to prevent it from happening again.
- MDH will create enforcement criteria to address abuse and neglect and prevent it from happening again.
- MDH will ensure that providers with confirmed violations develop and implement corrective action plans to protect residents' safety.
- MDH will work with providers to identify common areas where abuse and neglect occur and create helpful resources for residents, families, and facilities.
- By December 31, 2027, MDH will establish a baseline for the number of confirmed cases of staff-to-resident abuse.

Transition

Transition Data Project 1: More people will have access to peer support services.

Lead agencies: Direct Care and Treatment (DCT), Department of Human Services (DHS)

What are we working toward?

DCT and DHS are developing a goal about peer supports. This goal will be about services provided by certified Peer Support Specialists and Peer Recovery Specialists. They help people with behavioral health or substance use recovery through:

- Lived experience
- Recovery planning
- Navigating community resources
- Ongoing recovery support following discharge

The goal will be for DCT to offer peer support to all people in DCT facilities. All people who want those services will receive them.

Where are we now?

DCT employs three peer support specialists. DCT does not have existing contracts with community providers. Additionally, DCT does not track how many people are connected to peer support. The agency also does not have formal peer support training programs.

Why does this project matter?

Peer support promotes recovery, integration, and self-determination. Talking to someone who has been through the same experiences can be valuable. Peer support also benefits the person giving support. It helps them gain skills and prepare for jobs.

How will we collect the data?

Starting in August 2026, DCT will collect data on:

- The number and percentage of individuals interested in peer support services at discharge.
- The number and percentage of individuals already connected to a Peer Support Specialist or Peer Recovery Specialist.
- The discharge destination of individuals who express interest in peer support services.
- Identified barriers to successful connection with peer support services.

By July 1, 2027, DCT and DHS will create a baseline and measurable targets.

To achieve this project, DCT will:

- Engage communities to reduce stigma and build awareness and support for integrated behavioral health and peer support services.
- Enhance the transitional care record to systematically capture and track connections to community-based peer support services at the time of discharge from DCT facilities.
- Collaborate with DHS to identify and address systemic barriers that limit access to peer support services.
- Cultivate partnerships with community-based organizations that provide peer support services to expand referral pathways and service availability.
- Assess and address workforce challenges by exploring barriers to recruitment and retention of peer support specialists within DCT.

Transition Data Project 2: More incarcerated individuals with disabilities will access correctional facility programs.

Lead agency: Department of Corrections (DOC)

What are we working toward?

The DOC wants to ensure individuals with disabilities have equal access to programs in correctional facilities. DOC programs include activities and/or instruction that help people stay productive, learn skills and knowledge, continue their education, or support their mental or behavioral health.

Where are we now?

DOC policy states that all incarcerated people must take part in programming, but individuals with disabilities often experience barriers to participation. These could include accessibility barriers. Some examples include a lack of American Sign Language (ASL) interpreters and auxiliary aids.

Why does this project matter?

Programming provides benefits for incarcerated individuals. Educational programs are associated with better employment outcomes and higher pay following release. It is critical that individuals with disabilities have full and equal access to these programs.

DOC will collect data to ensure incarcerated individuals have ADA plans that recognize their strengths, address their individual needs, and support full participation in programs, services, and daily activities.

How will we collect the data?

To collect this data, the DOC will:

- Create a system to track how many incarcerated people have Americans with Disabilities Act (ADA) plans. An ADA plan is a written plan created by DOC. It explains what supports a person with disabilities needs to access programs and services related to daily living.
- Conduct annual accessibility audits by the ADA Compliance Manager for correctional facility programs. These accessibility audits assess the physical layout and access to programs and services within the correctional facilities.
- Analyze the percentage of people with and without ADA plans enrolled in programs. This will be done by the end of 2027.
- Set targets for improvement by 2029.
- Create measurable goals in 2029. This will be done after analyzed data is collected. It will include intersectional analysis to identify disparities in program access.

Transition Data Project 3: More people with disabilities will move from provider-owned or managed settings to integrated community living.

Lead agency: DHS

What are we working toward?

DHS proposes collecting data for a goal about people who move out of provider-owned or managed settings into community living. Community living means living arrangements that are considered someone's own home. Provider-owned or managed settings can include:

- Group homes owned by a service provider
- Assisted living facilities
- Adult foster care homes owned and staffed by a caregiver who is not a family member

A house or apartment is considered someone's own home when it is not owned by a service provider. Examples could include:

- Renting an apartment where you can choose your service providers and change service providers.
- Owning your own home.
- Living in a home owned by a family member, where you choose your service providers and can change service providers.

Where are we now?

DHS does not have data about the number of people who move from provider-owned or managed settings to integrated community living.

Why does this project matter?

All people with disabilities have the fundamental right to the same housing opportunities as anyone else. This includes autonomy to choose where they live and with whom they live.

Living in your own home creates a foundation for a self-determined life. It can help build:

- Independence: Developing personal autonomy and life skills.
- Community participation: Building natural support networks and neighborhood connections.
- Privacy and control: Having authority over your daily routines and personal space.

Minnesota uses the Community Living First planning standard to promote these rights. This standard requires support planning teams to first actively explore and consider individualized community living options that meet someone's needs. Then they can explore provider-owned or managed residential settings. This ensures people can make an informed choice about their housing.

The standard does not require people to move against their will. It also does not override person-centered decision-making.

How will we collect the data?

To collect this data, DHS will:

- Develop a method to track when someone transitions from a provider-owned or managed setting into a home of their own. DHS will use MnCHOICES data to create this methodology.
- Create a baseline by July 1, 2027.
- Publish findings about the methodology and project progress by 2030.

DHS will also:

- Use data to identify barriers to community living.
- Track the rate of people moving into more integrated living arrangements, the availability and equity of transition supports, and whether people have exercised informed choice to live in preferred settings.
- Align policies to make it easier for people to access supports in integrated settings.
- Update policies, procedures, and resources for case managers to promote person-centered planning in housing conversations.

Transition Data Project 4: Minnesotans with disabilities will have timely access to services.

Lead agency: DHS

What are we working toward?

DHS wants to write projects about how quickly people get access to disability services. The project will have three parts.

Transition Data Project 4A: Assessment timeliness for new waiver recipients

This project will be about new waiver recipients. It will measure the number of days between:

- Requesting an assessment and getting the assessment.
- Getting the assessment and getting a service plan.
- Getting a service plan and receiving the service.

Transition Data Project 4B: Reassessments and authorized services for current waiver recipients

This project will be about people who are already using waiver services. It will measure:

- The percentage of waiver recipients who got a reassessment within guidelines.
- The percentage of authorized services provided within the past 12 months.
- The number of days between reassessment and service authorization, then service authorization and service start if person changes services and/or providers following reassessment.

Transition Data Project 4C: Timeliness of service delivery and authorized services for personal care, homemaker, home health aide, and/or habilitation services

This project will be about people who are eligible for the following services:

- Personal care
- Homemaker
- Home health aide
- Habilitation services

Some people may receive these services through their waiver, while others may not. This project will include people who started receiving these services within the past year.

The project will track:

- The average time from when someone is approved for the service and starts receiving the service.

- The percentage of authorized service hours provided within the past 12 months.

Where are we now?

DHS does not currently have baseline data. DHS recently got access to new data from MnCHOICES. This data will be used to write a baseline and measurable targets. First, DHS has to conduct quality assurance of the data.

The 2024 Medicaid Home-and Community-Based Services (HCBS) Access Rule requires states to publicly report HCBS access measures related to:

- Waiting lists for HCBS waivers
- Service delivery timeliness
- Percentage of authorized services actually delivered
- Standardized HCBS Quality Measure Set (once finalized by the Centers for Medicare and Medicaid Services [CMS])

These reports must be publicly available on the state's HCBS website.

Why does this project matter?

People sometimes wait weeks or months to start getting disability services. These delays can harm someone's health, safety, and levels of community integration.

Additionally, choice and autonomy are vital for people with disabilities. However, disabled Minnesotans say they often feel they do not have real choices in services and supports. Their options are limited by systems and agencies. One way to increase opportunities for autonomy is by ensuring access to timely assessments and services.

How will we collect the data?

Transition Data Projects 4A and 4B

To collect the data, DHS will:

- Develop ways to measure how long people wait to access services by June 30, 2027.
- Align reporting with federal requirements by 2031.
- Collaborate with service recipients, counties, and service providers to improve access to services.

Transition Data Project 4C

Reaching this project would require funding from the state Legislature. DHS will request funding during the 2026 legislative session. DHS will then build out the data collection system and analysis.

Transition Data Project 5: Direct support professionals (DSPs) and people with disabilities will shape the future of Minnesota's Medicaid program.

Lead agency: DHS

What are we working toward?

DHS proposes collecting data for a goal about ensuring that people with disabilities, DSPs, and others who use Medicaid services have a strong influence in shaping the future of Minnesota's Medicaid program. Minnesota is redesigning its Medicaid advisory councils to comply with a federal regulation called the Access Rule. It is reforming the Medicaid Advisory Council and creating an Interested Party Advisory Group.

Interested Parties Advisory Group (IPAG)

The Access Rule requires states to create an Interested Parties Advisory Group (IPAG). DSPs and people who use direct support services will be IPAG members. They will advise the state Medicaid agency on issues related to the DSP workforce shortage. The shortage of DSPs is a barrier to people living in communities and settings of their choice. Without access to trained and qualified DSPs, people with disabilities are more likely to live in segregated settings or experience abuse and neglect.

Beneficiary Advisory Committee (BAC)

Historically, Minnesota has a Medicaid Services Advisory Committee (MSAC). This group advises DHS on Medicaid policy and administration. However, the group's recommendations have not meaningfully included people with disabilities. To make the group more inclusive, DHS is launching a Medicaid Advisory Committee (MAC) to replace the MSAC. Additionally, DHS is creating the Beneficiary Advisory Council (BAC). Members of the MAC who receive Medicaid services will also be members of the BAC. The BAC will meet before MAC meetings to prepare for MAC meetings. The group will provide more support for members to develop self-advocacy skills.

Where are we now?

Minnesota is in the process of redesigning these advocacy councils.

Why does this project matter?

It is vital for people with lived experience to have influence in Minnesota's Medicaid system. Beneficiaries often have less influence on committees than full-time Medicaid professionals who are paid to work in the system. DHS must support people with lived experience in advocating for positive changes that impact their daily lives.

How will we collect the data?

DHS will collect this data by:

- Measuring the number of MAC and BAC members with disabilities, as well as their participation in the meetings.
- Conducting regular surveys to measure members' comfort levels and confidence in meeting participation.
- Tracking how many items MAC provides feedback about, as well as the number of items DHS adopts.

Additionally, DHS will launch the IPAG by January 1, 2029. The IPAG will include 40 DSPs and 40 people (or their legal representatives) who use DSP services. DHS will track how many recommendations IPAG shares, and the outcomes of those recommendations.

Transition Data Project 6: People with disabilities are protected from increases in the use of mechanical restraint.

Lead agency: DHS

Where are we now?

Mechanical restraint is a type of restrictive procedure. Minnesota has significantly reduced the use of mechanical restraint since the *Jensen* lawsuit settlement agreement in December 2011. Goals around mechanical restraint vary by person and involve things like teaching the person new skills, addressing or managing complex medical conditions, changing service plans, increasing quality of life, or other strategies related to the assessed function of the person's self-injurious behavior. Mechanical restraint has been used for less than 10 people in the state for many years now, which is below the threshold that DHS will share information publicly due to the risk of identifying data for individual people. However, this data is tracked privately by the External Program Review Committee. Every individual person's data is continually reviewed every three months by the committee via submissions of Positive Support Transition Plan Reviews, DHS-6810A, in addition to annual required reports.

- Instances of unapproved uses of mechanical restraint can be reported as maltreatment. Maltreatment staff investigate each report received individually. If Maltreatment finds the report to be accurate, they will instruct the provider to end the unapproved use of restraint and may also issue a citation or financial penalty against the provider.
- The DHS Licensing Division does routine site visits to review the quality of programs. During their visits with service providers, they review for unapproved use of mechanical restraint. If a service provider is using unapproved mechanical restraint, the Licensing Division will work with the provider to immediately end the restraint use. The service provider might receive a citation or financial penalty for use of mechanical restraint that violates state laws.

- The External Program Review Committee (EPRC) monitors DHS-approved uses of mechanical restraint that meet legal requirements outlined in state law. The EPRC's work to review requests for use of mechanical restraint is legally required under a law called Minnesota Rule 9544. The EPRC will continue to meet three times monthly as a committee and as needed with teams that are using restricted and prohibited procedures to reduce the use of identified restraint.
- Members of the public are invited to attend monthly meetings with the committee. Private information is not shared in these public meetings. Connection information is available on the External Program Review Committee's webpage.
- Occasionally, though not often, individuals will experience an increase in mechanical restraint use, which is monitored and followed up on by the EPRC. Below are some examples of when the committee sees increases in restraint use:
    - The person experiences a new illness or injury and engages in more self-injurious behavior until they recover.
    - Substantial life events such as loss of housing, loss of staffing, loss or strained relationships, and working through grief may result in a person needing to use the mechanical restraints considered self-injurious protection equipment more frequently.
    - The mechanical restraint being used is a seat belt clip or harness that prevents the person from unbuckling during transportation. As the person spends more time in their community traveling to places they want to go, the use of the restraint increases proportionally to increase in vehicle use. In these situations, it would not be accurate to assume that an increase in restraint use means a decrease in quality of life.

Why does this project matter?

Community members shared the need to improve the safety and well-being of people with disabilities by:

- Increasing investigations into the use of mechanical restraint.
- Improving follow-up with reporters and victims.
- Strengthening collaboration across state and local systems to prevent future harm.

Minnesota has achieved a significant reduction in mechanical restraint use in settings licensed under Minnesota Statute 245A and 245D. Continued oversight is critical to prevent increases and identify emerging risks early. It is important to increase access to and use of trauma-informed, person-centered, and positive support practices across all service systems, and empower providers, people with disabilities, and their caregivers to recognize, prevent, and report abuse and neglect.

How will we collect the data?

This project impacts less than 10 people in the state, and each person's circumstances and services are individually monitored by the External Program Review Committee (EPRC). Sharing information publicly about a small number of people could violate privacy laws. The EPRC requires care teams to develop person-centered goals as they go through the following required processes:

- Functional behavior assessment
- Positive Support Transition Plan development
- Quarterly Positive Support Transition Plan Review
- Request for the Authorization of the Emergency Use of Procedures

DHS will work with other partners to ensure all ongoing uses of mechanical restraints from applicable services licensed under Minnesota Statute 245A are overseen and monitored by the EPRC or the Community Capacity and Positive Supports Team. This may result in data showing increased utilization, when it is actually an increase in assuring compliance with the measure. We will do this in the following ways:

- By June 30, 2027, the DHS Community Capacity and Positive Supports Team will partner with DHS Licensing to assure all instances of unreported mechanical restraint usage that are identified during licensing reviews are either stopped immediately or reported to the Community Capacity and Positive Supports team via a Positive Support Transition Plan, DHS-6810, and any other required forms.
- By June 30, 2027, the DHS Community Capacity and Positive Supports Team and DHS Licensing will partner with the Ombudsman for Mental Health and Developmental Disabilities (OMHDD), Governor's Council on Developmental Disabilities (GCDD), and the Olmstead Implementation Office (OIO) to publicize mechanisms for reporting prohibited use of mechanical restraints to assure DHS and the EPRC has the most updated and accurate information.

How else has DHS worked on this project?

DHS provides many resources, such as:

- Trainings on rule and statute requirements regarding mechanical restraint.
    - YouTube: Minnesota Rule 9544 for service providers licensed under Minnesota Statute 245A – Training
    - YouTube: Minnesota Rule 9544 for service providers licensed under Minnesota Statute 245D – Training
- Trainings on positives support strategies, person-centered practices, and other applicable topics through the College of Direct Support.
- Tools for helping people and providers communicate more with each other:

- Positive Supports: How to encourage and promote increased communication for people you support (DHS-6810H-ENG)
- Positive Supports: Plan for Supporting Communication Growth (DHS-6810J)

For more information on efforts made to phase out restraint use, the public is welcome to review the EPRC's annual reports on the committee's webpage. People are also welcome to attend the committee's monthly public meetings.

What will DHS do in the meantime?

The Division provides instructional materials for phasing out restraint use and developing positive support strategies, as listed within the Positive Support Transition Plan Instructions, DHS-6810B, many staff trainings through the College of Direct Support, and many other resources.

Annually, on July 1, the EPRC will publish an annual report on the committee's webpage detailing any concerns with restraint use and strategies that might be helpful in reducing restraint use.

Who to contact for help

Contact DHS for help if you or someone else are experiencing mechanical restraint against your will. Email PositiveSupports@state.mn.us or call the DHS Response Center at 651-431-4300 or 866-267-7655 (toll free). DHS Response Center staff are available 9 a.m. to 4 p.m. Monday through Friday. They can also report restraint use and request assistance from their ombudsperson, county, or tribal agency.

2026 plan update timeline

2023-2024

In 2023, the Subcabinet decided to update the Olmstead Plan using a co-creation model. This would be the first comprehensive update since the plan was adopted in 2015.

In 2024, working with the Subcabinet, OIO created a process for the update. The office issued a Request for Proposals for a contractor to support Inclusion Consultants. OIO also launched the statewide Disability Inclusion and Choice written survey. The goal of the survey was to learn about what issues were most important to Minnesotans with disabilities.

Additionally, OIO worked with a consulting firm, ACET, to host more than 20 community conversations. These community conversations focused on ideas of choice, integration, and inclusion. ACET worked with community partners for the conversations.

OIO also contracted with the Improve Group to conduct the fourth Quality of Life Survey. The survey measures quality of life over time for a specific population in Minnesota: people who access services in potentially segregated settings.

2025

In early 2025, OIO contracted with Dendros Group to bring on Inclusion Consultants. Inclusion Consultants received training over the next few months. They also created a Focus Area Report to help guide the work. The Focus Area Report laid out their priorities for the Olmstead Plan. The Inclusion Consultants were then assigned to up to three agency teams each.

Through summer and fall, agency teams and their assigned Inclusion Consultants drafted Olmstead Plan goals and strategies. OIO and their assigned Inclusion Consultants drafted the non-goal components of the plan.

Dendros Group partnered with community organizations to hold over 20 community conversations in the summer and fall. These conversations happened across the state. Agency teams considered this community feedback while drafting goals.

2026

The draft Olmstead Plan was published in early 2026. The Leadership Forum reviewed and discussed the draft at a meeting in February. The Subcabinet reviewed and discussed the draft at a meeting in March. The draft was available in English, Hmong, Spanish, and Somali.

In April 2026, OIO held a public comment period in partnership with the Dendros Group. The public comment period sought feedback on the draft plan. It included:

- An online survey open to the public. The survey was available in English, Hmong, Spanish, Somali, and American Sign Language (ASL).
- Virtual meetings intended to be an accessible alternative to the online survey. The meetings took place in English, ASL, Spanish, and Somali.
- Individual interviews intended to be an accessible alternative to the online survey and virtual meetings.
- Emails and letters submitted by organizations and individuals.

OIO provided feedback summaries to the agency teams in addition to providing all original feedback. Teams used the feedback to update their goals and strategies. Agency teams also completed feedback forms where they addressed themes from the public comment period. These forms explain how agency teams did or did not incorporate feedback and why. They are located on the public comment library on the OIO website.

In August, the Leadership Forum reviewed the revised draft plan. The Subcabinet reviewed the draft and voted to accept it in September. The final plan will be made available in English, Spanish, Hmong, and Somali, as soon as possible, after Subcabinet approval. OIO will report to the Subcabinet as soon as these plan documents are complete.

Olmstead Plan implementation

Updating goals and strategies

The Olmstead Plan is a five-year plan. There will be annual opportunities for state agencies to update goals and strategies. This process promotes accountability while allowing flexibility.

Reasons for goal updates could include:

- Making goals more ambitious after targets are met
- Public emergencies that affect goal progress
- Public feedback about goals or strategies
- Significant changes to funding

Annually, agencies can propose:

- Changes to existing goals
- New goals
- Changes to existing strategies
- New strategies

All proposals require public input and review by Leadership Forum and Subcabinet. Agencies may not propose changes that reduce a goal below its original target unless a documented funding reduction

or a statutory change outside the agency's control makes the target unattainable. For example, if a funding reduction outside an agency's control affects their ability to achieve the goal. If this happens, agencies must justify changing the goal.

Principles of community engagement

Community engagement is essential to the success of the plan. The plan was built using community engagement. Over the course of the plan, agencies and OIO will continue to engage community.

The Olmstead Subcabinet is committed to involve community in ways that are:

Accessible

Community engagement must be accessible for all who participate. This means physically accessible spaces, as well as sensory, language, and digital accessibility. Accessible engagement should include multiple ways for people to engage. People should be able to participate without financial and transportation barriers. They should also have what they need to be successful, including plain language information. Accessibility must be flexible and evolving.

Intentional

Community engagement is intentional when agencies have a clear idea of:

- Why they are seeking feedback
- What they will do with the information

Agencies should coordinate with each other to share information and data that may relate to the plan. They should also align their engagement efforts to avoid duplicative work.

State agencies must prioritize those most impacted by programs, decisions, or changes. Intentional engagement reduces barriers to participation by:

- Being culturally responsive, representative, and appropriate.
- Providing information and resources people need to actively participate.
- Meeting people in their communities.
- Building relationships and connections.

Accountable

Community engagement is accountable when there is full transparency with participants. The state must inform participants about how it addressed issues or used feedback. The goal of community engagement is meaningful outcomes. Accountable engagement means:

- Community members feel that progress is being made.

- Community members are a part of that progress.
- Agencies remain open to community feedback.

Additionally, it is important for the state to recognize and take accountability for systemic harm to disabled people. Some people with disabilities may not want to engage with the state at all. The state must work to prevent further harm as much as possible. This includes:

- Reducing the risk of retaliation against community members who share feedback.
- Promoting privacy and safety for participants.
- Considering trauma-informed approaches to community engagement.
- Respecting the boundaries and lived experiences of disabled Minnesotans.

Representative

Community engagement should represent the diversity of the disability community in Minnesota. This includes different disability types, regions of the state, and intersections with other identities such as race, culture, sexuality, gender, socio-economic status, education, and more.

Collaboration is key to achieving equitable representation. To address the diverse needs of the disability community, the state must collaborate with trusted partners.

Well organized

Community engagement is most effective for both the state and participants when it is well organized. However, well organized does not mean rigid. Genuine engagement is adaptive to the community.

Organization should happen before, during, and after the engagement. Well organized community engagement means the state:

- Plans engagement opportunities.
- Communicates with community early and often.
- Is as responsive as possible to community needs.
- Plans for time to build relationships with the community.

During engagement, facilitation must fit the needs of the community. Feedback should be well documented. The state should center people with disabilities by clarifying which feedback is from people with disabilities versus those without, when possible.

Conclusion

Community engagement is ever evolving. These principles may change or adapt, knowing that not all community needs are the same. Engagement shouldn't look the same across all communities and projects. We prioritize leading with a spirit of co-creation and honoring the community's feedback.

Olmstead Implementation Office roles and responsibilities

Community engagement

Community engagement is core to OIO's work. OIO will follow the Principles of Community Engagement. OIO's mission is to reach groups that reflect the diversity of the disability community. This includes increasing engagement with historically underrepresented communities. OIO commits to:

- Seek public feedback about:
  - The Olmstead Plan.
  - Progress on plan goals.
  - Disabled life in Minnesota.
- Share community input with Leadership Forum and Subcabinet.
- Educate the public about the Olmstead Plan and community integration.
- Ensure transparency by sharing plan performance updates.
- Regularly develop and share community engagement strategic plans.
- Regularly share updates about progress on community engagement strategic plans.
- Conduct research and surveys as directed by the Subcabinet and/or Leadership Forum.

Compliance

OIO will oversee implementation of and compliance with the Olmstead Plan. Accountability and community engagement are key to the success of the plan. State agencies are responsible for meeting their Olmstead Plan goals and strategies. To promote transparency and accountability, OIO will:

- Work with state agencies to track progress on measurable goals and data projects quarterly and annually.
- Share updates about plan progress, at least quarterly, with Leadership Forum, Subcabinet, and the public, including:
  - Publishing visualizations of goal progress.
  - Presenting about goal progress.
- Facilitate interagency work.
- Engage the public around goal performance, with a focus on accountability.
- Collaborate with agencies on performance improvement plans when appropriate.

Community surveys

OIO will oversee regular surveys of Minnesotans with disabilities to inform plan implementation. The surveys will follow the principles of community engagement, including representing the diversity of the disability community. The surveys will focus on:

- Quality of life for people in segregated settings.
- Community integration and inclusion.
- Autonomy in decision making.

Agency Connect and Agency Feedback

Agency Connect and Agency Feedback are two different ways the public can engage with the Olmstead Implementation Office (OIO) and state agencies. Both options are available on OIO's website.

Agency Connect

Agency Connect helps people with individual concerns related to state programs and services. Through this process, OIO connects people to the relevant agency. OIO will track state agencies' timeliness and responsiveness. Additionally, community members have the option to give feedback about the process. OIO will also track the types of issues people submit to Agency Connect. OIO will use this information to help the state tackle recurring issues in a systematic way.

Agency Feedback

People can share ideas about improving systems related to the Olmstead Plan through Agency Feedback. OIO will share these comments and ideas with Olmstead Subcabinet agencies. Agencies need to consider this feedback while implementing their Olmstead goals and strategies. Feedback can be submitted to MNOlmsteadplan@state.mn.us.

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Olmstead Plan: Appendix

Table of Contents

Policy consultants

As part of this project, the Technical Assistance Collaborative (TAC) chose Policy Consultants for specific disability topics. The policy consultants were:

- Rebecca Boss – human services
- Laura Conrad – education
- Sara Galantowicz – human services
- Ayana Dilday Gonzalez – housing
- Megan Lee – public safety
- Katharine London – health
- Jami Petner-Arrey – positive supports
- Virginia Selleck – employment
- Lisa Sloane – transportation
- Alicia Woodsby – Metropolitan Council
- James Yates – Veterans

Community conversation partners

OIO and contractors worked with community partners to do community conversations throughout the planning process. The community partners include:

- Access North
- Advocating Change Together
- The Arc Minnesota
- The Arc Northland
- Autism Society of Minnesota
- Bethel University's BUILD Program
- Bois Forte Band of Chippewa
- Center for Inclusive Childcare
- CloseKnit
- Compassion Chapel
- Confederation of Somali Community
- Cultural Diversity Resources
- Deaf Equity
- Every Third Saturday
- Fahan
- Faribault Deaf Club
- Governor's Council on Developmental Disabilities
- Hispanic Advocacy and Community Empowerment Through Research (HACER)

- Hilltop Rehab and Skilled Nursing
- Inclusive Moorhead
- Itasca Life Options
- L'Arche
- Minnesota Brain Injury Alliance
- Minnesota DeafBlind Association
- Minnesota State Academy for the Deaf, Alumni Association
- Monarch Waterview Shores
- MSS
- National Alliance on Mental Illness Minnesota (NAMI)
- Open Arts Minnesota
- Ourspace
- OutFront Minnesota
- Reach for Resources
- Roots & Wings
- Self-Advocates of Minnesota
- SEWA-AIFW (Asian Indian Family Wellness)
- Somali Parent Autism Network (SPAN)
- The Remember Project
- Touchstone Mental Health
- Union Gospel Mission Twin Cities
- United Hmong with Disabilities
- Community members from a seven-county metro area-based rare disease support group and a Special Olympics team

Themes from community feedback

This section describes themes from the Olmstead Implementation Office's 2024 community feedback efforts. About 2,000 people shared feedback.

Community feedback about specific topics

Some community feedback focused on specific topics, like transportation and employment. Examples of these themes are listed here.

- Minnesota needs to improve integration, inclusion, and choice for people with disabilities.
- Lack of accessibility is a major barrier for integration, inclusion, and choice.
- People with disabilities want more housing choices. Those housing choices should foster inclusion within the broader community.
- Students with disabilities need to be better integrated and included in schools.

- People with disabilities face barriers to competitive, integrated employment.
- Minnesota needs more affordable, accessible transportation infrastructure and options.
- Financial restrictions – like asset and income limits – hinder integration and choice.
- The shortage of direct support professionals harms integration, choice, and quality of life.
- People with disabilities need access to quality health care, services, and assistive technology.
- The state needs to protect and uphold the rights of people with disabilities Additionally, disabled people must be free from abuse and neglect. Minnesota needs more education and advocacy resources.
- Ableism, racism, and xenophobia are significant barriers to integration. People with multiple marginalized identities experience additional barriers to integration, services, and supports. More access is needed to culturally specific activities and supports.
- The systems for getting disability supports and services are confusing, time-consuming, and inefficient.
- The state needs to include disabled people when updating policies and programs.

Overarching community feedback themes

Community feedback also included broader themes. These themes showed up across multiple topic areas. Broader themes were inclusion and choice, anti-ableism, and intersectionality.

Inclusion and choice

Community members stressed the importance of inclusion and belonging for people with disabilities. The *Olmstead* decision centers on integration of people with disabilities. Integration alone does not always create the conditions for thriving. Real integration requires inclusion and informed choice. Inclusion means that everyone has equal access to all aspects of society. Informed choice means the information is presented to a person in an accessible format and manner that meets their needs, and that the tools, information, and opportunities they need to understand all their options are provided. It also means someone has multiple options to pick from. This is especially important for people who experience institutionalization or segregation.

People with disabilities should be able to define what inclusion means for them. For example, being the only disabled person in a classroom is not necessarily inclusion – and could actually be isolating. The *Olmstead* decision means the State of Minnesota must offer services in the most integrated setting, and the person has the right to refuse. People can make an informed choice to live, learn, work, and enjoy life in segregated settings. Everyone deserves to have autonomy when making decisions about their own life. This is called personal choice.

True inclusion fosters belonging. The Inclusion Consultant Focus Area Report identified belonging as: “Being fully accepted and valued for who you are, without having to hide or change yourself to fit in.

It's about being seen, respected, and included in community life - not just allowed to participate, but wanted and needed."

Minnesotans shared these quotes about inclusion and choice through the 2024 Disability Inclusion and Choice Survey:

- "Have people able to make their own choices. Reduce guardianship… and give people the education about their rights and the flexibility to decide where to use funding for services and where to live."
- "In the situation of the individual who I saw being unnecessarily institutionalized, the social worker did not ask the questions if the individual desired to stay in the community and then talk through how to make that possible. My observation has been that people with disabilities are not aware of all of the options that are available to them."
- "Acceptance [should be] the norm, as well as access being the default – not having to always ask for accommodations or take that effort on by yourself. Having that be the default setting is a big thing."

Anti-ableism

The harmful effects of ableism was another major theme from community feedback. Ableism is devaluing and discriminating against people with disabilities. Advocate Talila Lewis (2022) describes ableism as assigning value to people based on society's ideas of "normalcy, productivity, desirability, intelligence, excellence and fitness." Anti-ableism means challenging and dismantling ableism.

Ableism often takes form in small, discreet, and unintentional ways. It even shows up in the disability community. Some examples of ableism can include:

- Treating people with disabilities like children
- Believing people with disabilities need to be "cured" or "fixed"
- Judging disabled people as "not disabled enough"
- Assuming people with disabilities are vulnerable and always need help
- Thinking that disabled people can't or shouldn't make decisions about their lives
- Minimizing the lived experiences of disabled people

Ableism, stigma, and lack of awareness about disability are major barriers to inclusion. Physical accessibility alone is not enough. We must accept disabled Minnesotans as valuable members of our communities. Communities need to be fully accessible for everyone to thrive.

Three people shared these quotes through the 2024 Disability Inclusion and Choice Survey.

- "If Minnesota as a whole had a more educated, positive outlook towards people with disabilities, [people with disabilities] would have a much easier time securing the funding and space needed to make integration, choice, and inclusion a reality."

- “There needs to be more focus on bringing the community along. None of these plans matter if basic societal attitudes about disabilities don't change … We spend too much time focusing on change at the margin of systems and not on real transformation.”
- “Listen to my concerns. Let me make my own choices. My independence is important to me.”

Intersectionality

Another overarching theme from community feedback was the importance of intersectionality. Intersectionality describes how systems of oppression affect people with multiple marginalized identities. These identities can include race, ethnicity, gender, sexuality, socioeconomic status, language, and more.

Scholar Kimberlé Crenshaw coined the term “intersectionality.” As Crenshaw says, “All inequality is not created equal” (“Intersectional,” 2025). For example, a disabled woman of color may experience discrimination based on disability, race, and gender – not just one of her identities.

The Inclusion Consultants defined intersectionality in their Focus Area Report as, “the understanding that disability does not exist in isolation. People's experiences are shaped by multiple identities … and systems must address the full complexity of their lives.”

Someone shared in the 2024 Disability Inclusion and Choice Survey, “People of all races, cultures, languages, genders, sexual orientation, socio-economic status, etc. need to be considered when creating and updating programs and policies. … The disability community is so diverse.”

Another Minnesotan with disabilities commented: “Providers of home- and community-based services need to actually value people with disabilities and come at their work in a true person-centered manner, and understand trauma-informed care, and culturally competent care.”

Definitions of Key Terms

Abuse: Abuse is defined for vulnerable adults in the Minnesota Vulnerable Adults Act, Minnesota Statute, 626.5572, subdivision 2.

A state law called the Reporting of Maltreatment of Minors (Minn. Stat. chapter 260E) defines maltreatment of children, including various forms of abuse.

Agency teams: Agency teams are groups of Subcabinet agency staff and contracted Inclusion Consultants. They worked together to write goals and strategies.

Anoka Metro Regional Treatment Center (AMRTC): AMRTC is a state-operated psychiatric facility. AMRTC provides inpatient care to adults who community hospitals cannot or will not treat. Patients often have complex psychiatric and medical conditions. Most patients have been civilly committed by a court as mentally ill. Many are under more than one civil commitment. Many patients are facing criminal proceedings.

AMRTC is a secure facility, which means the building and treatment units are locked. AMRTC is an example of a segregated, institutional setting. On average, patients stay in the hospital about 90 days before discharge.

Americans with Disabilities Act (ADA): The ADA is a federal law that protects people with disabilities from discrimination, requires employers to provide reasonable accommodations, requires public spaces and businesses to be accessible, ensures equal access to government programs and services, and guarantees accessible communication. The ADA became a law in 1990.

Behavior Intervention Reporting Form (BIRF): Certain service providers must report uses of behavioral interventions to the Minnesota Department of Human Services. They report them with a document called a Behavior Intervention Reporting Form (BIRF).

Service providers that must submit BIRFs include:

- Day services
- Respite services
- Foster care
- Homemaking services
- Community residential settings
- In-home support services
- Integrated community settings
- And more, as defined by Minnesota Statute 245D.

- Additionally, if a 245A licensed setting is serving an individual with a developmental disability or related condition, they must also submit BIRFs for that individual.

Service providers must submit BIRFs for:

- Emergency use of manual restraint (for details, please see definitions of “manual restraint” and “emergency use of manual restraint”)
- A medical or mental health emergency caused by using a restrictive intervention
- Using a restrictive intervention as part of someone’s positive support transition plan
- And other situations as defined by Minnesota Rule 9544.

Co-creation: For this plan, co-creation means people with disabilities and Subcabinet agency staff worked together.

Inclusion Consultants describe co-creation as, "a process where people with disabilities are not just giving feedback, but are leading, shaping, and making decisions alongside agencies and leaders … Lived experience is given the same weight and value as bureaucratic, institutional, or professional expertise."

Civil commitment: Civil commitment is when a court orders someone to receive treatment. This could be treatment for people with the diagnosis of mental illness, mentally ill and dangerous, substance use disorder, or developmental disabilities under the Minnesota Civil Commitment and Treatment Act.

Civil rights: Civil rights are personal rights guaranteed and protected by the U.S. Constitution and state and federal law. Civil rights include protection from discrimination based on certain identities. Those identities may include (depending on state or federal law):

- Race
- Color
- National origin
- Disability
- Age
- Religion
- Sex
- Sexual orientation
- Gender identity
- Familial status
- Marital status
- Recipients of public benefits

Community-Based Services (CBS): (as defined by Direct Care and Treatment (DCT))

CBS are a range of supports for children and adults with:

- Complex behavioral health needs
- Intellectual and developmental disabilities
- Involvement in the criminal legal system

- Emotional challenges

The purpose of CBS is to support people in living in the community, rather than institutions. They promote stability, independence, and community integration. CBS includes:

- Small residential homes with daily living support and medical oversight
- Vocational programs to help people prepare for and keep jobs
- Mobile clinical teams that provide individualized behavioral health services
- Intensive therapeutic foster care for youth with mental health disabilities
- Specialized programs for people who may pose a danger to the community that offer:
    - Person-centered planning
    - Positive behavioral supports
    - Crisis stabilization
    - Transition services

Community conversations: Community conversations (or small community conversations) were public input events. People with disabilities and supporters shared perspectives in small groups. Contractors held these conversations, in partnership with community organizations. Inclusion Consultants facilitated some conversations.

Competitive, integrated employment (CIE): CIE describes jobs in the community where people with and without disabilities:

- Work together
- Earn at least minimum wage
- Have equal access to benefits

CIE can be full-time or part-time. People can have competitive, integrated jobs with or without supports.

County Veteran Service Office (CVSO): Every Minnesota county has a CVSO. These offices work with Veterans and their families. CVSOs help Veterans get state and federal benefits by:

- Giving advice and education about benefits
- Advocating for Veterans
- Starting the process of filing benefit claims

Disability: The ADA defines disability as someone who:

- Has a physical or mental impairment that substantially limits one or more major life activities,
- Has a history of such impairment, or
- Is perceived by others as having such an impairment.

Disability compensation (Veterans services): Disability compensation is a benefit for Veterans through the federal U.S. Department of Veterans Affairs. Veterans are eligible if they got sick or injured during military service. They are also eligible if military service made an existing condition worse. Disability compensation is a monthly, tax-free payment.

Early care and education (ECE): ECE programs and services are for young children and their families. ECE settings include:

- Licensed family childcare providers
- Licensed childcare centers
- School-based early childhood programs (preschool and early childhood family education)
- Head Start and Early Head Start programs
- License-exempt childcare programs

Early intervention services: Early intervention services support children from birth through age 3 who have or may have developmental delays or needs. The services also support children's families. These services are sometimes called "Part C" or "Infant and Toddler Intervention Services."

The focus is on helping children build skills and reach their own full potential. This can help reduce the need for special education services later on. The child's local school district or cooperative determines eligibility. These services:

- Are free, so there is no cost to families.
- Are based on the family's goals and priorities for their child.
- Happen in the child's natural environments like their home, child care, or community settings.

Services help families:

- Understand their rights.
- Communicate their child's needs.
- Support their child's growth and learning.

Emergency use of manual restraint (EUMR): EUMR means using manual restraints when someone is at risk of harming themselves or others. For more information, please see the definition of "manual restraint."

Minnesota Statute 245D defines EUMR as "using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own do not constitute an emergency."

Employment First: Minnesota is an Employment First state. This means we believe that all working-age Minnesotans with disabilities can achieve competitive, integrated employment (CIE). Minnesota's policy is that disabled people should be offered CIE first, before other supports and services.

Executive order (EO): An EO is a document issued by the governor. Executive orders direct the government to take certain actions. The governor can issue executive orders on many different topics. In Minnesota, OIO and the Subcabinet exist through EO.

External Program Review Committee (EPRC): The EPRC:

- Monitors the implementation of Minn. R. 9544.0130
- Recommends policy changes to the commissioner of Minnesota Department of Human Services (DHS)
- Reviews requests for the emergency use of procedures and makes recommendations to the DHS commissioner to approve or deny those requests
- Reviews reports of the emergency use of manual restraint and gives guidance to license-holders

Financial Exploitation: Is when someone uses, takes or steals the money, wages, income, or property of an adult who is vulnerable without authority or permission, or when a person loses money, income or property because of they were the victim of a fraud or a scam.

A state law called the Minnesota Vulnerable Adults Act (sections 626.557 to 626.5572) defines "abuse", "neglect", financial exploitation and "vulnerable adults." For more information, please see the definition for "vulnerable adult" in this glossary.

Fixed route transit: Fixed route transit refers to public transit services that follow set schedules and routes. Buses and the light rail are examples of fixed route transit.

Focus Area Report: A document created by the Inclusion Consultants. This report shares priorities for the Olmstead Plan. In the report, Inclusion Consultants describe it as using "a qualitative, narrative approach to understand and uplift the lived experiences of Minnesotans with disabilities."

Forensic Mental Health Program (FMHP): The FMHP is a residential treatment facility for adults. The FMHP serves patients who have been civilly committed by a court as "mentally ill and dangerous." Patients often have been charged with crimes. Many patients are civilly committed after being found not competent to stand trial or not guilty by "reason of mental illness or cognitive impairment." Patients may be under more than one type of civil commitment.

The FMHP has both secure and non-secure settings. The FMHP is an example of a segregated, institutional setting.

Home- and community-based services (HCBS): Home and community based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own homes or communities rather than institutions or other isolated settings. These programs serve a variety of targeted groups, such as

older adults, people with intellectual or developmental disabilities, physical disabilities, or mental health and substance use disorders.

Housing unit: A housing unit is a living space where a person, couple, or family can live independently. It has sleeping space, a kitchen, and a bathroom. Examples of housing units include:

- A house
- An apartment
- A townhouse

Inclusion: Inclusion means all people can choose to live and fully participate in all aspects of society. It requires intentional and ongoing effort. In inclusive spaces, people of all identities are valued, respected, and supported.

Inclusion Consultants describe true inclusion as, "full participation, not just appearances."

Inclusion Consultants: Inclusion Consultants are people with lived experience of disability. Lived experience includes people with disabilities and their supporters. They started work in 2025 to co-create the Olmstead Plan with state agency staff. OIO worked with a contractor, the Dendros Group, to support these paid consultants.

Individualized Education Program (IEP): Students with disabilities who are eligible for special education services have IEPs. A team including teachers, parents or guardians, and other school staff create the IEP together. IEPs include:

- Goals for the student, like academic progress
- What services the student receives
- How often the student is in integrated settings
- And more.

The IEP team meets regularly to review the program, discuss the student's progress, and update the IEP.

Informed choice: Informed choice means someone has the information they need to make a decision. It also means someone has multiple options to pick from.

Minnesota Statute 256B.4095, subd.1a defines informed choice as: A choice that adults who have disabilities and, with support from their families or legal representatives, that children who have disabilities make regarding services and supports that best meets the adult's or children's needs and preferences. Before making an informed choice, an individual who has disabilities must be provided, in an accessible format and manner that meets the individual's needs, the tools, information, and opportunities that the individual requires to understand all of the individual's options.

Institutes for Mental Disease (IMD): A hospital, nursing facility, or other institution of 17 beds or more that provides diagnosis, treatment, or care for people with mental illness.

Institutions: Institutions are segregated spaces where people live. People living in institutions have limited control over their own lives. They often don't get to choose where they live, who they live with, and what activities they do.

Institutionalization: Being institutionalized means someone lives in an institution. Someone may be placed in an institution or may choose to live there. A choice is meaningful only when genuine community alternatives are available, accessible, and known to the person. *See "informed choice."*

Institutional settings: This definition is about a Department of Children, Youth, and Families (DCYF) goal.

Children who are in foster care can be placed in different types of settings. One example is in institutional settings. Institutional settings for children in foster care include:

- Children's residential facilities
- Group Homes
- Shelters
- Juvenile detention facilities
- Intermediate care facilities for developmentally disabled individuals (ICF-DD)

Integration: Integration is when people with and without disabilities are together.

In the Focus Area Report, Inclusion Consultants described integration as, "not simply a legal requirement; it is a moral and practical imperative that reflects the dignity, autonomy, and aspirations of all Minnesotans."

Integration mandate: The integration mandate is a regulation in the ADA. It bans the unnecessary segregation of people with disabilities. It requires governments to offer services in communities, not just institutions.

State and local governments must take actions to ensure people have informed choice. Examples of these actions include:

- Sharing information about the benefits of integrated settings
- Organizing visits to other settings
- Giving opportunities to meet with people who live in integrated settings

Intermediate Care Facility for Developmental Disabilities (ICF/DD): An ICF/DD is a licensed supervised living facility. These facilities provide services to people who have developmental disabilities or related conditions.

Locked DCT setting/facility: A locked DCT facility is a treatment center operated by Minnesota Direct Care and Treatment (DCT). These facilities provide inpatient or residential behavioral health treatment in a locked setting. Examples include, but are not limited to the Anoka Metro Regional Treatment Center and the Forensic Mental Health Program. For DCT's Olmstead Goals, this term refers only to DCT-operated facilities and does not include psychiatric care provided in community hospitals.

Maltreatment of Minors: A state law called the Reporting of Maltreatment of Minors (section 260E) defines abuse, neglect, and maltreatment of minors.

Manual restraint: Manual restraint means physically holding someone to limit their movements.

Minnesota law defines manual restraint as “physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint.”

Mechanical restraint: Mechanical restraint means using equipment or practices to limit someone’s movements. Mechanical restraint is generally not allowed in Minnesota. To use mechanical restraints, service providers must get special approval from the Minnesota Department of Human Services.

Minnesota Statute 245D defines mechanical restraint as “the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. The term applies to the use of mechanical restraint used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury. Mechanical restraint does not include the following: (1) devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement; or (2) the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition.”

Medicaid Access Rule: The Medicaid Access Rule is a federal policy. It is also called the Ensuring Access to Medicaid Services final rule. It took effect in 2024. This policy sets regulations for Medicaid services, including home- and community-based services (HCBS). The Medicaid Access Rule:

- Increases oversight of person-centered planning in HCBS
- Requires states to report on waitlists for waiver services and other programs
- Requires states to meet certain standards for monitoring HCBS programs
- And more, as described in the Access Rule.

Metro Mobility: Metro Mobility is a shared ride public transit service for people with disabilities. The Metropolitan Council operates Metro Mobility. Riders must schedule trips in advance. To be eligible, people must be unable to use fixed-route transit at least sometimes. The Federal Transit Administration sets eligibility guidelines and regulatory requirements.

The federal definition specifically includes the term “unable” in the definition of paratransit eligibility under 49 CFR 37.123(e)(1).

Metro Move: Metro Move is a shared ride public transit service for people with disabilities. The Metropolitan Council operates Metro Move. Riders must schedule trips in advance. The service is for people who use certain Medicaid waiver programs. The waiver programs are:

- Brain Injury
- Developmental Disabilities
- Community Access for Disability Inclusion

Minnesota Rule 9544: This rule is called Minnesota’s Positive Supports Rule. It sets standards for disability services providers, including home- and community-based services (HCBS) providers. These standards are around the use of positive supports. The purpose of the rule is to improve quality of life for service recipients by promoting:

- Use of positive supports
- Person-centered practices
- Community participation
- Self-determination
- And more.

Minnesota Statute Chapter 245A: This law is called the Human Services Licensing Act. It describes what types of programs, services, and settings must be licensed by the Minnesota Department of Human Services. They include family foster care, residential programs, and others as defined in the statute.

Minnesota Statute Chapter 245D: This law is called Home-and Community-Based Services (HCBS) Standards. It regulates certain HCBS providers as explained in statute, examples include:

- Community Residential Services
- Day training and habilitation services
- Employment services
- Positive support services
- And more, as defined in Statute 245D.

This law also includes a list of rights for HCBS recipients. These include the rights to:

- Be free from maltreatment
- Be treated with respect and dignity
- Have privacy
- And more, as listed in the law.

Mobile crisis services: Mobile crisis services are teams of mental health professionals and practitioners who provide psychiatric services. These services are provided in someone's home and at other sites outside the traditional clinical setting.

Most integrated setting: The *Olmstead* decision and the ADA frequently refer to "the most integrated setting." This is a setting where disabled people and non-disabled people are together as much as possible.

The U.S. Department of Justice (28 CFR Part 35) defines "most integrated setting" as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."

Neglect: Neglect is defined for vulnerable adults in Minnesota Statute, 626.5572, subdivision 17.

For children and youth, neglect is a type of maltreatment defined in Minnesota Statutes, section 260E.03, subdivision 15.

Out-of-home care: Out-of-home care refers to services and placements for children who can't safely stay in their homes. Children might be in out-of-home care for a short time or long-term. Foster care is a type of out-of-home care.

Permanent Supportive Housing (PSH): PSH is permanent housing that involves housing assistance and support services. Housing assistance can include long-term leasing or financial assistance for rent. PSH is for households with at least one member who has a disability. The goal is to help people achieve housing stability.

Person who has a mental illness and is dangerous to the public (civil commitment): A legal designation for a person who has been civilly committed to Direct Care and Treatment by the court because they have a serious mental illness that significantly impairs their thinking, judgment, or perception of reality and, as a result of that illness, have caused or attempted to cause serious physical harm to another person. The court has also determined there is a substantial likelihood they will cause serious physical harm to another person in the future. This commonly abbreviated as MI&D.

Person-centered planning: Person- centered planning is legally defined as an individualized, empowering process where people who receive support and services direct their own care, exercise their rights, and make meaningful choices about their lives. Person-centered Practices are defined by DHS.

Person-centered thinking: In Minnesota human services and disability policy, person-centered thinking (PCT) and related person-centered practices are defined as a foundational approach ensuring that individuals receiving government supports or services maintain the same rights, responsibilities, and control over their lives as anyone else.

Positive supports: Positive supports are person-centered strategies for people who receive disability services. This includes students with disabilities. These strategies aim to:

- Promote community integration
- Improve quality of life
- Increase self-determination
- Uphold dignity and respect
- Reduce challenging or harmful behaviors
- Eliminate the use of restrictive procedures

See Minnesota Rule 9544 above. Positive Supports are defined by DHS.

Provider-owned or controlled setting: A setting is provider-owned or controlled when the setting in which the individual resides is a physical place that is owned, co-owned, and/or operated by a provider of home and community-based services.

Provisional discharge: A provisional discharge is when someone is released from a behavioral health facility or program but still under a civil commitment. Provisional discharge includes a plan of services the person will receive. It also includes a plan for what someone must do to avoid returning to the facility.

Restrictive interventions: Restrictive interventions include:

- Emergency use of manual restraint
- Prohibited procedures listed under Minnesota Rule 9544.0060; and
- Prohibited procedures such as:
    - Chemical restraints,
    - Mechanical restraints,
    - Manual restraints,
    - Time out,
    - Seclusion, or
    - Any other aversive or deprivation procedure used as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.

Restricted procedures (human services): The following restricted procedures are allowed when the procedures are implemented in compliance with the standards governing their use under Minnesota Statute 245D.06 and 245D.061:

- Permitted actions and procedures subject to the requirements in 245D.06 subdivision 7, such as using an intervention to protect a person known to be at risk of injury due to frequent falls as a result of a medical condition

- Procedures identified in a positive support transition plan subject to the requirements in 245D.06 subdivision 8; and
- Emergency use of manual restraint.

Restrictive procedures (education): Restrictive procedures include physical holding or seclusion of children. Restrictive procedures can only be used in emergencies. These are situations where a child is a danger to themself or others. Restrictive procedures can't be used as punishment.

Request for Proposals (RFP): The process used by state agencies seeking contractors. An RFP outlines:

- the tasks to be completed
- the desired timeline
- how interested contractors can submit their proposals

Segregation: Segregation means separating people with disabilities from people without disabilities. It is actively setting people with disabilities apart and isolating them from others.

Segregated settings: *Olmstead* defines segregated settings as settings that are mostly or only for disabled people. Segregated settings often have limited:

- Choice in daily schedules
- Privacy and informed choice
- Opportunities for visitors
- Access to community activities
- Control of daily activities
- Activities with non-disabled people

Examples of segregated settings include:

- Hospitals
- Nursing homes
- Mental health facilities
- Institutional settings
- Classrooms only for students with disabilities
- Employment settings only for people with disabilities

Service-connected disability (Veterans): A service-connected disability is a condition that was caused by or got worse because of military service.

Systemic Bias: When the rules, routines, or habits of an organization or society unfairly favor one group of people over another.

Subminimum wage: Subminimum wage means a worker is paid less than minimum wage. Minimum wage is the lowest amount of money a business can pay a worker.

Businesses can pay disabled workers subminimum wages with permission from the federal government. The government gives these businesses something called a 14(c) certificate.

Special Review Board (SRB): The SRB is a board that reviews requests for custody reduction, transfers, and discharges for people under certain civil commitments. The civil commitments include mentally ill and dangerous. The SRB is an external board. That means it is not operated by Direct Care and Treatment.

Subcabinet Procedures: A document that describes how the Olmstead Subcabinet does its work.

Substantiated maltreatment: Based on evidence, it is more likely true than not true that an act of maltreatment happened. More information can be found in Minnesota Statute Section 626.5572.

Technical Assistance Collaborative (TAC) report: A report written by TAC for the Olmstead Plan update project. This report is about effective practices for disability integration, inclusion, and choice. There is a technical version and a plain language version of this report available on OIO's website.

Transit Link: Transit Link is a shared ride public transit service in the Twin Cities metro area. It operates where fixed route transit is not available. Riders must schedule trips in advance. Unlike Metro Mobility or Metro Move, anyone can use Transit Link. Transit Link is not just for people with disabilities.

Universal design (housing): Universal Design is about creating spaces that can be used by as many people as possible without special changes or extra designs. These choices make living spaces more accessible, and easier to modify in the future if needed. Some examples of Universal Design features are:

- Lever-style handles for doors and plumbing
- Wider doorways and hallways
- Sleeping quarters (or a room that can be converted) and at least a ¾ bath on an accessible level

Unsubstantiated maltreatment: There is not enough evidence to show it is more likely true than not that an act of maltreatment happened.

U.S. Department of Justice (DOJ): The DOJ is a federal agency that oversees the enforcement of federal laws. The DOJ includes a civil rights division to protect civil rights. The DOJ can enforce the integration mandate by:

- Filing or joining *Olmstead*-related lawsuits against state governments
- Investigating claims that state governments are violating disability rights
- Reaching agreements with state governments to follow the ADA
- Sharing guidance related to the *Olmstead* decision and the ADA

Vulnerable adult/Minnesota Vulnerable Adults Act: A state law called the Minnesota Vulnerable Adults Act (Minnesota Statutes §626.5572) defines "vulnerable adults" and abuse and neglect.

Under this law:

(a) "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services required to be licensed under chapter 245A, except that a person receiving outpatient services for treatment of substance use disorder or mental illness, or one who is served in the Minnesota Sex Offender Program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under sections 144A.43 to 144A.482; or from a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under section 256B.0625, subdivision 19a, 256B.0651, 256B.0653, 256B.0654, 256B.0659, or 256B.85; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction: (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and (ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment.

(b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual. See Minnesota Statutes §626.5572, Subd. 21.

“Vulnerable adult” is a legal category defined by statute to trigger reporting and investigation duties. It describes a legal status, not a characteristic of a person.

Citations

Note to screenreader users: The citations in this section include URLs. Some URLs may be lengthy.

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Jensen v. Minnesota Department of Human Services, Civil No. 09-1775 (D. Minn.)

Common Acronyms

ACT – Assertive Community Treatment

ADA – Americans with Disabilities Act

AMRTC – Anoka Metro Regional Treatment Center

ASAM – American Society of Addiction Medicine

AT – Assistive Technology

BIRF – Behavior Intervention Reporting Form

CBS – Community Based Services

CIE – Competitive Integrated Employment

CMS – Centers for Medicare and Medicaid Services

CVSO – County Veterans Services Office

DCT – Direct Care and Treatment

DCYF – Department of Children, Youth, and Families

DD – Developmental Disabilities

DEED – Minnesota Department of Employment and Economic Development

DHS – Minnesota Department of Human Services

DOC – Minnesota Department of Corrections

DOJ – United States Department of Justice

DPS – Department of Public Safety

ECE – Early Care and Education

ECFE – Ealy Childhood Family Education

EPR – Emergency Preparedness and Response

EUMR – Emergency Use of Manual Restraint

FMHP – Forensic Mental Health Program

GCDD – Governor's Council on Developmental Disabilities

HCBS – Home and Community-Based Services

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

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IPS – Individualized Placement and Support

LIA – Lead Investigative Agencies

MA – Medical Assistance

MAARC – Minnesota Adult Abuse Reporting Center

MA-EPD – Medical Assistance for Employed Persons with Disabilities

MDE – Minnesota Department of Education

MDH – Minnesota Department of Health

MDHR – Minnesota Department of Human Rights

MDVA – Minnesota Department of Veteran Affairs

MHFA – Minnesota Housing Finance Agency

MnDOT – Minnesota Department of Transportation

MSAC – Medicaid Services Advisory Committee

NCI – National Core Indicators

OIO – Olmstead Implementation Office

OMHDD – Ombudsman for Mental Health and Developmental Disabilities

PBIS – Positive Behavioral Interventions and Supports

Pre-EST – Pre-Employment Transition Services

PRTF – Psychiatric Residential Treatment Facility

PSH – Permanent Supportive Housing

RSC–TCM – Relocation Service Coordination–Targeted Case Management

RTC – Regional Treatment Center

SFY – State Fiscal Year

SMRT – State Medical Review Team

SRB – Special Review Board

SSB – State Services for the Blind

SUD – Substance Use Disorder

VA – Veterans Affairs

VR – Vocational Rehabilitation

VRS – Vocational Rehabilitation Services

WIOA – Workforce Innovation Opportunity Act