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. These documents can be found on the OIO website.

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, shelters, juvenile detention facilities, and intermediate care facilities for developmentally disabled individuals (ICF-DD).

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 (AT) can be used as part of the IEP process. AT 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 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 (PTIC).
- 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 improves engagement with families, including Charting the LifeCourse at Disability Hub.
- Provide guidance to school districts and charter schools on available 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 to engage 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 the 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 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 improves 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 above 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 above 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 above 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 (CTICs).
- 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.