Accessible GCDD Response – Fully Accessible

Official GCDD Response to Proposed Olmstead Plan April 2026

April 27, 2026

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Dear Jenn,

On behalf of the Minnesota Governor's Council on Developmental Disabilities (GCDD), we submit these comments to the Olmstead Implementation Office in the spirit of collaboration and the hope that they will be used to improve upon the proposed Olmstead Plan. The feedback was collected from participants in Class 43 of Partners in Policymaking (8.5 hours) on February 20, 2026, and from GCDD members at our April 1, 2026, meeting (2 hours). This represents the input of over 50 people, including self-advocates, parents, and family members.

The GCDD has been involved with this work since the beginning of the Jensen lawsuit, as part of the first Olmstead Planning Committee convened in 2012, and as a member of the Olmstead Subcabinet. In addition to the hundreds of Subcabinet meetings where we have been represented, we have also participated in numerous specialty committees and Leadership Forum meetings. We also regularly review the progress of the Olmstead Plan at GCDD meetings and have provided input on every revision of the Plan to date.

The Olmstead Plan is something that the GCCD is very invested in and takes very seriously. This is why we are very grateful for this opportunity to provide additional suggestions for improvement.

We are working from a copy of the Olmstead Plan and the Appendix posted on the OIO website and retrieved on April 7, 2026.

EXECUTIVE SUMMARY

Like any large group of people, the disability community is neither homogeneous nor a monolith. Disability is a natural part of the human experience, which is why this community intersects with every community, population, and subpopulation throughout Minnesota. Defining the issues and setting goals to support and elevate the rights and dignity of the entire disability community is a great challenge. Still, the reach and impact of those issues on every Minnesotan mean we must make every effort to rise to that challenge fully. The GCDD agrees with the statement quoted in the appendix: “We spend too much time focusing on change at the margin of systems and not on real transformation.” We are concerned that the draft Plan focuses on the margins rather than on the transformative work needed to make a difference truly.

The following are the overarching themes that run through our collected feedback.

Readability is at an advanced high school-to-college level, making it inaccessible for much of the directly affected population to read and provide meaningful feedback independently.

Accountability, enforcement, monitoring, and verification of implementation are lacking across all sections.

The data and measurable goals as provided and written are insufficient.

Goals and approaches are incremental and not transformative.

Gaps are evident between measurable goals and real-world experiences.

Dignity, inclusion, person-centered, and person-directed practices should be included, centered, and clearly woven in as an integral part of the Plan.

We recommend that, as a first step, the Olmstead Implementation Office reference page 80 of the March 21, 2025, Olmstead Leadership Forum, where the forum established a guidance packet for state agencies on preparing and presenting goals. Please see the Leadership Forum March 21, 2025 Meeting Packet. A link to the specific materials is not provided because they appear to have been removed from their original location on the Olmstead website.

To further defend against potential federal lawsuits, Minnesota’s Olmstead Plan must be revised to address the DOJ's description of Olmstead issues and the SMART standards, and resubmitted for public review and comment. Please refer to the guidance and recommendations provided on the following ADA webpage to inform and guide the ongoing process: ADA Olmstead Mandate Guidance. The draft plan does not meet this guidance, including:

Target percentages, but no specific numbers.

Goals for schools, counties, cycle time, various reports, rides, staff, etc., varying from 1 to 5 years in length, though guidance from the Leadership Forum was to establish a clear, 5-year plan for the Plan and all associated goals. Public input is also a vital part of the Olmstead plan. There should be a clear link between the input from 2000 members of the public and the proposed plan's content. Goal selection should clearly reflect that this input was considered and applied. Rewriting the current language to make the draft Plan more concise will also clarify it.

Regarding the presentation of goals, it should be clear that the main Olmstead goals should carry the most weight. Data development goals should be secondary and not presented or described in a way that makes them appear coequal to the main goals. Additionally, state agencies already have much of this data, so many of the data development goals are obsolete, duplicative, and unnecessary. Any goals that aim to meet ADA compliance should also be secondary, as state agencies are required to uphold the ADA.

The reading level of this draft Plan is concerning as it is not accessible. Even if there are plans for a Plain Language version to be prepared later, access is vital at this stage. According to Grammarly, there are 278 suggested edits to the proposed plan and 71 suggested edits to the appendix. The proposed plan and appendix are both categorized as “difficult to read” by various readability scales (Flesch-Kincaid, Gunning Fog Index, ARI, and Dale–Chall). They are written at a senior high school-to-college reading level. Providing a draft Plan at this reading level will prevent many of the people most impacted by these goals from being able to read it and provide meaningful feedback.

Near the end of the draft Plan’s introduction, it is noted that a clear message was received from Minnesota’s disability community that “incremental progress isn’t enough.” Fulfilling the spirit of Olmstead will require large-scale transformation. Despite recognizing this, the draft Plan is not transformational, as noted by the Inclusion Consultants on March 13, 2026. More than 50 people who participated in GCDD-led discussions reached a similar conclusion: the targets are too low and the goals not large enough to spur true transformation. It is our sincere hope that the Olmstead Implementation Office will take our comments and recommendations in the spirit of the good faith effort they are intended and use them to create a final Plan that is not only transformative in scope, but representative of the needs, hopes, and desires of Minnesota’s disability community to live, learn, work, and enjoy life with the same respect, dignity, and autonomy enjoyed by any Minnesotan.

Missing Topics

The following is a list of major topics, settings, and subpopulations for and of the broader disability community are missing from the draft plan and, in the GCDD's opinion, must be addressed:

People with the Most Significant Disabilities: There is no mention or note of this population within the broader disability community, nor any indication that their specific needs or challenges are considered or accounted for within the plan.

Children and Youth: Education goals, though very important to this population, are not the same as children and youth issues, which are not raised or addressed in the report.

Subminimum Wages and Guardianship/Conservatorship: Neither of these significant issues is mentioned anywhere within the plan or the appendix, though they directly impact the rights and quality of life for thousands of people with disabilities, their families, and the communities where they live.

Racial Disparities: The Leadership Forum and the Subcabinet both committed to addressing this issue, but it is not mentioned or addressed in this plan.

Assistive Technology: This topic does not appear within the main report and is only mentioned once within the appendix as an example of a theme from community feedback.

Person-Centered Planning and Person-Directed Supports: Person-centered planning and person-directed supports should receive prominent attention.

Self-Advocacy, Leadership, and Civic Engagement: The plan does not address any of these areas or issues.

The disability community is both large and highly nuanced. For the plan and its goals to have a meaningful and transformative impact, specific segments of the disability population, certain age groups (children, youth, young adults), and specific segregated settings need to all be directly accounted for and addressed. We ask that you review the entire plan again to ensure it includes all disabilities, ages, and settings.

Collected Comments from the Disability Community

The following are the comments collected by the GCDD, edited for clarity, from more than 50 members of Minnesota's disability community, representing the thoughts and concerns of self-advocates, parents, and family members. The GCDD spent over 10 hours working with this broad group to collect feedback and testimonials. For ease of navigation, we have

arranged the comments to align with page order within the report and appendix, not the importance of the recommendation:

Cover Page

The current draft Plan has no cover page, inside page, acknowledgments, or ADA advisory about alternate formats.

Table of Contents

(Pg. 1): The draft Plan organizes measurable goals and strategies alphabetically. Reorganizing the final Plan to begin with person-centered and person-directed goals, then addressing the concerns of the 2000 people who provided input to the Plan, and finishing with crisis services would be a more impactful and engaging approach for the people reading and using the final Plan.

(Pg. 2): The final Plan would benefit from a more detailed explanation of the 2026 plan update timeline for the subheadings of 2023-2024, 2025, and 2026.

Introduction

(Pg. 2): Consider designating the Introduction as a major section of the final Plan and having it begin at the top of its own page rather than at the bottom of the page following the Table of Contents.

(pg. 3) Fifth Paragraph: Has a formal proposal been made to either replace the current Olmstead mission or append an additional, distinct vision statement? To this point, no explanation or proposal has been given to the Subcabinet, nor has a vote been taken to make this change. The current Olmstead Plan mission statement, “live, learn, work, and enjoy life,” was approved by the Subcabinet through a vote after careful attention was paid to select plain language, specifically one- or two-syllable words, for the mission language. It is concerning that this draft statement was not written with attention to readability and plain language, particularly given that the final Plan is intended to support and advance the rights of all people with disabilities. We recommend that, if a new vision statement is desired, it be rewritten in plain language and that it go through the proper process for approval by the Subcabinet.

(Pg. 3) Seventh Paragraph: This paragraph notes that incremental progress is insufficient and fulfilling the spirit of Olmstead requires large-scale transformation. Though noted, the draft Plan is not transformational, something noted by the Inclusion Consultants on March

13, 2026. Over 50 people who participated in GCDD-led discussions reached one conclusion: the targets are too low. In this same paragraph, the goals are noted as one to five years. The agreed-upon guidance discussed a five-year plan, not a one-to-five-year plan.

(Pg. 3) Eighth Paragraph: Consider whether there is a different inspirational concept that can be used other than the North Star, which has become a highly overused reference for state government reports.

History of the Olmstead Decision

(Pg. 4): Recommend providing more details to clearly connect the Olmstead lawsuit with the provision calling for the development and implementation of the Olmstead Plan. As currently written, this connection is unclear.

Creation of the 2026 Olmstead Plan

(Pg. 4): The content following this heading does not clearly introduce or segue to the remainder of the section. We recommend revising to better align with the broader section, including a narrative on the partners who supported the Plan's creation and bullet points that match the subheadings in the remainder of the section.

(Pg. 5) First Paragraph, First Sentence: Add the Executive Order number (19-13).

(Pg. 5) Fourth Paragraph: Note that DCT and DCYF contributed goals, but they are not members of the Subcabinet.

(Pg. 5) Fifth Paragraph: Please provide links or let the reader know where to find the Executive Order, the Subcabinet Procedures, and the Leadership Forum Charter.

(Pg. 6) The OIO duties are fully described in the current Plan, and not in the three documents mentioned.

(Pg. 6) The draft Plan only provides the names of the Inclusion Consultants. We recommend that you provide a list acknowledging all contributors to the final Plan, which should appear at the end of the report.

(Pg. 7) Overarching Themes from Community Feedback: The goals as written in the draft Plan have no clear connection back to the community input gathered from nearly 2000 Minnesotans. For example, the third bullet point in this section supports addressing disparities, but this issue is not fully addressed. The final Plan goals should clearly reflect the community's feedback.

(Pg. 8) The first sentence states that there is an in-depth explanation of the terms "Inclusion, Anti-ableism, and Intersectionality." However, the definitions in the appendix are not detailed and do not reference statutes or rules.

Vision Statement and Guiding Values

(Pg. 8) Has a formal proposal been made to either replace the current Olmstead mission or append an additional, distinct vision statement? Please review Comment 5 of this letter related to this concern.

(Pg. 9) Guiding Values: The guiding values as framed work for adults, but the plan is missing other essential segments, including children and youth. Additionally, each of the following requires specific attention despite each having a guiding value:

Person-centered services do not have, and are not addressed, in any goal in the draft Plan.

Transition lacks measurable goals that address the full range of segregated settings.

High-quality, inclusive education lacks goals for either Pre-K or Postsecondary Education.

Optimal health and well-being goals address issues of access to providers, services, and supports rather than disparities in health and well-being.

(Pg. 9): Add periods to all the sentences under Guiding Values.

(Pg. 9) Middle Paragraphs: This section is well-written, but it is not reflected in the rest of the Plan, which falls short in setting goals for ICFs, nursing facilities, assisted living, and all community residential settings.

(Pg. 9) Last Paragraphs: This section is well-written, but the rest of the Plan falls short in setting any specific goals related to person-centered services. Additionally, the three quotes, though important, are not directly connected to person-centered plans and person-directed services.

(Pg. 10) The quote provided is a broader statement about the overall system and does not address the true meaning of person-centered plans and person-directed services. Please choose a different quote.

(Pg. 10) Second, Third, and Fourth Paragraphs: These are all well-written and have quotes that match the subheading.

(Pg. 10) Final Paragraph. The Inclusion Consultants mention fair pay, being stuck in poverty, and being punished by the system, but the draft Plan includes no goals addressing subminimum wages.

(Pg. 11) Top Paragraphs: The text in quotes that constitute this section reads like Erik Carter's work. Did someone paraphrase or directly copy his writings? If the Plan is to quote Carter's work directly, please add a citation or credit.

(Pg. 11): The Guiding Value addressing health specifically and accurately states that health is more than access to doctors. However, the draft Plan goals focus solely on access to healthcare professionals, which falls short of seriously addressing broader health disparities.

Reaching our North Star: True Inclusion

(Pg. 11): The overwhelming reaction of more than 50 self-advocates, parents, and family members was that this Plan did not meet the SMART criteria. This paragraph specifically mentions commitments ranging from one to five years, which is contrary to what had previously been agreed: this is a five-year Plan. Including advocacy for transforming systems is important, but the reaction of the 50+ highly engaged and committed people who responded is unanimous: the draft Plan is not transformational.

(Pg. 12) First Paragraph ("true inclusion requires program and policy change"): Inclusion is more than program and policy change; it goes to the heart of a community and is person-to-person work. Creating a Council will not ensure inclusion for an individual or family. Additionally, there has been no discussion or vetting about a potential Disability Systems Change Council (DSCC). Questions that arise from this proposal:

Does the Subcabinet have the authority to create a Council with this membership and duties?

What is the budget, and has it been allocated?

Will members be compensated?

Has an organizational chart been developed to show what group has which responsibilities and authorities so that it can be produced for public review and comment?

Who is the appointing authority, and where and to whom would a DSCC report?

What is the established mission of this proposed council?

Does the OIO have the capacity to staff this proposed council, given the number of proposed goals that must be monitored and reported?

As an alternative, consideration could be given to creating a citizens' engagement council, as in SF3151. The Subcabinet can create a specialty committee. Sample wording--

Subd. 6. Citizens' Engagement Council; public engagement. (a) The Office of Healthy 4.4 Aging will establish a Citizens' Engagement Council composed of 20 diverse members 4.5 from different geographic regions and demographic groups, including older adults, caregivers, 4.6 elder advocates, the Minnesota area agencies on aging, Tribal Nations, county agencies, 4.7 nonprofit services, and business sectors. The purpose of the council is to: 4.8 (1) ensure the voices and perspectives of older adults are included in the recommended 4.9 initiatives and policies for implementing the Minnesota Healthy Aging Plan; 4.10 (2) provide feedback on current aging-related programs and services, identifying areas 4.11 for improvements and innovations; and 4.12 (3) provide ongoing input, advice, and strategies for the planning process to engage 4.13 older Minnesotans and families. 4.14 (b) Members of the council may be compensated under section 15.059 for council 4.15 activities.

Measurable Goals and Strategies

(Pg. 13) Measurable Goals and Strategies: This is a major section of this document and should more clearly stand out as a major section than it does currently. There were differing views from our more than 50 reviewers on whether this meets the SMART criteria. Regardless of whether they believe the content on page 13 meets SMART criteria, there was unanimity that the proposed goals themselves do not meet these standards. Referring to recommendation 2 in this letter, we recommend that the final Plan goals be organized by importance rather than in alphabetical order.

Crisis services

(Pgs. 14-15) Crisis Services Goal 1 — What is this goal about? Clarify the meaning of "children 17" by adding "who are 17 years old or under."

(Pgs. 14-15) Crisis Services Goal 1: Overall, we received six comments on the lack of accountability and enforcement; five on the low targets; four on how progress will be tracked or enforced; three on the lack of cross-system follow-through; and two on the justice system. The following is a summary of these comments:

Clarify whether this only accounts for or addresses children in foster care, or is this for any child, from any setting, who might enter institutions?

Clearly indicate the actual number of institutionalizations that will be prevented through this goal. The target appears to be that 72 children will avoid being institutionalized in a given year. Any reduction is welcome, but this is not an incremental nor a transformational goal.

This goal mentions race but should include specific strategies to reduce racial disparities.

Clarify if the race refers to all children or is specific to children with disabilities from racial and ethnic communities.

The review group does not see a connection between the strategies provided and how they will realistically produce the desired results.

Oversight, accountability, or follow-through of execution of the proposed strategies are not included or indicated.

Does this goal also include children in the justice system and the pipeline to corrections?

The goal appears to propose a continuation of the status quo approach to this issue, which is too small a step.

How will agencies be held accountable?

This goal needs to be more transformative.

Education

For Education Goals 1 and 2, received seven comments about the data gaps and misleading framing of the goal; six comments about historical trends rather than improvement goals and missing numeric targets; five comments about the vague strategies; five comments about the overuse of special education as enforced segregation plus the emotional harm to students; four comments about the lack of dignity and participation caused by special education, and three comments about training gaps and educators who are not prepared to support students.

Education Goals 3 and 4: received six comments about schools failing to follow IDEA and state laws and rules; six comments about schools punishing students for behavior related to disability status and the school to prison pipeline; five comments about teacher lack of preparation; four comments about behavior is communication and the need for positive supports; three comments about segregated settings limit opportunities; and two comments about lack of access to academics.

Goals #5 and #6 received four comments about the lack of qualified specialists and the high caseloads limiting services; four comments about failure to implement IEPs; three comments about targets being too low; and three comments about better accountability for schools.

(Pgs. 16-17) Education Goal 1: This is a critical goal for students with disabilities and for the Olmstead Plan. The target appears to be that, over one year, there will be a net increase of

~3,125 students with IEPs educated in the most integrated setting, compared to the previous year. If this is an inaccurate interpretation of the target, please clarify with the specific target number. Additionally, there is only a single-year target for this goal. Regardless of interpretation, our reviewers agree that this target is extremely low, and the lack of ongoing, targeted improvement raises even greater concern. It is also unclear how, or if, the proposed strategies would directly lead to any change in results. Minnesota has a long way to go in improving this area, and, as written, it can reasonably be assumed that the target could be met without implementing the proposed strategies. In addition to setting higher targets that continue over the course of 5 years, we recommend that the final Plan also set subgoals by disability type and race/ethnicity that create targets and accountability for schools to address disparities for children who represent groups disproportionately represented in segregated settings. Looking at the current data, there are over 55,000 students (>36% of students with disabilities in our public school system) who are kept in segregated settings. Framing it in more overtly positive terms, like in the draft Plan, undercuts the severity of the issue. Additional comments include:

There are many significant variables not accounted for within the proposed strategies that can subvert and undermine this goal. Of note, local teams can declare that individual students require a higher setting than can be provided by the school (i.e., they will say, “We just cannot support your student in this setting,”), effectively ending any discussion about inclusion.

There is a need for specific numbers beyond just percentages. As currently written, simple demographic changes can achieve the goal without intervention.

Special education has been used to suppress students in terms of psychological and emotional impact, which is not acknowledged or addressed in the goals or strategies.

If the goals are not measurable, how can we create strategies?

Account for the fact that the use of euphemisms perpetuate institutional thinking and instead set goals to stop dehumanizing students and center on each student's worth.

(Pgs. 17-18) Education Goal 2: The target appears to be that, over one year, there will be a net increase of 4 families reporting that their schools facilitate family engagement. This is a very low target, and it is equally concerning that the current goal is for a single year. If this is an inaccurate interpretation of the target, please clarify with the specific target number and the annual targets for the next 5 years. Additional reviewer comments include:

The sole target metric is volume (i.e., number of total engagements) and does not quantify or track quality. If the goal is better engagement, metrics and data must be added to improve the overall quality of each engagement.

Will better engagement support the values of the Olmstead Plan? If so, the strategies should convey the direction of the engagement, and training should be provided to help families engage more effectively in supporting integration and inclusive communities.

(Pgs. 18-19) Education Goal 3: It should be clarified that discipline as defined in draft goal only refers to suspension longer than 10 days or expulsion and not to all defined types of discipline in Minnesota Statutes 2025, Chapter 121A. The source of the definitions for the three terms that appear on page 18 should be provided. The measurable goal and outcomes appear to be about a small subset of specific, though unnamed, schools. This would indicate that, related to this goal, the draft Plan is only concerned with impacting students enrolled at the targeted schools, not with broadly addressing this issue for students across all districts. If the intent is to impact all students, please re-read Chapter 121A to look at all definitions of discipline to help better describe the intent of this goal. Clarify if the target is for a net decrease of 2.44% in the total school districts identified as disproportionately disciplining students with disabilities and include the actual number of estimated students this should impact. Additionally, annual target goals for a span of 5 years should be developed and provided, not a single year goal.

(Pgs. 19-20) Education Goal 4: We believe this goal should be written to center the children affected, not the staff. The target should be clarified to indicate whether it is 8% of the survey respondents (1050 respondents), which would amount to 84 staff, or 8% of all ECE staff across the State, which would amount to ~3,200 staff. Additionally, there is a single target goal set for 2029, and although this is better than the single-year targets for the other education goals, it is considered insufficient by reviewers. Though staff are self-identifying a need for training in behavior management, we are concerned that from an

Olmstead perspective, person-centered, positive supports are more appropriate topics and focuses, but are not mentioned. Additionally, the strategies described do not connect to the actual delivery of training to ECE staff. Additional comments and concerns provided by reviewers based on the current goal included:

Isn't it breaking the law to turn children away?

Not including numbers and percentages when setting goals is ridiculous.

Children are being excluded for not sitting still.

New professionals are overwhelmed because they are not prepared.

How are preservice programs changing to prepare professionals?

Funds should be allocated to early childhood programs to prevent future issues.

Would it make sense to change licensing requirements?

The first statement should be that public ECE programs should follow the law.

(Pgs. 21-22) Education Goal 5: We recommend the goal use the full definition of maltreatment established under the Minnesota Statutes, which states: “Maltreatment" means any of the following acts or omissions: (1) egregious harm under subdivision 5; (2) neglect under subdivision 15; (3) physical abuse under subdivision 18; (4) sexual abuse under subdivision 20; (5) substantial child endangerment under subdivision 22; (6) threatened injury under subdivision 23; (7) mental injury under subdivision 13; and (8) maltreatment of a child in a facility. Because this goal will only consider students with substantiated reports of maltreatment, success for this goal will be a one-time reduction of maltreatment for 2 students. If this is an inaccurate interpretation of the target goal, please clarify. Based on Minnesota Student Survey results, there are strong indications that maltreatment of students with IEPs is significantly underreported by hundreds of cases a year. A better goal would take this into consideration and look for ways to ensure these students are being heard and protected from harm. Additionally, this goal could create a perverse incentive to meet the goal of reducing the number of substantiated reports by slowing or stopping investigations during the 1-year target period. We consider that proceeding with this goal and its strategies as currently drafted will be to ignore hundreds of students who are experiencing maltreatment without notice or relief.

Testimonial #1: I don’t understand this goal. Are we saying that 20 cases of substantiated maltreatment are acceptable if we reduce the number by 2 students?

(Pg. 22) Education Goal 6: The target appears to be that in the course of one year, there will be a net decrease of 145 students with disabilities who experience restrictive procedures. In addition, the target is extremely low and confined to a single year, and the percentages in the goal appear to be miscalculated, as 2,932 is 2% of 144,720. If this interpretation is incorrect, please clarify with specific numbers. Regardless, the goal as written does not appear to center on the extreme trauma and harm these practices can cause students with disabilities, nor does it account for or address the companion issue of seclusion. The following are testimonials from advocates across Minnesota regarding the practice of restrictive procedures. Please read and consider them when rewriting this goal. These testimonials cover more topics than restrictive practices but seem to fit here as we reconsider new goals.

Testimonial #1: A parent of a child with Down syndrome and a resident of Greater Minnesota proposed a new goal by improving the quality of special education services. The recommendation was to increase the number of qualified staff while reducing caseloads.

Drawing from personal experience, she stated that students were not receiving services outlined in their IEPs due to staffing shortages. She suggested measuring progress through reductions in complaints about unmet IEP requirements.

Testimonial #2: Another parent argued that reducing the percentage of staff needing additional behavioral training from 48% to 40% was not ambitious enough. Her son has been sent home despite dedicated staff support. The personnel lack adequate preservice and in-service training. The Plan needs stronger goals, increased investment in preservice and in-service training, and accountability so families can trust that schools will keep children safe, supported, and understood.

Testimonial #3: A parent who has a disability and three children with autism described how her children are punished for behaviors already identified in their IEPs as related to their disabilities. One student was restrained, arrested, and charged for a school incident that could have been prevented if the child had received the support listed in the IEP. She urged stronger accountability, transparent reporting, and enforcement of IEPs before disciplinary action is taken. She stressed that punitive responses contribute to the school-to-prison pipeline and undermine inclusion.

Testimonial #4: Another parent explained that behavior is communication, and the behavior stems from unmet needs, triggers, or emotional dysregulation. Suspension removes students without addressing root causes and worsens student outcomes. She advocated for PBIS and added professionals to help schools identify triggers and implement positive behavioral plans, ensuring support rather than exclusion.

Testimonial #5: One parent shared her son's experience of being placed in a segregated behavioral classroom, which limited his opportunities for inclusive learning. She called for stronger implementation of manifestation determination reviews under IDEA to ensure schools assess whether a behavior is related to a student's disability before discipline occurs. She recommended improvements to functional behavior assessments and proactive behavior intervention plans, as well as public reporting of suspension data by race. She urged that suspension rates drop to below 1% while expanding staff training and inclusive practices.

Testimonial #6: This parent expressed concerns about whether personnel are prepared to support a student with both behavioral and sensory needs. The goals should be higher by expanding disability-informed training across all early childhood settings, aligning training with elementary schools, and ensuring that more than 50% of staff receive formal positive behavioral training, with 100% of staff trained within the next five years.

Testimonial #7: A person with a disability described her experience as a paraprofessional who received no training in special education or positive behavior supports. Substitute teachers are overlooked in their professional development despite staffing shortages and the frequent reliance on them. She urged ongoing training.

Employment

Employment Goal 1 received four comments about the lack of data and transparency (need to have meaningful metrics); four comments about the lack of oversight to ensure implementation; three comments about resource allocations; three comments about transition-age gaps; and two comments about the importance of employment as a key to independence and community integration.

(Pgs. 23-27) Employment Goal 1: Note, this goal references Goal 8A, 8B, and 8C in the body of the text and needs correction. The correct goals are as follows: Goal 1A, VRS/SSB; Goal 1B, VRS/SSB/HCBS Waiver; Goal 1C: Students aged 16 years and older with IEPs.

According to a newly released report by the Institute on Community Inclusion (Boston), 32,990 Minnesotans with disabilities were in non-work day programs (70.8% of the 46,566 people with disabilities served by DHS that year), with a much smaller total population served in both integrated employment (8,940/19.2% of the population) and facility-based work (4,536/10.0% of the population). With the draft goal, the hoped-for change is that ~177 (and fewer for 1B) more people with disabilities will have some form of community-integrated employment at the end of 5 years, which would represent .5% of the total population of people served by DHS not in integrated employment in 2023. In that broader context, the goal is just too low. Even taking the modest growth target of 1% improvement and applying it to the larger DHS population numbers (i.e., increasing the number of people with disabilities in integrated community employment from 19.2%-to-24%) would represent far more progress than the current goal envisions (~2,236 more people in integrated community employment as opposed to ~177).

It is clear from the experiences of both Oregon and Rhode Island, which have been sued for relying on traditional day programs and sheltered workshops, that this is more than a quibble over appropriate data sources; the goal must go much further to avoid the sort of litigation those states experienced.

Other comments collected related to this goal, including the testimony of a self-advocate, include:

The strategies seem to prioritize funding for staff training over direct support to help people with disabilities find work.

In addition to clearly stating the actual target number for employment, not just an undefined percentage, also explain why no numbers are offered for the students in transition goal.

Transition begins at age 14, but the goal only includes students 16 and up. Correct this if it is an error, and if it is intentional, it should be clearly noted in the goal and an explanation/justification for why the goal does not account for the full transition age population provided.

Testimonial #1: A self-advocate spoke in support of employment goals because she is now middle-aged, and she never had access to employment services growing up or navigating employment independently. She lives in rural Minnesota. It has been difficult to find and keep employment. It is isolating. She believes in more education and awareness beginning in high school. She emphasized that people with disabilities deserve meaningful work, adequate support, and full inclusion in their communities.

Testimonial #2: The discussion of the employment of Veterans needs more context and background. We appreciate the intent, but there is so much work to be done to improve employment rates for people with a wide range of disabilities. This goal does not seem to fit. The Veterans Administration is an entirely different ecosystem. Are there strong parallels or commonalities? If so, please provide that background.

Health and safety

We received eight comments about the barriers to health care (finding providers, long wait times, and transportation); six comments about system fragmentation and lack of continuity of care or coordination of care; six comments about low MA rates and decreasing provider participation because of rates; five comments about accessible equipment and facilities; four comments about data and accountability (MDH does not collect data); four comments about equity and how people are treated (dismissive treatment) and the need for trauma responsive care not just trauma informed care; and two comments about communication barriers at healthcare providers.

(Pg. 27) Health Goal 1: Two people with disabilities and advocates for Veterans commented that this goal should be expanded beyond compensation. Compensation alone may help with survival, but it does not support full integration into society. The Plan needs new wraparound programs designed and led by veterans to support housing, healthcare, and employment. Veterans experience trauma and mental health challenges after deployment, so there is a need to reduce isolation, improve well-being, and prevent suicide. Another observation is that there is overlap between having a disability, Veteran status, and homelessness. This advocate worked in a housing support program and illustrated the

urgency of improved services. This goal is too modest, and he urged more ambitious, coordinated statewide efforts led by Veterans to ensure access to benefits.

(Pg. 28) Health Goal 2: Please read and take into consideration the following testimonials from self-advocates when revising this goal:

Testimonial #1: A self-advocate with autism shared feelings of neglect within the service system due to staff turnover and delays in receiving services. He felt invisible and unsupported. He talked about care abandonment. He urged strengthening protections by educating people with disabilities about the signs of abuse and shifting to person-centered services, so individuals do not fall through the cracks. Prevention of abuse begins with valuing and caring about people with disabilities.

Testimonial #2: A person with a disability, disability advocate, and a professional specializing in violence prevention and human trafficking issues spoke about the need to prevent abuse and neglect. This person highlighted the disproportionate rates of violence experienced by people with disabilities, especially those with intellectual and cognitive disabilities. She recommended that this goal be strengthened through expanded data collection and research about power-based violence, including human trafficking, labor exploitation, and forced criminality. She emphasized the "victim-offender" overlap, noting that individuals who enter the criminal justice system are themselves victims of exploitation. She advocated for improved access to services within correctional facilities, stronger reentry housing supports, and better prevention strategies. There must be systemic change to prevent victimization.

(Pg. 28-29) Health Goals 2A, 2B, and 2C: Specific to goal 2A, it was noted that it has a timeline of 2027, and nothing beyond that date. Additionally, OMHDD and Elder Voice Advocates both report higher numbers than are shown in this document. It may also be important to list all the licensed settings within the scope of MDH. There are policies already in place for the prevention of abuse and neglect, so it is important to clarify that they exist.

More broadly, the more than 50 self-advocates, parents, and family members provided comments about health access goals that appeared in an earlier version of the Olmstead Plan. Those collected comments follow here, as well as two testimonials:

If you do not feel well, you cannot learn or work.

Dental care is a statewide problem.

When does MDH plan to start collecting disability data?

Clinics are not equipped with Hoyer lifts, and dental offices must rearrange their rooms when patients use wheelchairs.

Federal accessibility standards are not enforced.

It is hard to find any providers who accept Medicaid.

If you have an abscessed tooth, it can take a year to get an appointment.

There is a lack of medical transportation.

These goals are focused on adults and not children.

DHS and MDH are simply playing hot potato, and healthcare issues are not being addressed.

Healthcare is a mess. The number of people on Medicaid increases while the number of providers decreases.

Insurance providers should be putting pressure on professionals to accept people with disabilities.

The MA reimbursement rates are too low.

There is no discussion of "continuity of care" during crises in the proposed Plan.

We want accurate numbers and not a sample survey.

Clarify the goals: 3.5% with no numbers for health insurance; 2.8% and no numbers for routine check-ups; 6.9% and no numbers for dental checkups; and 4.1% and no numbers for fewer people going without health care due to cost. Is it 2%, and no numbers for receiving care coordination? Why are these goals set for 2028?

Testimonial #1: A self-advocate and a community advocate for chronically ill and those with disabilities spoke in favor of better healthcare outcomes. She described repeated misunderstandings and dismissive treatment by healthcare and mental health professionals. She urged trauma-responsive care and a better understanding of complex medical conditions among professionals. All people should be treated with dignity. There should be improved care for all people.

Testimonial #2: One family member spoke in favor of a new Purple Alert system for missing and endangered individuals who wander or elope, including individuals with autism or some other disability. Her daughter left home unnoticed, and she described the intense danger families face despite the extensive safety precautions. Children with autism have a

higher risk of drowning. Amber Alerts do not cover elopement cases. We need faster responses to save lives.

Housing

(Pg. 31) Housing Goal 1 (A and B): Several people commented on the general lack of housing, the lack of accessible, affordable housing, and the lack of data on the extent of the shortages. The State Legislature should act to require more accessible housing, which will lead to greater integration, longer stays at home, and less institutionalization. Building code issues were also mentioned, especially for newer technology and larger wheelchairs. We shouldn't prioritize affordable housing at the expense of accessible housing. In addition to these comments, please read and take into consideration the following testimonial from a self-advocate when revising this goal:

Testimonial #1: My feedback is primarily focused on affordable, safe, and accessible housing for people with disabilities. It has been too long since talking about safe, affordable, and accessible housing for individuals with disabilities. I use a power wheelchair for movement, and it's not always an easy thing for people like us. I can still remember when my wife and I were looking for a house or an accessible apartment in Minnesota with our kids. We searched for months and couldn't find an accessible home, all because I am in a wheelchair. Luckily, when we found a one-level house, it wasn't accessible at all. I had to ask friends to build a wheelchair ramp so I could access the house. So, safe, affordable, and accessible housing for the community of people with disabilities is essential to us. One reason this needs to be addressed urgently is that those living in group homes or institutions are affected. And yes, I said institution because there are in some group homes, people with disabilities don't have a say or are not allowed to make decisions of their own. I believe most of them want to live independently. But when housing is not affordable, safe, and accessible, they won't be able to do so.

(Pg 33) Housing Goal 2: The target appears to be that 7 additional households with at least one person with a disability will receive affordable financing through the Minnesota Housing Rehabilitation Loan Program. Additionally, data will be collected in the future to determine what share of this funding is allocated specifically to accessibility improvements. Data collection will also be improved for the Fix Up Loan program to set targets. If this interpretation is inaccurate, please clarify. Given that many of the target goals and metrics are not yet quantified or quantifiable, we recommend establishing specific interim goals for what, how, and when baseline data will be collected, and a specific timeline for when improvement targets will be set.

Transit and transportation

(Pg. 34) Transportation Goal 1: Comments included:

Why is the Plan focusing on buses rather than on the people?

Why is the focus on infrastructure rather than on the experience of the riders? People are losing their jobs and experiencing long waits for paratransit.

Transportation is a very high need and high priority in Greater Minnesota. We received feedback that the goals are too low. It was also difficult to understand why the goals were written as tables rather than following the standard format.

Transition

We received six comments about the unacceptability of ignoring moving people from segregated settings to integrated settings (the integration mandate); four comments about the complex, delay-ridden, and uncoordinated service system; four comments about services being authorized and not delivered; three comments about the lack of transparency and enforcement of rights; and two comments about workforce and funding issues.

(Pgs. 40-41) Transition Goal 1: The goals are set too low.

(Pgs. 41-42) Transition Goal 2: The goals are set too low.

(Pgs. 42-43) Transition Goal 3: On page 42, DCT proposes a goal (labeled 3A) to increase the number of people who receive supportive services in community-based settings. They indicate that this includes people in jails, hospitals, and detox centers, those on a waitlist for a locked DCT facility, and those eligible for a community-based setting. The numbers are 4, 5, 6, 7, and 8 for each of the five years, respectively.

(Pg. 44) Transition Goal 3B: DCT proposes a goal (labeled 3B) to increase the number of people moving from segregated mental health treatment facilities to more integrated facilities. This is about locked DCT facilities. The numbers are 10, 12, 14, 16, and 18 for each of the five years.

(Pgs. 45-46) Transition Goal 4: There are currently no measurable goals offered. Once they are available, the goal should be made available for public comment and review. On page 45, please italicize Olmstead in the following sentence: Providing people with disabilities the housing assistance they need to live in the community is fundamental to achieving the integration mandate of the Supreme Court's Olmstead decision.

The transition goals are the heart of the Olmstead decision, the reason that the Plan exists, and there is no data provided. This is unacceptable and raises the valid question of how the Plan loses focus on moving people from Nursing Facilities, ICFs, Assisted Living, and Community Residential Settings to more integrated settings. It is extremely critical and totally unacceptable that the Plan fails in this area.

(Pgs. 46-47) Transition Goal 5: The measure of this goal does not align with the language. It focuses on reducing the number of reports rather than helping people who are experiencing restrictive procedures. Please correct the following date in the first full paragraph on page 47 as follows: Reducing the use of restrictive procedures is foundational to Minnesota's Olmstead Plan. The Plan was created as part of a 2011 settlement arising from a 2009 lawsuit against DHS, known as 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 people with disabilities.

Data collection goals and strategies

(Pg. 47) This is a new section, and the heading does not make it clear to the reader that this is a different set of goals entirely.

(Pgs. 48-66) Related to all data goals: Please consider adding some context about the speed of moving from data collection to goal development; otherwise, it looks like this process could take up to five years. It would also help to clarify why some goals repeat an existing law that should be implemented.

The 50 participants did not provide feedback for every data development goal, but repeatedly asked why the Plan includes data goals for which data already exists.

The following appear to comply with the Americans with Disabilities Act: C, E, F, J. Items L and M comply with CMS rules. Minnesota has data for items N and O.

Crisis Services Data Goal 1: More people will stay in the community after a crisis.

Education Data Goal 1: Adolescent students with disabilities released from correctional facilities will have an opportunity to continue their education.

Education Data Goal 2: Incarcerated adults with disabilities will have access to education support before release.

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

Health and Safety Data Goal 1: DPS services will be accessible to people with disabilities.

Health and Safety Data Goal 2: MDH staff will receive training about access and functional needs during public emergencies.

Housing Data Goal 1: Incarcerated individuals will have accessible housing upon release. page 54, Housing Data Goal 1, which states incarcerated individuals with disabilities will have accessible housing upon release. DOC, DHS, and Minnesota Housing propose this goal.

Housing Data Goal 2 A and 2B. More people will have safe, accessible, affordable housing of their choice.

Transitions Data Goal 1: More people will have access to peer support services.

Transitions Data Goal 2: More incarcerated individuals will access programs.

Transitions Data Goal 3: Fewer Minnesotans will go out of state to receive services.

Transition Data Goal 4: Timely access to services (4A-New waiver, 4B Current waiver, and 4C Personal care, homemaker, etc.)

Transition Data Goal 5: DSPs and people with disabilities will shape Minnesota's MA program.

Transition Data Goal 6: People with disabilities are protected from increases in the use of mechanical restraints. Why is the data currently collected and available from the State insufficient or unacceptable that it requires the development of a new data set?

Transition Data Goal 7: More people will move from segregated settings to integrated settings. (correctional facilities, nursing facilities, hospitals, ICFs, IMD). Why is the data currently collected and available from the State insufficient or unacceptable that it requires the development of a new data set? Additionally, this newly envisioned data set will be incomplete, as it appears to omit other segregated settings under the broad heading of community residential services.

An in-depth analysis of 5 goals related to moving people from segregated settings to more integrated settings is presented in paragraph 61.

Testimonial #1: One family testified that timely access to services is important, but misses the systemic barriers that exist in navigating delays for waiver services. The system is complex and confusing. There are long delays, administrative inconsistencies, and a lack of coordination between agencies. Despite approval of services two years earlier, the family received no support. She called for stronger accountability, increased staffing, clearer timelines, transparency about rights, and accessible grievance procedures to ensure individuals are being served.

(Pg. 62): Please use italics when referencing the *Jensen* lawsuit, the following:

Mechanical restraint is a type of restrictive procedure. Minnesota has significantly reduced the use of mechanical restraints since the *Jensen* Settlement Agreement.

2026 Plan update timeline

(Pg. 66) Timeline: This is a set of general statements. Please revise the statements about the QOL survey to provide a clear context and greater accuracy than what is currently written. Points to clarify this are provided alongside the statement: "Survey participants are people who are eligible to receive services in potentially segregated settings." QOL is a longitudinal survey. The scientifically selected population comprises 2000 people living in segregated settings, and a sample is then drawn for each follow-up survey. The respondents are "not eligible to receive services" because they were placed in segregated services. The participants were selected based on their circumstances.

Olmstead Plan Implementation

(Pgs. 67-69) Olmstead Plan Implementation: On page 67, third paragraph, the draft Plan currently states, "The Olmstead Plan is a five-year Plan." This needs clarification, as the majority of the draft goals are not for five years.

(Pg. 67) Fourth paragraph: This currently states that the Leadership Forum approves changes in goals and strategies. The Leadership Forum has never had approval authority, and there is nothing in the charter to suggest it does. Please update this language to align with the charter.

OIO Roles and Responsibilities

(Pg. 67): The reader is directed to find details about updating goals and strategies in the Leadership Forum charter and the Subcabinet Procedures. We do agree and recommend that the final Plan provide readers with direction on where to find details on updating goals and strategies, but request that the direction to the correct location for this information be provided. There are very few details about that process in either document, which makes this sentence seem misleading.

(Pgs. 70-71) OIO roles and responsibilities: A few clarifications are needed in this section.

Executive Order 19-13 clearly states that the duties of the Subcabinet include: "4.c. Engage communities with the greatest disparities in health outcomes for individuals with disabilities and work to identify and address barriers to equitable health outcomes."

“4. i. Continue to implement the Quality-of-Life survey process to measure the quality of life of people with disabilities over time and continue to identify and implement quality improvement strategies.” These duties should be more clearly defined and highlighted in the Plan. Too little attention has been paid in the draft Plan to these critical tasks.

On page 70, next to the last paragraph, for more details about Olmstead Plan compliance, please see the Olmstead Subcabinet Procedures. When you go to the Olmstead Subcabinet Procedures, the reader will find a single sentence that does not provide details. “Article VIII, B. Compliance. The OIO Director of Compliance will maintain OIO Compliance Procedures that document how Subcabinet agencies will work with OIO.” Critical details are missing from the understanding of compliance. Accountability is a topic of deep interest to the disability community, and our more than 50 self-advocates, parents, and family members asked about it during their review.

Statement about Missing Goals:

Testimonial #1: As a parent with a disability who has a child with a disability, the Olmstead Plan is missing a goal about civic engagement. The caucus system is not accessible to people with disabilities. There were no accommodations such as amplification, captioning, disability supports, or building accessibility. The Secretary of State’s website lacked sufficient information on accessibility resources. Inaccessible political processes limit the civil rights of voters with disabilities.

Testimonial #2: Several comments were received about the deficiencies of Waiver Reimagine.

Testimonial #3: One parent said her daughter has multiple medical conditions. She needed mental health treatment, but the family was told that the daughter was not eligible because of an intellectual disability.

Detailed Analysis of 5 segregated settings goals

It might be helpful to the public to review five goals (3A, 3B, Transition Goal 4, Housing Data Goal 1, and Transition Data Goal 1) together and identify ways to communicate their intent better. One cause of confusion is the overlapping populations when reading the goals together (jails, hospitals, locked DCT facilities, detox settings, RTCs, correctional facilities, and locked residential treatment centers). Another cause of confusion is imprecise definitions, which require a reader to have inside information to understand the differences between these goals. Most importantly, there seems to be a lack of commitment to move people in segregated community settings to the most integrated settings. The focus has

shifted from moving people to developing data on IMDs, even though other goals already cover those facilities.

On page 42, DCT proposes a goal (labeled 3A) to increase the number of people who receive supportive services in community-based settings. They indicate that this includes people in jails, hospitals, and detox centers, those on a waitlist for a locked DCT facility, and those eligible for a community-based setting. The targets are 4, 5, 6, 7, and 8 people for each of the five years, respectively.

This goal appears to be a diversion from DCT programs, which could mean priority admission issues, voluntary engagement efforts being piloted in three counties, and the DCT pilot program on neuroleptic medication in jails. The idea is to stabilize someone so they don't need to go to a DCT-locked, segregated setting (AMRTC/FMHP, largely, but this could include CARE, CBHH, or the flex-locked DCT IRTS).

There are likely several reasons the numbers are low, including actions by county attorneys and courts, as well as their unwillingness to consider alternatives. Another reason could be that the goal is limited because the scope is counting diversions from locked settings into DCT-operated programs. Whatever the reasons, this goal is narrowly focused rather than getting people the right services at the right time, regardless of the service provider.

On page 44, DCT proposes a goal (labeled 3B) to increase the number of people moving from segregated mental health treatment facilities to more integrated facilities. This is about locked DCT facilities. The targets are 10, 12, 14, 16, and 18 people for each of the five years.

Unlike Goal 3A, which focuses on diverting people from entering the locked DCT segregated institutional settings, this goal is about moving people out of those settings. There is no clear definition of what locked DCT settings are included. AMRTC and FMHP are used as examples of locked DCT settings in the appendix definition. However, other DCT settings are also locked, including:

Community Behavioral Health Hospitals (CBHH)

DCT website says average stay is 60 days. If these are included in this goal as a "locked DCT" setting, the numbers are far too low for even one CBHH, much less all of them.

Community Addiction Recovery Enterprise (CARE) provides SUD treatment services

Intensive Residential Treatment Services (IRTS) are "flex" locked – how does that fall into the definition here?

MSOP is a DCT-locked facility. Are those discharges to the community included in this data set?

Child and Adolescent Behavioral Health Services (CABHS)

This goal is to move people to a DCT CBS program, not any other provider type. Again, the definition in the appendix is unclear, but it aligns with what's on DCT's website for its "Community-Based Services (CBS)" offered as a DCT/safety-net service provider. Community-Based Services (CBS): 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 in 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:

Let's clarify if this is basically just MSOCS and MITH homes? What about the new DCT Integrated Community Supports in the apartment building in Minneapolis that DHS purchased? Is this goal about internal movement from one part of DCT to another part?

On page 45, Minnesota Housing, DHS, and DOC present Transition Goal 4 to increase the number of people with disabilities to move from segregated settings to more integrated housing of their choice, where they sign a lease and receive rent support. This goal is about RTCs, hospitals, correctional facilities, and locked residential treatment settings. No measurable performance targets are provided.

It appears this goal is expanding options for integrated housing of their choice. Still, it is drastically limited because it receives rent support from "certain programs such as Bridges, Bridges RTC, and Section 811." This seems to exclude Housing Support under 256I, one of the main sources of rent support for people moving into community residential settings, integrated community support, and small assisted living or customized living settings.

Please clarify that Bridges and Bridges RTC are only for people with mental health issues, whereas 256I Housing Support has broader eligibility. Section 811 is a great program, but availability is limited.

There is no definition of "integrated housing of their choice". The definition of integration – people with and without disabilities together – could apply to an integrated community setting (ICS), where some people in the multifamily housing site receive services and others do not. This setting is also eligible for housing support under 256I. Please clarify the phrase "sign a lease for their housing." People in CRS, ICS, and Assisted Living all have a lease or a lease-equivalent. This goal is unclear on several levels. There are no measurable goals and no baseline.

Page 54, Housing Data Goal 1, which states incarcerated individuals with disabilities will have accessible housing upon release. DOC, DHS, and Minnesota Housing propose this goal.

Who will determine if the housing is accessible? DOC? The person? The housing provider?

"Create a system to track whether individuals with ADA plans have housing supports…" Was this goal about accessible housing? Clarify the term housing supports. Is this akin to the former Housing Stabilization Services, intended to help people maintain their housing?

Page 65 and Transition Data Goal 7 proposed by DHS. More people with disabilities will move from segregated settings to integrated settings. DHS wants to write a goal for people in correctional settings, nursing facilities, hospitals, ICFs, and IMDs. There is no definition of IMD in the Plan or the appendix. This is not plain language. IMD is stigmatizing language to someone who does not understand the federal definition and implications. Is this referencing DCT AMRTC and FMHP? How does this interact with earlier goals proposed by DCT?

Again, the definition of integrated settings is confusing here. Is this referring to settings where people with and without disabilities live, as defined in the appendix? If so, is consideration being given to provider-controlled residential settings in the community (CRS, ICS, Assisted Living, and exempt MI-supported housing providers), excluded from an integrated setting? Also, the housing goal starts with "from segregated to integrated settings," but the justification reads "people who want to move into community-based housing can move directly into it." Is this goal about integrated housing or community-based housing?

Also, the “where are we now” mentions data re: hospitals, nursing homes, and IMDs, but nothing on correctional settings. How does this goal interact with the other goals?

Finally, under the current Plan, DHS set goals to move people from a wide range of segregated facilities to more integrated settings. The draft Plan does not set goals for people with disabilities living in segregated community settings, but rather states that data must be developed to set targets and goals. DHS must reinstate goals for ICFs, nursing facilities, and community residential settings of all types. Failing to do so is a failure of the Plan, which, at its core, is about moving people out of segregated settings and into the most integrated community settings.

Suggested Edits to the Appendix

(Pg. 1) top of the page: It looks like the Table of Contents begins with the name "Olmstead Plan Draft: Appendix," and the next item is called "Table of Contents." The policy consultants’ section is missing from the Table of Contents. Those two items need updating.

(Pg. 3) Community feedback about specific topics: It would be very helpful to have a better connection between the input of 2000 people and the goal selection, such as analyzing the input of 2000 people in terms of relative strength or the number of mentions (Pareto charts).

(Pg. 4) Please look at this sentence and consider rewriting it: “The Olmstead decision does not require people with disabilities to be in the most integrated setting.” From previous discussions with national experts and attorneys, the Olmstead decision requires the State of Minnesota to offer services in the most integrated setting, and the person has the right to refuse. Minnesota continues to believe that the person must volunteer to leave a segregated setting, and then their team makes the decision. The Olmstead Plan should provide accurate information.

(Pgs. 4-5)Three overall themes are presented, but there is no apparent connection between them and the proposed goals in the draft Plan. For example, intersectionality is presented as an important theme, but there are very few goals that address intersectionality.

(Pg. 6): The Glossary has now been updated to include longer definitions. This will help with credibility. One definition that could be improved is the Americans with Disabilities Act. “Outlaws” seems too strong a term, considering infractions are addressed through civil rather than criminal means. The ADA 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. We recommend improving the definition.

(Pg. 7) Civil rights: This list appears to come from state law, such as the Minnesota Human Rights Act, not Federal sources as implied in the definition.

(Pg. 7): Under community-based services, please add a disclaimer stating that this definition comes from DCT, not DHS. Their list includes places that can be segregated or institutional.

(Pg. 8) disability: We recommend reverting to the specific ADA language, regardless of internal preferences. “Difference” and “impairment” do not have legally synonymous definitions, and in a federal court setting, “difference” will not meet the legal standard required.

(Pg. 9) Early intervention services: Please check the age range. Early intervention is typically defined as birth to 3 years.

(Pg. 10) inclusion:

Inclusion—the literature (especially John O’Brien) provides more complete definitions.

Presence: Increasing people's presence in local community life.

Participation: Expanding and deepening relationships.

Valued Roles: Enhancing the reputation and contributions of individuals.

Promoting Choice: Helping people have more control and choice in their lives.

Supporting Contribution: Assisting individuals in
contributing their unique gifts to the community.

(Pg. 13) segregation means more than separation; it is actively setting people with disabilities apart and isolating them from others.

We recommend including the Medicaid Access Rule in the Glossary.

The 2014 CMS Rule defines person-centered plans, but that definition is missing from the Glossary. We recommend that it be included.

Conclusion

On behalf of the more than 50 self-advocates, parents, and family members who offered their feedback, please take these recommendations seriously. The current draft Plan can be made much stronger, more person-centered, and more focused on the intent and spirit of the Olmstead decision. While this proposed Plan addresses some of the issues, we

believe it falls short of delivering on the promise of independence, productivity, self-determination, integration, and inclusion in the community.

In enacting the ADA, both branches of Congress concluded:

There is a compelling need to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities and for the integration of persons with disabilities into the economic and social mainstream of American life.

The ADA states:

Historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem…

Individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, or other opportunities.

The Department of Justice filed a response in Lane v. Kitzhaber (later Brown) on April 20, 2012, which reiterated the integration mandate. They cited courts in other jurisdictions that have broadly applied Title II, including its integration mandate. Courts have applied Title II's integration mandate to a variety of public services beyond institutional and residential services, including accessible polling places, adult day health care, and in-home supportive services. Moreover, the DOJ has interpreted its own regulations broadly in its Olmstead guidance.

The Minnesota Olmstead Plan must meet the needs, requirements, and expectations of Minnesotans with disabilities as well as promises made by Congress and the Courts.

Cordially,

Colleen Wieck, PhD, Executive Director

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