Technical Report: Best & Promising Practices to Support Olmstead Plan Development for Minnesota

Achieving Equitable, Positive Outcomes that Promote Community Integration in Eight Specific Topics

Technical Assistance Collaborative
15 Court Square, 11th Floor
Boston, MA 02108

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Abbreviations in this Document

AAC – augmentative and alternative communication

ABA – applied behavior analysis

ABI – acquired brain injury

ABLE – Achieving a Better Life Experience

AC – Alternative Care

ACAP – Adult Community Autism Program

ACL – Administration for Community Living

ACT – Assertive Community Treatment

ADA – Americans with Disabilities Act

ADHD – Attention Deficit & Hyperactivity Disorder

ADSIS – Alternative Delivery of Specialized Instructional Services

AHCCCS – Arizona Health Care Cost Containment System

AJC – American Job Center

ANCOR – American Network of Community Options & Resources

APSE – Association of People Supporting Employment

ARMHS – Adult Rehabilitative Mental Health Services

ARPA – American Rescue Plan Act

ASD – Autism Spectrum Disorder

ASL – American Sign Language

BI – brain injury

BIRF – Behavior Intervention Reporting Form

BPI – Building Partnerships Initiative

BRYT – Bridge for Resilient Youth in Transition

CAC – Community Alternative Care

CADI – Community Access for Disability Inclusion

CAHOOTS – Crisis Assistance Helping Out On The Streets)

CARE – Community Addiction Recovery Enterprise

CCBHC – Certified Community Behavioral Health Clinic

CCD – Consortium for Constituents with Disabilities

CE – Customized Employment

CFSS – Community First Services and Supports

CHW – community health worker

CIE – competitive, integrated employment

CMS – Centers for Medicare and Medicaid Services

COO – Chief Operating Officer

CRF – Children's Residential Facility

CRP – community rehabilitation provider

CTE – career and technical education

CWIC – Community Work Incentives Coordinator

DART – Disability Abuse Response Team

DCT – Direct care and treatment

DD – Developmental Disability

DEED – Department of Employment and Economic Development

DHS – Department of Human Services

DOC – Department of Corrections

DPS – Department of Public Safety

DSP – direct support professional

DV/SA – domestic violence/sexual assault

DWEL-AZ – Data Warehouse Enterprise for Linkage - Arizona

EBP – evidence-based practice

EOHLC – Executive Office of Housing and Livable Communities

EPSDT – Early and Periodic Screening, Diagnostic and Treatment

EW – Elderly Waiver

FACT – Forensic Assertive Community Treatment

FDP – Friendships and Dating Program

FEP – first episode psychosis

HC – home care

HCBS – Home & Community-Based Services

HIB – Housing Innovation Bond

HMIS – Homeless Management Information System

HSRI – Human Services Research Institute

HSS – housing stabilization services

HTC – housing tax credits

I/DD – intellectual or developmental disability/disabilities

IA – interdepartmental/interagency agreement

ICA – Institute for Community Alliances

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IHE – inclusive higher education

IMDs – Institutes for Mental Disease

IPS-SE – Individual Placement and Support – Supported Employment

IPS – Individual Placement and Support

IPTN – Inclusionary Practices Technical Assistance Network

IRTS – Intensive Residential Treatment Services

ISC – intensive support coordination

ISD – intermediate school district

LEA – local education agency

LGBTQ+ – lesbian, gay, bisexual, transgender, queer/questioning, and other marginalized sexual/gender identities

LIHTC – Low Income Housing Tax Credit

LRE – least restrictive environment

LSU – Louisiana State University

LTSS – long-term services and supports

MCO – managed care organization

MDE – Minnesota Department of Education

MDH – Minnesota Department of Health

MDVA – Minnesota Department of Veterans Affairs

METO – Minnesota Extended Treatment Options

MHEC – Minnesota Inclusive Higher Education Consortium

MHFA – Minnesota Housing Finance Agency

MN VRS – Minnesota Vocational Rehabilitation Services

MOU – memorandum of understanding

MRO – Medicaid Rehabilitation Option

MSA – Minnesota Supplemental Aid

MSOP – Minnesota Sex Offender Program

MTSS – multi-tier system of supports

NADSP – National Association of Direct Support Professionals

NADTC – National Aging and Disability Transportation Center

NAMI – National Alliance on Mental Illness

NASDSE – National Association of State Directors of Special Education

NCAPPS – National Center for Advancing Person-Centered Practices and Systems

NCI-AD – National Core Indicators® - Aging and Disabilities

NCI-IDD – National Core Indicators® - Intellectual and Developmental Disabilities

NEON – National Expansion of Employment Opportunities

NGA – National Governors Association

NHeLP – National Health Law Program

NRI – National Research Institute

NTACT – National Technical Assistance Center on Transition

ODEP – Office of Disability Employment Programs

OIO – Olmstead Implementation Office

OPWDD – Office for People with Developmental Disabilities

OSEP – Office of Special Education Programs

PBIS – Positive Behavioral Interventions and Supports

PCA – personal care attendant

PCP – person-centered planning

PE – progressive employment

POM – personal outcome measure

PORT – Point of Reentry and Transition

POST – Peace Officer Standards and Training

PRA – Project Rental Assistance

pre-ETS – pre-employment transition services

PRTF – psychiatric residential treatment facility

PSH – permanent supportive housing

PWD – person with a disability

QAP – Qualified Allocation Plan

QDE – qualified disability expense

RAP – Registered Apprenticeship Program

RCS – Residential Crisis Stabilization

REALD – race, ethnicity, language, and disability

RFP – request for proposals

RI DDS – Rhode Island Division of Disability Services

ROSC – Recovery Oriented System of Care

SAMHSA – Substance Abuse and Mental Health Services Administration

SDLMI – Self-Determined Learning Model of Instruction

SDOH – social determinant of health

SEA – state education agency

SEED – Support Education to Elevate Diversity

SMART – specific, measurable, achievable, relevant, and time-bound

SME – subject matter experts

SMI – serious mental illness

SOS – Start on Success

SPP – State Performance Plan

SSDI – Social Security Disability Insurance

SSI – Supplemental Security Income

STAR – Support Team Assisted Response

STEM – science, technology, engineering, and mathematics

SUD – substance use disorder

TA – technical assistance

TAC – Technical Assistance Collaborative, Inc.

TIC – trauma-informed care

TPSID – transition program for students with intellectual disabilities

UDL – Universal Design for Learning

VR-JIT – Virtual Reality Job Interview Training

VR – Vocational rehabilitation

WBL – work-based learning

WDBs – Workforce Development Boards

WIN – Workforce Innovation Network

WINTAC – Workforce Innovation Technical Assistance Center

WIOA – Workforce Innovation and Opportunity Act

WIPA – Work Incentives Planning and Assistance

Introduction

The *Olmstead* case was brought in 1995 by the Atlanta Legal Aid Society on behalf of two women with intellectual disabilities and mental illnesses who were patients in a state psychiatric hospital. Hospital staff recommended that both be served in community programs, but because such services were in short supply, the women remained at the hospital. In the landmark *Olmstead v. L.C.* decision (1999), the U.S. Supreme Court held that under the Title II of the Americans with Disabilities Act (ADA), states have an affirmative obligation to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

The Court ruled that if a state had a "…comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated, the reasonable modification standard [of the ADA] would be met."[i] States must both understand these obligations and take action to develop and implement systems-level approaches toward achieving the greatest degree of community integration possible for people with disabilities.

According to the Supreme Court's decision, an *Olmstead* Plan to serve as a reasonable defense against legal action, it must include:

> *"…concrete and reliable commitments to expand integrated opportunities….and there must be funding to support the plan."*

The Minnesota Olmstead Plan

As is the case in many other states, Minnesota's Olmstead Plan originated related to class action litigation: *Jensen et al v. Minnesota Department of Human Services, et al* (Court File No. 09-cv-1775, U.S. District Court for the District of Minnesota). In July 2009, the families of three people at the Minnesota Extended Treatment Options (METO) program, located in Cambridge, filed a federal class action lawsuit against the Department of Human Services (DHS). The lawsuit alleged that the METO program used restraint and seclusion in a way that broke the law and violated the rights of the plaintiffs. Rather than pursue a trial, the plaintiffs who brought the lawsuit and DHS entered into a settlement agreement. The Jensen Settlement Agreement contained many provisions that brought improvements to the care and treatment of people with developmental and other disabilities in Minnesota and included a requirement to develop an Olmstead Plan.

The development of Minnesota's Olmstead Plan served as a model for the country. Subsequent to the appointment of the initial Olmstead Planning Committee in 2012, Governor Mark Dayton issued an Executive Order in 2013 establishing a subcabinet to develop and implement a comprehensive plan supporting freedom of choice and opportunity for people with disabilities. The Olmstead Subcabinet was chaired by Lieutenant Governor Yvonne Prettner Solon and included representatives from several state agencies and stakeholders. The Plan was approved by the Court in 2015. It is not typical for a court to approve an Olmstead Plan, and this action helped affirm that the state's plan met core standards.

From 2015 through 2022, Minnesota updated its Olmstead Plan annually based on feedback from the community. In 2019, the Olmstead Subcabinet created workgroups to explore topic areas and provide recommendations, and in 2023, the Subcabinet decided to undertake a more comprehensive update, with an emphasis on co-creating a revised Plan with the disability community.

The Best & Promising Practices Report

In May 2025, DHS contracted with the Technical Assistance Collaborative (TAC) to provide consultation in the development of a new Olmstead Plan. The contract consisted of two primary tasks:

- Develop a best practices document, covering multiple topic areas and providing information on strategies and practices with demonstrated effectiveness in achieving equitable, positive outcomes that promote community integration.
- Provide Policy Consultants (subject matter experts) to Subcabinet agencies and Inclusion Consultants as they work to co-create Olmstead Plan goals.

This paper fulfills the first of these tasks, providing best and promising practices in the promotion of *Olmstead* compliance across eight topic areas:

- Education
- Employment
- Health
- Home and Community-Based Services
- Housing
- Positive Supports
- The Prevention of Abuse and Neglect
- Transportation

To author this report, TAC partnered with the Human Services Research Institute (HSRI) in assembling a highly qualified team of consultants and subcontractors with expertise in the services and housing policies and programs that promote community integration for people with disabilities, and in health and human services systems data

collection and evaluation. Each area was assigned to a Topic Lead, supported by the combined knowledge and expertise of the entire TAC-HSRI team.

After an initial kickoff meeting with the Olmstead Implementation Office (OIO) and the DHS Olmstead compliance office, the TAC team met with each of the 12 Subcabinet Agencies to share identified resources and elicit recommendations from state partners on relevant research documents, reports, data sources, and subject matter experts, both local and national, to inform this report. Policy consultants and Topic Leads also met with each Subcabinet Agency's assigned Inclusion Consultants. These consultants, hired by the Dendros Group, are individuals with disabilities. The voice of lived experience was crucial for Lead Authors to develop an understanding of the current state of *Olmstead* implementation in Minnesota and to provide direction in identifying practices to guide the next steps of Olmstead Plan co-creation.

Topic Leads conducted extensive literature reviews on effective state-level practices and policies in their area, including peer-reviewed articles and publicly available resources. The TAC team also engaged outside subject matter experts (SMEs) to provide further examples of best/promising practices. In identifying key informants, Topic Leads drew on TAC's own network and also sought input from DHS, OIO, and national organizations — enabling us to interview both government leaders and representatives of community-based organizations with documented success implementing policies or initiatives related to the topic areas. Recognizing that there are many factors to consider and capture in identifying and understanding best/promising practices, whenever possible, TAC examined important subtopics that relate to one or more of the eight topic areas.

This report highlights effective practices, policies, programs, and strategies that promote community integration, increase decision-making power, and improve the quality of life for people with disabilities. The report reflects our consideration of practices in each area for potential implementation, highlighting strengths, challenges, and opportunities, and suggesting possible strategies and metrics to evaluate efficacy. In each topic area, authors address current disparities specific to disabilities and other intersectional identities of people with disabilities and review the extent to which specific practices address such disparities. The report also reflects our evaluation of current and proposed practices for person-centered planning; informed choice; cultural responsiveness; the needs of specific populations (e.g., people experiencing homelessness, Veterans, and individuals who are criminal-justice-involved); and depth of connection with other governmental and community partners. This process did not include a thorough landscape analysis of all Minnesota programs and services. Therefore, identified best practices may be offered in Minnesota currently. In such cases, review of these best practices implemented elsewhere may inform consideration of expansion or improvement.

As the Minnesota Olmstead Subcabinet Agencies continue their engagement with Inclusion Consultants to co-create future *Olmstead* goals, we anticipate that this report will be a key source to help the Agencies in fulfilling their duties as they:

- Identify and address barriers to providing services and meaningful opportunities within the most integrated settings for people with disabilities throughout Minnesota.
- Identify and address areas of disparity in opportunities for individuals with disabilities to live, work, and engage in the most integrated settings.
- Engage communities with the greatest disparities in health outcomes for individuals with disabilities, and work to identify and address barriers to equitable health outcomes.

Cross-Cutting Considerations

While this report addresses best/promising practice recommendations and examples in eight critical areas, successful implementation of *Olmstead* strategies is contingent upon more than the adoption of isolated initiatives. For each topic area, we also offer insight into strategies for success — and all highlight the importance of a coordinated approach. We find that the best/promising practices and strategies described in this report rely on several key cross-cutting factors to support successful outcomes:

- Goals that involve multiple agencies and strategies must be supported by all the government entities associated with them through coordination, cooperation, or collaboration. These relationships should be outlined in writing, with clear expectations set for activities that lead to specific desired outcomes. States can employ various mechanisms to hold agencies accountable and provide transparency for persons served and their families.
- Broad implementation of these practices rests on the state's commitment to provide resources to support them. Data collection on outcomes demonstrates the efficacy of the practices and is essential to support the use of scarce public funds for implementation.
- Without a strategic plan to broadly implement the practices statewide — supported by the highest levels of leadership — inequities in access will persist. Creating pathways to engage county governments in the implementation of *Olmstead* strategies is essential to success.
- Early intervention is critical in promoting long-term progress toward integration. Systems may inadvertently contribute to institutionalization or segregation if they fail to prepare youth with disabilities for independent living or connect them with community supports. Effective Olmstead planning helps prevent such outcomes by focusing on integrated service delivery across the lifespan.
- The success of the Minnesota Olmstead Plan requires ongoing engagement and oversight of implementation at the county level. While counties can respond to the unique needs of their communities, the possibility of disparities in strategy implementation could present a challenge to equitable statewide outcomes.

The Importance and Strengths of Data Sharing and Data Coordination

Some states have removed barriers and improved the availability of supports and services to people with disabilities through data sharing and data coordination. Such efforts by local, state, and federal systems can result in a multitude of benefits:

- *Holistic care*: Sharing data creates a full picture of an individual's needs, supporting the coordination of their services across different agencies (e.g., housing, health care, employment). This means less duplicated effort and more seamless support for individuals.
- *Improved resource allocation*: Coordinated data helps policymakers identify service gaps and allocate resources effectively. It allows for evidence-based decisions, ensuring that programs meet actual needs and address disparities.
- *Efficiency and savings*: Sharing information reduces redundant paperwork and assessments, saving time and money for both individuals and the state. It streamlines processes and can help prevent fraud.
- *Proactive Planning*: By understanding individuals' needs and transitions (like aging caregivers), agencies can anticipate future demands and intervene early, preventing crises and ensuring smooth transitions between services.
- *Accessibility and inclusivity*: Data helps agencies tailor outreach and improve the accessibility of public resources for diverse groups within these communities.

Conclusion

Over the past ten years, Minnesota has learned a great deal about what works in supporting individuals with disabilities to live in integrated settings and receive the services they need in the community. Still, there is work to be done. Solutions to *Olmstead* require an all-of-government approach and must be woven into the everyday fabric of government to be successful. Programs have transformative potential when they are intentionally designed, consistently implemented, and adequately funded.

This report was developed with participation by the Inclusion Consultants and is intended to support the OIO, Olmstead Subcabinet Agencies, the Inclusion Consultants, and all other partners engaged in the co-creation of Minnesota’s next Olmstead Plan. Minnesota’s commitment to Title II of the Americans with Disabilities Act (ADA) and *Olmstead*, and to a co-creation process by people with lived expertise and state agencies, provides a pathway to transform service delivery systems for individuals with disabilities. This discussion of best practices and lessons learned in implementation efforts across the nation can structure options for consideration by all parties.

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Topic 1: Education

Laura Conrad, M.S.W., is a behavioral health care leader with over 20 years of demonstrated experience in government administration and special expertise in child-serving systems.

Kelly Nye-Lengerman, Ph.D., M.S.W., has worked in disability and transition services for over 25 years as a direct service provider, supervisor, educator, and researcher.

Overview of Education & Olmstead Planning

While *Olmstead* is often associated with health care and housing, education is an essential topic of interest for school-aged youth and young adults with disabilities. Nebraska's recent *Olmstead* evaluation indicates 11 states' Olmstead Plans explicitly include education as a goal area (Partners for Insightful Evaluation, 2024). Many state plans focus on areas like employment and transition, which are directly tied to educational opportunities for individuals with disabilities.

Subtopics

Four important themes/priorities should be part of all Olmstead planning related to education:

- *Inclusion and Least Restrictive Environment. Olmstead* reinforces the Individuals with Disabilities Education Act (IDEA) requirement that students be educated in the least restrictive environment (LRE), meaning alongside their nondisabled peers to the greatest extent appropriate. This mandate supports *Olmstead*'s emphasis on integration and avoiding unnecessary segregation.
- *Preventing institutionalization.* Access to high-quality, inclusive education can prevent unnecessary institutional or segregated placement, such as residential, juvenile justice and/or inpatient settings. Education systems can collaborate with other agencies to ensure that students with complex needs receive services in the community. By contrast, systems may inadvertently contribute to institutionalization or segregation if they fail to prepare students with disabilities for independent living or do not connect them with community supports. Effective Olmstead planning helps prevent such outcomes by focusing on integrated service delivery. Studies show that students who are integrated are more likely to be successful than those in less integrated settings (Oh-Young, 2015). One key strategy in education-related Olmstead planning is ensuring early identification and intervention. Through the early detection of students' disabilities and needs, educational institutions can reduce the risk of later institutional placement for these children.

- *Interagency collaboration.* Educational planning must be coordinated with community services to ensure that students with disabilities can fully participate in community life after completing their formal education. Education systems should collaborate and share data with Medicaid agencies, as well as with child welfare, juvenile justice, vocational rehabilitation, and housing systems and supports. Partners should design these joint efforts to ensure policy alignment, guiding policies in all state agencies toward support for integrated settings, assistive technologies, and person-centered planning.
- *Transition services.* Under IDEA, schools are required to provide transition planning for students with disabilities starting at age 16 (or younger in some states, including Minnesota). This aligns with *Olmstead*'s emphasis on integrated, community-based life options. *Olmstead* supports services that 1) facilitate transitions from school to integrated adult services, rather than institutional or segregated placements, and 2) help individuals with disabilities in institutional settings move back into the community, as well as into education settings for youth.

Populations of Particular Concern for Education & *Olmstead*

Minnesota's special education population has grown significantly in recent years, surpassing the growth rate of general education enrollment. Currently, the state serves around 144,720 (MDE, 2025) children and youth with disabilities from pre-kindergarten through age 21. This increase reflects both a greater demand for services and an expanded approach to identifying and supporting students with disabilities. Enrollment spans a broad spectrum of disability types and racial identities. Across many states, including Minnesota, approximately 1% of children with disabilities are placed in out of state facilities away from their families and community (National Center for Education Statistics, 2024). Currently, there is no readily available data on the number of children in out-of-state placements, which makes it difficult to determine the significance and scale of the issue.

According to 2024 IDEA Part B data (IDEA, 2024), more than one-third of Minnesota students receiving special education services are identified with learning disabilities (29%). Autism is the second most common category (17%), followed by behavioral disorders, which continues to rise and now accounts for 12% of special education students. Populations at elevated risk of needing special education include students of color, students experiencing homelessness, those with co-occurring disabilities, students experiencing behavioral health challenges and/or autism, and those involved with the child welfare (Gee, 2020) or juvenile justice systems (Kim, 2021). Currently, there is no readily available data on the number of children needing special education who are involved with child welfare and/or juvenile justice, which makes it difficult to determine the significance and scale of the issue in Minnesota.

Education & *Olmstead* in Minnesota

In this report, "school district" means both public school districts and charter schools. MDE oversees:

2023 school year figures:
- 325 public school districts
- 169 charter schools

Minnesota Education Statistics Summary 2025-2026

Minnesota has made notable strides in improving outcomes for students with disabilities, demonstrating its alignment with *Olmstead* principles that aim to integrate individuals with disabilities into all aspects of community life, including education. From 2013 to 2018, the state saw a 4.54% increase in graduation rates for students with disabilities, indicating progress in educational attainment. Additionally, the implementation of Positive Behavioral Interventions and Supports (PBIS) has played a vital role in creating supportive, inclusive learning environments that reduce disciplinary disparities and enhance academic engagement, particularly among Native American and other historically marginalized student groups. These initiatives underscore Minnesota's commitment to ensuring equitable, high-quality education for all students, especially those with disabilities. Minnesota Department of Education (MDE) roles include supporting and partnering with school districts, as well as ensuring that school districts comply with state and federal law. More than 140,000 Minnesota students receive special education services — nearly one in five students across the state. Minnesota is a leader in the use and implementation of PBIS in schools, supported by the State Implementation and Scaling-up of Evidence-Based Practices center, which uses the National Implementation Research Network's model of implementation to track how districts are implementing PBIS. More than 78 MDE schools were recognized in 2023 as exemplary. MDE has committed to improving graduation rates for Native American and Black students with disabilities, and since 2017, the state has increased that rate by 6 percentage points, from 57% to 63% (MDE, 2025). Minnesota's special education teacher licensure expectations encourage the use of Universal Design for Learning principles (UDLs) and reinforce the value of assistive technology (Minnesota Legislature, 2017).

Effective Education-Related Policies, Programs, and Strategies

1A: Education in the Most Integrated Setting, Increasing the Percentage of Students in Setting 1

- Setting 1: 80%-100% time in general education classroom.
- Setting 2: 40%-79% time in general education classroom.
- Setting 3: 0%-39% time in general education classroom.
- Other placements such as residential facilities, day schools not operated by the district, homeschooling, private schools, and more.

Effective and high-quality implementation begins with an approach and mindset dedicated to inclusive education, which requires discussion, cooperation, and inclusion within and between different levels of the LRE model with a multi-tier system of supports (MTSS) for the academic and behavioral support needs of students with disabilities. For example, PBIS is a multi-tier system that organizes the behavioral supports provided to students with disabilities.

Although there is ongoing debate about LRE and inclusion, including differing interpretations and how well they align with educational practices, the concept remains central to special education policy. The federal Department of Education and state education agencies use Education Environments data as one measure of the performance of special education systems, as part of each State Performance Plan (SPP). When comparing states, it is important to know that they may use different definitions and criteria for disability; may serve different numbers and proportions of students with disabilities; may serve students in different federally defined disability categories; and may serve populations of students with disabilities with differing levels of need both within a given state and from one state to the next. Data from all states can be summarized together, but comparisons between states requires attention to all these differences. In addition, the types of services, and the levels of services provided to students with disabilities may be different between two states. Students in Setting 1 in one state may be different than in another state, and the services and supports they receive in one state may be different than in another state. Because of this, the same number for two states can mean two different things.

Specifically for Minnesota, it is important to factor into any analysis of the number and percentage of students with disabilities served statewide in Setting 1 (80% or more of the school in the general education classroom setting) that the state has an extensive program to provide students with academic and behavioral services and supports before they require special education for those academic and behavioral supports. This statewide program is "Alternative Delivery of Specialized Instructional Services (ADSIS).” In the absence of ADSIS, as in many other states, it is likely that such

students would have required special education, and the majority of them would receive those special education services and supports in Setting I. Statistics may indicate that Minnesota serves a smaller percentage of students with disabilities in Setting 1 than other states, but this statistic may reflect the impact of the state's ADSIS program.

U.S. Department of Education data (2022–2023) shows that Minnesota serves a lower percentage of students with disabilities in Setting 1 than do a majority of other states. Data from Minnesota's Annual Performance Report submitted each year to the federal Office of Special Education Programs (OSEP), shown in Table 1.1 below, details the growth in the numbers of students with disabilities served in the state simultaneously with increased proportions of those students served in Setting 1.

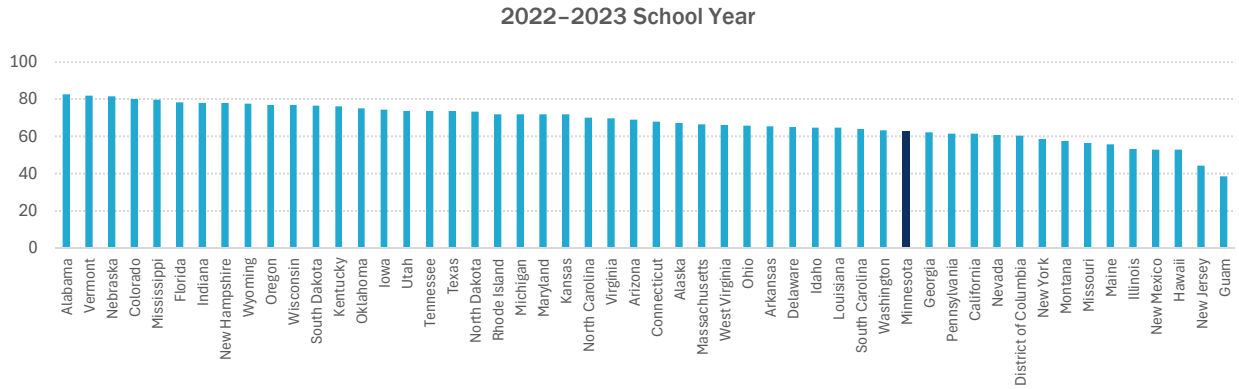
Table 1.1: Minnesota Students in Setting 1, 2019–2025

Data or School Year:	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23
Submitted to OSEP in:	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
Students with IEPs in regular classroom 80% or more of the day	72,365	75,291	77,639	82,605	84,233	87,162	91,377
Students with IEPs enrolled	123,845	128,377	132,341	132,571	134,309	138,853	144,270
Percentage of students in regular classroom 80% or more of the day	58.43%	58.65%	58.67%	62.31%	62.72%	62.77%	63.34%

Source: Data Profiles - Department of Education Open Data Platform

As of November 2018, Minnesota served 61% of students aged 6 to 21 in Setting 1. As of 2022, Minnesota served 63% of students in Setting 1, with 36 other states reporting that they serve a higher proportion of students with disabilities Setting 1. This data shows an improvement of 2 percentage points in Minnesota over a five-year period during which the number of students with disabilities also steadily increased. The national average increased by three percentage points during the same period. Alabama, Vermont, Nebraska, and Colorado reported the highest percentages of students with disabilities served in Setting 1, while New Mexico, New Jersey, and Hawaii reported the lowest. Some states observed to have large year-to-year improvements are Washington, Utah, and Mississippi.

Figure 1.1. From 2018 to 2022, Minnesota moved from 41st to 37th for the percentage of students served in Setting 1



Examples of Best Practices

- Vermont and Washington have made tremendous efforts, focusing on inclusive schooling using a variety of methods.
- Programs such as Bridge for Resilient Youth in Transition (BRYT) have also increased inclusion in schools by helping with transition.
- The use of support additional resources for students with disabilities.

Vermont is a leader in inclusive practices due to several factors. One is the state's use of UDL resources throughout state policy, initiatives, and programs. UDL is a foundational principle in Vermont's MTSS framework (State of Vermont Agency of Education, n.d.). Vermont also includes UDLs as an expectation for general education instruction, supporting all students, not just those with Individualized Education Programs (IEPs). Vermont implemented PBIS in 2006 but has continued to enhance its educational system by adopting an MTSS pyramid model, offering universal pre-Kindergarten (also providing Pre-K development grants), developing early standards (from birth to grade 3), and in 2019, publishing the VTmtss Field Guide. The Field Guide provides guidelines for educational staff to support schools in designing a comprehensive system that ensures all students have equitable access. In addition, Vermont offers statewide professional development that trains both general and special educators on UDLs.

Vermont also utilizes LRE data (Indicator 5) to monitor districts and may require districts to include an Indicator 5 improvement strategy in their annual continuous improvement plans. The state also offers coaching and ongoing professional development on inclusive practices. Vermont compares the LRE performance of each district, as well as subgroups in restrictive placements, against state targets and provides additional support and intervention for districts falling short.

The Washington legislature funded a project to increase students' access to inclusive education in 2019. Since 2018, the number of Washington students with disabilities who spend 80-100% of the school day in general education settings has increased by 11%. The Inclusionary Practices Technical Assistance Network (IPTN) has enabled over

22,000 students to transition to the least restrictive setting. IPTN is a group of state-supported technical assistance providers that provide training and technical assistance to districts. This legislative funding allowed the state to pilot the program in over 100 school districts. Washington has focused on six different areas: Data Monitoring and Analysis; Strategic Resource Use; TA — Evidence-Based Practices & Adaptive Leadership; Shared Ownership — "De-siloing"; Family and Community Partnerships; and Educator Recruitment & Retention. In each of these areas, the TA provider network supports school districts through targeted individualized TA, communities of practices and providing high-quality professional development resources. One example of this is the UW Haring Center, funded through the ITPN network, it provides opportunities for educators to observe inclusive practices in schools. For instance, there are 6 districts that are considered demo sites that showcase inclusionary practices aimed at reducing restraints and eliminating isolation, and there are 10 districts that are demo sites for inclusionary practices. The IPTN also has an advisory group that provides guidance on their activities. The state also set goals, such as increasing LRE 1 by 2% annually and reducing the gap for Black students with IEPs in LRE 1 environments by 4% annually, thereby closing the gap.[1] Washington has committed to addressing the disparities that exist in inclusive settings, particularly among Black students and those with intellectual or developmental disabilities.

BRYT, implemented by schools in Massachusetts and six other states, provides dedicated space and support for students who are experiencing dysregulation, transitioning back from a more restrictive setting, or at risk of being transferred to such a setting. The program was introduced in 2004, and BRYT has expanded into a national model, now operating in over 250 schools and 7 states. The program has shown a 78% reduction in rehospitalization rates among participating students. The model has also demonstrated that fewer than 20% of BRYT participants experience re-hospitalization after an initial hospital stay. Students in BRYT also report a 50% reduction in substance use disorders and a 50% drop in self-harming behaviors (White et al., 2017). The model focuses on supporting students with the most significant needs (i.e., Tier 3), with clinical supports, care coordination, and community supports. BRYT enables students with disabilities to transition back into the least restrictive school setting.

Other promising strategies include:

- Massachusetts supported transparency by creating district-level LRE dashboards to display progress in inclusion by race, disability type, and grade.
- Massachusetts and Ohio assign a Special Education Determination Level (1–4) to every district, based on compliance and outcomes, including LRE data, to inform tiered oversight and support. This information is *publicly shared.*

[1] In this report's descriptions of other states' programs, "LRE 1, 2, & 3" are used. These are equivalent to "Settings 1, 2, & 3" in Minnesota.

- The Massachusetts Department of Elementary and Secondary Education has also published a statewide Family Engagement Framework, promoting co-creation and equitable participation.
- In California, Colorado, and Pennsylvania, some state aid and grants (e.g., for literacy, behavior, and early learning) are available to districts that demonstrate improvements in inclusion quality, not just placement. By making financial resources contingent on measurable inclusion practices, these models promote real systemic change rather than just counting students.

One way to access additional revenue for school districts in support of students with disabilities is by increasing school-based Medicaid claiming. In 2014, the Centers for Medicare and Medicaid Services (CMS) reversed what was known as the "Free Care" rule, opening the door for states and districts to collect Medicaid reimbursement for health services for all students enrolled in Medicaid (Centers for Medicare & Medicaid Services, 2014). Since this change, according to CMS, 16 states have fully or partially expanded their Medicaid school-based services programs to allow reimbursement for all eligible Medicaid youth, not just those with an IEP or Individualized Family Service Plan. States such as California, Illinois, Michigan, and Louisiana have fully expanded their school-based Medicaid programs, covering a broad range of mental health services, including all medically necessary services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, and extending coverage to all students enrolled in Medicaid — not just those enrolled in special education.

Michigan is at the forefront of expanding access to school-based mental health services by effectively utilizing Medicaid funding. This progress is driven by the state's policy of covering all medically necessary services and by strong coordination between the State Medicaid Authority and the State Education Authority. Together, these agencies co-administer the program, providing consistent training, technical support, and joint communication to Michigan's 587 Local Education Agencies (LEAs).

The use of intermediate school districts (ISDs), which enable nearly all LEAs to participate, is a key element of Michigan's model. Under this structure, 56 ISDs assist smaller and rural districts by streamlining the Medicaid process and reducing administrative barriers. In addition to structural improvements, Michigan has invested more than $300 million over two years to expand mental health services for all students. The state's success is anchored in several core practices: strong collaboration between education and Medicaid agencies, dedicated staff focused on maximizing the impact of Medicaid in schools, active support for LEAs navigating the system, and intentional inclusion of rural and small districts in the program.

1B: Integrating State Data Systems — Programs/Policies that Reflect Promising Practices

Tennessee

Tennessee's P20 Connect TN data system links education, workforce, human services, and economic development data at the individual level. Since the system's inception in 2017, over 100 data use projects have been conducted, evaluating initiatives like Career and Technical Education and Tennessee Promise. In 2023, the state expanded its data integration efforts by establishing the TN DATA system, which integrates health and criminal justice data, facilitating comprehensive analysis for program improvement. Tennessee utilized its P20 Connect system to evaluate career and technical education programs and adjust funding priorities.

New Jersey

Some states provide educators and families access to relevant, timely data dashboards. This investment supports personalized instruction, informed family engagement, and local accountability. New Jersey's data dashboards enable districts to monitor special education placements and student outcomes, including data at the county and district level on the placement of students with disabilities, and compare them to state and national data.

Kentucky

By combining early childhood data with K-12 and health records, states identify children at risk for learning delays, chronic absenteeism, or behavioral issues. Kentucky's data system helps schools identify students who need additional services well before they fall behind. Individual districts are generally allowed to access identifiable data only to support their students' instruction, interventions, and assist in local decision-making. The system incorporates data points such as:

- Attendance and chronic absenteeism
- Early literacy and math assessment scores
- Behavioral incidents and disciplinary actions
- Special education referrals and evaluations

Ohio

Ohio is leading the way in publishing Medicaid data at both the district and individual school levels. A partnership between the Ohio Department of Medicaid and the Ohio Department of Education provides the Ohio Healthy Students Profiles as a data resource for needs assessments and planning. The profiles describe health care interactions, health conditions, and educational indicators for Medicaid-participating students. Other states, including Arkansas and Hawaii, are also collaborating across agencies and leveraging existing resources to develop public-facing dashboards that showcase Medicaid and educational data.

Shared data fosters collaboration between education, health, workforce, and social services agencies. Data sharing enables coordinated case management for students with complex needs, reducing service duplication.

1C: Facilitating Transition to Adulthood

Transitioning young adults with disabilities into adult services is a complex and challenging process for them, their families, and the systems designed to support them. This transition involves a significant shift from the education-based services guaranteed under the Individuals with Disabilities Education Act (IDEA), to a more diverse and often less robust adult service system. Individuals and families often describe a “transition cliff” where school-based services end, but adult services and supports may not be adequate. State and local education agencies (SEAs and LEAs) play crucial roles in facilitating a smooth transition into adulthood for students with disabilities graduating or aging out of services.

Under IDEA, the transition planning is primarily the responsibility of schools and LEAs as part of the student's IEP. In some cases, 504 plans may also help students with disabilities successfully navigate and prepare for adulthood. There are several evidence-based and best practice approaches that support positive transitions and outcomes for youth with disabilities. The strengths of these approaches include: providing tools and skills for youth to be successful in jobs, careers, and post-secondary education; increasing the likelihood of employment after school exit; utilizing person-centered approaches and self-determination; and prioritizing independence and engagement in community life.

Supporting Employment and Work-Based Learning (WBL)

For nearly two decades, there has been strong evidence across studies about the value and impact of paid work experiences while in high school or transition programming. These benefits also apply to students who have higher support needs. Paid work experiences can be provided through internships, on-campus jobs, after-school jobs, or as part of a formal program (e.g., Project Search). Regardless of the form of paid employment, the key is for students to have earnings and work experience. For students with disabilities, experiencing this valued social role as an employee is a predictor of post-school employment.

Project SEARCH is a one-year, business-led, unpaid internship program designed to help young adults with disabilities find competitive, integrated employment (CIE). The employment experience takes place entirely at a host business and focuses on total workplace immersion and skills development. Project SEARCH provides intensive, real-world training and support that bridges the gap between school and the job market. Project SEARCH is a growing evidence-based practice with consistently high success rates. According to the program’s website, graduates achieve significantly higher rates of CIE (over 70%) compared to national averages for individuals with disabilities. Project SEARCH, MN currently has nine sites.

Apprenticeship programs are increasingly recognized as a valuable pathway for students with disabilities to gain marketable skills and secure CIE. These "earn-while-you-learn" models combine paid on-the-job training with related classroom instruction, leading to a recognized credential. Registered Apprenticeship Programs (RAPs) are industry-vetted programs approved and validated by the U.S. Department of Labor or a state apprenticeship agency. They typically involve at least 2,000 hours of paid on-the-job training and 144 hours of related technical instruction, with a structured wage progression.

Example: Florida Department of Education's Division of Blind Services: Web Accessibility Specialist Training Program

Web accessibility specialists ensure that websites and digital content are usable by everyone, including people with disabilities. The Florida Department of Education's Division of Blind Services developed the Web Accessibility Specialist Training Program specifically to provide a pathway for blind and visually impaired individuals into the growing field of information technology. The training may also be applied toward further post-secondary education.

Apprenticeships are also a valuable approach to support adults with disabilities in developing work-based learning skills that can be translated into job and career opportunities. The Council of State Governments website includes resources and state examples of inclusive apprenticeship models to support states' growing workforce needs.

Example: LSU Health: Postsecondary Apprenticeship for Youth (PAY Check)

PAY Check is a multi-semester program for young adults with disabilities (ages 18–22), collaboratively run by the Louisiana State University Health Sciences Center's Human Development Center, Louisiana Rehabilitation Services, schools, and employers. The program combines community college coursework, career development, and independent living skills training with two paid 10-week internships to equip participants with the skills and experience needed for competitive, integrated employment and a clear career path. PAY Check provides continued support after job placement.

The Use of Technology to Enhance Independence

Augmentative and Alternative Communication (AAC) devices and other apps may significantly increase the independence of students with disabilities transitioning into adulthood. AAC enables clear communication in education, employment (e.g., interviews, workplace interaction), and daily life, fostering self-advocacy and decision-

making. Other apps support daily living skills (through, for example, visual schedules, budgeting tools, and medication reminders); community navigation (GPS, accessibility maps); social connections; and academic/employment tasks (organizational tools, text-to-speech). Beyond dedicated AAC devices, a range of mainstream and specialized apps can enhance independence and support choice-making. For daily living skills, apps like Choiceworks provide visual schedules to break down tasks (e.g., getting ready and chores), while Medisafe helps manage medication schedules. For community navigation, standard tools like Google Maps offer accessible routing, and specialized apps like Be My Eyes (connecting visually impaired users with sighted volunteers) or Wheelmap (crowd-sourced accessibility information for wheelchair users) facilitate independent travel. Social engagement can be supported by apps like Hiki or Dateability, which are designed for neurodivergent individuals and others with disabilities to find friendships and relationships. Finally, for employment and education, apps supporting organization (e.g., Microsoft To Do), note-taking, or text-to-speech (e.g., Voice Dream Reader) help people manage tasks and access information effectively in academic and workplace settings.

Example: JobPro Series (SimCoach Games)

The JobPro Series is a suite of apps/games designed to teach various aspects of job readiness. JobPro: Get Prepared! focuses on pre-interview steps like researching employers, updating resumes, and choosing appropriate attire. This approach gamifies the preparation learning process. JobPro: Get Hired! simulates the interview experience, helping users practice answering questions, managing body language, and maintaining composure. JobPro: My Life focuses on work-life balance, helping users balance the demands of a job with personal responsibilities.

Example: Virtual Reality Job Interview Training (VR-JIT)

VR-JIT is an evidence-based intervention that uses immersive virtual reality technology to help youth and adults with disabilities practice and improve their job interview skills. Individuals engage in simulated interviews with virtual characters, receiving immediate, objective feedback on aspects like content, communication, and body language. This safe, repetitive practice in a low-pressure environment builds confidence and helps transfer learned skills to real-world interviews, significantly increasing the likelihood of receiving job offers.

Leveraging Pre-Employment Transition Services and Wraparound Models

The Workforce Innovation and Opportunity Act (WIOA) significantly expanded the role of vocational rehabilitation (VR) agencies in supporting students with disabilities. Under WIOA, state VR agencies are required to set aside at least 15% of their federal funds to

provide pre-employment transition services (pre-ETS) to students with disabilities (generally ages 14–22) who are in secondary or postsecondary education. The five core pre-ETS services provided in coordination with VR are: 1) Job Exploration Counseling, 2) Work-Based Learning Experiences, 3) Counseling on Postsecondary Education Options, 4) Workplace Readiness Training, and 5) Instruction in Self-Advocacy. Pre-ETS, under WIOA, are intended to supplement, not supplant, the transition services schools are already required to provide under IDEA. A variety of evidence-informed models can be deployed at the school, district, or state level to promote employment and independence for youth with disabilities.

Examples: Digitability, Start on Success, and RENEW

Digitability is a comprehensive, online, STEM-focused pre-employment transition program designed for students with intellectual disabilities, autism, and Down Syndrome. Often used by schools and transition programs, this program teaches digital literacy, applied tech skills, workplace social and communication skills, self-regulation, resume writing, interviewing, and real-world workplace projects. It aims to prepare students for tech-enabled jobs and increase their employability. Digitability integrates functional academics with practical employment skills using a scaffolded and structured approach.

Start on Success (SOS) is a collaborative model from Virginia designed to provide WBL opportunities to high school seniors with disabilities. SOS emphasizes collaboration between special education; career and technical education (CTE); VR; and the business community. This model incorporates four evidence-based practices: interagency collaboration, a credit-bearing CTE course, a paid internship, and mentorship. The program aims to address the college and career readiness gap for students with disabilities, with 76% of participants from 2014–2019 graduating on time and entering postsecondary education, employment, or military service within one year of graduation.

Resilience, Empowerment, and Natural Supports for Education and Work (RENEW) is an evidence-informed, youth-driven planning process from the University of New Hampshire's Institute on Disability. Designed for transition-aged youth (14–26) with emotional, behavioral, or social challenges, RENEW supports their transition to adult life, including education, employment, and community engagement. This model's structured, four-phase process emphasizes self-determination, natural supports, and relationships, leading to improved outcomes in school engagement, academic performance, and employment. Key features of RENEW include its youth-driven and strengths-based approach, emphasizing self-determination, building natural supports, and fostering relationships.

A variety of currently available models and tools can assist states in designing and implementing pre-ETS. The National Technical Assistance Center on Transition (NTACT) has curated a list of Best Practices for Pre-ETS.

Supporting Pathways to Post-Secondary Education & Training

Pathways to postsecondary education are crucial for students with disabilities to directly address the college and career readiness gap they face compared to their peers without disabilities. Students with disabilities are less likely to attend college or be employed, making such pathways vital for improving their future outcomes. Postsecondary education, whether college, vocational training, or trade school, provides opportunities for students to learn new technical skills necessary for successful careers, earn industry credentials, and prepare for jobs and careers throughout adulthood. In recent years the University of Minnesota created the Minnesota Inclusive Higher Education Consortium (MHEC) to coordinate and support inclusive higher education for students with intellectual disabilities.

- ***Inclusive post-secondary education programs***. Inclusive higher education (IHE) programs designed with students with disabilities in mind are initiatives or programs that provide opportunities for individuals with intellectual or developmental disabilities (I/DD), autism, and other disabilities to experience college life, gain academic and vocational skills, and prepare for competitive employment and independent living. These programs go beyond traditional disability support services by offering a more comprehensive, integrated college experience tailored to students' specific learning and support needs. IHE funding may come from a variety of public, private, and self-pay options. Some IHE programs are embedded within a college or university, while others may be standalone programs. To date, only four IHE programs have been accredited by the Inclusive Higher Education Accreditation Council.
- ***Transition programs for students with intellectual disabilities (TPSID)***. TPSIDs represent a significant federal initiative, funded through grants from the U.S. Department of Education, aimed at vastly expanding postsecondary education opportunities for students with intellectual disabilities. These programs are specifically designed to provide a rich and comprehensive transition experience that extends beyond traditional K-12 special education services. At their core, TPSIDs empower students with ID to access higher education, fostering academic growth through inclusive coursework, developing essential vocational and career-specific skills, enhancing social integration within a college community, and building crucial independent living skills. The success of TPSIDs is evidenced by the improved post-graduation outcomes for program participants with ID, including higher rates of CIE, greater independence in daily life, and more meaningful social connections — as exemplified by successful programs like Virginia Commonwealth University's ACE-IT program (which is no longer TPSID funded). Some TPSIDs, though not all, are designated as "Comprehensive Transition and Postsecondary (CTP) Programs," which allows eligible students to tap into federal student financial aid, such as Pell Grants and federal work-study, thereby making college a more accessible and affordable reality.

Example: Support Education to Elevate Diversity (SEED), University of California, Davis

The UC Davis Redwood SEED Scholars Program is a unique four-year, residential, inclusive college program for students (ages 18–23) with intellectual disabilities. It integrates scholars into campus life with on-campus housing and participation in university activities, fostering social inclusion and independent living skills. Academically, students take specialized courses alongside typical UC Davis classes, working towards a learning credential. The program strongly emphasizes CIE through quarterly internships. With support from peer mentors, SEED guides the student through a person-centered approach, promoting independence, self-determination, and successful employment within a vibrant university setting.

- *Other inclusive higher education programs.* Not all IHE programs have access to federal or state funding. Many programs were conceived and grew through coordinated networks of educators, advocates, families, and policymakers. Many of these colleges and programs have been designed to serve specific populations, in recognition that a college degree or industry certification is a critical step to securing a job and a rewarding career.

Examples: Landmark College; ACE-IT at VCU

Landmark College in Vermont is a unique institution designed exclusively for students who learn differently, including those with dyslexia, ADHD, and autism. Its approach is deeply personalized and skills-based, featuring small class sizes and a cornerstone one-to-one tutorial for individualized academic support. All faculty are highly trained in meeting the needs of these students, applying Landmark's Six Teaching Principles™. Support services, including executive function assistance and assistive technology, are integrated directly into the curriculum and daily college life.

Virginia Commonwealth University's ACE-IT in College Program is an inclusive post-secondary initiative for students with I/DD. Students in the program audit college courses alongside non-disabled peers, participate in internships, and gain independent living skills while immersed in the university campus environment. The program focuses on preparing participants for CIE and a more independent adult life, leading to a certificate of completion rather than a traditional degree. ACE-IT reports a 90% post-graduation employment rate, which is remarkably high. Graduates secure jobs in various sectors, including local businesses and federal agencies. ACE-IT has also been accredited by the Inclusive Higher Education Accreditation Council.

Think College at UMass Boston provides resources, technical assistance, and training related to college options for students with intellectual disabilities, and manages the only national listing of college programs for students with intellectual disabilities in the United

States. A variety of tools, reports, and data are available to assist institutions of higher education, states, and programs in designing and implementing inclusive post-secondary programs.

Supporting Financial Independence and Self-Determination

Financial literacy and self-determination are critically important skills for students with disabilities to develop during their transition years, as they are foundational for achieving independence, competitive employment, and a fulfilling adult life. These two skill sets empower students with disabilities to navigate the complexities of adulthood, take control of their financial well-being, and actively shape their own educational, vocational, and personal futures, rather than having decisions made for them. Pre-ETS, covered above, can support students to develop self-advocacy and self-determination skills and should be cross-referenced here.

Example: Self-Determined Learning Model of Instruction

The Self-Determined Learning Model of Instruction (SDLMI) is an evidence-based instructional model designed to foster self-determination skills in students with disabilities. SDLMI is a multi-step, collaborative process that emphasizes student-led goal setting and achievement. The model typically involves three phases of questions that students answer, often with the support of a teacher or facilitator: 1) What is my goal? 2) What is my plan? and 3) What have I learned? Through this cyclical process, students learn to define their own goals, develop and implement strategies to reach them, monitor their progress, and evaluate their outcomes. This iterative process helps students internalize skills in decision-making, problem-solving, self-advocacy, and self-regulation. Research, including randomized controlled trials, has consistently shown that implementing SDLMI leads to increased student engagement, academic achievement, and improved post-school outcomes such as higher employment rates and greater independence.

In addition to the SDLMI, several other research-based curricula and approaches contribute to developing self-determination skills, including the ChoiceMaker Curriculum, which encompasses modules such as the "Self-Directed IEP" to help students participate meaningfully in their individualized education program (IEP) meetings; ME! Lessons for Teaching Self-Awareness & Self-Advocacy, designed for high school students to build critical knowledge and skills during transition years; Whose Future Is It Anyway?, a student-directed transition planning process emphasizing identification of preferences, interests, and needs, and the development of problem-solving, decision-making, goal-setting, and communication skills for post-school life; and the Take Charge Curriculum, an evidence-based practice that integrates student coaching, mentorship, peer support, and parent support to teach self-determination skills, with studies showing positive outcomes for students across various disability categories.

Many youth with disabilities receive public benefits, including Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid. Earnings and assets can affect eligibility for these benefits, creating a significant disincentive for people with disabilities, including youth, to engage in employment. Please reference the Topic 2: Employment for more about best practices related to benefits counseling and ABLE accounts.

Example: Better Money Habits

Better Money Habits, a free financial education platform by Bank of America in partnership with Khan Academy, offers comprehensive resources on budgeting, saving, and money management. Available in English and Spanish, the program provides videos, articles, and interactive tools for self-paced learning, and facilitates in-person or virtual workshops led by volunteers and community partners. The overarching goal is to empower individuals to make confident financial decisions and achieve greater economic independence.

Opportunities

The policies, programs, and strategies discussed in this chapter can significantly aid a state in addressing critical challenges related to education, community integration, and employment for individuals with disabilities within Olmstead planning. These practices may improve coordination of services by integrating state data systems to ensure seamless service delivery across education, health, human services, juvenile justice, child welfare and employment agencies, while also fostering increased partnerships between schools and VR agencies for comprehensive support. Ultimately, these approaches contribute to achieving equitable, positive outcomes and promoting community integration by emphasizing LRE to educate students with disabilities alongside their non-disabled peers, utilizing person-centered approaches to tailor services, and prioritizing independence and active engagement in community life, thereby fulfilling the core tenets of *Olmstead*.

Implementation Considerations

When implementing the best practices described in this section, a state or service delivery system must consider several crucial factors to ensure equitable outcomes and promote community integration. These include directly addressing systemic barriers such as insufficient staffing, training, resources, and attitudinal or funding issues. It is vital to guarantee that all students with disabilities have access to a full range of necessary services and supports to succeed within the general education curriculum, regardless of disability type or severity. Robust interagency collaboration and integrated state data systems across education, health, human services, and VR are essential for seamless

service delivery, informed policymaking, and efficient resource allocation, while also accounting for data governance and privacy. Special attention should be given to specific populations of concern, like youth involved in the juvenile justice system, those experiencing homelessness, immigrants/refugees, those with co-occurring disabilities, students experiencing behavioral health challenges and/or autism, or youth involved in child welfare, who often require tailored support. Finally, continuous improvement and accountability mechanisms must be in place to monitor, evaluate, and adjust policies and programs to ensure their effectiveness in achieving desired outcomes.

Evaluating Impact and Investments

To evaluate the impact and effectiveness of the best practices described in this chapter, a state could consider implementing a robust system of data collection, analysis, and feedback in the following ways:

- *Integrating state data systems*: Integrate data across various state agencies, including education, health, human services, child welfare, juvenile justice and VR.
- *Tracking post-school outcomes*: Systematically collect and analyze data on key outcomes for youth with disabilities after they leave school; many of these outcomes are included in state IDEA compliance monitoring. Include:
    - Employment rates
    - Post-secondary education
    - Independent living
    - Health and well-being
- *Monitoring implementation fidelity*: Assess whether the best practices are being implemented as intended. This involves looking at the quality-of-service delivery, adherence to program models (e.g., fidelity to SDLMI, proper implementation of pre-ETS components), and ensuring that LRE principles are genuinely applied.
- *Gathering stakeholder feedback*: Regularly collect qualitative and quantitative feedback from diverse stakeholders, including students with disabilities themselves, their families, educators, employers, and service providers.
- *Conducting longitudinal studies*: Follow cohorts of students over time to understand the long-term impact of specific interventions and best practices on their lives, gaining a deeper understanding beyond immediate post-school outcomes.
- *Performing cost-benefit analysis*: Evaluate the economic impact of investing in these best practices, comparing the costs of implementation with the long-term benefits to individuals (e.g., increased earnings, reduced reliance on public support) and to the state (e.g., increased tax revenue, reduced health care costs).

- *Establishing clear metrics and benchmarks*: Define specific, measurable, achievable, relevant, and time-bound (SMART) metrics for each best practice and set clear benchmarks or targets for improvement.

By combining these methods, a state can gain a comprehensive understanding of the impact and effectiveness of its efforts to implement best practices for students with disabilities, informing policy adjustments and resource allocation to ensure continuous improvement.

Cultural Responsiveness

Meeting the needs of diverse students in special education can be difficult because practices are often based on Western concepts of disability, medicine, and inclusion. These ideas may clash with non-dominant cultural values. The Western approach highlights individualism, a medical model of disability, and direct communication. This contrasts with some cultures' collectivistic perspectives, different interpretations of disability, and preferences for indirect communication and extended family involvement. Cultural mismatches like these can cause misunderstandings, ineffective interventions, family disengagement, and ongoing educational disparities, making it hard to serve all students effectively.

Informed by Lived Experience

The approach to transition to adulthood in this report is deeply informed by lived experience. This stems from the *Olmstead* mandate itself, which prioritizes community integration based on individuals' choice and independence. The feedback provided to OIO through the quality-of-life survey helped frame key areas of focus. Our emphasis on person-centered approaches and self-determination directly incorporates individuals' preferences and goals. Furthermore, the expertise of the Inclusion Consultants, national experts, and authors with extensive backgrounds in disability services inherently includes knowledge gained from working with and learning from people with lived experience. Addressing populations of particular concern acknowledges the diverse lived realities that shape effective strategies.

Challenges

When considering the best practices and promising examples described in this report section, the state of Minnesota faces significant challenges, including a persistent lack of appropriate staffing (i.e., educators, paraeducators, and administrators); insufficient training and resources for educators and service providers; initiative overload; and pervasive attitudinal barriers. Pervasive low expectations for youth with disabilities to be employed or pursue higher education are a major obstacle that can undermine efforts to promote independence and career readiness. Systemic issues related to funding

models and accountability further impede effective implementation, often exacerbated by competing priorities across the state that divert resources. Finally, significant reductions in federal support for this population can critically limit the capacity to fund and sustain crucial programs.

Key Informants & Subject Matter Experts Consulted on Education & Olmstead Planning

Key Informant or Subject Matter Experts Interviewed	Date & Venue/Modality	Topic(s)
Christine May, Ohio Department of Education and Workforce	June 2025, Virtual	Ohio Healthy Students data
John Eisenberg, NASDSE	June 2025, Virtual	States moving the needle on inclusive education practices, and CIE
Gretchen Godfrey, The Pacer Center	June 2025, Virtual	Current *Olmstead* education goals, family engagement
Daron Korte and **Thomas Delaney,** Minnesota Department of Education	June 2025, Virtual	School-wide supports, special education, PBIS
Eric Kloos, Minnesota Department of Education	June 2025, Virtual	School-wide supports, special education, PBIS
Paul Hyry-Dermoth, Bridge for Resilient Youth in Transition (BRYT)	June 2025, Virtual	Best practices in supporting youth transition to/from 24-hour level of care
Steve Schmidt, NHeLP	June 2025, Virtual	Current *Olmstead* education goals
Taylor O'Shea, **Mercedes Elder**, Inclusion Consultants, Dendros Group	June 2025, Virtual	Current *Olmstead* education goals, workforce development, LRE
Alyssa Klien (DEED), **Carrie Marsh** (DEED) & **Sarah Robinson** (MDE)	June 2025, Virtual	System coordination for transition-age youth, outcome tracking, public/private data reporting, LEA training & coaching
Judy Averill, Director for Center on Transition Innovations, Virginia Commonwealth University:	June 2025 (Virtual)	Best practices in transition services

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Topic 2: Employment

Virginia Selleck, Ph.D., has worked in psychiatric rehabilitation for over 40 years and has experience in recovery systems reform, program development and implementation, funding issues, legislation, and policy.

Kelly Nye-Lengerman, Ph.D., M.S.W., has worked in disability and employment services for over 25 years as a direct service provider, supervisor, educator, and researcher. She has designed, implemented, and evaluated employment interventions and policy approaches to advance competitive, integrated employment.

Overview of Employment & Olmstead Planning

Supporting people with disabilities to obtain and retain employment requires extensive and sustained cross-agency communication, coordination, and collaboration. All entities should be clear on the concept that employment is a social determinant of health (SDOH). It follows that employment outcomes should be reflected in the goals and objectives of all departments, as opposed to seeing employment as a "boutique" service for only a subset of persons served. Minnesota has stated an interest in a "transformative" approach to Olmstead planning. Addressing employment as a foundational responsibility of all state agencies would transform the system.

Minnesotans' needs for help in gaining and retaining employment fall on a continuum. Some individuals may use self-guidance or "light touch" assistance, referrals, and follow-along. Others need and want intense and ongoing supports and services. The state system must be able to identify employment needs across populations, offer individualized person-centered planning, and titrate services efficiently and consistently. Some people will need services across programs due to experiencing multiple needs. This is challenging.

A granular analysis of all Minnesota's employment-related programs and services is beyond the scope of this chapter; rather, we briefly describe both fully supported evidence-based practices, as well as promising models that would require closer examination before Minnesota might choose to enhance, adopt, or customize them. Considerations for each approach, associated strengths and weaknesses, and how each might most effectively be incorporated into Minnesota's *Olmstead* efforts are noted throughout.

"Employment is key to inclusion and purpose." —Dendros Inclusion Consultant

Subtopics

In this report section, we discuss evidence-based, best, and promising practices, many of which benefit all people with disabilities, while some are geared to specific disabilities, levels of need, and other parameters, such as age or other personal characteristics. We offer examples of overarching practices demonstrating how government works together to implement these practices and make employment services available.

The models, practices, and strategies discussed in this report section share several commonalities:

- *Person-centered*: Employment approaches must first apply an individual's preferences and needs.
- *Strengths-based*: An individual's strengths should always be highlighted and considered.
- *Informed choice*: An individual must always be informed of options and can change their choices.
- *Culturally responsive:* Employment approaches should consider multiple dimensions of the person's identity.
- *Trauma-informed:* Employment supports can be provided in a way that recognizes and respects how an individual's experience with trauma may impact how they navigate the world.

Populations of Particular Concern for Employment & *Olmstead*

Minnesota has a robust and diverse network of home- and community-based service (HCBS) providers who deliver day and employment services for people with intellectual and developmental disabilities (I/DD). A partially overlapping network of community rehabilitation providers (CRPs) also provides employment services through contacts with Minnesota Vocational Rehabilitation (VR). Over the last decade, the state's Department of Human Services (DHS), Department of Employment and Economic Development (DEED), and Department of Education (MDE) have sought to improve collaboration and ensure that individuals who want to work have a pathway and support to do so. Minnesota's E1MN partnership showcases the value of interagency collaboration, and has focused on advancing Employment First principles since the Olmstead Subcabinet adopted the state's Employment First policy statement in 2014. These agencies have made great strides to coordinate information and service delivery, particularly for transition-aged youth and some waiver populations. Transition-age youth and emerging adults require customized attention, and we note programs of interest for them below. School-to-work transition is discussed in Topic 1: Education.

People with mental health diagnoses and issues have received employment services in Minnesota primarily through DEED rehabilitation services contracts. This population is not typically served by Medicaid HCBS Waivers due to the federal rules, which have excluded people served in Institutes for Mental Disease (IMDs). Typically, mental health services in the community have been supported by the Medicaid

Rehabilitation Option (MRO), designated in Minnesota as Adult Rehabilitative Mental Health Services (ARMHS). While there is some very minimal language referencing supporting employment in the policies and rules describing ARMHS, the state has chosen a relatively constrained interpretation of the federal rules regarding the MRO. Creative partnerships between CRPs and mental health centers have created a network of evidence-based supported employment programs in Minnesota. However, they are not available in all counties and cannot fully meet demand for people requesting services. The state's previous Olmstead Plan included a goal of increasing employment for people who use Medicaid, but today, the development of a new Olmstead Plan creates the opportunity to include additional populations of interest.

Veterans often need employment supports and services due to the unique challenges faced during their transition to civilian life. These can include difficulty translating specialized military skills into civilian job market language, a potential lack of understanding among employers regarding the value of military experience, and the need to adjust to a different workplace culture and structure. Some Veterans may be managing service-connected health issues, both physical and mental, which can result in barriers to securing and maintaining stable employment.

For **all people with disabilities**, employment can affect the receipt of public benefits such as Medicaid or Supplemental Security Income (SSI). However, there are many programs, tools, and strategies to support employment without impact on other public benefits that are not well understood by people receiving benefits or by service providers. The fear of loss of benefits when working keeps most people with disabilities from being employed or fully employed. Misinformation often thwarts people who want to work. People with lived experience and their families and caregivers report concerns and confusion about retaining entitlements and benefits. We heard this clearly from the Inclusion Consultants, who shared their own experiences and relayed those of others. Literature, anecdotal experience, and employment outcomes reveal that support professionals (case managers and others) are often equally confused or unable to provide accurate and timely information across various programs. Due to the fears of caregivers and family, people with disabilities sometimes choose to work "just enough" to retain benefits, which may still result in a life on the brink of poverty. Further, employment is a path to health, beyond financial gains. This is important to convey to persons served and their families and caregivers.

Minnesota continues to prioritize competitive, integrated employment (CIE) through multiple statewide investments like E1MN and the MN Transformation Initiative. There are several best and promising practices Minnesota may consider expanding or adding to improve rates of CIE across all populations, enhance provider networks, and leverage business and community connections.

Employment & *Olmstead* in Minnesota

Minnesota is an Employment First state, with the Olmstead Subcabinet approving the policy statement in 2014. During the 2020 first special session, the state legislature added Employment First language to state law, writing…"*It is the policy of the state that all working-age Minnesotans with disabilities can work, want to work, and can achieve competitive integrated employment, and that each working-age Minnesotan with a disability be offered the opportunity to work and earn a competitive wage before being offered other supports and services."*

Historically, many of Minnesota's HCBS employment services providers maintained a Department of Labor subminimum wage certificate (i.e., 14c certificates). At one point, Minnesota had nearly 16,000 individuals earning subminimum wage, one of the highest rates in the nation (WINTAC, 2020). Minnesota's Olmstead Plan advanced several priorities to reduce the use of subminimum wages and offer supports for CIE. Several state agencies have made substantial efforts to modernize employment services and provide coordinated supports to maximize CIE for all. DHS, in partnership with other agencies, advocates, and providers, developed an updated menu of employment services along with reimbursement rates that were more in line with market costs. In a 2022 brief for Minnesota's Task Force on eliminating subminimum wages, staff from the DHS Disability Services Division and Management Analysis and Development (within the Department of Management and Budget) estimated 4,500 to 6,000 subminimum wage earners in the state (page 2). Significant progress has been made across the state to reduce the number of subminimum wage earners.

Currently, Minnesota continues to invest in building capacity to increase CIE rates (through such programs as E1MN and the MN Transformation Initiative), and while there has been marked growth in CIE, many who want or need employment services are unable to access them for a variety of reasons, including workforce shortages, provider waiting lists, lack of local providers, closed categories in VR (due to Order of Selection), and divergence of preference with a parent/guardian. Minnesota closed service categories 2, 3, and 4 on April 7, 2025; the state is currently serving individuals in category 1 (Minnesota Department of Employment & Economic Development, 2025).

Effective Employment-Related Policies, Programs, and Strategies

2A: Individual Placement and Support

In behavioral health, the gold standard evidence-based practice for helping people get and keep jobs is Individual Placement and Support (IPS). IPS is a model of supported employment (SE) for people with serious mental illness (SMI). IPS-SE helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations exist, IPS refers to the evidence-based practice of supported employment.

Mainstream education and technical training are included as ways to advance career paths. IPS is based on these eight principles:

1. Competitive Employment
2. Systematic Job Development
3. Rapid Job Search
4. Integrated Services
5. Benefits Planning
6. Zero Exclusion
7. Time Unlimited Supports
8. Worker's Preferences

Minnesota is a member of the International IPS Learning Community (LC), which is composed of 26 states; the District of Columbia; Alameda County, California, Broward County, Florida; and seven countries and regions outside the United States. The LC collects quarterly data uniformly from all these entities. Minnesota excels in outcomes, having the highest rate of employment in the LC. In Minnesota, the rate is 59% compared with the LC average of 44%. (It should be noted that the National Research Institute (NRI) reports an employment rate of about 20% of adults with SMI nationally.) Minnesota prepares an biennial report on the IPS program which contains the history and growth of the program, funding of the service, outcomes, distribution of the services, and provider profiles.

This report also provides demographic data concerning the prevalence of SMI in Minnesota in the working age population. The report notes that the number of persons served (1,151 from 2023 to 2024) represents less than 2% of the people who could benefit. Minnesota is hampered in the full implementation of the IPS practice by insufficient funding, which is provided primarily via DEED Rehabilitation Services contracts. Minnesota could boost funding for IPS by following the practices of many other states that use the strategies of braiding and sequencing several funding sources, particularly Medicaid, to fund the medically necessary elements of the program, or by funding the total service through the Certified Community Behavioral Health Clinics (CCBHCs) as is being done in Oklahoma and explored in other states. The U.S. Department of Labor's Office of Disability Employment Programs (ODEP) recently published guidance for states seeking to overcome barriers in funding.

Strengths of IPS

IPS has been thoroughly researched using randomized controlled trials, the most rigorous type of study. More than 28 studies have demonstrated IPS's advantage over other practices, and the number of studies showing IPS effectiveness continues to grow, showing positive long-term outcomes. Studies are also exploring cost effectiveness. Compared to usual services, IPS has superior employment outcomes on numerous criteria. IPS shows 33% fewer days to first job; four times as many weeks worked during follow-up; triple the earnings from employment; triple the number working 20 hours/week or more, and greater job satisfaction (Bond et al., 2020).

Opportunities with IPS

Minnesota has several opportunities to increase the penetration of IPS. First, the state could consider using the mechanisms of the CCBHCs to fund the practice and include its elements in the cost base of the Prospective Payment System. Some states have followed this path, Oklahoma in particular. Second, Minnesota could use the strategies of braiding and sequencing funds between Medicaid (via ARMHS), VR, and potentially county contributions. Many states have used this method.

The use of IPS has been found effective for people with traumatic brain injury and young adults with anxiety and depression. Researchers are exploring its use with people who have intellectual disabilities, autism spectrum disorders, and chronic medical conditions (Bond, 2020).

Implementation Considerations for IPS

Minnesota is in the enviable situation of having some excellent IPS programs, as well as training technology for standing up the practice. Minnesota's participation in the LC provides further technical assistance. There would be considerable policy work connected with either of the above opportunities, but the challenges should not be insurmountable.

Evaluating the Efficacy of IPS

IPS includes a fidelity component that has been correlated with better employment outcomes; that is, the more closely programs adhere to fidelity, the more participants find employment. The metrics are collected quarterly and submitted to the LC, which tabulates and shares the outcomes broadly. At the state level, Minnesota could potentially match the outcomes of IPS with Medicaid status to evaluate how employment affects health care spending.

Person-centered planning, informed choice, and cultural responsiveness in IPS

The keystone of IPS is its person-centeredness. Client choice and preferences for types of employment and the subsequent activities of the staff create an individualized experience.

How IPS was informed by lived experience

The literature about IPS details how years of client input have shaped the program. The element of "zero exclusion," meaning that anyone who wants to work is considered an appropriate client, came partially from the experiences of people being told they were "not ready" or staff using their clinical or historical attributes to exclude them.

Challenges in IPS

The first challenge will be to commence interdepartmental discussions to clarify and endorse the need for more IPS. With this structure in place, stakeholders can work together through the details of multiple rules, policies, and bulletins to determine the

levels at which barriers arise. Some perceived barriers may turn out to be historical ideas, rather than codified rules.

2B: Customized Employment

Customized Employment (CE) is a personalized approach to CIE and self-employment, creating mutually beneficial relationships between employees and employers. This universal strategy supports a wide range of individuals, especially those with disabilities and those who have complex barriers to employment (e.g., justice-engaged and disconnected youth, Veterans, individuals with substance use disorders) and may not have thrived using other employment methods. There are four components to CE: Discovery, job search planning, job development and negotiation, and post-employment support. CE was formally incorporated into Title IV of the 2014 Workforce Innovation and Opportunity Act (WIOA) as a recognized strategy under the definition of supported employment. The states with the highest rates of integrated employment for adults with I/DD, as reported by state I/DD agencies, are Washington (83%) and Oklahoma (68%); Minnesota reports 33% (Winsor et al., 2025).

Over the last 10 years, Minnesota has invested heavily in increasing knowledge, access, and uptake of customized employment. The state's E1MN partnership demonstrates this along with many training and technical assistance programs DHS and DEED have offered to providers, schools, and individuals across the state. Minnesota's use of CE is increasing but there is still room for considerable growth across populations, lead agencies, and providers.

Strengths of Customized Employment

CE offers significant strengths by creating a mutually beneficial, personalized employment relationship. For job seekers of any type, CE is highly effective for individuals with significant barriers, as it is person-centered, matching jobs to each person's unique strengths and interests and leading to competitive, integrated, and sustainable employment. In some cases, CE can support self-employment and entrepreneurial endeavors. CE components also foster independence and self-esteem. In turn, CE helps businesses by identifying and filling unmet needs with dedicated employees, tapping into a previously unrecognized talent pool, and improving business productivity, retention, and workplace diversity.

Implementation Considerations for Customized Employment

Being trained and/or certified to provide CE is crucial for today's employment professionals due to a fundamental shift in how we approach employment for diverse populations. Historically, employment expectations for individuals with disabilities were low, often leading to segregated settings like sheltered workshops. Customized Employment, however, champions CIE, which demands a new set of specialized skills. Professionals need training in areas like discovery (uncovering unique strengths), business negotiation (creating custom jobs), and person-centered planning to genuinely facilitate positive outcomes.

Specialized training isn't just about best practices; it's also about meeting benchmarks and achieving outcomes. Ultimately, proper training ensures the quality and fidelity of CE services, maximizing successful employment outcomes for individuals and providing tangible benefits for employers. Including this element of CE can continue to move Minnesota decisively beyond segregated models of thinking and service delivery, building a skilled workforce.

Opportunities with Customized Employment

CE effectively supports diverse populations facing employment barriers by tailoring jobs to individual strengths and employer needs. CE's strength is its adaptable approach, moving beyond typical hiring limitations to create a successful, personalized fit between diverse job seekers and employers.

Evaluating the Efficacy of Customized Employment

Fidelity of implementation in CE is vital to maximize its potential for positive outcomes. Deviations from the model may significantly hinder success. To ascertain whether CE is improving employment outcomes, a state could monitor data in several areas. Currently, many of these data points are collected for some, but not all, populations.

Employment Outcomes

- Number/percentage of individuals achieving CIE
- Wages and hours worked (average, median, and change from baseline)
- Job retention rates (e.g., 90-day, 180-day, 1-year retention)
- Benefits received by individuals (e.g., health care, retirement)

Quality of Employment

- Job satisfaction (for both employee and employer)
- Career advancement or wage increases over time
- Degree of integration within the workplace

Process Fidelity

- Adherence to the four CE components (Discovery, Job Search Planning, Job Development and Negotiation, Post-Employment Support) using established fidelity scales
- Completion rates and quality of Discovery profiles.
- Number and success rate of informational interviews and customized job negotiations

Efficiency/Resource Utilization

- Time to job placement
- Cost per successful placement

Workforce Capacity

- Number of trained professionals

- Number of trainings offered
- Type of setting and population served
- Turnover and vacancy rates in CE-related positions

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Customized Employment

CE is inherently person-centered because its foundational step, "Discovery," involves deeply exploring an individual's unique strengths, interests, talents, and ideal conditions for employment. The entire process is driven by the job seeker's choices and aspirations, building a job around them rather than fitting them into a pre-defined role.

The model is culturally responsive by nature because the person-centered approach encourages understanding and integrating an individual's cultural background, values, community connections, and family dynamics into the Discovery and job development process. This ensures that the employment path and job match are not only personally meaningful but also respectful of and aligned with each person's cultural context and identity.

How Customized Employment was Informed by Lived Experience

CE is shaped by an individual's lived experience through its Discovery process. This means professionals delve into a person's unique life journey, including their passions, informal skills, daily routines, and social connections. This first-hand knowledge directly informs and guides the customization of job tasks and work environments, ensuring a truly personal and sustainable job match. Inclusion Consultants mentioned that access to CE is limited across the state, with only some providers able to offer the service and many disabled people not knowing it was available either through VR or DHS. They identified CE as an important option for job seekers with disabilities.

Ways for Customized Employment to Collaborate across State Government

To implement CE programs and training effectively, states must actively break down silos through interagency collaboration:

- *Unified leadership and vision*: Establish a high-level state champion and an interagency council (e.g., VR, DD, Workforce, Mental Health) to set a vision for CE shared by all relevant agencies. Minnesota's Employment First policy is an important component.
- *Aligned policies and funding*: Jointly review and revise policies, blend funding streams, and agree on common definitions and outcome metrics to ensure consistent support for CE.
- *Cross-agency training*: Develop or adopt common CE competency models and conduct joint training and certification programs for staff from all participating agencies, building a shared language and skill set. Minnesota Vocational Rehabilitation Services (MN VRS) has developed its own CE training, but it is unclear at this writing port how readily available it is across the state.

- *Integrated service delivery*: Promote co-located staff and, where possible, shared information systems to streamline referrals and service coordination, so individuals can experience seamless support. While robust resources are available through DB101, this does not mean they are universally understood or used across populations. Integrated delivery should be part of each person's experience of their services. While internal activities in some state agencies are shared or coordinated, it does not necessarily result in coordinated support in the field for individuals.

Challenges in Implementing Customized Employment

Overcoming these challenges requires continued commitment to innovative funding models; expanding to serve additional *Olmstead* populations of interest; ongoing investment in workforce development; and robust interagency collaboration. Components of CE are available through Minnesota's employment services; however, not all Minnesotans are eligible to receive these services.

Cost and Funding Structures

- CE is often more intensive and time-consuming per individual than traditional placement models, especially in the discovery and negotiation phases. This can lead to higher upfront costs per person. The DHS-funded Employment Development Service does include a higher reimbursement rate.
- State funding mechanisms, like VR or Medicaid waivers, may not be adequately structured or reimbursed at rates that fully cover the true cost of comprehensive CE services (e.g., extensive discovery, prolonged job development, ongoing negotiation). Some rates are low, making it difficult for providers to sustain quality services.
- Securing braided or blended funding from multiple agencies is complex and often requires navigating different eligibility rules and reporting requirements.

Workforce Availability and Turnover

- There is a significant shortage of adequately trained and certified CE specialists. The unique skills required for discovery, business negotiation, and person-centered planning are not typically covered in general employment service training. E1MN continues to offer CE training.
- High turnover rates among employment support professionals, often due to low wages paid by provider agencies (which are tied to low reimbursement rates), make it hard to retain experienced staff.
- Training itself is an investment of time and money, which agencies may struggle to provide.

Providers Payment Rate

- Reimbursement rates for CE services, set by state agencies, are frequently insufficient to cover the actual cost of delivering high-quality, individualized services.

This disincentivizes providers from offering CE or forces them to cut corners, reducing fidelity.

- Rates may not differentiate adequately between the intensive phases of CE (like discovery) and less complex job placement services, underpaying for the specialized expertise CE demands.

Waiting Lists and System Capacity

- Due to the individualized nature and resource intensity of CE, providers often have limited capacity, leading to long waiting lists for individuals seeking services. This delays access to employment for those who could benefit most.
- Scaling up CE programs statewide can be challenging due to the need to expand both funding and the specialized workforce simultaneously.
- MTI, reports from the Task Force on Eliminating Subminimum Wages, and state data gathered through National Core Indicators on I/DD and autism disorders can provide insight into the scope of service access and employment support staff shortages.

Systemic and Policy Barriers

- Lack of a clear, unified vision or prioritization of CE across *all* state agencies and provider networks hinders collaborative efforts and resource allocation. E1MN continues to provide a coordinated effort, but it could be expanded to include additional state agencies and populations.
- Inconsistent policies, definitions, and data collection methods across agencies create administrative burdens and make it difficult to measure collective impact. For example, previous Olmstead reporting and Employment First dashboards have not universally included rates of employment, CIE, employment service access for individuals with mental health conditions, substance use disorder, justice involved, Veterans, and out-of-school youth. See 2I below for consideration of an Employment First office, which could address this issue.
- Standardized definitions of participation in integrated employment across populations can provide a more precise understanding of the rates of integrated employment. Currently, Minnesota uses an individual's receipt of $600 per month as a proxy measure for determining participation in integrated employment.
- Resistance to change from traditional employment models, both within agencies and among some stakeholders (e.g., families or older providers still accustomed to segregated settings), can slow adoption.

Employer Engagement

- While CE benefits employers, initially engaging businesses to consider customizing roles can be challenging, as this practice requires a different mindset than traditional hiring. Employment specialists need strong business acumen to identify and articulate unmet business needs.

2C: Progressive Employment

Progressive Employment (PE) is a unique model designed to benefit both job seekers and businesses simultaneously. It centers on work-based learning strategies, which means using activities directly in real workplaces to introduce job seekers to potential employers. This approach quickly immerses job seekers in actual work settings, helping them make informed choices as they develop their career goals. For businesses, the PE model provides a variety of flexible options for meeting, interacting with, and effectively "trying out" a new pool of potential job applicants.

Models such as PE and IPS take the approach that job seekers are ready now, and leverage skills, networking, and matching to increase employment. Early adopters of the PE model include the Vermont Division of Vocational Rehabilitation, the Oregon Commission for the Blind, the Maine Bureau of Rehabilitation Services, and the Nebraska Division of Vocational Rehabilitation. Program details and success stories can be found at Explore VR.

Strengths of Progressive Employment

The PE model focuses on improving employment outcomes for individuals with disabilities by providing a flexible and individualized approach to job development and support. It emphasizes a dual-customer approach, considering the needs of both job seekers and employers. PE leverages work-based learning to rapidly engage job seekers and meet business needs, leading to improved employment outcomes, high employer satisfaction, and a collaborative environment.

Implementation of Progressive Employment

PE offers a flexible, replicable model that can increase integrated employment rates and that is adaptable to diverse agency structures, fostered through peer-to-peer learning collaboratives that also develop valuable resources. MN VRS is currently engaged in a PE pilot with funds provided by the U.S. Department of Education and is engaging job seekers through Career Force Centers in Apple Valley, Rochester, Willmar, Winona, and Woodbury.

Evaluating the Efficacy of Progressive Employment

To evaluate PE, states should track employment outcomes (e.g., job placement, retention, wages), business engagement and satisfaction, and fidelity to the model's core components and processes.

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Progressive Employment

PE is inherently person-centered as it facilitates informed career choice through real-world work experiences and adapts to individual needs and preferences; its flexibility also supports cultural responsiveness by accommodating diverse backgrounds.

How Progressive Employment is informed by lived experience

PE utilizes actual work experiences as a practical form of assessment and career exploration, allowing individuals to build skills, confidence, and self-esteem in real-world settings, directly addressing challenges like lack of experience or stigmatizing histories.

Challenges in Implementing Progressive Employment

PE is a relatively new model of employment support with a growing body of data and evidence. PE shares some similarities with CE, but differences between the models can be confusing to teams, administrators, and policymakers. Implementation faces hurdles such as ensuring adequate funding and reimbursement rates, addressing a shortage of trained staff, managing waiting lists, overcoming systemic and policy barriers, and effectively engaging employers in new recruitment approaches.

Example: Maine Department of Labor

Progressive Employment, a strategy first developed in Vermont and now widely used in Maine, helps both job seekers and employers. It assists individuals in gaining skills and experience through practical, work-based activities like interviews and paid work. For businesses, it offers a low-risk way to find motivated talent. A key component of this model is the "Jobsville" meetings. What makes Progressive Employment truly unique is its collaborative team approach. Picture this: Every two weeks, a dedicated group of professionals — including VR counselors, community rehabilitation providers, and business account managers — convene at "Jobsville" meetings. These aren't just your average meetings; they're vibrant hubs where referrals are made, progress is celebrated, and crucial labor market insights are shared. This coordinated effort ensures that job seekers receive comprehensive support, and employers find quality matches. To learn how this system works, training modules created by UMass Boston are available for both practitioners and job seekers.

2D: Clinical Connections: Assertive Community Treatment and First Episode Psychosis Programs

First Episode Psychosis (FEP) and Assertive Community Treatment (ACT) programs are designed to support individuals with mental health conditions in many aspects of their lives. Employment supports are a key component of both these models' recovery-oriented approach. ACT, an evidence-based practice, uses a total team-based intervention that provides employment, psychiatry, substance use disorder (SUD) treatment, housing supports, and general social support to people who have experienced multiple psychiatric hospitalizations and hospital emergency department visits, and who do not thrive with routinized care. Research has demonstrated that the practice reduces hospital visits and length of stay significantly compared with treatment as usual. Minnesota also supports one Forensic Assertive Community Treatment (FACT) program focusing on individuals who have been diagnosed with thought

disorders and are involved in the criminal justice system. Individuals referred to FACT are on probation or being released from a correctional facility at the time of enrollment.

Please see Topic 6: Positive Supports for additional information about ACT.

FEP programs are modeled on a team approach that includes specialists covering a broad range of needs. These programs are designed to provide early intervention and treatment for people at risk of, or experiencing, their first psychotic episode. The programs offer a multidisciplinary, coordinated approach, bringing together specialists offering psychotherapy, medication management, family education and support, case management, and education and employment supports**.** Several Minnesota providers currently offer FEP services.

Strengths of Clinical Connections in ACT and FEP programs

Both FEP and ACT programs recognize that employment is not just about earning money, but also about recovery, self-esteem, social inclusion, and a sense of purpose. By integrating specialized employment services directly into their comprehensive treatment models, these programs significantly increase the likelihood that individuals with mental health conditions can find and maintain meaningful work. This total team approach can produce employment results similar to those of IPS; however, in both instances, the strength of the employment emphasis determines the robustness of the employment outcomes.

Opportunities with ACT and FEP Programs

While ACT is an appropriate service for a defined group of people with especially challenging issues, it incorporates employment strategies within a total team approach, which is a hallmark of the IPS evidence-based practice described above. Many people in the past have failed to receive care early and went on to experience a lifetime of psychotic episodes and poor functioning. ACT and FEP models support shared decision-making and informed choice. Sharing decision-making, using a person-centered approach and including family and significant others, brings the lived experience of people served in the program to bear on treatment choices.

Implementation Considerations for ACT and FEP Programs

It is not uncommon for ACT team Employment Specialists to be pulled into more general case management tasks. It is the responsibility of team leaders to protect this aspect of team operations. Financing for the employment parts of the service typically requires scrutiny, depending upon which Medicaid source is supporting the team. States can use general revenue to supplement this part of the service if needed. Broad implementation requires training staff, organizing the team, and reducing silos in services. As with other interventions involving multiple departments and service providers, leadership and clear mission identification, along with funding considerations, are all key to successful collaboration.

Evaluating the Efficacy of ACT and FEP Programs

The research base for ACT and for its ongoing evaluation typically rests upon data collected by the teams and forwarded to the state program manager, who ensures the service is adhering to fidelity and is reporting outcomes in important domains such as emergency department use, inpatient hospitalization, and housing and employment status. Metrics for evaluation include symptom reduction, functional improvement, treatment adherence, and quality of life. Additional measures include patient and family satisfaction and cost effectiveness. Programs use standardized metrics as well as measures of employment and education.

Challenges of ACT and FEP Programs

As state mental health systems improve generally, it is necessary to titrate the use of ACT appropriately. Some states choose “ACT light,” using some but not all specialist positions (such as not requiring a psychiatrist as lead, or other variations).

In rural regions, early identification of potential clients can be difficult, due in part to the stigma surrounding mental illness and to denial on the part of families and persons served. Due to struggles with accessibility of providers, there may be limited movement between levels of care, and across child and adult systems.

2E: Benefits Counseling and Planning

Benefits counseling helps people with disabilities understand how working will affect their federal and state benefits, such as Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, and Medicaid. The primary role of such counseling in supporting employment is to dispel fears of losing essential benefits, a common barrier to work, by providing accurate, individualized information on work incentives and how to manage income while maintaining crucial supports. Literature strongly suggests that individuals who receive benefits counseling are more likely to be employed and to have higher earnings than those who do not.

Benefits counseling services are often provided by trained Community Work Incentives Coordinators (CWICs) through programs like the Work Incentives Planning and Assistance (WIPA) program. However, many other types of professionals have also received training or have extensive knowledge of coordinating work and benefits, and can help individuals navigate complex benefit rules, utilize work incentives (e.g., Trial Work Period, Impairment-Related Work Expenses, PASS Plans), and achieve greater financial independence through employment. Some service providers and social service agencies have chosen to embed benefits counselors within their organizations.

Strengths of Benefits Counseling and Planning

Benefits counseling empowers individuals with disabilities by providing accurate, individualized information on how working affects their benefits, dispelling fears of loss and encouraging employment and financial independence. This practice supports

beneficiaries in increasing earning capacity and successfully maintaining employment over time, leading to long-term economic security.

Implementation of Benefits Counseling and Planning

WIPA has a national infrastructure of trained professionals, CWICs, available in every state and territory. This widespread availability offers a significant opportunity to scale up services and integrate them with other employment support systems; disrupt the link between poverty and disability; and address misconceptions about work and benefits. Minnesota does have a network of CWICs and has developed tools within the Disability Hub to assist job seekers in navigating benefits and work.

Evaluating the Efficacy of Benefits Counseling and Planning

Efficacy can be evaluated by measuring increases in beneficiaries' earnings, reductions in poverty rates among beneficiaries, increases in the percentage of beneficiaries who successfully maintain employment over time, and increases in the number of individuals who utilize work incentives. Tracking beneficiaries' satisfaction and their ability to independently manage their benefits also indicates success.

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Benefits Counseling and Planning

Benefits counseling is highly individualized, tailoring advice to each person's unique benefit situation and employment goals through in-depth analysis and customized counseling. This personalized approach supports informed choice by allowing beneficiaries to understand options and consequences, which inherently allows for responsiveness to individual contexts, including cultural factors.

How Benefits Counseling and Planning is Informed by Lived Experience

Extensive literature identifies fear of losing benefits as a primary reason that people with disabilities do not pursue employment. Many research studies reveal that individuals often will only work up to the "Substantial Gainful Activity" limit. The Inclusion Consultants identified benefits counseling and support as a key need for individuals.

Ways to Collaborate on Benefits Counseling and Planning

Benefits counseling programs like WIPA collaborate by coordinating services with beneficiaries' employment support teams, which can include state VR agencies, Employment Networks (under the Ticket to Work program, and other community resources. This collaboration ensures beneficiaries receive comprehensive support across various systems.

Minnesota has made good use of DB101, an online benefits calculator created by the World Disability Institute that allows people to input their data and see how working will affect their income. Greater efforts to disseminate this valuable tool are apparently needed. While DB101 is a self-guided program, many people will benefit from coaching to trust it and use it more consistently.

Challenges of Benefits Counseling and Planning

Key challenges include the complexity of Social Security and other benefit programs, the need for continuous training and certification for counselors to stay current, and the fact that demand for WIPA services often exceeds capacity. Additionally, maintaining high-quality, individualized services requires significant time and effort per beneficiary.

- *Shortage of trained professionals*: There is a significant need for highly trained and certified benefits counselors (CWICs/CPWICs). The specialized knowledge required for this role demands intensive training and ongoing professional development.
- *Funding and capacity limitations*: WIPA projects rely on federal funding, and the capacity of these projects to serve all eligible beneficiaries may be limited by budget constraints or the number of CWICs they can employ and retain.
- *Integration into service delivery*: Fully integrating benefits counseling as a seamless, routine component of employment services (such as IPS or PE models) across different state agencies (e.g., VR, workforce development, mental health, developmental disabilities) can be challenging due to differing policies, referral protocols, and data systems.
- *Maintaining expertise*: The constant changes in Social Security rules and other benefit programs necessitate continuous training and updates for CWICs, which is an ongoing logistical and financial commitment for state-level initiatives.
- *Referral streamlining*: Establishing clear, consistent, and efficient referral pathways between employment specialists (in IPS/CE/PE programs) and benefits counselors is crucial but often a systemic hurdle.

Example: Work Without Limits

Housed within the UMass Chan Medical School, Work Without Limits is a network of employers, educational institutions, employment service providers, and state and federal agencies. Their work represents a public and private partnership, which includes benefits counseling and planning, with a goal to position Massachusetts as the first state in the nation where the employment rate of people with disabilities is equal to people without disabilities. Work Without Limits programs and services are geared to meet the needs of businesses that actively recruit people with disabilities who are seeking jobs, and the employment providers that serve them.

2F: Achieving a Better Life Experience (ABLE) Accounts

Concerns over a change or loss of benefits are a significant barrier to employment for disabled people. An extensive body of research indicates that individuals who receive Social Security and/or Medicaid benefits do not pursue employment, increased work hours, increased salary, or promotion due to fear of loss of benefits and earnings. First passed in 2014, the Achieving a Better Life Act created a protected pathway to saving.

"ABLE" accounts allow people with disabilities to save money without reductions to benefits like Medicaid or SSI. Normally, benefits for some public programs may stop if an individual exceeds asset limits. With an ABLE account, individuals can save up to $19,000 per year. People who work can add additional funds, up to their income (with maximums around $34,000-$37,000 depending on the state). The total amount an individual can save in an ABLE account over their lifetime varies by state but can be between $235,000 and $596,000 (ABLE National Resource Center, n.d.).

Example: State-Driven ABLE Programs

The states of Maryland, California, and Pennsylvania have invested heavily in the creation of websites and resources to inform individuals, families, and payee about the benefits and opportunities of ABLE accounts. These states also identified a state director for their ABLE program who engages with the National Association of Treasurers, which provides some reporting coordination. State ABLE directors and affiliated staff have dedicated time to encourage participation in ABLE through education, collaboration, and outreach to stakeholders.

Strengths of ABLE Accounts

ABLE accounts allow eligible individuals with disabilities to save and invest money without jeopardizing their eligibility for most federally funded, means-tested benefits like SSI, Medicaid, housing vouchers, and food assistance. Funds in an ABLE account grow tax-free and can be used for a broad range of qualified disability expenses (QDEs) that enhance independence and quality of life, including housing, transportation, education, and employment support. They offer greater flexibility and control over funds compared to some trusts, and the cost to establish them is typically lower.

Opportunities with ABLE Accounts

Beginning on January 1, 2026, the ABLE Age Adjustment Act will significantly expand who can open an ABLE account. Currently, to be eligible, the person's disability must have begun before age 26. According to the new law, onset of disability must now be by age 46. This change means that millions more individuals, including many Veterans and people who acquire disabilities later in life due to accidents, traumatic brain injuries, or conditions like multiple sclerosis, will be able to benefit from these tax-advantaged savings accounts. This expansion aims to provide greater financial independence and security for a wider population of people with disabilities and shows promise to increase rates of employment for people with disabilities.

Implementation of ABLE Accounts

While Minnesota does offer ABLE accounts through the National ABLE Alliance, there is extremely limited uptake and use, as in many other states. Many states have not invested in ABLE account outreach and education to eligible populations. Other states, however, under the auspice of their State Treasurer's Office, have developed

standalone ABLE offices and teams focused on increasing enrollment in ABLE accounts along with providing public education and technical support.

Evaluating the Efficacy or Impact of ABLE Accounts

Efficacy can be evaluated by metrics such as the number of ABLE accounts opened, total assets under management, the average savings per account, and the number of beneficiaries who maintain or increase their earnings while using an ABLE account. Tracking the use of ABLE funds for employment-related QDEs (e.g., training, transportation to work) could demonstrate their direct impact on employment outcomes. Surveys on beneficiary satisfaction with financial independence and quality of life could also be valuable.

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in ABLE Accounts

ABLE accounts support person-centered planning by allowing the individual (or their authorized legal representative) to control and make choices about their savings and how funds are used for QDEs. The broad definition of QDEs, encompassing "basic living expenses" and not limited to disability-specific or medically necessary items, provides flexibility to meet diverse individual needs and preferences. This flexibility empowers individuals to make informed choices about their financial future, supporting their unique path to independence.

How ABLE Accounts are Informed by Lived Experience

ABLE accounts were directly informed by the lived experience of people with disabilities who faced significant financial disincentives to save money, due to strict resource limits imposed for means-tested public benefits. “The Extra Costs of Living with a Disability in the U.S. — Resetting the Policy Table,” published in 2020 by the National Disability Institute, highlighted the increased income needed, emphasizing the need for a savings vehicle that wouldn't jeopardize essential benefits and directly addressing a core challenge faced by individuals with disabilities trying to achieve financial security.

Challenges of ABLE Accounts

While ABLE accounts are widely available, challenges to greater adoption include the initial age of onset eligibility (before 26, expanding to 46 in 2026), excluding many working-age individuals whose disabilities begin later in life. Another challenge is the annual deposit limit, which, while substantial, can still be a constraint. Furthermore, while ABLE accounts generally don't affect most benefits, exceeding $100,000 can trigger the suspension of SSI payments (though Medicaid coverage continues), requiring careful financial planning. Ongoing education is needed to debunk common myths and ensure that individuals with disabilities and their families fully understand the benefits and rules of ABLE accounts. Opening and managing an ABLE account does require effort and some understanding of finances, especially given that many individuals with barriers to employment have not received training or support to enhance their financial literacy. Finally, outreach and public education for ABLE accounts requires ongoing funding that

most states do not supply. For all these reasons, public awareness and uptake of ABLE accounts are extremely limited across the United States.

2G: Data Integration and Interagency and Interdepartmental Coordination

Implementation of all the models and strategies above rests on successful communication, cooperation, and collaboration between local and state government entities. Improved practice implementation, regardless of disability type, has been demonstrated in other states to expand the availability of supports and services that can increase employment for people with disabilities. Federal guidance on blending, braiding, and sequencing government funding sources for employment services was published in 2022. The E1MN partnership continues to model a coordinated approach to implement Employment First principles including the Engage, Plan, Find, and Keep framework between DEED, DHS, and MDE.

Strengths of Data Integration and Interagency and Interdepartmental Coordination

Formalized data sharing and data coordination across local, state, or federal systems can result in multiple benefits including:

- *Holistic care*: Sharing data creates a full picture of an individual's needs, leading to coordinated services across different agencies (e.g., housing, health care, employment). This means less duplicated effort and more seamless support for individuals.
- *Improved resource allocation*: Coordinated data helps policymakers identify service gaps and allocate resources more effectively. It allows for evidence-based decisions, ensuring programs meet actual needs and address disparities.
- *Efficiency and savings*: Sharing information reduces redundant paperwork and assessments, saving time and money for both individuals and the state. It streamlines processes and can help prevent fraud.
- *Proactive planning*: By understanding the needs of different individuals (like aging caregivers), agencies can anticipate future demands and intervene early, preventing crises and ensuring smooth transitions between services.
- *Accessibility and inclusivity*: Data helps agencies tailor outreach and improve the accessibility of public resources for diverse groups.

Opportunities with Data Integration and Interagency & Interdepartmental Coordination

Several interviewees noted Minnesota for crafting memorandums of understanding (MOUs) that fit the parameters of best practices, illustrating the administrative capacity to use the levers of government in this way. This mechanism could be used even more broadly to increase implementation and penetration of evidence-based and best

practices across disability sectors. E1MN models many coordinated practices but does not universally collect and monitor employment services and outcomes with other *Olmstead* populations of interest.

The National Expansion of Employment Opportunities (NEON) presented a webinar (Building Better MOUs: Strategies for Cross Collaboration and Funding Coordination) on June 4. 2025 (add link) that reported on a national survey of MOU's which was requested by the NEON state intermediary organizations and the Association of People Supporting Employment First (APSE). A key goal of the MOU survey was identifying pathways to "overcome the paralyzer of progress, i.e. the payer of last resort conundrum." The survey yielded 50 examples and of this number, only 15 states (18 distinct MOUs) met the standards for Best Practices. The following is a summary of the domains and the states:

- Division of payment responsibility: MI, MD. AL, OH, WI (3 examples).
- Agency commitment to being the primary payer: TN (2 examples, MN (between VR/SSB and DSD). MI, IA (2 examples), MA
- Division of responsibility in supporting informed choice: MN (between VR/ED/LTSS)
- Commitment to braiding funding and services: AK, WA, VA
- Addressing blending funding: MI (this involved cash transfers between departments for the purpose of drawing down increased federal funds)
- Coordination of provider payment rates: VA, MN (between VR, ED, LTSS)
- Align provider networks: TN (2 examples)
- Addressing language on ending or diverting people from subminimum wage work: MA
- Commitment jointly to expand evidence-based practices and seek funding: AL (the only one related to IPS), MN (VR and DEED agreed to consult and identify related legislative priorities and develop proposals in time for submission to the governor's budget).

While the ODEP-funded MOU repository is not yet publicly available, an additional ODEP resource, Promoting Competitive Integrated Employment through MOUs and Other Inter-agency/-departmental Agreements may also be helpful.

Minnesota was noted in several instances above for creating MOUs that met best practice standards.

Evaluating the Efficacy of Data Integration and Interagency & Interdepartmental Coordination

The efficacy and outcomes of the MOUs and interdepartmental/interagency agreements (IAs) can be determined, potentially, by comparing outcomes before and after implementation. One of the features of many of these instruments is to create data sharing agreements to better define and count outcomes.

How Data Integration and Interagency & Interdepartmental Coordination was Informed by Lived Experience

A recommended feature of effective MOUs and IAs is to ensure that people with lived experience and their families have an opportunity to vet the drafts of these agreements to make sure they are understandable. People often need help to understand the workings of government policies, and these agreements can illuminate agency responsibilities and paths for advocacy.

Challenges of Data Integration and Interagency & Interdepartmental Coordination

As with all government policy work, finding time for staff to work through the details of these agreements, and keep the process moving through hierarchies, is a challenge. Staff need support from supervisors to step out of day-to-day tasks to do this work.

2H: Coordination with American Job Centers

Millions of Americans are unemployed or underemployed and are seeking work. Local workforce boards and American Job Centers (AJCs) are often the first stop for those looking for employment. These job seekers may not be formally connected to state or county services but do have a demonstrated need. Additionally, AJCs can also serve populations such as Veterans and individuals with a mental health or related need. In many cases these groups may be unreported or underreported in Minnesota-specific data, yet these are the very populations the Minnesota Olmstead Plan is trying to connect with. The National Governors Association (NGA) has made significant investments in the Workforce Innovation Network (NGA WIN), across several states. Although ongoing funding is not currently available to states, NGA WIN has led to several innovations to provide more coordinated service delivery to job seekers across populations.

Minnesota currently has 16 local workforce development areas, each with boards that are under the direction of local officials. MN Career Force operates as the state's AJC, providing supports to both job seekers and employers. WIOA outlines how state workforce agencies and local Workforce Development Boards (WDBs) work together. State agencies (e.g., DEED) are responsible for providing guidance and oversight to local WDBs, as well as administering and coordinating workforce programs. In turn, local WDBs are crucial for implementing these programs, following the lead and oversight of the state.

Strengths of American Job Center Coordination

Coordinating with AJCs presents several notable strengths. AJCs offer universal access to an integrated array of labor exchange services for *all workers, job seekers, and employers*, providing a comprehensive and centralized point for various supports. They deliver a wide range of essential services, including job search assistance, job referrals, placement assistance, job training, and free internet access for job searches, alongside recruitment and other support services tailored to employers. A key strength of the

AJCs lies in their ability to provide attention and services to diverse target populations, such as individuals with disabilities, Veterans, youth, minorities, and other groups. Lastly, WIOA's statutory mandate to co-locate employment service offices and collaborate with various partners, including VR agencies, establishes a robust framework for integrated service delivery and shared objectives.

Opportunities from American Job Center Coordination

Coordinating with American Job Centers offers states significant opportunities to enhance their workforce systems. This collaboration enables the advancement of digital skills among the workforce, including those with limited proficiency, by integrating crucial digital literacy training and leveraging federal investments. States can also expand accessible virtual support services for job seekers and employers, building upon recent shifts in service delivery. Furthermore, coordinating with AJCs facilitates the deeper integration of individualized employment models, such as Customized Employment and Progressive. The AJCs can serve as case management "extenders" when case managers assertively facilitate connections. For example, for people with mental illness served in community mental health centers under the Adult Rehabilitation Mental Health Services of Medicaid, AJC staff can help clients who need a modest amount of support to gain employment. Finally, this collaboration allows states to engage employers more strategically, fostering inclusive workplaces and effectively utilizing the diverse talents of people with disabilities.

Implementation of Stronger Coordination with American Job Centers

States can implement stronger coordination with American Job Centers by fostering clear, unified leadership in relevant agencies to align policies, regulatory guidance, training, and reimbursement structures, thereby prioritizing integrated employment outcomes. It is crucial to establish robust interagency coordinating councils that can facilitate collaboration and resolve systemic barriers. Furthermore, states should invest in comprehensive cross-training and capacity building for professionals within the AJC network and partner agencies, ensuring consistent delivery of employment supports. Implementing integrated service delivery models, such as co-locating staff and streamlining referral pathways, can enhance seamless service for job seekers. Leveraging digital transformation by integrating digital literacy training and navigation support into AJC services also strengthens coordination and prepares the workforce for evolving demands.

To reach disconnected but potentially eligible job seekers, some states and local communities have been coordinating their efforts with formal service networks (VR, Medicaid, Education) to improve employment outcomes.

Evaluating the Efficiency and Impact of Coordination with American Job Centers

States can determine if American Job Centers are effective in supporting job seekers by rigorously collecting and analyzing data. Key metrics include the number of job placements, job retention, and wages/earnings improvement. States can evaluate

impact by examining the utilization of services, understanding which populations are being served, and assessing how well AJCs collaborate with partner agencies to provide integrated and seamless support. The systematic use of performance data, coupled with qualitative feedback and broader economic indicators, provides a comprehensive picture of an AJC's success in connecting job seekers with meaningful employment opportunities and enhancing their long-term financial well-being.

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Coordinating with American Job Centers

American Job Centers can become more person-centered by deeply individualizing services, training staff in person-centered planning, and empowering job seekers in their choices. AJCs should train staff in cultural competence, adapt outreach strategies, and tailor services to respect diverse backgrounds, potentially collaborating with community organizations to build trust and relevance for all job seekers. Many such training and certification programs are provided around the state: however, they are often not offered to or connected with MN Career Force staff or networks.

How Coordination with American Job Centers was Informed by Lived Experience

The Inclusion Consultants acknowledge there are many people who want and need employment support and guidance but cannot receive it, as many people are not eligible for Medicaid waiver supports or VR. However, they recognized that MN Career Force centers could be enhanced to engage more diverse job seekers who are underserved by other systems.

Ways for American Job Centers to Collaborate across State Government

AJCs can engage in targeted outreach and establish formal partnerships with community-based organizations that serve specific groups, including minority communities, justice-involved individuals, and migrant and seasonal farm workers, thereby building trust and ensuring culturally responsive service delivery. By actively participating in and contributing data to statewide digital equity planning initiatives, AJCs can work with education and other agencies to address digital skill gaps in various populations, ensuring equitable access to employment opportunities in a technologically evolving economy. This multifaceted collaboration, supported by clear policy alignment and integrated service models, allows AJCs to serve as central hubs for a truly coordinated state workforce system.

Challenges of Coordination with American Job Centers

Coordinating with American Job Centers at the state level is challenging because some AJCs have historically struggled to effectively serve diverse or high-needs job seekers. This difficulty often stems from internal capacity gaps and a lack of specialized training for staff. Furthermore, coordination is complicated by persistent systemic silos, with AJCs not always integrating closely with other vital public programs like VR or Medicaid, leading to fragmented services and complex navigation for job seekers with complex

needs. Overcoming these entrenched operational and philosophical divides will require significant effort.

2I: State Employment First Office

Colorado has developed an Office of Employment First in response to the state's *Olmstead* legislation. States find diverse paths to manage the many functions involved in supporting and implementing Employment First across the disability community. Colorado's Office of Employment First has evolved since its inception. Based on our understanding that Minnesota reached out to Colorado to learn about the Office, we present details here about the concept generally and this state in particular.

The Office has a cross-disability focus and provides training in IPS and CE as well as broad technical assistance to increase implementation of evidence-based and best practices that support positive employment outcomes. E1MN and MTI offer some of the same services as Colorado's Office of Employment First.

Strengths of an Employment First Office

A dedicated state Employment First office can provide a centralized hub for elevating equitable employment for all people with disabilities. It establishes a clear mission to prioritize real jobs in the community for real money as the first choice, countering outdated views that people with significant disabilities cannot work and that they do not need or merit a living wage for the work they do. Such an office can drive systemwide policy alignment and foster interagency collaboration, which are both crucial for effective implementation of evidence-based practices like IPS-SE, Customized Employment, and Progressive Employment.

Implementation of an Employment First Office

A dedicated office can create significant opportunities for systems innovation by convening stakeholders to improve policies, remove barriers, and promote technology in employment services. It can ensure that publicly financed systems align policies and reimbursement structures to prioritize CIE. An office can also lead efforts in "training excellence," elevating evidence-based strategies through training and learning communities, thereby building a more skilled and unified workforce.

Evaluating the Efficacy of an Employment First Office

To evaluate the efficacy of a state Employment First Office, metrics could include increases in the number of people with disabilities (especially those with significant disabilities) engaged in CIE, higher average wages for disabled workers, and a decrease in participation in segregated settings like sheltered workshops. The number of state agencies with aligned policies, the penetration rates of evidence-based employment models (like CE and PE), and improvements in interagency data sharing would also be key indicators.

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in an Employment First Office

A state Employment First office's mission, by emphasizing "equitable employment for all people with disabilities," implicitly supports person-centered planning and informed choice. It advocates for individuals to be able to choose to work in their communities, get the supports they need, and receive the same wage as non-disabled people. By driving a cultural shift that recognizes people with disabilities as full participants in the economic mainstream, it creates an environment conducive to individualizing services and respecting diverse needs, thereby supporting cultural responsiveness.

How an Employment First Office is Informed by Lived Experience

Minnesota is an Employment First state, and the Inclusion Consultants noted the state's coordinated efforts by DEED, MDE, and DHS to advance CIE. This coordination and related investments were a direct result of Minnesota's first Olmstead Plan; however, Inclusion Consultants acknowledge that the Employment First framework is still not fully embraced by all state agencies or service providers. While significant work and value have resulted from the DEED, MDE, and DHS collaboration, more could be done to coordinate statewide efforts to advance Employment First and CIE.

These efforts need not be under an "Office" umbrella. For example, contracts with counties and providers (DHS providers as well as DEED) can include benchmarks for tracking employment outcomes. States can use communication vehicles (such as Governor's proclamations, as was done in CO) to raise up the issue broadly; the state can look deeply at funding strategies of Medicaid to support employment under ARMHS and CCBHC, braiding and sequencing resources to improve penetration of IPS (as noted above).

Ways for an Employment First Office to Collaborate across State Government

A state Employment First office can serve as a central coordinating body to "promote work as part of a financially secure, healthy, and fulfilled life" through extensive collaboration. Such an entity can convene state agencies — such as VR, AJC, Medicaid Services, and other disability service agencies — and ensure that they align their policies and practices to make integrated employment the primary option. For instance, Colorado's Employment First legislation includes implementation efforts like staff training, credentialing, and data collection, which require interagency cooperation.

Challenges of an Employment First Office

Even with a dedicated office, challenges persist. (In Colorado, funding destabilization has created uncertainty for the Office of Employment First.) Longterm commitment to comprehensive systems change involves shifting resources towards integrated employment and ensuring consistent, high-quality assistance. Overcoming ingrained but outdated ideas about disability and work, ensuring adequate and flexible funding mechanisms, addressing workforce issues (like training and retention of skilled employment professionals), and navigating the complexities of coordinating multiple state agencies with diverse infrastructures and funding streams remain significant

challenges. E1MN and MTI continue to tackle many of the ongoing challenges of Employment First implementation. The state could consider an evolution of E1MN to extend its approach across addtional state agencies and populations.

Key Considerations Across Program Models and Strategies

The evidence-based, best, and promising practices/strategies described above rely on several key factors to support enhanced employment outcomes. The practice must be supported by all the government entities associated with it, whether through coordination, cooperation, or collaboration. These relationships should be outlined in writing, with clear expectations of activities that lead to specified desired outcomes. States can use MOUs, interagency agreements, or other instruments to hold each other accountable and provide transparency for persons served and their families.

For practices that have fidelity scales or measures, these should be systematically applied. States have differing approaches to this imperative; for example, with IPS, some states have a team including state VR and mental health staff. Other states hire external Centers of Excellence or TA Centers; for example, Louisiana contracts with Case Western Reserve University to provide fidelity reviews of its ACT teams (which incorporate IPS); Case Western shares its findings with the state's Managed Care Entities, which then follow up with Plans of Correction as needed.

Broad implementation (penetration) of these practices rests on the state's commitment to provide resources to support them. While Minnesota is engaging in several of the best practices presented, populations of need continue to lack access to these practices. While many adults with intellectual and developmental disabilities (I/DD) are accessing Customized Employment, CE is not widely available to Veterans, individuals with mental health and SUD needs, or justice-involved populations. Pathways to increase the use of best and promising practices in the employment domain can include creative and thoughtful uses of Medicaid (both State Plan and Waivers), VR contracting, and other potential sources such as county or MCO participation. Data on outcomes can demonstrate the efficacy of these practices and is essential to justify the use of scarce public funds.

Workforce development issues require attention and analysis. States determine who can provide specific services and may inadvertently shrink the workforce by overreliance on academic or licensure requirements when functional competency or lived experience could be an alternative qualification. Providing ongoing training to deliver a practice with fidelity is a big commitment. States rely on various methods to address this challenge, including contracting for technical assistance and training, deploying state staff for the task, or using a combination. Whichever path Minnesota takes, it is essential to have a plan to support the workforce.

Without a strategic plan to broadly implement the practices statewide — supported by the highest levels of leadership — they may remain islands of excellence, leaving many people who could benefit from them at sea.

Key Informants & Subject Matter Experts Consulted on Employment & Olmstead Planning

Key Informant or Subject Matter Experts Interviewed	Date & Venue/Modality	Topic(s)
Deirdre Sage, **Tiffany Cron**, Colorado Office of Employment First	Zoom	Pros and cons of a statewide office devoted to support and technical assistance to implement evidence based and best practices across disability groups
Chris McVey, MN Vocational Rehabilitation Services	Zoom	Introductory meeting with TAC SMEs
Joe Marrone, Consultant/SME, former Institute on for Community Inclusion professional	Zoom	CIE, CE, Progressive Employment, state implementation challenges
Andrea Zuber, Skifte Consulting, former Arc MN Director, Former Ramsey and Dakota County Administrator	Zoom	CIE, Employment First, subminimum wage, wage justice
Sue Abderholden, NAMI MN, Director	Zoom	Employment supports for youth and adults with mental illness. Employment training by NAMI to state networks
Cindy Thomas, UMass Boston, Director, Institute for Community Inclusion	Phone	MN Transformation Initiative, Progressive Employment pilot, UMass touch point with MN employment providers
Alyssa Klien, DEED & **Sarah Robinson**, MDE	Zoom	System coordination for transition-age youth, outcome tracking, public/private data reporting, LEA training & coaching
Dawn K. Miller and **Darren Paschke**, Washington State Health Care Authority	Zoom	State employment policy and services
Catherine Fowler and **Dawn Rowe**, National Technical Assistance Center on Transition (NTACT:C)	Zoom	CIE, state models for cross-population employment support, transition support
Robert Wagner and **Alesha Alexcee**, Inclusion Consultants, Dendros Group	Zoom	Current *Olmstead* employment goals, barriers to employment, service coordination vs. benefits, MA/SS benefits & work, recommendations for improved employment inclusion

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Topic 3: Health & Health Care

Katharine London, M.S., has 35 years of experience working with state governments, nonprofit agencies, providers, and other stakeholders to address underserved individuals' health and health-related social needs.

Overview of Health & Olmstead Planning

Minnesota's Olmstead planning for health is rooted in its excellent health care system. The state has first rate hospital and clinic systems. America's Health Rankings considers Minnesota the fourth healthiest state overall, in part because of the state's exceptionally low uninsured rate and high rates of delivering preventive clinical services. However, America's Health Rankings also noted that the share of adults in Minnesota who have a dedicated health care provider is only average for the country, and that the state's racial disparities in premature death are among the worst in the country. These challenges, though they are faced by the state as a whole, are magnified for Minnesotans with disabilities.

Nationally, mortality rates for people with disabilities are nearly twice as high as for people without disabilities; mortality rates are highest for people with multiple disabilities, especially disabilities associated with limitations in daily living (e.g., difficulty with dressing or bathing) (Landes, 2024).

Populations of Particular Concern for Health & *Olmstead*

Access to affordable, high-quality health care is a basic human need. It is even more essential for people with disabilities to ensure that they can live successfully in a non-institutional setting. For example, difficulty accessing or coordinating health care services can make it more challenging for people with complex medical conditions to live independently, work, or attend school.

People with serious behavioral health needs or intellectual and developmental disabilities (I/DD) are at higher risk of institutionalization (Bixby, 2022); access to appropriate community-based care is essential to supporting these individuals. Moreover, people with serious behavioral health needs who are released from incarceration are at high risk of destabilization and overdose, often resulting in an emergency department visit, inpatient stay, or even death (Frank, 2014; Binswanger, 2007; Binswanger, 2013).

People of color and those who do not speak English as a first language have worse health outcomes on most national quality measures. People in these population groups

who have a disability need access to culturally competent and responsive care and assistance meeting their health-related social needs to be able to live successfully in the least restrictive environment.

Finally, a 2017 Minnesota study determined that certain "population groups experience poor health and health outcomes that are associated with the social, economic and environmental circumstances of their lives." Assistance meeting health-related socail needs is particularly important for people in these population groups:

- People living in deep poverty (below 50% of the Federal Poverty Guideline)
- People with substance use disorders (SUDs)
- People with severe and persistent mental illness (SPMI)
- People experiencing homelessness
- People who were previously incarcerated
- Children who have been involved in the child protection system
- People with Native American heritage (Breslin, 2017)

Health & *Olmstead* in Minnesota

Minnesota's Olmstead Plan has an appropriately ambitious vision for health: "People with disabilities, regardless of their age, type of disability, or place of residence, will have access to a coordinated system of health services that meets individual needs, supports good health, prevents secondary conditions, and ensures the opportunity for a satisfying and meaningful life."

The Olmstead Plan largely relies on larger state health reform initiatives to achieve this vision for all residents, including people with disabilities. For example, the strategies include implementing the statewide Oral Health Plan and enrolling more individuals in health care homes and behavioral health homes.

However, respondents to the Disability Inclusion survey, Inclusion Consultants, and key informants indicate that these strategies are not sufficiently targeted to meet the needs of people with disabilities. In particular, these sources specified that people with disabilities in Minnesota need better access to physical, mental, and oral health providers who have expertise in treating people with disabilities and who accept Medical Assistance and/or Special Needs plans. Key informants noted that most Health Care Homes in Minnesota focus on chronic conditions like diabetes and congestive heart failure; they generally do not focus on providing comprehensive health care for people with disabilities.

Survey respondents also expressed frustration that people with disabilities are treated as a single group in *Olmstead* health planning and in data reports; they felt that *Olmstead* health strategies should reflect the different types of challenges faced by people with different types of disabilities.

Minnesota's *Olmstead* Implementation Report findings are consistent with the qualitative responses from people with disabilities. The report documents that readmission rates for people with disabilities were virtually unchanged from 2014 through 2022, and that emergency department use for non-traumatic dental care by children with disabilities was flat from 2017 to 2022. The data shows that the number adults with disabilities who used an emergency department for non-traumatic dental care went down, but this improvement was insufficient to meet the goal.

Minnesota can look to successful strategies around the country to make better progress in these areas. Because people with different disabilities and at different stages of life may have very different needs, the state should consider implementing a series of targeted interventions, rather than attempting a one-size-fits-all approach. This chapter highlights targeted interventions that can address particular needs.

Effective Policies, Programs, and Strategies Related to Health & Health Care

3A: Support Provision of High-Quality Health Care Services for People with Disabilities

As noted above, respondents to the Disability Inclusion survey, Inclusion Consultants, and key informants asserted that people with disabilities in Minnesota need better access to physical, mental, and oral health care providers who have expertise in treating people with disabilities. There are a number of strategies that states can use to make high-quality health care services more accessible and available to people with disabilities. Key strategies include the following:

1. **Ensure health care providers provide access to care**. States can enlarge the pool of accessible health care services by encouraging or requiring all health care providers to implement evidence-based practices (EBPs) for access to care for people with disabilities. EBPs generally fall into the following categories.

    - *Person-centered care* that aligns with the person's goals and actively involves the person in decision-making
    - *Physical accessibility* of buildings and medical equipment, including exam tables, dental chairs, weight scales, and radiology equipment, as well as sensory-friendly environments with adjustable lighting and reduced noise
    - *Effective communication* that accommodates differing needs, including using clear, plain language; providing information in accessible formats (e.g., large print, Braille, or auditory); and, where requested, including caregivers, sign language interpreters and other interpreters in office and telehealth appointments

- *Technology and innovation* that enhances engagement and communication, including assistive devices, digital accessibility, and telehealth platforms that can include caregivers and interpreters
- *Cultural humility and respect* for the knowledge and experience people with disabilities bring as experts on their own lives, including ensuring that programs and services are culturally competent and responsive to individual needs

States can use a variety of policy levers to promote implementation of these best practices. For example, some states include requirements for meeting specified EBPs in:

- Health care provider licensure requirements (Alaska)
- Medicaid program and payment regulations (all, to some degree)
- Medicaid MCO contracts (California, Massachusetts, New York, Nevada)
- Pay-for-performance arrangements (Arizona, Arkansas)
- Performance/quality measurement and reporting (Illinois, Michigan, Virginia)
- Network adequacy regulations (Washington)
- Provider education and training

2. **Support integrated health care organizations designed specifically to serve people with specific disabilities**, e.g., intellectual and developmental disabilities (I/DD), Autism Spectrum Disorder (ASD), and serious mental illness (SMI). A number of provider organizations ensure that people with I/DD, ASD, and SMI have their needs met by professionals who are specially trained to serve these populations and have the equipment and resources they need to do so. Areas of focus include:

   - *Specific age groups* (Gillette Children's Hospital and Clinics)
   - *Specific services*, such as dental care (Access Dental Care, North Carolina) or urgent care telehealth (StationMD, 40 states)
   - *Comprehensive coordination of health and social services* (Woods System of Care, New Jersey and Pennsylvania)

   States can support specialty provider organizations by providing initial grants to cover startup costs, by establishing enhanced rates to cover longer visit times and specialized capital needs, and by recruiting multistate specialty providers to expand into their state.

3. **Promote education for clinicians on caring for people with disabilities.** States can enlarge the pool of accessible health care services by promoting professional training to address the health care needs of people with disabilities.

   - States can encourage medical, nursing, and other health care professional schools to provide education and training to their students on caring for people with disabilities

- States can encourage continuing education credits for state licensure on caring for people with disabilities
- States can encourage provider organizations that specialize in treating people with disabilities to establish affiliations with medical, nursing, and other health care professional schools to provide clinical rotation sites for students and medical residents (e.g., Access Dental, North Carolina; Woods System of Care, Pennsylvania and New Jersey)

Strengths of Supporting the Provision of High-Quality Health Care Services

Providing access to high-quality health care services enables people with disabilities to get the care they need in a timely manner, and improvements may produce savings for the health system overall. Without such access, people with disabilities may seek care in hospital emergency departments (EDs), which is much more time-consuming and expensive than community-based care.

To visit an emergency department, a person with a disability and a caregiver may need to take a full day away from school or work. For people who live in a staffed group home, a caregiver may need to accompany them for a full shift, leaving the group home short-staffed.

Moreover, ED physicians who do not know a patient well, especially patients who do not communicate well in spoken English, frequently order additional lab tests and radiology scans and may even hold a patient overnight to rule out potential diagnoses. Providing care in the community prevents the need for these expensive services.

Opportunities to Support Provision of High-Quality Health Care Services

Minnesota's excellent health care system provides a solid foundation for growing the system of accessible health care services. Many providers are highly motivated to provide high-quality care to people with disabilities; providing the training, skills, and resources they need to do so would enable these clinicians to meet their own goals.

Minnesota could consider adapting its existing Health Care Home structure and enhancing its payment system to support the development of Health Care Homes specifically designed to provide comprehensive care for people with disabilities.

Implementation Considerations for Supporting Provision of High-quality Health Care Services

The state could implement these strategies incrementally over time through its existing regulatory and payment structures. For example, the state could require or encourage each provider organization to choose the improvements it most wants to make each year and then document improvements over time. Establishing a public dashboard that shows each provider organization's progress toward implementing accessibility standards could provide an incentive for improvement. The state could also consider making small grants each year for planning, infrastructure, hiring, and training.

Improvements in these areas would likely produce savings to the health care system over time by reducing the need for emergency visits and hospitalizations. An incremental strategy would enable the state to reap the benefits of such improvements without having to make a large upfront investment.

In addition, Minnesota's Equitable Health Care Task Force is examining "inequities in how people experience health care based on race, religion, culture, sexual orientation, gender identity, age, and disability" and identifying "strategies to ensure that people living in Minnesota receive care and coverage that is respectful and promotes optimal health outcomes." State agencies and advisory bodies, such as the Juvenile Justice Advisory Committee, should ensure that initiatives intended to improve access to high-quality health care services for people with disabilities are aligned with this Equitable Health Care strategy.

Evaluating the Efficacy of Supporting Provision of High-Quality Health Care Services — Proposed Metrics

The Minnesota Olmstead Plan health measures include tracking preventable hospital readmissions for people with disabilities and use of EDs for non-traumatic dental services, in addition to survey responses. These are evidence-based proxy measures for access to community-based primary care, behavioral health, and oral health services. It would be helpful to stratify these measures by type of disability, so that policymakers can target interventions to areas of greatest need (see Section 3C).

It is also important to track the progress of each initiative over time, as well as lessons learned.

Person-Centered Planning, Informed Choice, and Cultural Responsiveness In Supporting the Provision of High-Quality Health Care Services

Person-centered planning, informed choice, and cultural responsiveness are essential elements in any intervention to improve accessibility of health care services.

How Supporting the Provision of High-Quality Health Care Services is Informed by Lived Experience

Disability Inclusion survey respondents, Inclusion Consultants, and key informants all highlighted difficulties they have encountered in finding health care providers that meet their particular needs. Key informants and Inclusion Consultants identified the promising strategies listed in this section.

Ways to Collaborate across State Government to Support the Provision of High-Quality Health Care Services

Ensuring access to high-quality health care services requires health agencies to work together to agree on standards, goals, priorities, and messaging. In particular, the Department of Human Services (DHS), the Department of Health (MDH), and the Board of Medical Practice should coordinate to support each other without duplicating efforts or producing unintended consequences.

Challenges to Supporting the Provision of High-Quality Health Care Services

Ensuring access to all health care services for all people with disabilities is a broad and far-reaching goal. Establishing a comprehensive strategy will require detailed planning and careful coordination by multiple agencies and programs. An incremental strategy with small tests of change will allow the state to make progress while it is developing a more comprehensive approach.

3B: Help People Access Needed Services through Targeted Assistance

A second approach to ensuring people with disabilities in Minnesota get the services and supports they need is to provide targeted assistance in accessing those services in an efficient, timely, and culturally responsive manner. This section describes several approaches to providing targeted assistance.

1. **Provide navigation assistance**. States can support the use of auxiliary health workers to help people with disabilities navigate health and social services and engage in treatment. Navigation assistance can be particularly helpful during major life changes, such as onset of a disability, transition from childhood to adulthood, or discharge from a residential treatment facility. Employing auxiliary health workers is cost effective, helps mitigate workforce shortages, and can result in savings to the overall health and social services system. Extensive evidence shows that these workers help people achieve improved health outcomes, especially among members of underserved communities. (Kim, 2016; Scott, 2018, SAMHSA, 2017).

    - Community health workers (CHWs) are trusted members of the community who connect people to health and social services and help people manage their own health conditions. Medicaid programs in California, Kansas, Kentucky, Michigan, and Rhode Island cover CHWs providing navigation assistance services.
    - Peer specialists are people in recovery from mental illness and/or SUDs who support others to achieve long-term recovery. Medicaid programs in New Mexico and Virginia cover peer specialists providing navigation assistance services.

2. **Engaging people with serious behavioral health needs in integrated care before they are released from prisons and jails.** States can support programs to engage people with SMI, substance use disorders (SUDs), and I/DD in treatment before release. People are often held in county jails for short periods of time and are released back to the community with little support. After release from incarceration or detention, these individuals are at extremely high risk of destabilization and overdose. (Frank, 2014; Binswanger, 2007; Binswanger, 2013).

    Some programs have implemented interventions in which a staff member from a community clinic (e.g., a Certified Community Behavioral Health Clinic [CCBHC], behavioral health home, or community health center) makes regular visits to the county jail or state prison. During visits, the staff member (often a peer specialist or community health worker) meets with people with SMI, SUD, or I/DD in the days and

weeks before they are released. The goal is to build a trusting relationship and connect the person to an integrated care program immediately upon release.

Evidence shows that people who have forged a relationship with a staff person before release from incarceration are more likely to engage in community-based treatment after release and less likely to require emergency treatment. Building a trusted relationship with a staff person during incarceration and engaging in a behavioral health treatment program after release improves health outcomes for individuals and frees up scarce behavioral health staff and beds for other patients (SAMHSA, 2019; Hopkin, 2018). The following programs have successfully implemented both carceral care and connection to services at reentry.

- MassHealth Behavioral Health Supports for Justice Involved Individuals, Massachusetts Medicaid program
- MISSION model **(programs in 16 states)**
- Point of Reentry and Transition (PORT), New York City
- Transitions Clinic Network: 48 clinics in 14 states, including Hennepin Healthcare in Minneapolis

3. **Implementing strategies to improve access to care for people with private insurance.** People with disabilities or complex health care needs often need help navigating the requirements of private health insurance coverage. States can play a role in improving access to health care through private insurance by:

   - Encouraging private health plans to establish complex care management programs, similar to Anthem in Indiana, HealthChoice in Tennessee, and Boston Medical Center in Massachusetts.
   - Enforcing parity requirements: for example, Pennsylvania requires insurers to cover assessment and treatment of autism spectrum disorders; Maryland limits wait times for behavioral health care.
   - Establishing an office or funding a helpline to help patients navigate insurance coverage issues, similar to the New Jersey Office of Insurance Claims Ombudsman and the Massachusetts Office of Patient Protection.

Strengths of Targeted Assistance

There are many advantages to interventions that rely on community health workers and peer specialists to assist people with disabilities in navigating the health and social service system. First, these health workers can take time to understand a person's goals and connect them to services that meet their needs. People who are less trusting of the health care system, especially those who have had bad experiences in the past, may feel more comfortable confiding in a peer and following their recommendations.

These interventions are generally less expensive than other, similarly effective strategies, and may achieve savings in the overall health care and social services system. Moreover, the time these peer workers spend assisting people with disabilities

frees up other health care staff to work with more patients, which can help to lessen the effect of workforce shortages.

Opportunities to Provide Targeted Assistance

CHWs and peer specialists who are trusted members of their communities are particularly effective in helping underserved individuals establish their own personal goals and navigate the health care system to achieve those goals. These goals may include, for example, managing their condition sufficiently to allow them to get a job.

Interventions that rely on CHWs and peer specialists provide an opportunity to hire members of the community with lived experience. This experience and perspective can be especially valuable to people facing similar challenges. In addition, community health worker and peer specialist positions provide a path to professional employment for people who may face challenges gaining employment because of their disability or background.

These types of interventions can also work well within county systems that are not under state agencies' jurisdiction by connecting individuals to county services and linking county behavioral health systems with county jails.

Implementation Considerations for Targeted Assistance

Minnesota could build navigation assistance into existing regulatory and payment structures, for example by including them in Federally Qualified Health Center (FQHC), CCBHC, and behavioral health home covered services. Minnesota already pays for some CHW and peer specialist services.

Minnesota could use new billing codes (HCPCS codes G0023, G0024, G0136, G0140, and G0146) established by the Centers for Medicare and Medicaid Services (CMS) in 2024 for services provided by CHWs, peer specialists, and other auxiliary personnel. Allowable services under these codes include conducting a social determinants of health risk assessment, person-centered planning, health system navigation, building patient self-advocacy skills, and facilitating access to community-based resources.

Note that the state should not limit navigation assistance to people with disabilities; a person with a serious health condition may need navigation assistance to get the diagnoses and assessments required to document a disability.

Evaluating the Efficacy of Targeted Assistance — Proposed Metrics

The most important measure of navigation services is patient satisfaction. It would also be helpful to survey clinical staff regarding their view of the effects of navigation services on patient health and on the workloads of other clinical staff.

If feasible, it would be informative to track utilization of emergency department and inpatient hospital services for people who did or did not receive targeted assistance.

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Targeted Assistance

These types of interventions are especially effective when the peer worker shares experience, culture, language, or community with the person they are assisting. For example, a native Spanish speaker may communicate more easily in Spanish; a person raised in Native American culture may speak more openly with a person who holds similar cultural values; a Veteran may have a stronger connection with another Veteran; the parent of a disabled child may feel reassured working with another parent who has navigated the same systems. Helping people to achieve their own personal health goals in this culturally responsive way reduces the likelihood of disparities in health outcomes.

How the Need for Targeted Assistance was Informed by Lived Experience

Respondents to the Disability Inclusion survey, Inclusion Consultants, and key informants consistently noted their desire for assistance in finding providers and services that both meet their needs and are covered by their insurance. People with less common conditions face particularly acute challenges. In addition, these sources asked for assistance coordinating care across their various providers because of the time, effort, and technical knowledge required.

Ways to Collaborate across State Government to Provide Targeted Assistance

DHS could leverage Medical Assistance to help people with disabilities gain access to community services, including county-based services. It is important to connect these services with county and Tribal Veterans services officers.

Challenges to Providing Targeted Assistance

Although these strategies eventually produce savings for the health care system, they do require upfront funding. Phasing in services can help to minimize initial outlay.

3C: Use Data to Inform Health Policy and Strategy

Minnesota should make full use of its data resources to identify disparities and develop evidence-based strategies to address them. People with different types of disabilities and in different parts of the state may face very different challenges. The state should make every effort to stratify its data analysis to document this range of experience.

While it is difficult to identify all people with any disability in administrative databases, analysts can select records associated with many disabilities using diagnosis codes and claims for certain types of medical equipment. Making full use of available data would enable state policymakers to make evidence-based decisions.

- Oregon and Colorado enacted legislation requiring better collection of race, ethnicity, language, and disability (REALD) data.
- Oregon includes questions about disability in its youth health surveys. Oregon uses this data to report, for example, by type of disability, youth experience with bullying

and sexual assault, as well as incidence of pregnancy and sexually transmitted diseases.

- Massachusetts directs agencies to work together on using existing data to examine disparities experienced by people with disabilities, for example risk of severe maternal morbidity in women with physical disabilities.

Strengths of Using Data to Inform Health Policy and Strategy

Stratifying data by type of disability enables policymakers to identify the most severe disparities in health outcomes so that they can target solutions to address the greatest needs. For example, Minnesota has a goal of reducing hospital readmission rates for people with disabilities. But the reasons for readmissions, and therefore the best intervention to prevent them, might be quite different for people who were initially hospitalized to treat a complex medical condition than for those admitted for a severe behavioral health condition.

Implementation Considerations for Using Data to Inform Health Policy and Strategy

Collecting new data and building new databases can be costly and time-consuming. The state should begin by making better use of existing data, and then identify any remaining needs.

Evaluating the Efficacy of Using Data to Inform Health Policy and Strategy — Proposed Metrics

The key question is whether the state can report *Olmstead* health metrics by type of disability.

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Using Data to Inform Health Policy and Strategy

In Oregon and Colorado, legislation directs state agencies to report on race, ethnicity, and language, together with type of disability.

Ways to Collaborate across State Government on Using Data to Inform Health Policy and Strategy

State agencies will need to collaborate to learn the most from existing administrative data, including Medical Assistance data and All Payer Claims data.

Challenges to Using Data to Inform Health Policy and Strategy

Any data analysis will need to meet privacy requirements established by both state and federal law.

Key Informants & Subject Matter Experts Consulted on Health & Olmstead Planning

Key Informant or Subject Matter Experts Interviewed	Date & Venue/Modality	Topic(s)
Bill Milner, President, Co-Founder and **Betsy White**, COO, Co-Founder Access Dental Care, North Carolina	June 23, 2025	Specialized, comprehensive mobile dental service for people with I/DD
Kristine Sundberg, Executive Director Elder Voice Advocates / Disability Voice Advocates	June 23, 2025	Concerns of families of children with disabilities with health care and HCBS
Carolyn Allshouse, Director **Jamie O'Connor**, Assistant Director Family Voices of Minnesota	June 24, 2025	Concerns of families of children with disabilities with health care and HCBS
Marnie Falk, Director of Public Policy **Rhonda Cady**, Clinical Scientist, Health Services Researcher Gillette Children's Hospital and Clinics	June 30, 2025	Gillette clinic model, concerns regarding children transitioning to adult services, concerns regarding access to dental services
Gregory Wellems, VP Operations, Director of ID Services **Julie Rizzo**, Director, ACAP Keystone Human Services, Pennsylvania Adult Community Autism Program	July 2, 2025	Managed health care and social services model for adults with autism
Dr. Maulik Trivedi, Chief Strategy Officer Station MD	July 23, 2025	Specialized urgent care telehealth program for people with I/DD operating in 40 states
Tine Thansen-Turton, President & CEO Woods System of Care, New Jersey and Eastern Pennsylvania	July 2, 2025	Comprehensive service model for children and adults with ID/DD, ASD, and ABI; medical, dental, behavioral health; residential, social, educational, employment/ vocational;respite, 24/7 access to support for urgent needs

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Topic 4: Home & Community-Based Services (HCBS)

Sara Galantowicz, M.P.H., has 30 years' health policy research and evaluation experience, including with the Minnesota Department of Human Services (MN DHS), and brings subject matter expertise in Medicaid HCBS and long-term services and supports (LTSS) systems, with a particular emphasis on quality measurement development and implementation.

Kelly Nye-Lengerman, Ph.D., M.S.W., has worked in disability policy and services for over 25 years as a direct service professional, service provider, educator, and researcher. She has designed, implemented and evaluated interventions and policy approaches nationally to advance Home and Community Based Services.

Overview of HCBS & Olmstead Planning

A robust and well-functioning home and community-based services (HCBS) system is critical to meeting the intent of *Olmstead* and achieving the outcomes inherent in Minnesota's Olmstead Plan vision that people with disabilities "live, work, and thrive in their chosen communities, with real choices and real belonging" (Minnesota Olmstead Implementation Office, 2025). These community-based services and supports play an important role in enabling people to live how and where they want. Comprehensive and effective HCBS service planning brings together paid and unpaid supports — including from other federal and state programs such as employment and housing, and from community organizations — to enable people to live as full members of their communities.

Subtopics

These three themes/priorities should be part of Olmstead planning related to HCBS:

- *Person-centered planning* is a core federal requirement for Medicaid HCBS programs and was one of the most frequently mentioned areas in the 2021 and 2022 Olmstead Plan satisfaction survey results.
- *Informed choice* requires that people have options from which to choose, are aware of these choices, and are supported in making decisions, including dignity of risk.
- *Addressing disparities, including addressing culturally competent and responsive programs and services* is paramount to making sure Omstead goals are met for all Minnesotans. As one respondent in the 2021 Stakeholder Feedback report noted, "*Some of the goals may be achieved, but there are probably still people left out due to the color of their skin, the language they speak or their ability to advocate on their*

own behalf." The 2024 Small Community Conversations confirmed that racism, poverty, language barriers and isolation are barriers to real change.

Populations of Particular Concern for HCBS & *Olmstead*

As Department of Human Services (DHS) staff have noted, now that Minnesota is no longer under a lawsuit for its Olmstead Plan, the state has the opportunity to focus on a more expansive population in its Olmstead goals. In addition to people residing in institutions, the Olmstead Plan can address current and potential HCBS users, people with a wide range of disabilities, and Minnesotans of all ages. Within this expanded scope are older adults aging in place who want to maintain community connections, rural residents, people who interact with multiple systems, and people experiencing or at risk of homelessness who need long-term services and supports (LTSS). In addition, recent research via the HCBS Evaluation of Racial and Ethnic Disparities has underscored HCBS access barriers experienced by historically marginalized groups. Finally, while the majority of LTSS spending in Minnesota is for HCBS, state staff have noted the reliance on residential supports that may resemble institutional settings and continue to leave residents segregated from the wider community.

HCBS & *Olmstead* in Minnesota

Currently, HCBS in Minnesota are delivered through several programs with varying eligibility criteria and service arrays; listed here, these programs are managed by DHS:

- Brain Injury (BI) Waiver
- Community Alternative Care (CAC) Waiver
- Community Access for Disability Inclusion (CADI) Waiver
- Developmental Disabilities (DD) Waiver
- Elderly Waiver (EW)
- Alternative Care (AC) program
- Essential Community Supports (ECS)
- Personal Care Attendant (PCA) and Home Care (HC) services
- Consumer Support Grant program
- Housing Stabilization Services

DHS is in the process of consolidating or modifying some of these programs. Through the Waiver Reimagine project, DHS plans to consolidate the first four waivers, operated by the Disability Services Division, into two waivers (community and residential) and move people who use these waivers to individualized budgets. The PCA program will be replaced by a new Medicaid 1915(i) and 1915(k) program known as Community First Services and Supports (CFSS).

Minnesota has a strong reputation as a national leader in HCBS and was rated number one on the most recent AARP LTSS scorecard. Notable system strengths include a wide range of HCBS programs and services and the balance of spending between community and institutional LTSS, with approximately 83% of Medicaid LTSS

expenditures going to HCBS in 2021 (Wysocki et al., 2024) DHS has also historically been proactive in seeking community input and identifying and implementing new initiatives, and is often cited for its promising practices.

There are still opportunities to bring the state closer to meeting the expectations and goals of all the people it serves. Community input on HCBS and the current Minnesota Olmstead Plan has indicated a desire for more flexible and person-centered programs and more choice, and has also highlighted workforce challenges that hinder meeting personal goals. The lead agency structure for administering HCBS programs is an important context for understanding and addressing systemic issues. This decentralized administration has contributed to variability in service access and individual experience, with delays in waiver funding (which is administered by the lead agencies) noted as a particular concern. This chapter focuses on two key areas where Minnesota can leverage current initiatives to strengthen its HCBS system, selected based on input from DHS, the Inclusion Consultants, and community feedback.

Effective HCBS Policies, Programs, and Strategies

4A: Aligning Resources and Instruments to Promote Person-Centered Planning and Measure Implementation and Impact

Person-centered planning (PCP) is a proven strategy for addressing needs and promoting community living (Chong et al., 2024), as well as both a federal and state requirement. Minnesota's current PCP Olmstead Plan goal, "People with disabilities are asked what they want," is assessed in a sample of case files from Minnesota lead agencies using eight standards of person-centered planning.

PCP is a process of discovery and action to improve individual quality of life and includes services and supports both within HCBS programs and outside of them (such as housing). A comprehensive and integrated approach includes understanding the impact of state and federal policies, such as Medicaid estate recovery, that can affect housing access and ownership. National PCP best practices and requirements, as defined by the Centers for Medicare & Medicaid Services (CMS), the Administration for Community Living (ACL), and the National Center for Advancing Person-Centered Practices and Systems (NCAPPS) include:

- Driven by the person's needs, preferences, goals and desired outcomes
- Strengths-based
- Person-centered language/person's own language
- Balance of important to/important for
- Informed choice
- Defined roles, including monitoring
- Individualized mix of Medicaid, unpaid, and other supports

Based on interviews with three states that have designed and implemented enhanced processes for promoting and monitoring/assessing PCP, as well as our literature review and environmental scan, we have distilled common promising practice elements and strategies for aligning PCP expectations, support, and measurement. A recurring theme across these states was a clear linkage between components in the PCP process to promote an overall culture of person-centered thinking. A second was persistence; one state staff member noted that it is essential to not get "weary, negative or tired."

1. Ongoing, state-specific, cross-disability trainings on PCP core competencies

- The Tennessee Department of Disability and Aging offers a range of free person-centered thinking and practice trainings of varying lengths and topics, as well as some mandatory case manager trainings that are required in agency contracts, through its Person-Centered Planning unit. Certified trainers include mentor trainers who can train other trainers.
- The Indiana Division of Disability and Rehabilitative Services conducted a series of trainings on PCP principles and compliance to explain the "why" of PCP and the meaning of "strengths-based" in supporting a culture shift for intellectual and developmental disabilities (I/DD) providers. This effort is now applied to HCBS programs serving the nursing facility level of care and brain injury populations.
- The Maine Office of Aging and Disability Services created a series of person-centered trainings to support its Enhanced PCP process.
- The New Hampshire Department of Health and Human Services has launched a free person-centered practices training series and companion supervisor's guide for case managers and support coordinators; training content includes case studies, content specific to the state's HCBS waiver programs, and badging.

2. Embedding expectations in care planning documents

- Maine and Indiana revised their care plan templates, organizing them around the Charting the Life Course domains to reinforce person-centeredness. This helped capture what is important to/for people receiving services, their goals in each life domain, their desired outcomes, and the specific supports they need.
- Maine replaced dropdown boxes in its Evergreen online care planning system with a structure that forced more thoughtful documentation and provided tools and prompts to support person-centered thinking during the planning process.

3. Moving beyond checklists in evaluating plans

- Indiana has developed a nine-point rubric for evaluating the degree of PCP (exemplary, proficient, marginal, unacceptable) in three areas (see Table 4.1 below). The state conducted joint coding exercises with case management agencies to reach consensus understanding and has seen scores increase over time.

Table 4.1. Sample Scoring Language from Indiana's PCISP Evaluation Rubric

Person Centered			
All team meetings should only occur when the individual is present AND, if applicable, the family or guardian. The PCISP is driven by the individual and family. The outcomes, wants, and needs are centered on the individual's and/or family's vision for a good life. Their desires, cultural beliefs, and values are recognized, respected, embraced, and reflective in outcomes, formal services, and community activities. The PCISP demonstrates the individual's informed choice and allows for opportunities for learning.			
Exemplary (3 Points)	**Proficient** (2 points)	**Marginal** (1 Point)	**Unacceptable** (0 Points)
My good life and/or vision of a preferred life specific to any life domain are reflective of the individual's input and/or interests. **AND** If applicable: PCISP identifies the wants and desires of the guardian. **AND** All outcomes, strategies, and/or action steps are linked to the individual's interests, good life and/or vision of a preferred life specific to the coordinating life domain. **AND** Team discussions on outcomes reflect input from the entire team, including the individual and family.	My good life and/or vision of a preferred life specific to any life domain are reflect of the inidivdual's input and/or interests. **AND** If applicable: PCISP identifies the wants and desires of the guardian. **AND** All outcomes, strategies, and/or action steps are linked to the individual's interests, goodlife and/or vision of a preferred life specific to the coordinating life domain.	My goodlife and/or vision of a preferred life specific to any life domain are reflective of the individual's input and/or interests. **AND/OR** Individual's interests, desires, and wants are identified in the PCISP.	PCISP states that it is written without the individual present. **AND/OR** PCISP states that it is written without the guardian (if applicable) present. **AND/OR** Individual's interests, desires, and wants are not identified anywhere in the PCISP. **AND/OR** Individual and/or family vision for a good life is not identifies anywhere in the PCISP. **AND/OR** Individual and/or family's, if applicable, cultural beliefs and values are violated, discriminated against, disrespected or disregarded.

Source: Person-Centered Service Planning in HCBS: Requirements and Best Practices (CMS)

- Tennessee developed a Review Tool for individual support plans that assesses plan strengths and opportunities for improvement in 11 domains, including relationships and decision-making.
- Maine is developing and testing new quality assurance tools for care plans with case management agencies; these tools will focus on alignment between life vision and plan, to ensure there are no unaligned goals. It includes imbedded definitions that are tied back to PCP expectations.

4. ***Soliciting participant feedback and integrating it into review processes***

   - Indiana publicized its case management core competencies so individuals and families know what they should expect. The state surveys all participants on its Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) waiver using its Case Management Satisfaction Survey to see if their PCP experience aligned with these expectations.
   - In Tennessee, independent support coordinators and case managers are trained in the Council on Quality and Leadership's Personal Outcome Measures (POMs) for use in PCP. The state trends the POMs data over time and uses results to identify changes to the Quality Assurance survey to ensure PCP.
   - The Florida Developmental Disabilities Council has developed a Working with Case Managers guide that includes a survey worksheet for providing feedback on case management.

5. ***Technical assistance to case management entities***

   - Tennessee has a dedicated person-centered planning unit with three staff who serve as a resource across the state, including providing support for organizations seeking official person-centered status. In addition, PCP facilitators are available on request.
   - Maine employs dedicated state staff, including a Community Case Management Manager, to work directly with case management agencies and has expanded its focus from regulation to PCP technical and training support.

Strengths of an Integrated PCP Approach

In addition to aligning with federal expectations and national best practices, respondents noted the value of creating consistency around PCP expectations through training and care planning documents, and of clarifying what is measured through quality assurance. This helps create a consensus understanding of desired outcomes and provides accountability. Ongoing technical assistance from state staff also supports the shift toward PCP culture across case management providers.

Opportunities of an Integrated PCP Approach

While the state has been achieving its *Olmstead* PCP targets, people using services see options for more growth, including more flexibility and "freedom to make decisions" (Minnesota Olmstead Implementation Office, 2024). They also want to see evidence that the process of person-centered planning is working: "*I want outcome data on the extent to which person-centered planning as conducted in Minnesota is actually having an impact on people with disabilities achieving desired life outcomes"* (ibid.) National Core Indicators® - Intellectual and Developmental Disabilities (NCI-IDD) data from 2023–24 on choice and decision-making shows Minnesota below national averages on several indicators related to making choices about housing, schedules, and staff.

Minnesota has created standardized expectations and guidance for PCP and informed choice; however, the state still faces challenges in knowing how well and how consistently these expectations are being met by lead agencies. Currently, performance against the Olmstead Plan PCP goal is assessed using a checklist to confirm the presence of eight required criteria in administrative documentation. Better aligning the current support plan template in MnCHOICES and lead agency review process with DHS's expectations could help further promote a person-centered culture and accountability for achieving outcomes. Technical assistance and potentially requiring standardized trainings can promote consistency.

Implementation Considerations with an Integrated PCP Approach

Minnesota has several building blocks in place that could help create a process for aligning PCP expectations, supporting implementation, and robustly assessing PCP and outcomes. Specifically, DHS can update and build on its Person-Centered, Informed Choice, and Transition Protocol, which has been in place since 2017 and communicates required expectations for the lead agencies administering HCBS programs. Similarly, the comprehensive definition of PCP presented in both the 2022 Olmstead Plan and on the DHS website provides a strong foundation. Potential implementation options include:

- Identify any needed updates to the protocol, including fixing broken links, in collaboration with people with lived experience, lead agency staff, case managers, and other providers.
- Expand or refine existing training materials to reinforce core competencies and include case studies that tie specifically to the protocol requirements, along with knowledge checks. Explore options for requiring training to promote consistency.
- Explore modifications to the support plan template in MnCHOICES to reinforce and align with protocol expectations, including more explicitly capturing desired outcomes across life domains and linking these with supports.
- Consider modifying MnCHOICES to gather more detailed information on relationships, meaningful activities, housing satisfaction, and choice to replace or supplement current forced choice options and help monitor individual experience.
- Modify the lead agency review of care plans, in partnership with people with disabilities, to focus on the expectations in the protocol and assess and score the degree of PCP; train agencies in the review tool and conduct joint coding exercises to promote consensus understanding of expectations. Expand the review sample as feasible to examine disparate populations, including historically marginalized groups.
- Provide technical assistance (internal/DHS or externally contacted) upon request to lead agencies and case management providers.

As noted by state interviewees, implementation requires buy-in across the system, and in Minnesota the lead agencies would be key partners in any initiative. There are also

varying levels of resource investments associated with the options above, including staffing for technical assistance and enhanced monitoring.

Evaluating Efficacy — Proposed Metrics for an Integrated PCP Approach

Data sources to monitor PCP and informed choice:

- NCI-IDD and NCI-Aging and Disability indicators related to choice and other dimensions of person-centeredness, and any state-specific questions DHS may choose to add
- MnCHOICES data, including outcomes tied to specific care plans
- Care plan numeric ratings from a revised lead agency review process
- Feedback from case managers and reviewers

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in an Integrated PCP Approach

A robust PCP process that is built around the person and explores individual preferences by life domain encompasses cultural responsiveness. The process can be further enhanced by including historically marginalized populations in designing any updates to the protocol and PCP trainings, as well as stratifying lead agency review results by specific populations.

How an Integrated PCP Approach was Informed by Lived Experience

Other states' drivers to enhance their PCP processes included federal policy and findings, as well as data on the experiences of people using services. Tennessee contracts with Support Development Associates and models its requirements about the role and involvement of people with disabilities and community members in leadership positions and other activities. Indiana staff noted they were "very intentional" in having conversations and engagement with individuals with disabilities in their families, including holding meetings across the state with no agenda to better understand lived experience, to inform their PCP initiatives. Maine recruited 12 "rock star" supervisors to provide feedback from case managers and what they need to do their jobs, and solicited feedback from self-advocates on new processes.

Ways to Collaborate across State Government on an Integrated PCP Approach

While Minnesota's HCBS programs are managed by DHS, achieving person-centered outcomes often involves programs and services managed by other state entities. To promote a shared understanding of person-centered principles and thinking, Minnesota could offer PCP training across the Subcabinet Agencies involved with *Olmstead* work and explore aligning other, non-DHS documents and processes with person-centered principles, to embed person-centered thinking into the state's organizational culture. Partnering on process updates and training is an opportunity to strengthen and leverage engagement with parts of state government that control resources such as housing and employment.

Challenges with an Integrated PCP Approach

The current state and federal fiscal climate present clear challenges in securing funding for new staff positions or initiatives, such as providing technical assistance, reviewing and revising care plans and review processes, updating MnCHOICES, or expanding review samples. Other challenges include an insufficient workforce, an issue that impedes both choice and the achievement of desired outcomes. The lead agency model of program administration creates barriers to consistency and will require buy-in and collaboration with many partners. Finally, as noted by Minnesota community members, there are larger societal attitudes and expectations regarding people with disabilities that are at odds with person-centered thinking and that can prevent people from experiencing true community inclusion.

4B: Ongoing Technical Assistance and Data-Driven Support for Workforce Development and Retention

While the current Olmstead Plan does not include a goal specific to workforce development and retention, this underlying issue cuts across many *Olmstead* goals and challenges. As noted in the 2021 *Olmstead* satisfaction survey report, "*The most important aspect in helping people achieve their outcomes is a stable support of DSPs (direct support professionals) and caregivers. If staff are always turning over, it is hard to get beyond the basics of health and safety. Person-centered services and meaningful outcomes are reliant on stability and consistency" (Minnesota Olmstead Implementation Office, 2024).* Expanding, diversifying, and improving the direct care staff pool is one of the strategies in the 2022 Plan for meeting the PCP goal.

A recent research synthesis (Scales, 2022) enumerates the multiple requirements for a strong and stable direct care workforce, including competitive wages, adequate employment benefits, updated trainings aligned with care needs, career mobility, workforce flexibility, well-trained frontline supervisors, and elevated roles for direct care staff on their teams. Our environmental scan and key informant interviews underscored the importance of a customized approach to address recruitment and retention that includes providers, direct care staff, and multiple components of state government. State investment in technical assistance (using internal or external subject matter expertise) and accountability was a common theme, along with engagement with the workforce to gather their input and co-create solutions. Other promising practices and considerations included:

- Recognizing the diversity of the direct care workforce, including unique roles, skills, and tasks, e.g., direct support professionals (DSPs) vs. certified nursing assistants
- Using data-driven approaches that start with detailed discovery at the system and provider levels and includes direct care worker and frontline supervisor input to create customized approaches
- Developing a strategic plan that brings together all constituencies and builds in accountability

- Prioritizing initiatives and notching some "easy wins" to build momentum
- Building workforce requirements into contracting

Below are two examples of promising efforts that address recruitment and retention.

Example: Perspectives Corporation, Rhode Island

Perspectives employs approximately 800 staff who support people with a range of disabilities across Rhode Island. The organization was experiencing high rates of staff loss, including middle management/supervisors, with the highest turnover rate among direct care staff with a 3–6-month tenure. COVID exacerbated these trends, and the organization found that overtime was leading to burnout. Leadership engaged the University of Minnesota's Institute for Community Integration to support a process of discovery to identify priorities for organizational change. The resulting Project Align saw a reduction of staff vacancies from 89 full-time and 34 part-time positions to 22 and 5 vacancies respectively a year after launch, and earned Perspectives ANCOR's Moving Mountains award for impact.

A central component of Project Align is its competency-based throughline, where required competencies inform job descriptions, and employee selection using behavioral interviewing, training, and performance reviews. Staff characterized these policies as a shift from filling positions to "hiring for fit." Additionally, the organization worked to develop career and learning paths for staff, as employee feedback revealed that perceptions of DSP work as a "dead end job" was a factor in turnover. Leadership credits the career paths for the company's current 87% retention rate in middle management. Work groups with a range of participants and focus areas helped promote culture change and staff buy-in, provided a venue to "work out the kinks," and created accountability. Other strategic initiatives included:

- Extensive up-front data analysis and external technical assistance to drive priorities, and new data systems to support analysis and monitoring
- Benefits review, including unused or underused benefits
- Wages that reward longevity and commitment
- Use of grant funding for National Association of Direct Support Professionals (NADSP) certification with financial rewards upon completion, such as pay increases and bonuses
- Widespread leadership and supervisor training, including "Learn to Lead"
- Mentoring, with training linked to the NADSP Code of Ethics
- Engagement in policy development on DSP wage increases
- System-level advocacy involving DSPs and other constituencies, such as families and people receiving services
- New recruiting sources/bonuses
- More inclusive marketing and recruitment materials, realistic job previews

- Employee feedback, including 30- and 90-day check-in with new hires and follow-up after trainings
- Internship program

Perspectives has a full-time human resources position devoted to this work, and uses both quantitative (e.g., vacancies and turnover) and qualitative (e.g., staff feedback) to monitor progress. Along with several other providers in the state, Perspectives enters key workforce metrics into a shared system that enables tracking and benchmarking.

Example: Regional Centers for Workforce Transformation, New York

As part of its DSP initiative, the New York Office for People with Developmental Disabilities (OPWDD) funds Regional Centers for Workforce Transformation. Operated by the NY Alliance for Inclusion and Innovation, the Regional Centers provide training and other resources to support DSP workforce development throughout the state. These centers are linked to the core competencies that are used to hire and assess all state and privately employed DSPs and frontline supervisors via a standardized evaluation tool. Training, including 10 to 12 workshops monthly, is free and available to staff at all levels, with frontline supervisors being a key audience. Training priorities are set by the state and by training participants, and are designed to deliver standardized content and messaging across the state. Topics have included burnout recognition, and supporting the workforce, with a shift in focus from retention to engagement.

The NY Alliance also recently completed an ARPA-funded Recruitment and Retention technical assistance project, which generated a DSP podcast; learning collaboratives; a Diversity, Equity, Inclusion, and Belonging toolkit; and a DSP Handbook that includes realistic job previews, the NADSP code of ethics, and other resources. The McSilver Institute for Poverty Policy and Research at New York University evaluated the project and found that structured observations, site visits, and meeting with current DSPs and people receiving services provided potential employees with a realistic preview of the job and were some of the most effective hiring and recruitment practices.

When asked about factors contributing to success, staff from OPWDD and NY Alliance highlighted the following:

- Worker credentialling to promote professionalism and engagement
  - Credentials are available through NADSP and the SUNY/CUNY systems and can be used for college credits and a degree
  - Linked to recognition, including new or expanded responsibilities and public celebrations
  - An evaluation found increased tenure among credentialled direct care workforce staff and reduced turnover compared to staff who were not credentialled

- Making a variety of investments and ongoing experimentation to see what works
- Centralizing the training and support infrastructure
- Communicating and collaborating to avoid duplication, such as multiple diversity, equity, and inclusion initiatives
- Encouraging providers to participate in the NCI State of the Workforce initiative, to track progress
- Using workgroups to guide initiatives that bring a variety of perspectives from self-advocates, families, DSPs, and underserved populations

Strengths of Supporting Workforce Development and Retention

HCBS workforce issues are longstanding and have multiple causes. Building on existing state initiatives, Minnesota can weave promising strategies into an integrated effort that is customized to the state. Given chronic workforce shortages, efforts that improve staff retention and engagement are central to sustained community living and informed choice. As one respondent noted, a well-trained workforce of staff members who love their jobs also means better quality care.

Opportunities to Support Workforce Development and Retention

Direct care workforce shortages in Minnesota, as is the case nationwide, are well-documented. According to one respondent to the Disability Inclusion and Choice Survey, the personal care attendant shortage in Minnesota is “breaking the system.” DHS staff also noted the challenges of case manager turnover. These staff play a central role in PCP and connecting people with the services and supports that can help them achieve their personal goals. The lack of a sufficient, stable, and culturally responsive workforce has multiple consequences that underscore the opportunity for promising practices:

- People don’t get needed services in their communities
  - It is harder to have person-centered care, with informed choice

- Lack of continuity influences the quality of supports
  - Ongoing recruitment and loss of trained staff is costly for providers
  - Turnover undermines efforts to build connections and support a culturally responsive system

Implementation Considerations for Supporting Workforce Development and Retention

Currently DHS is collaborating with other state agencies on a five-year plan to address workforce shortages, informed by its mandatory Labor Market Survey, participation in national workforce meetings, and input from partners. This new plan will support several strategies listed in the 2018 workplan developed by the Direct Care Workforce Shortage Cross Agency Steering Team formed in 2017 at the direction of the Olmstead Subcabinet. Many of the priorities and strategies of that workplan are still relevant. In addition, DHS maintains a dedicated page of workforce resources.

Potential next steps for DHS:

- Develop an internal training and technical assistance function or contract for an external one, similar to the NY Regional Centers, to support providers — including assistance applying the strategies from *Recruitment and Retention in Supports for Minnesotans with Disabilities*.
- Standardize and publicize expectations for all direct care workforce staff that align with CMS core competencies, and develop companion materials that reflect these competencies to support hiring, training, and assessing staff.
- In partnership with providers, direct care staff, and people using services, explore modifications to the Labor Market Survey to facilitate using it as a diagnostic tool for individual provider agencies.
- Explore participating in the NCI State of the Workforce to allow benchmarking against national workforce data, while being mindful of provider burden.

Potential next steps for the legislature:

- Provide funding for worker credentialling, once DHS identifies common criteria.
- Sustain rate increases.

Evaluating Efficacy in Supporting Workforce Development and Retention

Minnesota has several options to measure the impact of state initiatives to improve recruitment, retention, and engagement of its HCBS workforce:

- Data on turnover from the Labor Market Survey (and potentially data on vacancies if the survey were modified)
- NCI-IDD and NCI-AD data on the percentage of people who think their workers change too often
- Training and technical assistance penetration/uptake in the provider market
- Credentialling data
- Benchmarking as feasible with national data
- Data collection with direct care staff on their workforce experience

Additionally, the state should consider stratifying workforce data by staff and service recipient characteristics for more granular insights, as statewide statistics can mask equity issues (Muench et al., 2021).

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Supporting Workforce Development and Retention

Devising and implementing a care plan that is truly centered on personal needs, preferences, and desired outcomes requires a sufficient and stable workforce. Addressing workforce retention and engagement is foundational to PCP and *Olmstead*. Data-driven approaches to supporting providers in hiring and retaining culturally competent staff can yield a diverse workforce that aligns with the HCBS population and offers the range of cultural values necessary to ensure a positive HCBS experience for all people receiving services.

How Support for Workforce Development Projects has been Informed by Lived Experience

Data gathering and collaboration with staff, people receiving services, and family members are core elements of workforce initiatives in Rhode Island and New York. Interviewees repeatedly emphasized "the voice of the DSP" as integral to their work. Addressing vacancies and turnover is responsive to the experience and priorities of people with disabilities in Minnesota as well. Worker shortage was a major theme from the Community Input Report.

Collaborating across State Government on Supporting Workforce Development and Retention

Minnesota has undertaken previous cross-government efforts to address workforce issues. Those workgroups provide a foundation for future collaboration. The state could consider convening a workforce summit to bring together different constituencies with expertise and efforts related to workforce issues, including community-based organizations and the still-active ad hoc direct care workforce committee. Subcabinet Agencies that should be partners include, at a minimum, the departments of Employment and Economic Development, Health, Human Services, Education, and Labor, along with the relevant lead agencies. Collaboration should be broader than state staff, encompassing providers, direct care staff, and self-advocates as well. It will be important to establish a single point of contact and accountability for leading and managing workforce initiatives.

Challenges in Supporting Workforce Development and Retention

Moving the needle on workforce issues is not easy. Funding is a major limitation, including both projected state budget cuts and recent federal legislative cuts to Medicaid HCBS funding. While some strategies can be no- or low-cost, investments in state or contracted staff, resources, IT changes, and rates could pose a fiscal challenge. The Minnesota provider network is large and diverse; reaching, engaging, and supporting them will also require sustained efforts.

Key Informants & Subject Matter Experts Consulted on HCBS & Olmstead Planning

Key Informant or Subject Matter Experts Interviewed	Date & Venue/Modality	Topic(s)
Heather Dane, Chief Program Officer Bureau of Disabilities Services Division of Disability and Rehabilitative Services Indiana Family and Social Services Administration	June 12, 2025 via Teams	Person-centered planning training and assessment
Angela Faulkner, Community Case Management Manager Developmental Disability and Brain Injury Services Office of Aging and Disability Services Maine Department of Health and Human Services	June 13, 2025 via Teams	Person-centered planning training and assessment
Tennessee Department of Disability and Aging **Jordan Allen**, Deputy Commissioner **Kimberly Black**, Statewide Director of Operations **Shalita Wells**, Director of Person-Centered Planning **Jeremy Norden-Paul**, Director of Program Innovation **Carrie Brna**, Director of Employment Innovation **Holly Wilson**, Executive Assistant	June 13, 2025 via Teams	Person-centered planning training and assessment, employment and housing
Alison Pingelski, Associate Commissioner New York State Office for People with Developmental Disabilities	July 8, 2025 via Teams	Direct service workforce recruitment and retention
Amy M. Page, Chief Administrative Officer Perspectives Corporation North Kingston, RI	June 18, 2025 via Zoom	Direct service workforce recruitment and retention
Amy Hewitt, Director Institute on Community Integration University of Minnesota	June 20, 2025 via Teams	Direct service workforce recruitment & retention
Melody Johnson **Monica Robinson,** Associate Vice President of Workforce Advancement, NY Alliance for Inclusion and Innovation	June 30, 2025 via Zoom	Direct service workforce recruitment and retention
DHS Inclusion Consultants **Mao Yang** **Ivory Taylor** **Riss Leitzke** **Angela Harper**	June 24, 2025 via Zoom	Priorities, working vs. not working

Home and Community Based Supports (HCBS): Works Cited & Additional Resources

Muench, U., Spetz, J., Jura, M., & Harrington, C. (2021). Racial disparities in financial security, work and leisure activities, and quality of life among the direct care workforce. *Gerontologist, 61*(6), 838-850.

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Chong, N., Caldwell, J., Kaye, H., & Mitra, M. (2024) Outcomes of person-centered planning in Medicaid Home- and Community-Based Services. *Gerontologist, 64*(6).

Topic 5: Housing

Ayana Dilday Gonzalez, M.A., has over 20 years of experience in policies and practices related to affordable housing development and permanent supportive housing.

Overview of Housing & Olmstead Planning

> People with disabilities will choose where they live, with whom, and in what type of housing. They can choose to have a lease or own their own home and live in the most integrated setting appropriate to their needs. Supports and services will allow sufficient flexibility to support individuals' choices on where they live and how they engage in their communities. — *Putting the Promise of Olmstead into Practice; Minnesota's Olmstead Plan*

Minnesota Housing has a robust and well established permanent supportive housing (PSH) production system that produces a stable portfolio of supportive housing units for people with disabilities. Minnesota benefits from high-level political and systems support for *Olmstead* housing development, and this support provides a solid foundation for continued advancement towards the state's *Olmstead* goal of increasing the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing. Efforts towards achieving this goal benefit significantly from Minnesota Housing's successful history of collaboration with the Minnesota Department of Human Services (DHS) and its county human services offices. The implementation and expansion of high-quality housing opportunities for people with disabilities necessarily requires continued and expanded partnership and collaboration at both the system and program levels between the housing and health care sectors.

Minnesota Housing is remarkably adept at developing integrated, community-based housing units targeted to the state's *Olmstead* population. The agency's Low Income Housing Tax Credit (LIHTC) department offers incentive points within its Qualified Allocation Plan (QAP) and RFP process for capital funding sources, resulting in broad participation and buy-in among affordable housing developers statewide in the effort to build units for people with disabilities. Minnesota Housing awards points on a sliding scale, based on the percentage of PSH units committed by the developer, with a required minimum of 5% or four units committed. This strategy has proved to be very successful in producing a predictable pipeline of high-quality units, resulting in an average of 116 new units each year.

Additionally, DHS has developed and sustained an innovative use of its State Supplemental Security Income (SSI) resource, providing vitally important support to

Minnesota Housing funded properties and other community-based housing. Through the Housing Support program (formerly known as Group Residential Housing), county and Tribal human services offices provide operating assistance and supportive service funding for housing produced by Minnesota Housing, as well as other housing resources that serve people with disabilities.

This kind of interagency collaboration and cross-system braiding of funds will continue to be necessary in the creation of housing solutions for *Olmstead* populations across the country, and in Minnesota specifically. The continued success of Minnesota's *Olmstead* housing efforts would be bolstered significantly by increased, intentional, and systemized partnership activities between the Minnesota Housing Finance Agency (MHFA) and DHS.

Effective Policies, Programs, and Strategies Related to Housing

5A: Increased Interagency Collaboration to Strengthen Housing and Health Initiatives

Historically, many 811 PRA tenants have received services through DHS's Housing Stabilization Services (HSS) program, which leverages Medicaid funds to help seniors, individuals with disabilities, and people with substance use disorders find and maintain stable housing. However, in August 2025, DHS suspended payments to several HSS providers in response to credible allegations of fraud and issued a formal request to CMS to terminate the program entirely. MHFA is hopeful that state-level efforts to redesign and relaunch the benefit with additional oversight and enforcement will be successful, and that the program will continue to support 811 PRA households, and others, moving forward.

Authentic cross-sector partnership is a key strategy and best practice to increase the output and efficacy of efforts to produce housing opportunities for people with disabilities in Minnesota.

Cross-system collaboration that integrates both health and housing systems of care and delivery is integral to the successful implementation of *Olmstead* housing solutions for people with disabilities. "Alignment between state health and housing agencies facilitates successful supportive housing programs, enabling braiding and blending of funding sources and data sharing" (Atkeson et al., 2020); and when health and housing sector leaders come together, share their knowledge, resources, and experience, and work collaboratively towards shared goals, the quality of policy, program and system outcomes can increase exponentially. Minnesota has a solid foundation in this kind of collaborative work, exemplified in the partnership between Minnesota Housing and DHS. The two agencies have worked together to produce a number of highly successful initiatives in support of *Olmstead* housing goals, including the Section 811 Project Rental Assistance (811 PRA) program.

Minnesota's 811 PRA program is one of the most successful in the nation. The Section 811 PRA Program awards funds to state housing agencies that allocate rental assistance funds to housing units set aside in affordable housing projects and partner with state Medicaid and/or health and human services agencies to identify, outreach, and refer low-income people with disabilities to the funded units. Minnesota's program establishes an occupancy restriction for people with disabilities in eligible multifamily properties funded through Minnesota Housing's annual Multifamily Consolidated Request for Proposals (RFP)/Housing Tax Credits (HTC) funding rounds. In accordance with federal requirements, up to 25% of the units in each funded property can be reserved for people with disabilities, through a closed referral system managed by DHS. Although Minnesota Housing applied for, manages, and administers funds for 811 PRA, the program is governed by a written partnership agreement between Minnesota Housing and DHS. Relevant staff from the two agencies hold monthly inter-agency planning and implementation meetings on the program. These multi-disciplinary, cross-system team meetings provide an opportunity to triage pipeline properties, vacant units, and tenants in transition on an individual, by-name basis. This established pattern of regular communication ensures that the program is led collaboratively, with shared information, priorities, and purpose; creating a highly effective program with markedly successful outcomes. Minnesota could benefit from replicating this project management model across other supportive housing programs and initiatives in the state.

Opportunities to Strengthen Housing and Health Initiatives

Although Minnesota Housing and DHS collaborate well on a number of successful housing initiatives in support of *Olmstead* goals, there is considerable opportunity for deeper partnership and alignment. The two state agencies, and others, like the Metropolitan Council, the Department of Transportation, the Department of Veterans Affairs, and the Department of Corrections, should consider adopting policies that intentionally foster promising models of cross-sector, cross-agency collaboration, based on proven techniques from current projects and demonstrations both locally, like the 811 PRA model, and across the country.

5B. Interagency Data Matching and Data Integration

Collecting and sharing data across sectors is a promising practice to ensure that information is available across programs to facilitate data-driven decision-making, resource targeting, and outcomes assessment.

Matching participant data fields across housing and human service agencies is beneficial in many ways, including estimating the number of housing units needed by geographic location by target populations and helping the state to identify, prioritize, and refer members eligible for housing-related services to the most appropriate housing option of the individual's choice. "Successful data sharing between state or regional Homeless Management Information Systems (HMIS) and state Medicaid programs or Medicaid managed care organizations (MCOs) improves a state's ability to identify and engage vulnerable populations." (Atkeson et al., 2020). Data matching allows states to identify participants engaging with both systems of care, prioritize those most in need of

housing and services interventions, and help determine how to best allocate scarce resources in an equitable, data-informed way.

For example, states and counties across the country are pairing records from their Continuum of Care (CoC) program's Homeless Management Information Systems (HMIS) with Medicaid or other DHS partners' client data systems and using the integrated data to inform cross-system planning, prioritization, and resource allocation. Many states, including Minnesota, collect and report demographic and enrollment data at the time of housing referral or services authorization and implementation. A number of states also track and report on identified health related social needs outcome measures that are examined as implementation progresses. In addition to this, however, there are emerging best practices in cross-system housing and health care data management and integration to support housing and services implementation for people with disabilities.

Example: Data Warehouse Enterprise for Linkage Arizona

The State of Arizona is currently implementing an initiative called the Data Warehouse Enterprise for Linkage (DWEL-AZ), a sophisticated data integration warehouse that provides the infrastructure to support system prioritization alignment between HMIS data and the state's AZ Health Care Cost Containment System (AHCCCS) Medicaid data. DWEL is a component of Arizona's 1115 waiver and "H2O" demonstration whose goal is to enhance and expand housing and service interventions for members served by AHCCCS who have a serious mental illness (SMI) diagnosis and are homeless or at risk of becoming homeless. DWEL is designed to identify Medicaid members who meet both housing and related social needs prioritization criteria and housing resource prioritization criteria with a focus on members of shared priority. Leadership at AHCCCS and Arizona's Department of Housing intend to utilize this data to make strategic decisions about their respective and shared systems of care; enhance care coordination through targeted interventions; identify priority populations to maximize resource allocation; and support program evaluation (Solari, n.d.). DWEL-AZ is projected to go live in October 2025.

The success of any interagency data integration project is highly dependent upon the state partners' ability to establish and enter data-use agreements that allow them to share data across multiple agencies. In Arizona, DWEL data contributors share information on:

Housing Data

- Service and program enrollments
- Participant demographics and characteristics
- Housing status and history
- Benefits and income status
- Service history and referrals
- Program outcomes

Medicaid Data

- Demographics
- Enrollment and eligibility
- Health plan type
- Indicators for DDD, ALTCS, Tribal or TAY enrollment
- Veteran status
- Pregnancy indicator
- Medicare enrollment

Challenges in Interagency Data Matching and Data Integration

All data contributors will sign a single data sharing agreement that outlines access protocols, privacy plans and practices, and data security policies. All CoC participants in Arizona are currently asked to sign an HMIS release of information when they enroll in the program, so the staffing and infrastructure necessary to collect DWEL releases is already established and in place. Collecting releases of information from Medicaid members in Arizona will likely prove more difficult. AHCCCS members do not provide written consent for their information to be collected in the Medicaid Management Information System. All members' information is collected unless they affirmatively opt out; however, every Medicaid match in DWEL will require a documented release of information, so Solari is currently training every Medicaid-funded provider to talk to members about completing one. Although this process is time-consuming, the training has been well received across the state, in large part because the release of information form and training protocols were developed in the DWEL Governance Collaborative, with considerable input from community-based providers.

Opportunities for Interagency Data Matching and Data Integration

Housing agencies that think more broadly and inclusively about data may be able to produce better housing (Arena & Pettit, 2018). Using data to inform resource allocation, project planning, and design can help create projects that are more effective in meeting the needs of the community. With access to an integrated, cross-system data warehouse that matched individuals who meet both *Olmstead* priority criteria and affordable housing resource prioritization, Minnesota Housing could allocate financial resources and assign QAP scoring with more strategy, site projects geographically with more intention, and better ensure that accessibility features and assistive technology are aligned with the needs of tenant populations. At a minimum, a cross-system data warehouse could enable the state to:

- Identify and analyze demographic and socio-economic variables to assess *Olmstead* population needs across multiple state agency programs and services
- Allocate capital and rental assistance resources in alignment with the size, geographic location, and housing needs (e.g., mixed housing or majority PSH buildings) of the target population

- Evaluate the need for specific accessibility design features to better serve households with mobility, sensory, intellectual, and other types of disabilities
- Communicate the rationale for policy and resource allocation decisions to stakeholders and community members

Integrated data systems can support and increase care coordination and leverage additional partnerships. Cross-system data sharing supports cross-system care coordination, helping to facilitate the often-difficult process of locating individuals for engagement, collecting and sharing vital documents, and collaborating among multiple case managers and providers. Data sharing can support homeless verification, income verification and disability status verifications while reducing effort and paperwork for the participant.

Data sharing initiatives often begin with member/participant level matching and coordination, but once established, they have the potential to support collaborative prioritization and resource allocation; improved efficiency and reduced service redundancy; shared outcome tracking; and impact measurement of shared community metrics.

5C. Targeted Production and Referral to Housing

“Eighty-four percent of disabled people with low incomes in the United States are eligible for housing assistance but do not receive it” (Sloane, 2024).

The scarcity of affordable housing in general — and of affordable accessible housing in particular — means that eligible individuals with disabilities are often placed on long waiting lists, making it difficult for them to transition quickly from institutional settings, homelessness, or other inappropriate environments in alignment with *Olmstead* goals. The National Low Income Housing Coalition estimates that Minnesota has a deficit of 101,209 affordable rental units for extremely low-income renter households, defined as a household income at or below 30% of area median income (AMI) (National Low Income Housing Coalition, 2023).

To address this, *Olmstead* strategies implemented by Minnesota Housing and DHS have established dedicated or prioritized housing resources for target populations. For example, Minnesota Housing’s LIHTC incentives assign capital resources explicitly to units dedicated to people with disabilities. The 811 PRA program and the Bridges program provide dedicated project- and tenant-based rental assistance specifically for people with disabilities and prioritized for those exiting institutional settings. The Housing Support program provides room and board assistance for people with disabilities in particular, and Minnesota Supplemental Aid (MSA) Housing Assistance provides direct cash assistance to people with disabilities relocating to the community from a residential facility. Targeting certain housing and service opportunities for *Olmstead* populations prioritizes people with disabilities for limited resources and shortens the wait time for households that are prioritized. Minnesota Housing produces or preserves more than 100 homeless- and disability-targeted units each year, in two primary configurations. Two-thirds of these units are located in mixed properties, where fewer than half of the units are

designated as PSH. These are typically funded with 811 PRA or with other targeted subsidies within multifamily properties, where a small subset of units is designated for people with disabilities referred by DHS. The remainder are located in majority-PSH projects. On average, 90% of adults living in majority-PSH properties have a disability of long-term duration (Human Services Research Institute, 2020).

Challenges in Targeted Production and Referral to Housing

Currently, the allocation of targeted capital (e.g., LIHTC) and operating (e.g., 811 PRA) is not determined by population need. Instead, Minnesota Housing determines how many disability-targeted units to produce in mixed properties and how many to produce in majority-PSH properties based on the developer demand for funding for each type of property. Minnesota Housing provides LIHTC incentives and financial resources to support housing models, and they fund the project applications that they receive in accordance with agency underwriting standards and close review of supportive service plans, supportive service budgets, and tenant selection plans. However, neither the LIHTC incentive structure nor the point scale that helps determine the distribution of units funded in each of the two housing types is informed by DHS or other state agency data on *Olmstead* target population demographics or need.

Minnesota Housing uses CoC point-in-time count data, coordinated entry system data, and CoC needs assessment data to inform QAP scoring priorities for PSH projects, but it does not at this time incorporate Medicaid system data. If Minnesota Housing were able to access and analyze DHS participant data, MHFA's housing development division could align its *Olmstead* housing resource allocation with the documented needs of transition-ready populations in the DHS system. With a comprehensive data sharing agreement in place, the two agencies could work together to determine what types of housing to fund, how much of it to build, what populations of housing to build it for, and where to build it in order to best serve the target populations and meet the state's *Olmstead* goals.

Targeted Referral

Minnesota Housing already has considerable experience with targeted referrals. The agency currently requires property managers in state-funded affordable housing properties to utilize the CoC coordinated entry system as the referral mechanism for all state-funded PSH units targeted to people experiencing homelessness. Through this collaboration, the CoC program confirms that all applicants referred to homeless-dedicated PSH units are prioritized as the most vulnerable and in greatest need of a PSH opportunity by local homeless service systems of care and ensures that state-funded housing resources for people experiencing homelessness are allocated in a targeted way. Similarly, DHS's Moving Home Minnesota program, the state's Money Follows the Person program, manages referrals to the 811 PRA program provided by Minnesota Housing funded properties.

Opportunities for Targeted Production and Referral to Housing

Matching participant data fields across housing and health care systems, as described in the promising practice above, would enable Minnesota to better prioritize resources within its *Olmstead* target populations. This internal prioritization within the target population could be based on several important factors including service authorization and waiver eligibility, population-based transition needs, clinical needs, housing eligibility, homeless status, and of course, individual choice.

Learning from Lived Experience

Results of the 2022 Olmstead Satisfaction Survey document that nearly half of respondents (47%) report that Minnesota's Olmstead Housing Plan goals do not represent what they want the future to look like for people with disabilities, and (46%) say that the goals will not help them live the life they want. One of the key issues raised by respondents was that they wanted more focus on "choice" and less focus on "integration" in the formulation of goals. This emphasis on choice over integration should not be used to minimize the harm that past institutionalization has done. Instead, it may be an indication of how far Minnesota has come in its *Olmstead* efforts to move away from institutionalization. Choice was defined expansively, including choice among housing options (family homes, individual apartments, shared living, group homes, etc.). Similarly, Minnesota Inclusion Consultants working with the Metropolitan Council and Minnesota Housing reported that the housing resources prioritized by *Olmstead* were often not desirable options for them and their peers. Specifically, they noted that the focus on integration does not necessarily prioritize the housing needs of people with disabilities who are experiencing homelessness. People with disabilities and histories of homelessness reported not feeling that their priorities were adequately represented in the current *Olmstead* goals. Additionally, Inclusion Consultants reported that the goal of integration is not well aligned with the needs of individuals who use ASL to communicate, many of whom would prefer to live among other Deaf individuals who speak their language. This sentiment is amplified by the National Consortium for Constituents with Disabilities (CCD) Task Force, which highlights the importance of peer socialization among Deaf people who use sign language and notes that traditional efforts at community integration may unintentionally subject them to language deprivation and social isolation (Consortium for Constituents with Disabilities, n.d.). Better data collection, data integration, and data analysis can ensure that future *Olmstead* housing goals are designed to be reflective of and responsive to the needs, preferences, and priorities of Minnesota residents living with disabilities.

Leveraging Continuum of Care and Veterans System Data

It is important to highlight that Minnesota Housing has successfully established meaningful and collaborative partnerships with the state's CoCs, particularly in the areas of project prioritization, project selection, tenant selection, and data collection, but the agency does not manage CoC HMIS data for the state. The Institute for Community Alliances (ICA) serves as the State HMIS Administrator and the HMIS Lead Agency for all ten of Minnesota's CoCs. Any efforts at housing and health care at data sharing and collaboration in Minnesota would necessarily need to include ICA from the outset.

Additionally, the Minnesota Department of Veterans Affairs (MDVA) manages its own data registry of Veterans in need of housing, called the Minnesota Homeless Veteran Registry. Nearly half of all Veterans in the registry report having a disabling condition. The Homeless Veterans Registry is an important source of client data that, through partnership, could be included in a data sharing agreement. TAC recommends that Minnesota Housing work with the statewide HMIS administrator, ICA, with MDVA, and with DHS to create a standardized, cross-system set of PSH performance measures or outcomes and corresponding benchmarks to evaluate overall success.

Leveraging Department of Corrections Data

In order to ensure the inclusion of people with the highest barriers to accessing housing resources, it is also important to prioritize collaboration with the Minnesota Department of Corrections (DOC). The inclusion of DOC reentry data in a cross-system Olmstead housing data warehouse would enable Minnesota to better forecast housing needs, coordinate reentry housing supports, and align *Olmstead* housing resources with the unique needs of people with disabilities leaving correctional institutions. Additionally, increased data sharing between Minnesota Housing and MHFA, DHS, and DOC could facilitate the creation of referral pathways that connect reentering individuals with disabilities directly to targeted Olmstead housing resources, reducing barriers and wait times for this critical and underserved population.

Additional Emerging Practices and Opportunities to Consider

State Bond Funds to Target Special Populations

In March 2024, California passed a ballot proposition and state bond measure funding a general obligation Behavioral Health Bond of nearly $2 billion in state bond funds for supportive housing. These funds are managed by the California Department of Housing and Community Development, and the resource is targeted to individuals with behavioral health disabilities who are experiencing or at risk of homelessness. Included in this allocation, which is intended to create 4,350 units of PSH, is a set-aside for Veterans who have behavioral health needs and are experiencing or at risk of homelessness. The Veterans resources are administered in collaboration with CalVet, the California Department of Veterans Affairs. Veterans are an important subpopulation for Olmstead planning because they are much more likely to have a disability when compared with people who never served in the armed forces. These higher disability rates stem from service-related injuries, the physical and psychological demands of military service, and the fact that Veterans are older than the population in general. As the veteran population ages and faces additional age-related health issues, disability services will become increasingly important for this population.

Many states, in addition to California utilize bond financing to create supportive housing for special populations of people with disabilities. The Massachusetts Executive Office of Housing and Livable Communities (EOHLC) manages a state-bond-funded program called Community Based Housing as a capital resource to support the development of integrated housing for people with disabilities, with priority for individuals who are in institutions and nursing facilities or at risk of institutionalization. The program is

administered in close alignment with MassAbility, a state agency that supports people with physical, cognitive, intellectual, and mental health conditions. MassAbility worked collaboratively with EOHLC to develop a set of required architectural design standards for Community Based Housing units, and certifies all applications for funds before they are reviewed by the HFA.

Minnesota Housing is well positioned to explore similar opportunities. The 2025 legislative session in Minnesota resulted in a two-year housing bill that includes $50 million in new Housing Infrastructure Bond Authority. Minnesota's Housing Innovation Bond (HIB) program is a limited obligation tax-exempt bond fund used to provide capital funds for the acquisition, rehabilitation, and construction of low- and moderate-income housing. HIB projects are already designated specifically for individuals with behavioral health needs, including mental illness and SUDs. Additional collaboration with state agencies like MDVA could help to target the program more specifically to Veterans with disabilities in the state who are in need of integrated, community-based housing opportunities.

5D. Group Home Alternatives

Per the *Olmstead* decision, states have an affirmative obligation to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. While small group homes may not be the immediate image of an institutional setting, for the individuals residing there, they may very well have an institutional feel. Given that 24% of Minnesotans with I/DD live in group home settings, alternatives may provide greater opportunity for community-integrated settings. Creating more options for integrated living aligns with the Olmstead Plan housing strategy to "Improve Future Models for Housing in the Community."

Shared living is a model of housing and care for people with disabilities that involves individuals with disabilities sharing a home with a caregiver or host family. Shared living is not a place. It is not a "facility," or a group home. It is not traditional foster care or a bed in a boarding home. Shared living is not a supported "setting" serving three or four individuals with multiple "come-in" staff. Many of the practices and routines built into our system to manage residential facilities make no sense to citizens living in their own homes. The goal of shared living is to provide individuals with disabilities with the opportunity to experience community living and the benefits of a supportive, family-like environment while maintaining their independence. A shared living arrangement is usually in the shared living provider's house/apartment, but it could also be in the individual's house/apartment. States employ different funding mechanisms to support these arrangements, and some states have developed different levels of service provision in the homes. For instance, Rhode Island offers a standard Shared Living Option in which the individual continues to engage in other outside supports and services; the state also offers a Whole Life Shared Living Arrangement.

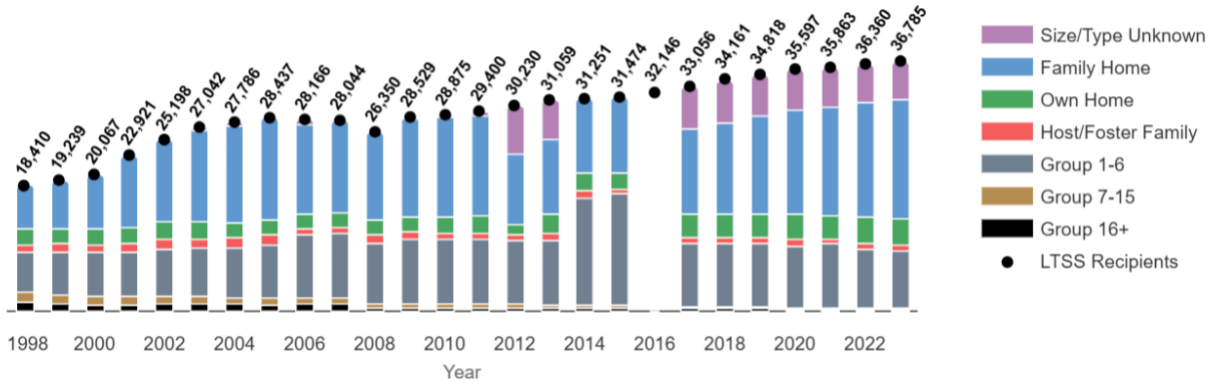
In addition to group home diversion or transition, shared living may be a housing choice for individuals leaving institutional settings such as nursing homes or Intermediate Care

Facilities for Individuals with Intellectual Disabilities (ICF/IIDs). Many states have developed or expanded shared living models recently, providing more options to individuals who need some level of support but do not want or need a group home setting. While Minnesota does have the Life-Sharing program, efforts to expand could result in more integrated community living choices. Over the last 15 years, nearby Wisconsin has seen significant growth in the use of shared living arrangements for individuals with I/DD. Efforts to expand could involve sharing cost savings with residential providers, reducing regulatory burden, and conducting marketing campaigns.

Example: Shared Living in Vermont

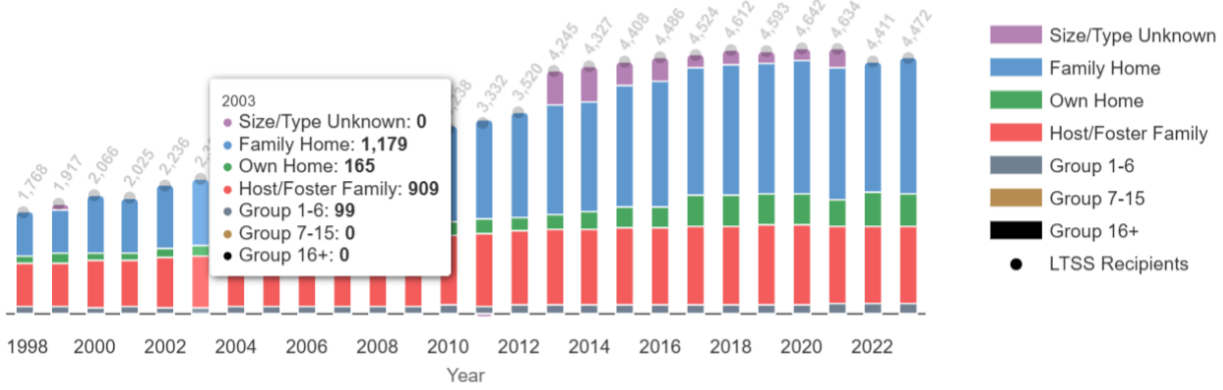
Vermont has invested heavily in the shared living model for decades. Ninety-two percent of individuals with I/DD who receive residential services live in homes, using a model that draws upon the transformative power of relationships. Individuals in shared living continue to receive supports, and shared living providers are eligible for respite services. Funding has been available from the state to support both home and vehicle modifications necessary for specific shared living situations. Younger individuals needing residential services are increasingly choosing shared housing options with peers as opposed to shared living models that are family-based. Vermont is developing more options for peer shared housing, though as more individuals choose this model of independent living, lack of affordable housing in the state has become more of a barrier. Providers are working with developers to create accessible units in larger developments with shared staffing models.

Figure 5.1. Minnesota Long-Term Supports and Services Recipients with I/DD by Residence Type and Year



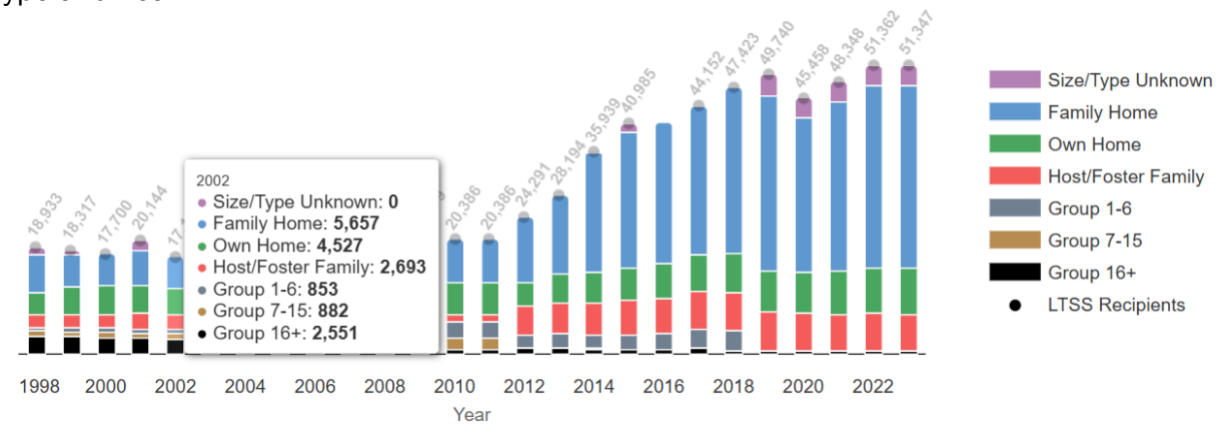
Source: [RISP State Profiles FY 2023 | Minnesota | State Profiles]

Figure 5.2. Vermont Long-Term Supports and Services Recipients with I/DD by Residence Type and Year



For regional comparisons: Wisconsin (less than 1% in group homes)

Figure 5.3. Wisconsin Long-Term Supports and Services Recipients with I/DD by Residence Type and Year



Shared housing differs from shared living in that there is not an identified provider who acts as a caregiver. Shared housing involves two or more people who live in one permanent rental housing unit, sharing costs or, basically… roommates. Roommates may include people with and without a disability. As noted earlier, Vermont is focusing on increasing this housing option. The state of North Carolina has engaged its managed care organizations to expand this option and facilitate client matching for shared housing. Essentials to successful shared housing arrangements include client choice, personalized support, shared responsibilities, and roommate agreements (formal or informal). The housing access and financial benefits of shared housing include increased access to diverse housing markets with desirable and affordable housing options and reducing the housing cost burden. There are also psychosocial benefits which include:

- Increased social networks and decreased isolation
- Sustained independent housing
- Improved community integration
- Increased opportunities to improve problem-solving skills

Crisis Respite Programs to Support Community Tenure in Group Home Alternatives

For individuals with disabilities experiencing crisis, a safe response and if needed, a safe place to go are critical components for maintaining community integration. Too often, moments of crisis result in unnecessary hospitalization or even incarceration. Temporary crises ending in prolonged institutional stays have progressively detrimental impacts on individuals. Respite programs, including programs that are peer-run, offer alternatives to emergency departments.

One of the goals of peer-run crisis respite is to provide connections and relationships that can lessen the intensity of the crisis. These non-medical alternative programs offer a comfortable, non-judgmental environment in which individuals can process stress as well as explore new options. As people have an opportunity to stay connected to peers while moving through challenging thoughts, feelings, and impulses, the need for external intervention is diminished. This alternative approach to handling crisis teaches people healthier attitudes about themselves and others.

Example: Peer-Run Respite, New York

Rose Houses are run by People USA in upstate New York. Rose Houses are 24/7 short-term crisis respites that are home-like alternatives to hospital psychiatric emergency departments and inpatient units. Individuals can stay up to seven days, and can come and go for appointments, jobs, and other essential needs. These homes are 100% operated by peers who have their own lived experiences. Individuals experiencing crisis can either self-refer or be referred by health care or other providers. Services include peer support and engagement, recovery and

wellness education, solution planning, wellness activities, 24/7 support lines, and linkages to needed resources.

Example: Crisis Respite that is Not Peer-Run, Vermont

The Vermont Crisis Intervention Network is a three-tiered crisis response system that includes two crisis beds for individuals with I/DD experiencing a psychiatric, emotional, or behavioral crisis. The program offers onsite crisis consultation and if assessed to be necessary, individuals are referred to the crisis beds. Each bed provides individualized 24-hour supervision and support in a safe and calm environment. Supports may include psychiatric, medical, therapeutic, personal care and community participation, dependent upon the needs and wishes of the individual. Weekly clinical conference calls assess stabilization progress and collaborate on planning for a return to home and community.

Prior to COVID, the average length of stay in these settings was 14 to 21 days. Since COVID, the average length of stay has increased and has been skewed by a few individuals whose stays have been prolonged relative to discharge placement challenges.

Challenges in Shared Living and Shared Housing Models

Lack of affordable housing and a diminishing workforce were noted as challenges by Vermont in its ability to meet the needs of participants in their shared living and shared housing programs. While onsite crisis response is available statewide in the small state of Vermont, a state as large and rural as Minnesota may be more challenged in full-scale implementation.

Opportunities for Shared Living and Shared Housing

In addition to promoting greater community inclusion, shared living and housing alternatives could provide significant cost savings to the state as an alternative to four-bed group homes. Minnesota could expand this program through active marketing and recruiting, decreasing regulatory burden (i.e., not requiring licensure for shared living with only one disabled individual), and providing share savings incentives to providers.

Increasing access to crisis respite programs, whether peer-run, clinical, or both, will require some initial investment from the state, but will yield long-term savings. Unnecessary hospitalizations are costly not only to the state, but to the individuals served by the system. In addition, crisis respite provides opportunity for diversion from engagement with the criminal justice system.

Learning from Lived Experience in Shared Living and Shared Housing

In response to the voice of lived experience, Vermont has adapted its programming and shifted to more shared housing. Peer-run respite programs are designed and run by individuals with lived experience.

Key Informants & Subject Matter Experts Consulted on Housing & Olmstead Planning

Key Informant or Subject Matter Experts Interviewed	Date & Venue/Modality	Topic(s)
Adria Teni, Program Administrator DWEL-AZ, Solari	July 9, 2025 via Zoom	Arizona Cross-System Data Watehouse
Gloria Quinn, Executive Director **Patrick Frawley**, Director Upper Valley Services	July 8, 2025 via Zoom	Housing for people with I/DD in Vermont
Dee Martineau and **Alesha Alexcee**, Minnesota Housing Inclusion Consultants	July 2, 2025 via Zoom	*Olmstead* housing successes and challenges in Minnesota
Jeremy Norden Paul, Director of Program Innovation **Allison Moore**, Director of Housing Innovation, Tennessee Department of Disability and Aging	July 1, 2025 via Zoom	Assistive technology to support community-based housing opportunities
Scott Beutel, Assistant Commissioner for Special Projects **Ryan Baumtrog**, Assistant Commissioner for Policy and Community Development, Minnesota Housing Finance Agency	June 4, 2025 via Zoom	Minnesota Housing *Olmstead* initiatives

Housing: Works Cited & Additional Resources

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Topic 6: Positive Supports

Jami Petner-Arrey, Ph.D., has over 25 years supporting people with disabilities and contributing to the disability field as a direct support provider, special education teacher, university instructor, and researcher.

Overview of Positive Supports & Olmstead Planning

Positive supports, also known as positive behavior supports (PBS) or positive behavioral interventions and supports (PBIS), began to take prominence in the 1980s as concerns about aversive behavioral support intensified. These supports also reflected increasing recognition that behavior is communication, and that people often have reasons for engaging in behavior deemed to be problematic. Positive supports were advanced specifically to allow for a more positive, strength-based response to people who demonstrate complex behavioral support needs. Since then, research has demonstrated the effectiveness of positive support strategies. The advocacy community has been at the forefront of some of these shifts, though some strategies used in positive supports may not be favored by different communities. In this report chapter, "positive supports" is used to describe a broad array of strategies to address complex behavior. In some instances, terms (e.g., "problem behaviors") may follow those used in the research or promising practices, but are not used across all populations and may not be favored by the advocacy community today.

Positive supports are a collection of interventions and strategies used to mitigate behaviors that interfere with a person's life. PBS have been defined as an approach that:

> *Unites the precision of a careful analytical examination of the functions of problem behavior, a broader framework of person-centered values and processes, and an emphasis on teaching alternative skill repertoires. PBS involves a conceptual shift in our approach to addressing difficult behavior associated with disabilities away from a simple reduction of the occurrence of such behavior (e.g., punishment) to a comprehensive strengths-based teaching approach that considers the person and his or her total life span or ecology (Sailor et al., 2009, p. vi).*

Positive supports can be achieved through many different strategies that share important values including:

- A conceptual shift from problematizing behavior to focusing on strengths and empowering people with complex behavioral support needs

- A focus on interventions that put control in the hands of people with complex behavioral support needs
- Person-centered interventions and progress monitoring
    - Person-centered planning that bolsters people's system of support within their communities, focusing on strengthening the family and on learning from lived experience

While different approaches call on a range of strategies, most positive supports share some common elements including:

- Systemwide implementation
- Evidence-based interventions
- Engagement of the person, family, and other supporters
- Individual assessment and planning
- Data collection and outcome evaluation
- Person-centered approaches to supporting behavior (Association for Positive Behavior Support, n.d.).

Positive supports are used in different programs and settings, from schoolwide educational interventions to Home and Community Based Services (HCBS), and even in corrections settings. They are also used to support people with a variety of diagnoses and needs including people with intellectual or developmental disabilities (I/DD) who are dually diagnosed, older adults, people with diagnosed behavioral health conditions, and people with substance use issues. The Minnesota positive supports rule is intended to "promote community participation, person-centeredness, and inclusion in the most integrated setting." This rule outlines requirements for providing positive supports, and includes several approaches, though it is limited to only specific populations.

Different approaches may be called something other than positive supports. For example, people with diagnosed behavioral health conditions may use recovery-oriented models while similar strategies used with people with substance use issues may be referred to as harm reduction. Minnesota wants to secure the broadest application within its Olmstead Plan, so in this report chapter, we consider the *intent* of positive supports, rather than the current populations and programs referenced in positive support policy or the positive supports rule (see Minnesota Statute 245D and Minnesota Rule 9544).

People with complex behavioral needs may experience greater risk of institutionalization. Minnesota offers an array of services for people with a range of behavioral health needs (see Table 6.1), and recognizes the importance of addressing these needs in ways that are not only person-centered, but also effective in reducing the need for more invasive and restrictive interventions. Minnesota has statutes, rules, and policies in place that define and regulate positive supports, as well as a series of initiatives intended to expand and grow them. In this chapter, we point out some key areas where Minnesota can look to improve its adoption and application of positive supports.

Table 6.1. A Snapshot of Minnesota's Behavioral Health Safety Net System (Au-Yeung & Bray, 2024)

As characterized by the literature and key informants

Service Category	Standard Services	Safety Net Services	Safety Net Services	Safety Net Services
Acuity Type[a]	**Low Acuity**	**Medium Acuity**	**High Acuity**	**Highest Acuity – Emergent/Urgent**
Description	Providers serve individuals with low-intensity mental health and/or substance use disorder (SUD) symptoms in an outpatient setting	Providers and resources serve individuals with serious mental illness in their community i.e., outpatient or residential	Providers and resources serve individuals with serious mental illness in their community i.e., outpatient or residential	Providers and services address the needs of patients with severe symptoms in primarily inpatient settings
Providers	Basic behavioral health outpatient providers e.g., therapists, psychiatrists	Specialty and enhanced service providers e.g., social workers, substance abuse specialists, rehabilitation workers	Comprehensive residential safety net care providers e.g., time-limited residential facilities, primarily unlocked	Crisis response providers in the community and inpatient service providers in facilities that are primarily locked e.g., usually psychiatric units in larger hospitals or psychiatric hospitals
Patient Population	Patients with low-intensity mental health or SUD symptoms and diagnoses	Patients with more intense mental health or SUD symptoms or cooccurring illness[b]	Patients with high intensity mental health or SUD symptoms, or co-occurring symptoms who require a residential level of care	Patient in crisis and patients with symptoms of mental health or SUD or cooccurring disorders that are so severe they cannot be treated in the community
Facilities and Services	• Screening and Assessment • Emergency room treatment • Outpatient therapy • Medication management • Intensive outpatient programs • Partial hospitalization • Day treatment programs	• **Community Residential Settings**[c] • Children's Residential Facilities (CRFs)[c] • Community Access for Disability Inclusion (CADI) waiver and Home and Community-Based Services (HCBS) services • Targeted case management • **Wraparound care coordination**[c] • Assertive Community Treatment (ACT) Teams • Peer supports and non-clinical providers • Adult Rehabilitative Mental Health Services (ARMHS) • Certified Community Behavioral Health Clinics (CCBHCs)	• **Intensive Residential Treatment Services**[c] (IRTS; potentially locked) • **Psychiatric Residential Treatment Facilities**[c] (PRTFs) • Children's Residential Facilities (CRFs)[d] • Residential Crisis Stabilization (RCS) • Jails	• Crisis response teams • Inpatient hospital (psychiatric unit) • Minnesota Intensive Therapeutic Homes • **Community Behavioral Health Hospitals**[c] (inpatient) • **Child and Adolescent Behavioral Health Hospital**[c] (inpatient) • Minnesota Sex Offender Program (MSOP) • Anoka-Metro Regional Treatment Center (inpatient) • Community Addiction Recovery Enterprise (CARE) facilities

[a] Refers to the severity of a patient's illness and the level of attention/service they will need from professional staff

[b] Includes specialty populations such as justice-involved patients, individuals with intellectual and developmental disabilities (IDD), individuals with traumatic brain injury (TBI), and patients coming from the child welfare system

[c] Areas identified by key informants as greatest need with respect to bed and/or facility numbers

[d] CRFs may be categorized as either medium or high acuity depending on their certifications (Minnesota Department of Human Services, n.d.).

Subtopics

Positive supports are used in many federal systems, including the Department of Veterans Affairs; the Indian Health Service; Medicaid and Home and Community Based Services; services provided under the Older Americans Act and Medicare; and throughout the county in correctional systems. Each system uses strategies relevant to the people supported (see Section 6A: Expanding Supports to More People below). Many of these approaches are adopted and modified by groups serving specific populations or cultures. Positive supports focus on person-centeredness and allow people to make informed choices; several approaches also highlight lived experience and peer support.

Populations of Particular Concern for Positive Supports & *Olmstead*

People with complex behavioral support needs are served across different settings and programs in Minnesota. These include:

- Minnesota Department of Education, including students receiving Special Education
- Department of Health (MDH) and Department of Human Services, particularly people served by the aging and disability waivers, and those receiving HCBS services
- Minnesota judicial system, particularly people served by correctional systems, including juvenile facilities
- Veterans Affairs
- Other programs and entities not specifically noted

In Minnesota, these programs may be administered statewide or operated at the county level. Key informants have also noted that a number of children and adults with complex behavioral support needs are served out of state due to constraints in providing support within the state. Though programs in Minnesota are under the purview of the positive supports rule, individuals served out of state may not be receiving the protections afforded through the rule.

Positive Supports & *Olmstead* in Minnesota

Currently Minnesota places focus on positive supports within its Olmstead Plan. Specifically, the Plan outlines a vision that:

> *People with disabilities will be treated with respect and dignity. They will receive services that provide positive, therapeutic supports and practices; trauma-informed care; and person-centered thinking and planning. Physical intervention will occur only in an emergency when an individual's conduct creates an imminent risk of physical harm to self or another, and less restrictive strategies will not achieve safety.*

The Olmstead Plan includes goals to significantly reduce incidents of seclusion and restraint from baseline figures. To achieve these aims, Minnesota has engaged in numerous positive support initiatives such as providing training for prison staff and implementing schoolwide PBIS grants.

Strengths of Minnesota's adoption of positive supports include:

- Policies enacted in rule to advance positive support strategies
- A robust set of values that demonstrate commitment to people with complex behavioral needs
- A network of highly skilled, committed experts to advance evidence-based practices
- Regional networks that share education, innovate, and problem-solve
- Multiple initiatives aimed at providing population-specific improvements
- For some programs, such as PBIS, a rigorous measurement protocol to assess progress
- Infrastructure for coordinating behavioral health care for some populations and people with serious behavioral needs
- Infrastructure in place for the use and measurement of positive supports

Barriers to these efforts include:

- Difficulties in coordinating care across distinct and disparate support systems (e.g., Department of Human Services (DHS), Department of Children Youth and Families, Department of Health, Minnesota Department of Education (MDE)
- Inadequate services or programs in all locations throughout the state, increasing potential for more restrictive placements or inability to transition people out of restrictive placements
- Lack of consistency in how different regions and counties operate similar programs
- Issues with tracking and measuring behavioral incidents
- Issues with turnover, rates, and incentives for providers and staff responsible for implementing positive support strategies; these issues reduce the ability to support people effectively in the community and stand in the way of transitioning people into less restrictive settings.
- Inability to successfully manage the needs of people with complex behavioral concerns due to case management limitations
- Lack of county mental health supports (e.g., fewer than half of Minnesota's counties have Assertive Community Treatment (ACT) teams)
- Reliance on police intervention for challenging behaviors Unnecessary guardianships that prevent individual decision-making
- Gaps in implementation of PBIS statewide

The state has adopted a systemwide approach that promotes positive supports, and has embraced valuable underpinnings of the positive support model intended to reduce stigma and meet people where they are. Minnesota also has significant structures in place to spread innovative practices throughout the state; has created fertile avenues for education and information sharing; and has advanced a values framework that

allows flexibility in practice. Additionally, Minnesota has recently studied barriers to positive support in several different populations, and has reported on findings and included recommendations for improvement (Au-Yeung & Bray, 2024; Merz & Berg, 2024; Direct Care & Treatment, 2025; Dillon et al., 2017).

Regarding *Olmstead*, however, there are several areas where Minnesota could further strengthen its approach to positive supports:

- Expand positive supports to be inclusive of more people and populations by adopting strategies with demonstrated effectiveness for specific populations.
- Improve care coordination for people with complex behavioral needs who interact with multiple systems of support.
- Support people to remain in the community and to transition back as soon as possible.

Effective Policies, Programs, and Strategies Related to Positive Supports

6A: Expanding Positive Supports to More People

Positive supports, as conceptually defined, can be applied to a broad range of people and populations in Minnesota. In rule, however, these approaches appear to cover only select people and populations. The rule specifically states that it "applies to providers of home and community-based services to persons with a disability or persons age 65 and older governed by Minnesota Statutes, chapter 245D… or to other licensed providers and in other settings licensed by the commissioner under Minnesota Statutes, chapter 245A, for services to persons with a developmental disability or related condition." This is expansive coverage, but may miss opportunities to cover other populations served by providers not governed by these statutes such as people served in the corrections system, people served by the Department of Veterans Affairs, or other populations. Additionally, the rule (likely on purpose to allow for flexibility) does not define the various approaches under its umbrella. This may lead to confusion about which strategies, including those known to and used by different populations, constitute positive supports. Note that the state, community organizations, and providers have widely adopted many of these strategies, though there is not a clear connection between practices used in the community and what is considered positive supports. Below are recommendations for expanding the strategies to accommodate the needs of more people and populations. Additionally, the state can make clear that these strategies can be part of a positive supports approach.

Other strategies that may be helpful to consider are:

- Positive Behavioral Intervention and Support
- Recovery Oriented Model

- Trauma-Informed Care
- Harm Reduction

Note that there is an overlap of practices among these strategies.

Positive Behavioral Intervention and Supports

Positive Behavioral Intervention and Supports (PBIS) is an evidence-based, three-tiered framework that is implemented in a school or an entire district. PBIS includes three tiers targeted towards different needs (Center on Positive Behavioral Interventions and Supports, n.d.a). Tier 1 includes preventive supports that are available to all students. Tier 2 includes more frequent and targeted supports for students who demonstrate some needs for behavioral supports. Tier 3 includes individualized supports for students with the most intensive needs, whether or not they are receiving special education services.

PBIS has been shown to:

- Improve academic and other important outcomes.
- Reduce restrictive school intervention such as suspension and seclusion and restraint.
- Improve teacher and school outcomes, such as improved school culture and climate and reduced teacher burnout (Center on Positive Behavioral Interventions & Supports, n.d.b)

The Minnesota Department of Education (MDE) has embraced PBIS and offers grants for schools throughout the state to become PBIS schools. PBIS has been in place for about 20 years and nearly half of the students in Minnesota attend school in a PBIS district (Minnesota PBIS, n.d.a). According to key informants, becoming a PBIS school is a significant investment, as it requires multiple years for a school to be fluent in implementing PBIS and even longer for schools to be ingrained in PBIS (up to 10 years). MDE has a team that is tasked with supporting these schools and districts. This team has considerable expertise and has made substantial progress in implementation over the years. There is, however, an opportunity to better integrate schoolwide mental health through the Interconnected Systems Framework. The interconnected systems framework is a way to create a unified system of behavioral supports that integrates PBIS and school mental health strategies, along with including families and community partners as part of the approach. California began adoption of this approach several years ago and researchers have found that it significantly reduced out-of-school suspensions and expulsions (Gage et al., 2020). Creating better coordination of PBIS and mental health support is one approach that may help MDE further advance the decades of progress that it has made in PBIS.

Recovery Oriented Systems of Care (ROSC)

The recovery-oriented model aims to support people with mental health needs or substance use issues by removing stigma and helping them plan for recovery. Like

positive supports, ROSC is person-centered, strengths-based, outcomes-driven, grounded in research, and focused on continuity of care. Minnesota has several small- and large-scale initiatives driven by the state, community, and professionals to focus on recovery including the Minnesota Alliance of Recovery Community Organizations whose mission is to educate, advocate, and mobilize resources for recovery.

Michigan Health and Human Services implemented a ROSC by creating a vision for reform, defining relationships and responsibilities between supporting agencies, developing a ROSC office, and developing tools and resources for people seeking support. Michigan's adoption of ROSC started over 10 years ago to address the behavioral needs of people with substance use issues and has expanded to include more populations.

The Ohio Association of County Behavioral Health Authorities developed a ROSC blueprint in 2016. The blueprint, website, and other documents are emblazoned with the phrase "Recovery is Beautiful" and focus on the celebration of recovery. The Ohio ROSC is a coordinated network of community services and supports building on the strengths and resiliencies of individuals, families, and communities to advance wellness and health. Ohio assessed how well the ROSC was meeting its recovery-oriented goals in 2018 and found that the system was organized in a way that is consistent with principles though identified areas for improvement (Bunger & Beer, 2018).

Recovery-oriented and trauma-informed approaches are encouraged in Indian Health Service programs nationally, and through dedicated programs targeting different groups. For example, the Tribal Youth Resource Center includes resources for youth with behavioral health needs and substance use issues. The Winnebago wellness court is an optional program in on the Winnebago reservation in Nebraska that allows adults who are involved with the court system to choose a wellness track that focuses on their recovery. The wellness track has been culturally adapted and a youth wellness track was also developed.

Trauma Informed Care

Trauma-informed care (TIC) is an approach that seeks to prevent and ameliorate the impact of trauma in the lives of children, adults, and families. When people experience trauma, it can cause lasting harmful effects by negatively impacting people's resiliency and ability to cope and adapt to stress thus contributing to poorer health outcomes overall (Hughes et al., 2019). TIC focuses on creating systems that are firmly rooted in supporting choice, safety, empowerment, trustworthiness, and collaboration for both those receiving and those providing services (Fallot & Harris, 2011; Substance Abuse and Mental Health Services Adminstration, 2014). TIC has been associated with a number of benefits including decreased use of restrictive behavioral interventions (Azeem et al., 2017; Bloom & Farragher, 2011), improved organizational culture, increased staff satisfaction and retention (Hales, et al. 2019), and decreased staff burnout (Handran, 2015). Minnesota has begun several approaches grounded in TIC, including recieving support through a SAMHSA grant. See Topic 7: The Prevention of Abuse and Neglect for more TIC approaches that may be leveraged.

Trauma Informed Oregon is a statewide collaborative to promote and sustain trauma-informed policies and practices across physical, mental, and behavioral health systems and disseminate promising strategies to support wellness and resilience. It is also a centralized source of information, resources, and training for health care and related systems.

In order to support greater adoption of TIC approaches, the Indiana University School of Public Health developed a free online course to enhance professional development in TIC. This course is self-paced, and available for anyone. Learners earn a certificate of completion and can earn anywhere from six to ten continuing education hours.

6B: Coordinating Care

People with complex behavioral support needs may access many different types of systems, with each touch point offering an opportunity to address support needs and mitigate harmful consequences of behavior. People with complex behavioral needs generally receive more services than those with lower behavioral support needs, and they may receive services from many professionals and organizations, fracturing their care (Rich et al., 2012). Effective care coordination requires collaboration, communication, and advocacy across provider systems (Albertson et al., 2022).

Minnesota has recently engaged in several initiatives with the express intent of overseeing or coordinating care for specific populations. For example, Minnesota has adopted a single point of entry for community-based crisis and residential services for people with I/DD, so that effective care can be provided to meet their needs, no matter the source of the referral. Minnesota recently carved out a unique state agency for "Direct Care and Treatment" (DCT), tasked with overseeing and coordinating the services of people with mental illnesses, substance use disorders, I/DD, and other serious or co-occurring conditions who cannot be served by other systems (Direct Care and Treatment, 2024). Minnesota also enacted behavioral health homes about a decade ago (Dillon et al., 2019). This evaluation found these to be supportive of people with complex care needs, while noting areas where improvements could be made. Minnesota also has targeted case management for children with behavioral health needs. Minnesota received grants to develop a system of care strategy that helps to coordinate care between MDE, MDH, DHS, and corrections.

Integrated Care Coordination

To meet the needs of people with complex medical and behavioral needs, Georgia implemented intensive support coordination to offer more holistic services, more frequent care coordination, and greater specialization. Nearly 2,000 people with complex behavioral support needs have been enrolled in Intensive Support Coordination (ISC) and receive specialized coordination of waiver services and medical and behavioral support services (Georgia Department of Behavioral Health & Developmental Disabilities, 2024). These Intensive Support Coordinators have caseloads of fewer than 20 people and conduct monthly in-person visits. They receive

clinical supervision from a registered nurse or licensed behavioral professional and have at least a bachelor's degree in the human services field (ibid.).

North Dakota implemented a program for people involved with the corrections system called Free Through Recovery. This program includes coordination of care for people who have behavioral health needs to ensure that they can access treatment and recovery services. It also pairs people with a peer who can provide mentorship, advocacy, and help them in recovery. One primary aim is to prevent recidivism.

Cherokee Health Systems in Tennessee has an integrated behavioral health care and primary care model that involves strong coordination between primary care providers and a team of specialty mental health care providers. This allows for timely and efficient psychiatric consultations, case management, therapy, and follow-up both in person and virtual. This program includes a dedicated training model for practitioners and teams of mutli-disciplinary experts and offers a broad range of holistic services, from substance abuse services to parenting classes and stress management.

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) models provide intensive supports in the community and when implemented with fidelity, have demonstrated success in supporting people to remain in their community (Herinckx, H., 2021). Minnesota offers ACT services, though fewer than half of the counties have ACT teams in place.

The New York State Office of Mental Health has an ACT program that not only helps to coordinate treatment, but also provides family education, community integration, and peer and vocational support. In an effort to provide these supports statewide and to many populations, New York developed a specialized forensic ACT team that coordinates with court systems, parole and probation programs, and corrections systems to ensure that people can access mental health supports. The state also provides specific guidance for rural ACT teams that reduce staffing ratios and requirements to ensure that rural teams can build capacity. Finally, New York has developed guidance for supporting older adults, who require strong collaboration between support systems.

6C: Supporting People to Remain In and Transition Back to their Community

People with complex behavioral support needs are often at risk of institutionalization and when institutionalized, may experience barriers in transitioning back to their communities. Minnesota has a complex transitions team that can support people who meet certain criteria to transition back to the community from acute care settings. The state also released a report and recommendations from an Acute Care Transitions Advisory Council on improving support for people to transition from institutional settings back into the community (Acute Care Transitions Advisory Council, 2025). The report found that the state needed more resources for regional support, stronger collaboration between state and regional supports, and systemwide measurement.

Telehealth and Technology Supports

Telehealth and remote supports offer alternatives for people with behavioral support needs to receive services using technology in their homes (Fisher et al., 2017). Such support also helps to expand services to rural areas. These supports are widely used in Minnesota and have been found to be effective (Minnesota Department of Health, 2024). When these services are used for behavioral health support they may be called tele-behavioral health (TBH). They provide a collaborative approach to treatment and can improve access (Fisher et al., 2017).

Remote supports (e.g., smart homes) can promote autonomy and person-centeredness by ensuring that people can receive services that are not restrictive, are provided in their own homes, and can allow for privacy. Increasingly, people with disabilities are benefiting from these types of support (Tassé et al., 2020). While not applied broadly as an approach for meeting behavioral health needs, in many circumstances, people with complex behavioral needs can benefit from a combination of remote and in-home supports to maximize opportunities across environments (Tanis and ANCOR, 2021).

Vermont uses a telepsychiatry model to meet the needs of nursing home residents in rural areas. The model provides psychiatric exams and medication reviews, and can be used to adjust medication. This program has demonstrated improved access to services and reduced the cost of psychiatric services (Fisher et al., 2017).

The Nebraska Department of Health and Human Services allows for several services that can be provided through telehealth to support people with behavioral health needs and substance use issues. Services that can be provided remotely include a 24-hour crisis line, emergency community support, crisis response, assessment therapies, and medication management. A report found that while there were communication barriers preventing full use of these services, there was also great potential for people to receive tele-behavioral health services in the community (Watanabe-Galloway et al., 2018).

The Ohio Department of Mental Health and Addiction Services uses telepsychiatry for people with I/DD and mental health conditions. This program provides people with access to highly specialized behavioral health services even when they live in underserved areas. The program serves more than 1,800 individuals in 83 counties (Ohio Department of Mental Health and Addiction Services, 2025).

Diverting Institutional Placements

Rather than supporting people to transition from institutions, several programs exist to reduce the need for institutional placements in the first place. These programs provide specialized support to people who, without appropriate intervention, might be served in restrictive settings or institutions, or might interact with the corrections system.

The Colorado Department of Health Care Policy and Financing offers Behavioral Health Support Transition Grants in order to divert people with behavioral health needs away from institutional supports. The services are provided to people with a history of

institutionalization. These grants enabled local communities to provide housing assistance and transportation support, as well as crisis and counseling services.

Peer supports are non-clinical supports that help people with behavioral health needs learn from people with lived experience. Minnesota certifies peer specialists who can offer support in a variety of settings. Peer support can help people with everyday behavioral support needs during crisis, and as they transition from restrictive settings back into the community. National Alliance on Mental Illness, Multnomah Chapter in Oregon provides peer supports for Veterans with behavioral health issues to help them navigate services in the community. Peers provide information, support people as they work towards goals, help them access resources and services, help them develop plans, support them as they make informed choices, support their education, and help them as they recover.

In Arkansas, Benchmark Human Services developed a model of support for people with I/DD and behavioral health needs that includes wrap-around services. The model provided active consulting and training for providers of I/DD services to help them develop a continuum of care that is flexibly adapted to support people to remain in their homes. The wraparound supports include hands-on training to caregivers, support for dealing with law enforcement or courts, and other daily supports.

Transition Supports

It can often be difficult for people to transition from restrictive settings back into the community, due to lack of coordination and transition supports. Several efforts have been undertaken in Minnesota to transition people from restrictive settings. The Jensen Settlement required DHS to transition people served at the Minnesota Specialty Health System–Cambridge to community settings. Transition to Community supports the transition of people served in Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter into community settings of their choice, and DCT also supports people as they transition into community settings. Several states and programs have developed unique strategies to offer continuity of care during transitions.

The New York Alliance for Rights and Recovery offers a Peer Bridger program to support people transitioning from psychiatric hospitals to the community. Peers offer support from the point of transition, for as long as the person desires it. They provide coaching and mentoring, offer meetings open to all participants, hold daily peer support meetings, and help people develop transition plans. Their aim is to help people get out of the hospital and stay out of the hospital.

North Dakota's Life Skills and Transition Center, an institution serving people with I/DD, was modified to support improved transition from the institution back into the community. The institution changed its mission from supporting people indefinitely to supporting people temporarily, and changed its name to reflect this mission. Transition planning starts on the first day of receiving services, and each plan is individually tailored to the person's needs. While served at the Center, people can receive services, such as vocational supports, that will enable them to transition back into the community

successfully. When referrals can be supported effectively in the community, the Center connects the person to community services instead of keeping them in the facility.

Considerations

Strengths of Positive Supports

Many of the strategies and practices outlined in this report chapter are based on evidence and have proven their effectiveness over time. These strategies are also rooted in values that are similar to Minnesota's positive supports. In nearly every area addressed in this chapter, Minnesota has made strides. For example, Minnesota has already implemented behavioral health homes and ACT teams, and highlights TIC as a practice that should be integrated into services. Minnesota has developed significant infrastructure for coordinating care and offering peer support. Finally, Minnesota has identified gaps and shortcomings in its safety net and other critical supports for people with complex behavioral needs and has ample recommendations available to move its system forward.

Opportunities for Positive Supports

There are opportunities to provide more options for using a variety of strategies that may enable a broader adoption of positive supports and strategies, enabling more people to benefit from the positive supports framework that Minnesota has adopted. Minnesota should explore means to create more cohesion between the different strategies and practices and offer support to help people determine which practices and strategies work best for them. In order to make most effective use of these opportunities, Minnesota may need to expand the professional network (e.g., increase the number of licensed behavioral analysts providing support), provide timely services that can limit the need for more restrictive interventions, and work to eliminate barriers to receiving these supports.

Coordination of care can help to strengthen people's interactions with disparate systems, encouraging a more uniform experience across systems, shared values of positive supports, and increased responsibility for individual progress. There are efforts to coordinate care, but these efforts may also be siloed in a limited selection of systems; may serve only a narrow population; or may be available only in certain areas of the state. As an example, ACT teams are available in fewer than half of Minnesota counties, and when people do require out-of-home placements or an extraordinary amount of support there may be even narrower options available. Efforts to expand services that can be coordinated, data sharing investment, and aligning responsibilities can all help to strengthen Minnesota's integrated care coordination.

Minnesota does allow for tele-behavioral health services, but could strengthen these programs to meet the needs of more populations and expand their coverage to rural areas. Minnesota has identified issues with transitioning people from institutions into the

community that can be addressed, in part, by exploring alternative approaches, such as peer transition supports.

Implementation for Positive Supports

In some cases, adopting new strategies and practices, or expanding existing ones, may require only the convening of committed people and development of resources; in others, significant infrastructure may be needed. For example, hosting resources for TIC may come at little to no cost, but requiring statewide training for all providers to promote adoption of TIC, modifying provider requirements, and creating systems to measure progress may be costly.

Developing coordinated care models is a significant and complex undertaking. For example, financial constraints for funding existing program coordination may be prescriptive and determining how to fund coordinated care which crosses several programs can be difficult. Since each program may have its own information systems and other technology, it can be challenging to share information. Further, diverse programs have different rules and regulations. The same is often true of providers and supporting organizations who use different, and sometimes foundationally incongruent practices, making a person's experience across multiple systems less supportive and leading to potential loss of progress.

If care coordination is not possible, data and information sharing, as well as means to collaborate across programs through cross-system councils or formal memorandums of understanding, may offer promising results. To start, Minnesota could inventory the different definitions, practices, and strategies used in the state and how they are used.

Minnesota has already enacted telehealth and remote supports in several systems and has expertise and infrastructure in place to build these out further. It will be important to engage people with behavioral health needs, their families, and providers to determine how these services can best be adapted to serve them.

Minnesota has a commitment to supporting people in the community and transitioning people back to the community as soon as possible; however, there are barriers to transitioning people due to a lack of community services and accessible and affordable housing; continuing stigma for the population; and limitations in data sharing and coordination to support people across a range of systems. At a minimum, Minnesota could review its transition planning protocols and ensure that they are implemented on day one and are highly individualized to meet people's needs.

Evaluating the Efficacy of Positive Supports

PBIS has built-in metrics that can be aggregated throughout the state and are routinely reported. Reporting mechanisms for other strategies are less clear. Reporting statewide on positive support strategies would be helpful for assessing how well interventions are working and allow for development and progress in the state. Ideally, this information would be collected uniformly across the state; however, early efforts could be targeted

towards reporting data collected in different systems or conducting surveys to gather data on current practices. Such efforts could also contribute to developing a robust and flexible definition of positive supports, and to identifying the strategies that are used as part of a positive supports approach. Collecting stronger data would allow Minnesota to track and trend positive supports and to modify services offered over time.

To measure the efficacy of coordinated care models, it is critical to have means to track and measure the care that people receive as they move through different systems, and to have metrics in place to ascertain whether each system is effective. Evaluative metrics may also be helpful for engaging in continuous system improvement.

Telehealth will be important to measure if it is expanded in any meaningful way to people with behavioral health issues. Minnesota would want to be sure that these supports are adequately meeting people's needs and keeping them safe. Some metrics that would be useful to track are critical incidents, Behavior Intervention Reporting Form (BIRF) data, Adult Protective Services or Children, Youth, and Families investigations, interactions with the corrections system, hospitalizations, and other key metrics. If expanded, Minnesota is likely already taking on improvements to some of the measurements through requirements stipulated in the Access Rule. Minnesota would also want to measure individual experience with telehealth supports. Collecting these measures would enable Minnesota to improve telehealth services to meet diverse needs, including people with complex behavioral needs.

Minnesota already tracks psychiatric stays and recidivism. Collecting historical data on people who are institutionalized may be helpful to understand what services and supports were accessed before the point of institutionalization and what could be done to reduce the need for institutional services.

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Positive Supports

Minnesota's positive supports rule allows for maximum flexibility since it is not prescriptive and allows for a variety of strategies that can be modified to match a person's needs as outlined in their person-centered plan. Further, the approach of positive supports and many of the associated strategies focus on putting control in the person's hands, so they are innately adapted to allow for informed choice. States have also adopted culturally relevant practices.

Person-centered planning is a critical component of coordinated care, as this is often the mechanism that can help each disparate system understand and meet the person's needs. The person-centered plan can describe the various systems that the person engages with, explain why, and include plans to reduce engagement with unwanted systems and strengthen support in desired systems.

Telehealth and other technological supports can help people to be more independent in managing their own behavioral needs in their own homes and communities, and can potentially reduce the need for restrictive services.

How Positive Supports were Informed by Lived Experience

Advocacy groups have raised concerns about some positive support strategies. For example, positive behavior supports are rooted in applied behavior analysis (ABA). Members of the disability advocacy community, particularly people with autism, have raised concerns about ABA because of its past reinforcement of negative notions of disability and strategies that negatively impact autistic people (Autistic Self-Advocacy Network, 2024). Recovery-oriented frameworks, however, are rooted in advocacy and supported by people with mental illness and substance use issues. Some strategies rely heavily on peer support, which acknowledges the expertise of lived experience.

Challenges of Positive Supports

One challenge with expanding strategies is that it may be difficult for people to know which strategies are most effective, and which frameworks are best suited to different programs. Another challenge will be measurement across different strategies if the strategies are not uniform. Minnesota can consider means to gather cross-system measurement. There are likely resources that can be leveraged to inform a review of the strategies that make up a positive supports approach.

Care coordination development often involves a years-long process of learning how people navigate disparate systems and what happens to them in transition, mapping out responsibilities across systems, aligning important values and care strategies, and developing infrastructure for care coordinators. Programs often take smaller steps to developing care coordination, such as starting work with smaller populations and selected systems, or focusing on specific transitions. Minnesota has already advanced some of these efforts.

Even in care coordination models, challenges may remain. For example, for behavioral health care, stigma may continue to affect treatment in different systems. People receiving services may not understand the connections between disparate systems and may struggle to be engaged in a way that best promotes continuity of care.

More attention should be given to preventing institutionalization so that the state does not incur the difficulty of transitioning people back to their communities. Transition between services and programs is challenging for the person and their family, provider staff, and the larger community.

Key Informants & Subject Matter Experts Consulted on Positive Supports & Olmstead Planning

Key Informant or Subject Matter Experts Interviewed	Date & Venue/Modality	Topic(s)
Rachel Freeman, University of Minnesota	July 9, 2025, Virtually	Minnesota history, positive supports network, and national best practices

Key Informant or Subject Matter Experts Interviewed	Date & Venue/Modality	Topic(s)
Daniel Baker, **Michal Frank**, **LeAnn Ristow-Kyro** Direct Care & Treatment	July 7, 2025, Virtually	Support in practice, programmatic needs
Eric Kloos, Minnesota Department of Education	June 24, 2025, Virtually	PBIS Implementation, gaps, and measurement
Erik Adolphson, Direct Care & Treatment	June 6, 2025, Virtually	Direct care & treatment, strengths, barriers, and Olmstead Plan
Daron Korte and **Thomas Delaney** Minnesota Department of Education	June 5, 2025, Virtually	School-wide supports, special education, PBIS

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Topic 7: The Prevention of Abuse and Neglect

Megan Lee, M.A., L.P.C., has nearly 15 years of experience working with federal, state, and local government; providers and community partners; and other stakeholders to address the needs of people with behavioral health conditions.

Overview of Abuse and Neglect Prevention & Olmstead Planning

In 2018, the Olmstead Prevention of Abuse and Neglect Specialty Committee made the bold claim in its *Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities* report that "Vulnerability to abuse and neglect does not lie within people with disabilities but within society and the perpetrators" (Fitzsimons & Minnesota Olmstead Implementation Office, 2018). The report illustrates how societal assumptions that people with disabilities are inherently more vulnerable to abuse and neglect stand in the way of meaningful prevention efforts. The prevailing ableism views individuals with disabilities as the problem and as responsible for their own victimization.

The current Minnesota Olmstead Plan takes a three-fold approach to addressing abuse and neglect: prevention, reduction, and remediation — but in 2022, more than half of respondents to an annual satisfaction survey disagreed that the Plan fully represented their future vision of zero people with disabilities experiencing abuse or neglect (Minnesota Olmstead Implementation Office, 2022b). Working toward this goal requires bold strategies rooted in the expertise of people with lived and living experience; the implementation of proven best practices; and strong interagency collaboration. This venture will be comprehensive and successful only if the state understands that integration, the opportunity to live a full and meaningful life, and direction over one's own care form the bedrock of the prevention of abuse and neglect.

Populations of Particular Concern for Abuse and Neglect Prevention & *Olmstead*

The current Olmstead Plan focuses on broad populations of students with disabilities, vulnerable adults, and vulnerable individuals. Community feedback asked for a greater focus on people with disabilities at elevated risk of violence, such as women and girls; older adults; people with disabilities who interact with law enforcement; and individuals who live in institutional, group home, or other congregate care settings. National research, organizational positions, and reporting align with this feedback, and extend the focus to also include students and children with disabilities and people who are

deaf, deafblind, or hard of hearing. The Inclusion Consultants, and feedback from other sources, call on the state to ensure focus on the more marginalized or vulnerable populations of people with disabilities. Practices illustrated in this chapter span populations and disabilities, with one in particular focusing on people with disabilities (PWDs) who are victims of sexual assault and domestic violence.

Abuse and Neglect Prevention & *Olmstead* in Minnesota

The prevention of abuse and neglect is not tied to a specific agency, provider type, or role. Everyone has a responsibility for primary prevention and reduction, and many key players have a role in remediation when abuse occurs. Minnesota has a strong resource in the *Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities*, yet the current *Olmstead* goals do not reflect a comprehensive prevention approach. Overcoming the ableist tendency to place the blame and responsibility on the vulnerability of individuals with disabilities requires a systemwide and societal mindset shift. The Olmstead Subcabinet has a far-reaching influence on Minnesota's approach to developing the infrastructure that can address ableism responsively and reflect the feedback and stated priorities of the community, in alignment with best practice at the three levels of prevention: primary (prevention); secondary (reporting and investigation); and tertiary (redress). Specifics are outlined in this report chapter; success will require robust interagency collaboration to ensure a values-based system that centers the responsibility of the state-directed infrastructure to promote a culture of dignity and respect for individuals with disabilities as a primary prevention strategy, with publicly shared levers for accountability when these principles are violated. Five promising sets of practices are described that require strong collaboration across all Olmstead Subcabinet Agencies to advance improvements. These practices reflect dignity, integration, and autonomy as the bedrock of prevention of abuse and neglect — empowering individuals to know and understand their sovereignty and rights; empowering caregivers and providers with tools and skills to manage difficult situations through centering the experience of the individual; empowering agencies tasked with investigating reports with the person-centered set of skills to adequately investigate and make right what was done wrong; and providing public transparency into all of it. All practices require collaboration and a commitment to cultural and policy reform to attain the goal of zero.

Effective Policies, Programs, and Strategies Related to the Prevention of Abuse and Neglect

7A: A Cross-Sector Alliance for the Prevention of Abuse and Neglect

Strengths of a Cross-Sector Alliance

Heavily cited in the *Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities* report, the Building Partnerships Initiative (BPI) in Massachusetts is a statewide, multidisciplinary approach to preventing abuse and neglect. BPI links law enforcement, adult protection and human services, medical personnel, public health,

academia, victim services, PWDs, and others to address abuse, neglect, and crimes committed against PWDs and older adults. The initiative has many strengths, namely offering demonstrated outcomes of interagency collaboration and addressing all levels of abuse and neglect prevention, including effective redress. BPI was formed in response to a report authored in partnership with a District Attorney and the Disabled Persons Protection Commission which outlined recommendations for improving investigations into abuse reports following two high-profile abuse cases. The then-governor endorsed the recommendations in the report, and an implementation committee was formed thereafter, appointed by the state's Secretary of Health and Human Services.

Here, we will put this model in the context of Minnesota's Olmstead planning implementation considerations.

Opportunities of a Cross-Sector Alliance

Similar to the Rhode Island policy reforms highlighted in 7B below, the BPI model shows how cross-agency partnerships can update policies and build systemwide capacity for prevention. A more unified, collaborative structure would benefit Minnesotans with disabilities by:

- Creating a clear, coordinated system for prevention, reporting, investigation, and accountability
- Aligning agencies under a shared responsibility to prevent abuse, rather than placing that burden on individuals with disabilities

In interviews and community feedback, Inclusion Consultants and people with lived experience noted gaps in Minnesota's redress process. Many wondered, *"What happens after an organization is reported?"* Public reporting shows that only 7% of reports received are assigned to be investigated and that there is tremendous variation in county reporting. A coordinated model like BPI directly addresses this concern, embedding redress as a core element of prevention and holding all systems to a common standard of accountability. Redress restores power to the person who experienced abuse and signals that the system takes their dignity and rights seriously. Successes of the BPI include increased rates of reporting, investigations, and prosecutions; uniform reporting requirements; successful joint investigations with law enforcement; creation and monitoring of an abuser registry; increased rates of providers receiving standardized trainings; partnerships with rape crisis centers and nurse examiners; promotion of "no wrong door" reporting through triage; and strong data sharing agreements to make the collaboration work well.

Implementation Considerations for a Cross-Sector Alliance

A statewide, multidisciplinary approach to the prevention of neglect and abuse necessarily requires cross-sector coordination and infrastructure. While the Department of Human Services (DHS) oversees the Minnesota Adult Abuse Reporting Center, the Child Protective Services hotline, and licensing, it is the Department of Health (MDH) that

oversees health facility complaints. The Department of Public Safety (DPS) investigates use-of-force complaints through the Bureau of Criminal Apprehension. The Office of Ombudsman for Mental Health and Developmental Disabilities and the Minnesota Disability Law Center can open investigations. When the *Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities* was released, an abuse workgroup was formed, but the state agencies that participated report that because the charter was unclear, very little was accomplished, and the group was disbanded.

In Massachusetts, the Disabled Persons Protection Commission was designed to be an independent investigator of reports of abuse against adults with disabilities and to work closely with agencies handling other types of reports and complaints, serving an essential role to help the BPI bridge the gap between the levels of abuse and neglect prevention. Minnesota can adopt a similar approach through Olmstead planning, as outlined in the *Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities* report — the formation of a cross-sector council with executive endorsement, including an Investigations Advisory Panel, would promote the interagency partnerships needed to streamline cross-sector reporting and pathways of accountability for wrongdoing. This council would additionally be responsible for designing, implementing, and tracking *Olmstead* goals and actions, and could house many of the other activities of primary prevention; this proposed initiative and the council will be referenced throughout this chapter. As shown in Table 7.1 below, the council would take a lead role in streamlining and updating infrastructure for the report and investigation dashboards already in existence, using these as a centralized place for tracking cross-sector trends in reports, results, and redress. This reporting can capture data on organizations with repeat complaints that do not rise to the level of abuse; rates of investigated abuse claims; results of investigations; and steps toward remediation. The council can also support the capacity of the entities doing the investigations and promote accountability when that process is inadequate.

Table 7.1. Proposed Actions of a Cross-Sector Council

Area	Actions
Olmstead oversight	• Establishes Prevention of Abuse & Neglect goals for *Olmstead* • Primary responsible entity • Reporting on goals
Collaboration	• All parties identified • Workgroup formed, including expectations of membership • MOUs signed for cross-sector investigation
Streamlined reporting	• Reports can be made through a centralized location and triaged to other agencies
Streamlined investigation and public-facing accountability	• Criminal investigation training • Updated public dashboard of reports, including results
Increased public awareness, education, and self-advocacy	• Trainings and education as outlined in other sections

Evaluating the Efficacy of a Cross-Sector Alliance

Table 7.2 below suggests how a cross-sector alliance could be evaluated.

Table 7.2. Proposed Cross-Sector Council Metrics

Area	Action	Metrics
Olmstead oversight	• Establishes prevention of abuse and neglect goals for *Olmstead* • Primary responsible entity • Reporting on goals	• Public and transparent reporting on *Olmstead* goals' progress
Collaboration	• All parties identified • Council/taskforce formed, including expectations of membership • Cross-sector investigation	• MOUs signed
Streamlined reporting	• Reports can be made through a centralized location and triaged to other agencies	• Public feedback on ease of reporting • Decreases in fragmentation
Streamlined investigation and public-facing accountability	• Criminal investigation training • Public dashboard of reports and results	• Fewer repeat offenders • Fiscal penalty for offenses • Improvements in timeliness • Penalty for repeat complaints
Increased public awareness, education, and self-advocacy	• Trainings and education as outlined in other sections	• See outcomes in other subsections

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in a Cross-Sector Alliance

Massachusetts' Building Partnerships Initiative promotes informed choice and self-advocacy through trainings, including several related to specific disabilities and populations.

How a Cross-Sector Alliance is Informed by Lived Experience

While not directly involved in BPI's formation or implementation, the Peer Support Network, supported by the BPI, brings survivors of sexual violence together on their path to healing and is overseen by a peer support leader. PWDs also sit on the curriculum development team for all BPI trainings.

Ways for a Cross-Sector Alliance to Collaborate across State Government

This collaborative approach brings together cross-sector experts to streamline and centralize reporting and investigations. Since DHS has a central role in this work, the council can function through DHS, but participating organizations should bear equal

responsibility to carry out the recommendations. Minnesota can also consider raising this to the level of a governor-formed task force or council to give weight to the importance of collaboration in this effort; in 1999, it was the Massachusetts Secretary of Health and Human Services who expanded and formalized the scope of BPI.

Challenges of a Cross-Sector Alliance

To fully actualize a cross-sector oversight body takes significant commitment from the executive teams of each department and possibly the executive or legislative branch. To reform reporting and investigation systems requires cooperation and transparency from each agency involved, as well as significant fiscal and resource allocation to improve data systems, provider performance, licensing impacts, public-facing reporting, and comprehensive community education. In Massachusetts, this took nearly 10 years. Minnesota already has some of the infrastructure in place, including the Vulnerable Adult reporting dashboard. The state could strategically leverage existing resources and processes in a streamlined approach to updating protocols and identifying additional funding streams. The council can take the lead in adopting approaches from other sections of this chapter.

7B: A Multipronged and Collaborative Approach to Prevention and Investigation

The Rhode Island Division of Disability Services (RI DDS) adopted a multipronged approach to addressing abuse and neglect, recognizing that successful policies confront the problem through primary prevention and improvements in reporting and investigation processes. This comprehensive approach produced outcomes of increased interagency and state-provider collaboration on solving abuse and neglect; greater trust in the state system; the development of new trainings, policies, and procedures with demonstrable pre- and post-training skills and knowledge gained; and transparent reporting of abuse and neglect investigation trends and outcomes.

Strengths of a Multipronged & Collaborative Approach to Prevention and Investigation

Primary prevention involved robust training and public awareness campaigns. RI DDS developed training for people with disabilities on building body literacy, healthy relationships, and self-protection, recognizing that informed choice and self-direction are important tools in the prevention of abuse and neglect. Community, caregivers, and family members of individuals with disabilities received training on human rights, healthy socialization and sexual behavior, and self-direction. Providers of disability services were trained by the Attorney General's office to improve documentation and received additional, ongoing training on human rights, quality of life, promoting self-direction and self-advocacy, and reporting standards.

Centering people with lived experience in the development of updated reporting and investigation strategies, Rhode Island adopted a collaborative, solution-oriented approach that included these four elements:

1. Training
   a. RI DDS hosted three or four required trainings per year on reporting and investigation, teaching investigativia Teams to ask non-leading questions in investigation interviews and to perform accurate record-keeping, among other skills. These trainings were often designed and co-led by people with lived experience.
2. A cross-agency incident management team was responsible for report and incident reviews including::
   a. Leaders of cross-agency offices met for standard reviews and the mortality review committee
   b. Team produced a summary of incident reviews with lessons learned written by directors of the provider agencies
   c. Presentation of findings to the executive director and the entire team at the provider agency, led by people with disabilities
3. Monitoring and technical assistance groups
   a. Led by people with disabilities and workers from other agencies not being investigated
   b. Smaller focus groups on quality of life, socialization, employment, and self-direction as important aspects of the prevention of abuse and neglect
4. Transparency with the provider community
   a. Quarterly newsletters illustrating the prevalence of incidents, removing shame and stigma, often including results from summary incident reports

   "When you publicize something, it becomes less likely to occur." (S. Babin, personal communication, 2025).

Opportunities of a Multipronged & Collaborative Approach to Prevention and Investigation

Establishing a multipronged and collaborative approach is aligned with several action areas in the *Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities* report and its assertion that "neither risk reduction nor public awareness and outreach are enough to change the behaviors, attitudes, cultural norms, and policies that reinforce and perpetuate the problem." Each Subcabinet Agency can take responsibility for the prevention of abuse and neglect, and their efforts can be centralized under a council, as described in section 7A.

Implementation Considerations for a Multipronged & Collaborative Approach to Prevention and Investigation

While Rhode Island's example was operated out of the state's Division of Disability Services, Minnesota has the opportunity to address its own often-disjointed complaint and redress systems by adopting a standardized statewide approach that includes managing centralized complaint and/or report information-sharing; developing and maintaining a statewide provider and community curriculum; and increasing resources for complaint redress. Developing the infrastructure for this collection of tasks will require a significant commitment of human and financial resources; the elements may

be phased in over time, with different aspects rolled out concurrently or separately. Establishing a council can incorporate many of the principles and values of the other sections of this report. A state-led curriculum and training program for PWDs, families/caregivers, and providers can be developed collaboratively across agencies, with elements of the curriculum customized based on provider types. Basic procedures should be established for provider misconduct investigations, including standards for the escalation of investigations to a centralized hub (i.e., a council, as in Section 7A), and procedures for how complaints are researched, documented, interviewed, and resolved should also be updated and standardized. Oversight of investigation redress should address the community-reported trend of providers not being held accountable for complaints received. Building standard operating procedures for restoration and reparation should be required at each state agency and provider level, orchestrated by the task force. Minnesota has many of these elements in place already — it is essential to focus on standardizing reporting and investigation protocols that center a joint approach aimed at transparency into investigation results. The success of these initiatives depends on interagency cooperation.

Evaluating the Efficacy of a Multipronged & Collaborative Approach to Prevention and Investigation — Proposed Metrics

While Rhode Island's strategy was comprehensive, one missing piece was the establishment of success metrics to track the reduction in rates of abuse and neglect of people with disabilities (though RI DDS did track other outcomes). Should Minnesota take a similar approach to Rhode Island's, it will be important to establish success criteria in each area — prevention, reporting & investigation, and redress — with specific measures tied to initiatives within each area. Some of the metrics listed in tables 7.3, 7.4, and 7.5 below were used by Rhode Island, while others are suggested additions.

Table 7.3. Proposed Criteria to Evaluate Abuse and Neglect Prevention

Success Criteria	Metrics
People with disabilities and their families increase skills and knowledge of body literacy, human rights, healthy relationships and sexual behavior, and rights and processes for reporting.	Pre- & post-training self-assessment in these topic areas
Organizations serving people with disabilities understand their role in prevention.	Pre- & post-training improvement on scores in these topic areas

Table 7.4. Proposed Criteria to Evaluate Abuse and Neglect Reporting and Investigation

Success Criteria	Metrics
There is a clear entry point for complaints or allegations; determining the appropriate level of investigation is not the responsibility of the reporter.	Publicly available, no-wrong-door entry point for complaints

Success Criteria	Metrics
Standardization in training is reflected in the standardization of responses and investigations to complaints and allegations.	Training standards completed Updated Policies & Practices Public perception of the efficacy of the complaint and investigation process Timely investigation processes with clear outcomes

Table 7.5. Proposed Criteria to Evaluate Abuse and Neglect Redress

Success Criteria	Metrics
There is public transparency about where violations have occurred and rigorous standards for remediation.	Public dashboard of complaints, resolutions, and redress Standard post-incident debriefing and training

Person-centered Planning, Informed Choice, and Cultural Responsiveness in a Multipronged & Collaborative Approach to Prevention and Investigation

Informed choice runs through the ethos of the multipronged and collaborative approach to prevention and investigation. By providing education to PWDs in body literacy and self-advocacy, RI DDS centers informed choice as the foundation of the prevention of abuse and neglect. Including people with lived experience in the approach, as outlined below, increased the relevance of the many factors in this design.

How the Multipronged & Collaborative Approach to Prevention and Investigation was Informed by Lived Experience

RI DDS worked closely with PWDs to develop training for the community, providers, and other PWDs, and involved PWDs in the incident investigation debrief. This allowed the trainings to be relevant and the debriefs to be informed by people with lived experience. In the interview, RI DDS pointed out that “This made it harder to deny findings” (S. Babin, personal communication, 2025).

Ways for a Multipronged & Collaborative Approach to Prevention and Investigation to Collaborate across State Government

Standardization requires cross-agency collaboration. All agencies should participate in a cross-agency workgroup dedicated to both the development of training and building on existing successful public education campaigns (such as Treat People Like People -— Abuse Stops with Us) as well as standardizing operating procedures and centralizing investigation policies and outcomes, including publicly reporting agency violations. Since every agency has a role in the prevention of abuse and neglect, it is essential to identify who holds responsibility for the Olmstead Plan goals and reporting so that implementation and outcomes progress can be tracked.

Challenges of a Multipronged & Collaborative Approach to Prevention and Investigation

Rhode Island took a comprehensive approach to prevention and improvements in reporting and investigation, including plans of action for future prevention. Effective redress for providers with multiple or egregious violations is an important part of this topic, and an area that the community sees as lacking (Minnesota Olmstead Implementation Office, 2022b) in current goals. Given current workforce and resource challenges, financial consequences for providers may be hard to implement.

7C: The Use of Trauma-Informed Care to Prevent Abuse and Neglect

The prevalence of abuse and neglect in residential and institutional settings is of high concern to advocacy organizations and the community, and use of legal measures such as seclusion and restraint can blur into other coercive or abusive tactics. Perspectives Corporation is a multifaceted, interdisciplinary private provider agency in Rhode Island serving people with disabilities in a variety of settings, aiming toward the greatest degree of independence for people served. In 2013, Rhode Island banned the use of prone restraint for adults with developmental disabilities. Perspectives viewed the new law as an opportunity to move away from all forms of restraint and coercive interventions, instead adopting trauma-informed care (TIC) as a de-escalation strategy, becoming the first disability-serving organization to collaborate with parents of PWD to implement a mission of TIC as a de-escalation strategy.

Strengths of Trauma-Informed Care

Informed by data on physical and controlled procedures, and already having a grounding in positive supports, Perspectives fully adopted TIC in 2018 in its residential settings. Perspectives' approach to TIC has a foundation of hands-off crisis intervention through the Ukeru program and, over two years, continued using data to inform additional approaches to full adoption of Ukeru strategies, eventually ceasing to train staff in hands-on interventions. Perspectives deeply supports staff members in the actual intervention of Ukeru, but also in addressing their own trauma responses that may increase the likelihood of a fear-based reaction to escalating behavior. Through continuous data monitoring, robust incident debriefing, ongoing training, and building a culture of TIC, Perspectives has achieved compelling outcomes (Ukeru Systems, n.d.):

- Perspectives’ use of restraint fell by over 96% in three years
- Serious staff injuries nearly gone
- Between 2018 and 2020:
  - Physical escorts dropped 97%, from 805 to 26 per year.
  - Standing holds fell 96%, from 231 to 10 per year.
  - Use of “seated wraps” dropped 97%, from 147 to 4 per year, and are no longer permitted.
  - Instances requiring the use of blocking pads fell 94%, from 349 to 20 per year.

The involvement of people with lived experience and parents in program design; the use of data and continuous program evaluation; and robust training, incident debriefing, and remediation are all key to the success of TIC to prevent abuse and neglect.

Opportunities of Trauma-Informed Care

Trauma-informed care can be instituted at any provider, agency, or organization, regardless of population or disability type, and aligns with the "Risk Reduction Awareness, Education, and Outreach to Service Providers" action area in the *Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities* report. This gives Minnesota flexibility in implementation considerations to adopt the TIC approach for specific populations or in designated regions of the state, complementing work from the Positive Supports Rule.

Ukeru is useful in residential or congregate settings and is one specific approach to TIC, but because TIC is a set of principles, it can be applied universally as a tool in the prevention of abuse and can be used in community-based training; provider-specific training, quality assurance, and investigations; and as a statewide approach to positive supports, integrated classrooms, outpatient therapies, policing, and many other arenas. The organization Trauma Policy highlights that TIC "promotes positive outcomes by emphasizing physical, psychological, and emotional safety and enhances wellbeing by empowering individuals to define their needs and goals and make choices about their care and services" (Trauma Policy, 2025). This approach has considerable overlap with positive behavior supports (PBS), and indeed, PBS is a form of abuse and neglect prevention. A notable feature of this approach is its reduction of coercion and power imbalances to build safety through empowerment, collaboration, and compassion. TIC recognizes that behavior is often a response to past trauma and works to rebuild a sense of safety in interactions. Minnesota can build programming and promote approaches that blend TIC and PBS for the prevention of abuse and neglect when prevention is considered on a spectrum: primary prevention includes PBS; the use of emergency interventions like seclusion and restraint are well-documented and used only according to approved protocol; and if a provider crosses the line into abuse or neglect, investigations are swift and appropriate. TIC should be infused along this entire spectrum. For more on positive behavior supports, see Topic 6: Positive Supports.

Implementation Considerations for Trauma-Informed Care

As a set of principles, TIC can infuse programming and oversight. Minnesota can adopt these principles and consider approaches at various levels of prevention, reporting, investigation, and redress. This complements the Positive Support Rule already in existence in Minnesota.

Prevention

- Training principles at every agency and organization that interacts with PWDs
- Training families and caregivers
- Consider implementation of Ukeru or something similar for residential, congregate care settings, hospitals, crisis teams, schools, and other higher acuity settings

Reporting and investigation

- Develop TIC-driven processes for investigation including ascertaining the degree to which TIC training was implemented in the intervention under investigation, use of TIC interviewing

Redress

- Develop TIC-driven processes for redress, including adequate debriefings and public reporting, training on TIC to prevent future incidents, assessment of where TIC was not adequately implemented

Evaluating the Efficacy of Trauma-Informed Care — Proposed Metrics

Perspectives Corporation tracked several metrics related to TIC training and use of Ukeru, including use of restraint, staff and resident injuries, use of physical escorts, use of other physical interventions, use of 911, cost of response types, and client-to-client aggression. These are worthwhile metrics from a program efficacy standpoint. Should Minnesota adopt TIC principles or a crisis management training like Ukeru for all high-acuity or congregate settings, additional metrics should be considered based on questions the state might want answered. In Table 7.6 below, some questions and associated metrics are proposed; however, other factors may also influence outcomes.

Table 7.6. Possible Efficacy Metrics for the introduction of Trauma-Informed Care Principles in High-Acuity or Congregate Settings

Question	Metrics
Does the use of TIC principles impact rates of reporting?	• Rate of adoption of principles/practices • Rate of reporting • Rate of substantiated reports
Does the use of TIC principles in investigations reduce the rate of reports at a provider agency?	• Rate of reports from agency over time, before and after TIC policies introduced
When caregivers are equipped with TIC-informed behavior management, do rates of abuse and neglect go down?	• Rates of caregiver training • Rates of reports

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Trauma-Informed Care

TIC is person-centered, recognizing that an individual's past experience informs their present behavior, and works to reduce retraumatizing them through interventions. Person-centered planning should identify trauma responses and proactive TIC approaches based on the individual's particular needs. Various Minnesota agencies can develop standardized policies and procedures to support that inclusion.

How Trauma-Informed Care was Informed by Lived Experience

Parents of people with disabilities partnered with Perspectives Corporation to design the TIC approach and build agency buy-in for its adoption. Minnesota can take a similar approach to infuse TIC throughout all aspects of the prevention of abuse and neglect. Since TIC pertains to all levels — prevention, reporting and investigation, and redress — varying degrees and areas of expertise are required to build culturally relevant programming and interventions.

Ways to Collaborate across State Government on Trauma-Informed Care

To implement specific program and policy improvements based on TIC principles, cross-government collaboration is required, again with oversight by the council recommended in section 7A. Since multiple agencies oversee the state's many disability-serving programs, agencies should work together on identifying training on TIC principles and, where appropriate, standardized TIC-informed crisis management training. All agencies with a role in complaint or abuse report processing and investigation should collaborate on TIC-informed investigation and redress processes.

Challenges of Trauma-Informed Care

Because TIC is a set of principles, it can be challenging to monitor statewide adoption and impact — especially related to abuse and neglect, which are influenced by so many factors. It will not be possible to directly link the use of TIC crisis management approaches with changes in rates of abuse reports statewide, but inferences can be drawn at a provider or regional level. Perspectives Corporation reported that uptake of the TIC principles was not fully actualized for a few years. Garnering buy-in through cost-saving analyses or other measures to demonstrate benefit can help with momentum.

7D: Specialized Approaches to the Prevention of Domestic Violence and Sexual Assault of People with Disabilities

Focusing prevention efforts on populations of people with disabilities more likely to experience violence aligns with community feedback and best practice guidance, as well as DPS stated focus areas for upcoming Olmstead planning. Alaska has two programs that do this well.

In partnership with the State of Alaska, the University of Alaska Anchorage has adopted a prevention approach to the support of people with disabilities through two programs.

The Friendships and Dating Program (FDP) equips people with disabilities with deep body literacy, self-advocacy, and relationship skills. The University trains providers and other individuals to facilitate this 10-week curriculum. According to the Alaska interviewee, with increased reach, the program has seen a decrease in violence perpetrated against participating disability populations after completion.

With funding from the Council on Domestic Violence and Sexual Assault, the Disability Abuse Response Team (DART) offers support, training, and technical assistance to provider agencies so they can make their services for individuals experiencing interpersonal violence more accessible. The trainings include a webinar series available to any domestic violence/sexual assault (DV/SA) provider, focused on increasing accessibility throughout the different aspects of their work with PWDs. The partnership also offers $5,000 mini-grants to eight different agencies. Funded agencies use the Vera Institute of Justice's Center on Victimization and Safety Performance Indicator Tool. Based on those results, the partnership offers tailored TA to build greater accessibility into programming, culminating in a self-directed project to update accessibility in one key area identified. Grantees report improved self-assessment scores after participation, indicating greater accessibility for PWDs in their agency.

Opportunities of Specialized Approaches to DV/SA Prevention

FDP has an evidence base to demonstrate effectiveness in violence reduction and has been scalable throughout Alaska and other states and programs. While funded through the Alaska Mental Health Trust and implemented through the university, there is a strong local and community-based feel through the program's train-the-trainer model, with an impact on the lives of individuals receiving the training.

DART has a direct and tangible impact on programming in DV/SA-serving organizations and is in alignment with Minnesota's DPS-stated focus areas for the next Olmstead Plan. DART has been used in a variety of settings, including juvenile justice and acute psychiatric facilities.

Implementation Considerations for Specialized Approaches to DV/SA Prevention

FDP is an effective strategy in primary prevention and aligns with the "Risk Reduction Education and Outreach to People with Disabilities" action area of the *Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities* report. The curriculum is available for other states and programs, and the program model is scalable; through training the trainer, many disability-serving organizations can receive and then offer the training. As in Alaska, partnering with direct service providers and PWDs will ground the implementation in relevance to Minnesota. This can be built on the Institute of Community Integration's feature issue of *Impact* magazine on "Sexuality and Gender Identity for People with Intellectual, Developmental, and Other Disabilities".

DART is an effective strategy with people who need services after an experience of abuse; it potentially prevents ongoing abuse; and it is aligned with the *Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities* "Tertiary Prevention — Long Term Response, Intervention, and Evaluation" action area. The DPS Office of Justice Programs awards state grants to nonprofits that provide emergency shelter, housing, and support services to domestic violence victims and could incorporate some of the principles of the Alaska approach, including the use of the Vera Institute of Justice's Center on Victimization and Safety Performance Indicator Tool and

the provision of targeted technical assistance to increase accessibility. Effective collaboration between DPS, DHS, MDH, and MDE should focus on developing domestic violence programs that are designed, trained, and implemented to include all PWDs in Minnesota exposed to domestic violence.

Evaluating the Efficacy of Specialized Approaches to DV/SA Prevention — Proposed Metrics

FDP

- Longitudinal data on confidence level in pursuing healthy relationships, social network size
- Facilitator fidelity to curriculum

DART

- Improved scores on the Vera Institute of Justice's Center on Victimization and Safety Performance Indicator Tool
- Other self-assessment indicators on the degree of practice change after having received support

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Specialized Approaches to DV/SA Prevention

FDP focuses on informed choice in relationships, and DART's success hinges on bringing forth cultural responsiveness in updating accessibility in DV/SA-serving organizations.

How Specialized Approaches to DV/SA Prevention are Informed by Lived Experience

FDP was developed with direct service providers and incorporates the voice of PWDs in program design and development of tailored trainings for different groups (e.g., family members and guardians) and leveraged results from a national survey about what individuals with autism want regarding sexual education.

Ways to Collaborate Across State Government on Specialized Approaches to DV/SA Prevention

FDP requires a centralized agency for funding and programming but should be implemented through the counties. One option would be for DHS to house the program in partnership with county human services offices. It is logical for a program like DART to be housed at the DPS Office of Justice Programs in partnership with domestic violence organizations. DPS partnering on this work with DHS could be helpful to promote alignment in accessibility measures across programs.

Challenges of Specialized Approaches to DV/SA Prevention

In Alaska, these programs (like many) are subject to a changing funding landscape. In partnerships with trusts or through grants, the risk of losing funding is ever-present.

Long-term sustainability should be considered in the early planning phases to avoid rolling out an effective program that will then have to be rolled back.

7E: Reduce Abuse through Crisis Response Reform

Across the country, jurisdictions are actively working to reduce abuse in crisis systems through training, policy reform, and restructured response models. These reforms focus on both law enforcement and civilian-led teams, recognizing that harm can occur in either setting if personnel are underprepared or unsupported. This report highlights several crisis response models with promising outcomes for people with disabilities:

- Eugene, OR – CAHOOTS: A (now unfunded) civilian-led, non-police response team widely recognized for its trauma-informed, disability-competent approach to crisis care (Gerety, 2020).
- Pima County, AZ – Crisis Response Center: Integrates behavioral health with emergency response and features strong coordination with Arizona's I/DD and mental health systems.
- Colorado – STAR Program and Statewide Crisis System: The STAR program diverts people in crisis from law enforcement entirely, while the statewide system mandates specialized, skills-based training for civilian crisis teams, including disability-specific competencies.
- Minneapolis, MN – Behavioral Crisis Response Teams: A model of civilian-led response recognized for alignment with civil rights standards. Since its launch, the city has seen a measurable decrease in police use-of-force reports.

Each takes a different approach, but all share key features of successful reform:

- De-emphasizing police response to nonviolent behavioral health crises
- Providing meaningful alternatives to institutionalization or jail
- Requiring robust training and accountability measures
- Recognizing that crisis response exist on a continuum from law enforcement to co-response to fully civilian models

Effective crisis reform is based on harm reduction principles and on systems that are competent, confident, and well-supported so that responders can de-escalate safely, connect people to care, and avoid traumatic or coercive interventions. Another important aspect of crisis response is building upstream and ongoing services that can meet people's needs without higher-level interventions. These principles are referenced throughout this report. Crisis response reform focuses mainly on prevention but can also have a component in reporting and investigation, and in redress.

Strengths of Crisis Response Reform

Crisis response is a critical component of *Olmstead* implementation. When designed effectively, crisis systems can divert people with disabilities from unnecessary institutionalization and reduce harm. However, when crisis responses rely on coercive or punitive tactics — such as excessive force, restraints, or involuntary hospitalization

— they can lead to trauma, rights violations, and further system involvement (Lazar et al., 2024). People with disabilities, particularly those with intersecting marginalized identities, are disproportionately impacted by abusive and coercive crisis interventions (Flynn & Arstein-Kerslake, 2017). While not every person who interacts with the crisis system has a disability, disability is strongly overrepresented in these encounters (Flynn & Arstein-Kerslake, 2017). Reforming crisis response is therefore central to promoting safety, autonomy, and community integration (Dunklin et al., 2024).

Opportunities of Crisis Response Reform

As either the gateway to institutionalization or an effective tool to keep people with disabilities in the community, crisis response can play a key role in actualizing an *Olmstead* ethos. Effective crisis response promotes stabilization in the community and does not use coercive or abusive tactics. Building upon the success of Minneapolis' Behavioral Crisis Response team, DHS can continue building civilian-led crisis response capacity through skills-based training for crisis teams to gain non-coercive de-escalation skills and disability etiquette. Additionally, DPS can strengthen the partnership with the Peace Officer Standards and Training (POST) board to promote noncoercive intervention training for peace officers. As in the highlighted examples, these efforts should be expected to produce outcomes of increased rates of community-based stabilization, decreased rates of physical intervention and other coercive tactics, and eventually increased trust in crisis response teams among community members with disabilities. Effective crisis response should keep people in the community and away from the use of force, restraint, and other coercive and abusive tactics.

Implementation Considerations for Crisis Response Reform

In Minnesota, DPS and the POST board are separate entities. As an Olmstead Subcabinet Agency, DPS is compelled to adopt *Olmstead* goals, but POST is not. Requiring training, procedural updates, or funding allocations is the most logical approach, and will require a robust collaboration between DPS and POST. DHS will also have a role. While collaboration with POST via DPS is required for co-responder models, any updates to civilian-led crisis response will occur through DHS, the regulatory body overseeing crisis response in Minnesota. This work can and should be cross-sector so that reform is aligned. Co-response and civilian-led models are both important pieces of the crisis continuum, and updates to training, policies, and both of these intervention models should include similar measures to prevent abuse.

Training and program adequacy require some fiscal investment. Building a competent workforce requires skills training but also adequate compensation for responding teams, in recognition of the degree of effort that is part of crisis response, and the safety considerations they must manage. Additional infusion of abuse and neglect prevention into upstream and ongoing supports and services also requires a strategic fiscal approach; these efforts are part of crisis prevention and promote community-based stabilization. Multipronged and braided investments can be useful here at the prevention level. The state should consider partnerships with its university and college systems to

provide pre-practicum foundational skills. The adoption of strategies throughout this report can bolster the community-based services system.

For reporting and investigation, and for redress, streamlining the reporting of coercive or noxious tactics and building public awareness of how to report incidents is essential. The Bureau of Criminal Apprehension at DPS can play a role in this, as well as partnering with POST to investigate law enforcement misconduct. DHS should work closely with the Ombudsman's office and its own complaint line to monitor trends in reporting abuse by teams under the DHS purview. Adopting strategies from BPI, as highlighted in section 7A, will be useful in building effective partnerships at all levels of prevention — and the law enforcement partnership with civil investigations is critical.

Evaluating the Efficacy of Crisis Response Reform

The proposed metrics are specific to crisis interventions. While these metrics can be tracked across jurisdictions, for *Olmstead* purposes, only crisis encounters specific to behavioral health or other disability populations should be tracked.

Metrics for law-enforcement-led crisis teams:

- Use of force report and investigation rates
- Rate of physical intervention like seclusion, restraint, or other hands-on interventions
- Rate of reports of law enforcement misconduct
- Referrals to higher levels of care
- Transports to higher levels of care

Metrics for civilian-led crisis teams:

- Rate of physical intervention like seclusion, restraint, or other hands-on interventions
- Referrals to higher levels of care
- Transports to higher levels of care
- Number of calls for law enforcement standby resulting in intervention

Person-Centered Planning, Informed Choice, and Cultural Responsiveness in Crisis Response Reform

Informed choice is a bedrock of noncoercive intervention, and the recognition of intersectionality should drive interventions offered in a crisis response. DHS can promote the use of psychiatric advance directives to drive interventions offered on an individual level.

How Crisis Response Reform was Informed by Lived Experience

Highlighted programs had varying degrees of lived experience involvement, from program or curriculum design to co-creating legislation. Minnesota should consider leveraging lived expertise in program updates and in its assessment of the use of abusive and coercive tactics in the current crisis response system, drawing particularly on the experience of individuals who have interacted with law-enforcement- and civilian-driven crisis response systems.

Ways to collaborate across State Government on Crisis Response Reform

While specific knowledge areas and skills learning may differ from peace officers to civilian crisis teams, the principles of both models should be the same, and both should require strong collaboration between POST/DPS and DHS. Ensuring adequate community-based supports is the work of the entire Olmstead Subcabinet and should focus on those supports that are needed to promote community-based stabilization for individuals with disabilities who access the crisis system. Subcabinet Agencies can undergo a quick assessment of reasons why people with disabilities access crisis services; any reasons related to health-based social needs or other upstream supports can be addressed with the agency *Olmstead* goals. DHS should be a strong leader in the promotion of crisis prevention and response, which centers on community-based and noncoercive interventions. This work can also play a key role in the task force, as was the basis of the formation of Massachusetts' Building Partnerships Initiative highlighted in section 7A.

Challenges of Crisis Response Reform

Crisis response has historical roots as a gateway to institutional care through dispatching teams into the community or hospital emergency departments to offer level-of-care assessments. The recent move to use crisis teams for community-based stabilization has not been without challenges, and controversy abounds in discussions of the role of law enforcement in crisis response. Navigating community tension can make crisis response reform challenging. The interagency partnerships required to build an effective continuum also require a great degree of fortitude and shared commitment to a vision of noncoercive crisis care. Indeed, even garnering support for that commitment can be a challenge. Finally, building and connecting to the upstream services that can prevent reliance on the institutional pipeline requires a huge fiscal and personnel commitment.

Conclusion

Minnesota has the opportunity to effectively address stakeholder feedback and reflect the priorities of people with disabilities through a multifaceted approach to the three levels of prevention of abuse and neglect: primary prevention, reporting and investigation, and redress. Adopting this comprehensive approach allows the state to both make a widespread impact and target approaches to specific populations and areas of need. A multipronged approach to prevention and investigation (7B), The use of trauma-informed care to prevent abuse and neglect (7C), and Specialized approaches to the prevention of domestic violence and sexual assault of people with disabilities (7D) all reflect a person-centered approach to primary prevention. Building body literacy and self-advocacy skills equips the individual with the knowledge to recognize abuse when it happens. The approaches described in 7B and 7C also focus on systemwide training to prevent victimization by caregivers and build appropriate responses when violations occur. A cross-sector alliance for the prevention of abuse and neglect links multidisciplinary entities to address abuse, neglect, and crimes

committed against people with disabilities. Reducing abuse through crisis response reform (7E) focuses specifically on the prevention of abuse at a high-risk and highly vulnerable time of service access. All these principles and approaches center on one thing: honoring the dignity of the individual and promoting accountability when systems do not abide by this core value. These approaches work together and complement each other, and can be rolled into Minnesota's *Olmstead* goals. Minnesota can also consider goals that reflect the spectrum of and complement PBS, reflecting the spectrum of interventions and data reported and specifically documenting interventions that are working to reduce problematic interventions. The *Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities* is a keystone document, and Minnesota can consider the practices outlined in this best practices report as tangible examples of actualizing the vision in that document.

Key Informants & Subject Matter Experts Consulted on Prevention of Abuse and Neglect & Olmstead Planning

Key Informants or Subject Matter Experts Interviewed	Date & Venue/Modality	Topic(s)
Sondra LeClair, University of Alaska Anchorage	June 27, 2025, via Zoom	Specialized approaches to the prevention of domestic violence and sexual assault of people with disabilities
Christine Hathaway, Perspectives Corporation	June 18, 2025, via Zoom	Use of trauma-informed care
Tina Rucci, **Mai Thor**, Arc of MN	June 16, 2025, via Zoom	MN landscape
Gretchen Godfrey, Pacer	June 11, 2025, via Zoom	MN landscape
Sue Babin, RI DDS	May 30, 2025, on Phone	A multipronged and collaborative approach to prevention and investigation
James Poteet, Inclusion Consultant	June 26, 2025, via Zoom	MN landscape
Madam Robinson, Inclusion Consultant	July 3, 2025, via Zoom	MN landscape
Betsy Scheibel, **Nancy Alterio**, Massachusetts Building Partnerships Initiative	August 5, 2025, via Zoom	Cross-Sector Alliance for the Prevention of Abuse and Neglect

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Topic 8: Transportation

Lisa Sloane, M.P.A., has 40 years of experience working with federal, state, and local governments as well as nonprofit agencies, to address the supportive housing needs of people with disabilities and of individuals and families experiencing homelessness.

Overview of Transportation & Olmstead Planning

People with disabilities and older adults rely on public transportation far more than others do. A 2021 Bureau of Transportation Statistics study found that only 60.4% of U.S. residents with disabilities drive, compared to 91.7% of those without disabilities. Without affordable, accessible, reliable, readily available, and user-friendly public transportation, people with disabilities and older adults face barriers to employment, recreational and social participation, and non-urgent health care access. These barriers can lead to reduced income, social isolation, poorer health outcomes, and even increased risk of institutionalization. As Jansuwan et al. (2013) noted, “Transportation is a requirement for full participation in a community.”

Subtopics

Transportation is a multifaceted issue with numerous subtopics relevant to disability. The topics highlighted in this report section were identified by multiple sources and confirmed by national organizations, technical assistance centers, and peer-reviewed research as currently relevant best, promising, or emerging practices.

- *Person-centered planning and informed choice*: Public transportation creates efficiencies by transporting groups of people at once. Some transportation models, such as vouchers, lend themselves to person-centered planning more than others — such as fixed route transit. One-call/one-click systems such as those described in this section can provide a person-centered, informed choice experience for people with disabilities, maximizing transportation opportunities and choice among the options available in a community, even in rural communities with more limited transportation resources.
- *Addressing disparities, including addressing culturally competent and responsive programs and services:*
    - Culturally competent and responsive transportation recognizes that people with disabilities are not a monolithic group. Transportation must meet the needs of people with disabilities from diverse cultural backgrounds, including immigrant and refugee communities, people of color, and LGBTQ+ individuals.

- To date, many transportation agencies have focused on the access needs of people with physical disabilities such as people who use wheelchairs, walkers, or canes as well as people with visual disabilities. As agencies become more involved and aware of the needs of people with other types of disabilities, including invisible disabilities, new and potentially competing issues may arise. For example, people with visual disabilities need accessible pedestrian signals to better ensure safety at street crossings, but people who are neurodivergent may find these signals problematic. Research indicates that people with different types of disabilities experience different barriers to using public transportation (Bezyak, 2017). Finding ways to meet cross-disability needs is critical.
- Several national organizations have sought to support transit driver education to ensure sensitivity and responsiveness to the varied needs of people with disabilities. The National Aging and Disability Transportation Center (NADTC) Access Matters video series, for example, was created to train drivers to be more sensitive to the needs of people who have visual, hearing, and other disabilities. The series of five videos covers important topics such as communication, service animals, what access means, and tips for serving people with a variety of disabilities.

Populations of Particular Concern for Transportation & *Olmstead*

People with disabilities living in rural areas are of particular concern. Non-drivers with disabilities in rural areas take fewer trips for health, social, and occupational reasons compared to nondrivers in urban areas. Lack of transportation can potentially result in decreased income opportunity; social isolation; poorer health; and lack of access to dental or mental health care for these individuals and their families – and can potentially increase the risk of institutionalization.

According to SAMHSA's GAINS Center, transportation barriers pose significant challenges for individuals involved with the criminal justice system, including people with mental illness and substance use disorders who are reentering the community following incarceration. During reentry, returning citizens face a variety of difficulties related to safety, accessing services, and meeting conditions of release, all of which can be exacerbated by insufficient access to transportation. People reentering the community from jail or prison often face specific challenges related to transportation, described as the "five A's": affordability, accessibility, applicability, availability, and awareness. Many individuals do not have the financial means to own a car or may lack appropriate identification to get a driver's license or may have an infraction, such as a DUI, that keeps them from using a car even if they have one. As a result, this population is especially reliant on public transportation. Transportation issues such as outstanding fines/fees, suspended licenses, and parole restrictions limit travel options and may compound racial and economic inequities in the justice system for people with disabilities and others. People with disabilities reentering might qualify for paratransit services, but Metro Council notes that others would have to rely on other options such as microtransit. People with disabilities can also experience barriers to physically accessing courthouses in order to participate in the legal process.

People with disabilities whose behavior is more aggressive often lose transportation services due to damaging a vehicle or harming a driver. The national Rural Transit Assistance Program (RTAP) provides online driver training, including a series of modules on "Managing Difficult Passengers & Situations." Veterans with disabilities are another population of interest that has access to various transportation assistance programs to help them get to medical appointments and other essential locations. These programs range from VA-provided services to those offered by Veteran service organizations and community-based initiatives. Examples include:

- Veterans Transportation Service (VTS)
- Beneficiary Travel Program
- Non-Emergency Medical Transportation (NEMT)
- Highly Rural Transportation Grant (HRTG) program
- Disabled American Veterans (DAV) Transportation Network
- County Veterans Service Officers (CVSO)

Transportation & *Olmstead* in Minnesota

The Minnesota Department of Transportation (MnDOT) and the Metropolitan Council (Met Council) are the state's two critical transportation agencies. MnDOT oversees transportation by all modes including land, water, air, rail, walking, and bicycling. MnDOT administers Federal Transit Administration (FTA) 5310 and 5311 funding, which supports capital and operating projects to meet the transportation needs of older adults and people with disabilities including projects that go beyond the scope of the Americans with Disabilities Act (ADA) complementary paratransit services. MnDOT has also developed the Moving Greater Minnesota Forward (MGMF) program, which funds innovative shared mobility programs in rural, Tribal, and small urban areas with fewer than 200,000 people; many of these projects benefit older adults and people with disabilities. Accessibility is one of the agency's priority areas. Currently MGMF has funded 43 projects in Phase One or Early Idea Development and ten projects in Phase Two or Real-World Testing. The program has three phases. MnDOT staff are currently updating the ADA Transition Plan.

Met Council is the regional governmental agency and metropolitan planning organization for the Twin Cities seven-county metropolitan area, accounting for over 55% of the state's population. The agency provides most bus service, operates light rail and commuter rail lines in the Twin Cities, and develops future transportation options. However, road and street corridor planning are administered by county and city governments. The metropolitan highway system is planned in coordination with MnDOT. In addition to working to ensure its transit system is fully accessible to people with a variety of disabilities, Met Council administers Metro Mobility, a shared-ride paratransit service, as required by the ADA and Minnesota law. Trips are provided for any purpose, helping people get to jobs, medical appointments, and social events. The Premium On-Demand pilot program is a service that invites any Metro Mobility customer to book a taxi ride at a reduced rate for a same-day ride, or any other ride up to four days in advance. Premium, on-demand trips are an option for customers who are able to pay

more for a faster trip, or for the convenience of a same-day ride and are not shared rides. Metro Move serves people who have a disability and are served by one of the state human service waivers. The service links waiver participants to day support programs, work, and other community destinations.

The Minnesota Council on Transportation Access (MCOTA) is a legislatively created entity charged with making recommendations to improve the coordination, availability, accessibility, efficiency, cost-effectiveness, and safety of transportation services provided to the transit public. The members include MnDOT and Met Council as well as state human services, disability, aging, employment, and other agencies, providing an infrastructure for coordinating transportation planning and programs. MCOTA has an Accessibility and Olmstead Work Team.

Effective Transportation-Related Policies, Programs, and Strategies

8A: Coordination/collaboration across entities responsible for transportation

Coordination across entities that are responsible for transportation is a recognized best practice. In Minnesota, such collaboration would include:

- State-level coordination between MnDOT and Met Council
- State-level coordination between MnDOT + Met Council and the state human services agencies
- Regional-local coordination between transportation and human service agencies responsible for transportation of people with disabilities and older adults

Promising Practices in Coordination/Collaboration

The Coordinating Council on Access and Mobility Technical Assistance Center (CCAM-TAC) identified Mobility Ohio as a promising model due to its high-level coordination between state human services and transportation agencies and its innovative pilot program.

Mobility Ohio (National Center for Mobility Management, 2023) began as a collaboration among 14 state agencies, which collectively fund over $500 million annually in human services transportation (HST). The goal was to break down silos, align policies, and improve HST efficiency and effectiveness — ultimately delivering more trips to more people without increasing costs. In addition to the Department of Transportation (ODOT), state partners included the Departments of Aging, Developmental Disabilities, Health, Jobs and Family Services, Medicaid, Disabilities, and others. In 2015, a governance structure of high-level administrators was formed. Over the last 10 years, this working group's successes include:

- Consensus on consistent safety and quality standards (e.g., driver qualifications, vehicle types, insurance, training)
- Development of a rate-setting tool
- Successful Innovative Coordinated Access and Mobility (ICAM) and Centers for Disease Control and Prevention (CDC) funding applications
- Establishment of a pilot Regional Transportation Resource Center (RTRC)

A notable strength is Ohio's sustained collaboration across changes in political leadership, attributed to a strong "top-down" approach. However, collaboration across all levels — top-down and bottom-up — might have yielded broader effectiveness. Opportunities include greater uniformity (e.g., rate-setting), streamlined operations for providers across jurisdictions, and improved mutual understanding among agencies.

The goals of Mobility Ohio's pilot – just entering its Phase II – are to:

- Demonstrate the effectiveness of consolidating HST policies, sharing costs, and coordinating trips through a one-stop center, prior to statewide implementation.
- Improve safety, quality, and availability of transportation for older adults, people with disabilities, and those with lower incomes.

The pilot RTRC, operated by Mid-Ohio Mobility Solutions (MOMS, a non-profit organization), uses a combination of existing and new brokerage technologies and inter-agency procedures to function as a "one-stop hub where clients and customers can conveniently schedule trips by phone or online (National Center for Mobility Management, 2023)." The RTRC schedules, dispatches, and funds client trips in four rural counties. This allows HST funded by federal, state, and local programs (estimated 40 programs) to be tracked and reported in a central location. These providers comply with the Mobility Ohio driver and vehicle safety and quality standards, developed by the state agencies. Using consistent provider standards will allow the pilot RTRC to leverage opportunities to braid federal funding streams, sharing trip costs among multiple funding sources. Concurrently, ODOT will expand use of a provider database to provide real-time information about drivers' criminal and motor vehicle history and training status, and vehicle registration and safety information, allowing the pilot RTRC to confirm compliance with Mobility Ohio's safety and quality standards. In Spring 2025 MOMS issued a request for proposals to evaluate the pilot; the evaluation is not yet available.

Advances like GTFS — a standardized data format that provides a structure for public transit agencies to describe the details of their services such as schedules, stops, fares, etc. — have improved real-time access to transportation data. Yet users still struggle to identify and book the best options. Hopelink and the King County Mobility Coalition (KCMC) in Washington State are addressing this problem through a One-Call/One-Click (OC/OC) platform. Hopelink and KCMC received an Inclusive Planning Grant to support the public outreach phase of their project. The grant stipulated that KCMC and Hopelink

engage in at least six months of outreach activities that meaningfully include people with disabilities and seniors.

Hopelink and KCMC plan to incorporate accessibility features into the OC/OC platform for its deployment, including screen readers, translation, and interpretation services. Developers might also look to integrate AccessMap, a platform that helps individuals plan for pedestrian portions of trips and accounts for concerns like sidewalk accessibility. KCMC has beta-tested the OC/OC platform with community members to identify any concerns with accessibility and other software functionality. Throughout 2023, the trip planner went through two accessibility audits and several rounds of community testing. The trip planner became available to the public in March 2024. Hopelink Mobility Management's commitment to inclusive planning is matched by the strong participation of people with disabilities in the Coalition's advisory committee.

The project has identified these cross-cutting implementation concerns:

- *Accessibility*: A significant portion of public-facing technology tools are designed for rapid deployment and aimed at non-disabled users. Ensuring accessibility for a wide range of users will require thoughtful planning and engagement with a diverse range of riders who can test the systems in ways that mirror real-world scenarios.
- *Data privacy*: Personally identifiable information (PII) must be managed with proper controls at every level in terms of the software's security and on the human side, through policies and procedures for every participating organization. Plain language user-facing privacy policies will need to be put into place.
- *Assistors*: It is often the case that riders need assistance accessing mobility options. This can include family members, neighbors, social workers, schedulers, etc. It is important to consider how assistance can be provided effectively and securely for all users: riders, assistors, and transportation providers.
- *Reporting*: Every element of the system that generates data will need to have a corresponding reporting capability to monitor the system's performance, track key performance indicators (KPIs), and comply with funding and legal requirements.
- *Data collection and evaluation*: The early design must be clear on what problems each system is solving and what KPIs will measure progress towards stated goals both for the systems themselves and ways the systems can help evaluate the transit network they are describing.

Promising Practices in Data Sharing

Both MnDOT and Met Council have expressed interest in obtaining data from state and local human services partners to better understand and plan for transportation needs. Enhanced coordination between transportation and human service agencies can facilitate valuable data sharing.

Some human service agencies and providers assess and record client transportation needs as part of broader social determinants of health assessments. The Centers for

Medicare and Medicaid Services (CMS), for example, encourages Medicare Advantage Organizations to conduct such assessments, recognizing that transportation barriers account for over 25% of missed medical appointments, a significant risk factor for poor health outcomes. Mobility Ohio demonstrates how state human services agencies are beginning to share data and align planning efforts (Dyles & Sarles, 2023; Federal Transit Administration, 2025; Ohio Department of Disabilities, 2025).

With emerging technologies enabling new mobility services, transit agencies and cities are increasingly partnering with private mobility providers to implement mobility on demand (MOD) solutions. These partnerships aim to enhance public transit and offer alternatives to traditional ADA paratransit services, with goals including expanded mobility options, cost reduction, and improved flexibility for riders. Agreements with MOD providers often include detailed data reporting requirements tied to service, funding, or regulatory needs. Such data can help demonstrate ADA service equivalency and track key metrics. The white paper "Objective-Driven Data Sharing for Transit Agencies in Mobility Partnerships" (Gururaja & Faust, 2019) outlines challenges public agencies face in securing needed data from private partners, citing examples like the Massachusetts Bay Transit Authority's (MBTA) and LA Metro's partnerships with transportation network companies or rideshare companies. For example, the Massachusetts Bay Transportation Authority (MBTA) provides data on wheelchair accessible vehicle (WAV) rides as part of its reporting. The white paper outlines some of the challenges that local and regional agencies have faced in attempting to obtain the data that they might need, including: traveler privacy, competitiveness, public records laws, data security, aggregation, National Transit Database (NTD) and performance-based funding, and capability limitations. Approaches to addressing these challenges are also outlined.

8B: Inclusive Planning

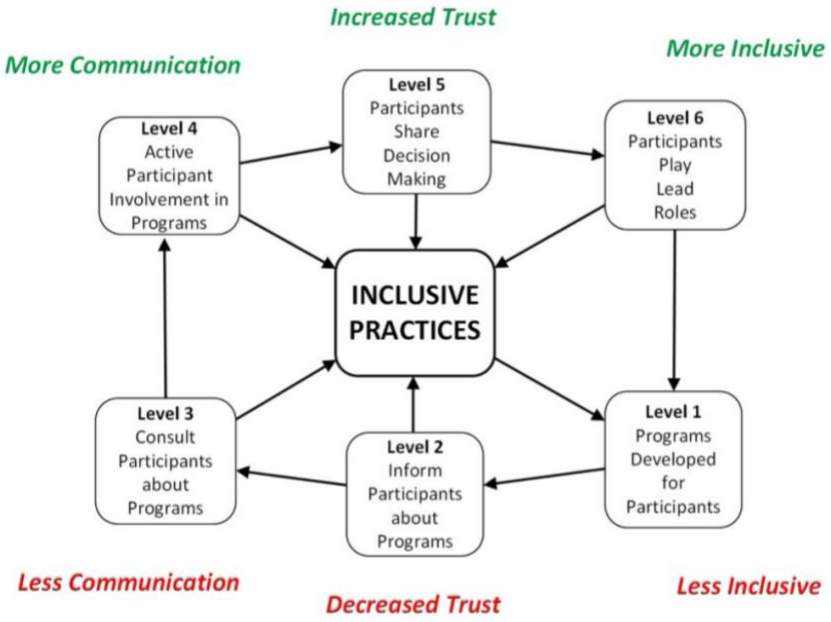
Inclusive planning is widely recognized as both a regulatory requirement and a best practice for achieving better transportation outcomes. Involving people with disabilities in transportation planning — through surveys, focus groups, equipment testing, and advisory committees — has been shown to improve program design and implementation.

Transit Planning 4 All (TP4A) is a U.S. Department of Health and Human Services initiative that promotes inclusive transportation planning practices. Through demonstration projects, TP4A helps empower people with disabilities and older adults to participate in designing and implementing coordinated transportation systems. Outcomes from these efforts include:

- Shared knowledge among participants, fostering innovative solutions
- More sensitive program design informed by people with lived experience
- Increased support and advocacy for project implementation
- Enhanced community capacity through skill-building and engagement

TP4A's framework is illustrated in its "Pathways to Inclusion" model in Figure 8.1 below.

Figure 8.1. Inclusive Transportation Practices



Hopelink and KCMC, noted earlier, applied these principles to ensure their One-Click platform met diverse accessibility needs. They developed an Inclusive Planning Toolkit in collaboration with TP4A, offering resources to improve engagement with people with varied disabilities.

The MBTA's RIDE program further exemplifies inclusive planning through its Riders' Transportation Access Group (RTAG), a community-based group that advises the MBTA on transportation matters affecting people with disabilities and older adults. Anyone is welcome to become a general member. The group's by-laws, memorandum of understanding with the MBTA, meeting dates, and minutes are posted publicly. The MBTA also offers temporary job opportunities through the Internal Access Monitoring (IAM) Program, a "secret shopper" program created to ensure that the MBTA is continually meeting the highest standards of accessible service. Teams of people, both with and without disabilities, ride buses, trains, and ferries and provide feedback on their experiences. Monitors earn $20/hour and generally work three to five hours a week. Note that riders have the same ability to rate drivers as any other Lyft or Uber passenger; riders cannot rate drivers mid-trip, but can do so as soon as the trip is completed.

8C: Rural Transportation Challenges

The same challenges faced by people with disabilities in urban areas are exacerbated in rural areas as there are more limited transportation options and distances are greater between bus stops, hospitals and medical buildings, grocery stores, and other locations to meet basic as well as recreational and social needs. Transit agencies may not only

have fewer modes of transportation but also fewer financial resources to address access needs such as wheelchair lifts, ramps, and accessible vehicles. The lack of adequate sidewalks and well-paved roads may also be limiting and pose safety concerns. According to the Rural Health Information Hub, non-drivers with disabilities in rural areas take fewer trips for health, social, and occupational reasons compared to non-drivers in urban areas. As described earlier, lack of transportation can potentially result in decreased income opportunity, social isolation and poorer health, dental or mental health care for these individuals and their families — and potentially increase risk of institutionalization.

State transportation agencies and Rural Transit Assistance Programs (RTAPs) are implementing a broad range of innovative transportation programs, models, and ideas in order to address these challenges. Serving the needs of residents by focusing on achieving a more coordinated system across transportation modes through enhanced information, communication, and service organization, the CCAM-TAC has called the One-Call Center in Scott and Carver Counties, MN a promising practice. An early version of mobility management with One-Call Transportation Information Services, the program also created a type of data warehouse, in which any qualified transportation provider could enter information on trips requested and provided. This data was fed directly into SmartLink's scheduling software, enabling the counties to separate out trips by funder type for reporting purposes, service area, etc., and making billing and payment more efficient. Minnesota uses 5310 funds specifically designated for the seven-county metro area (administered by MnDOT on behalf of the Council) to establish and support a Mobility Management program in each county that works to coordinate transportation needs of its residents. Dakota and Washington counties also have mature Mobility Management programs that have done a lot of meaningful coordination. Newtrax serves as the Mobility Management program for Ramsey County, and Metro Council reports that it has done a fantastic job as a 5310 grant recipient for mobility management. County-level coordination programs work well in Minnesota because DHS has established each county as the agent for waiver programs.

The University of Montana's Research & Training Center on Disability in Rural Communities is developing a Toolkit for Operating a Rural Transportation Voucher Program**.** In this model, transportation vouchers can be set up for riders to use for employment, non-emergency medical, daily living chores, and social activities. Transportation voucher programs provide eligible consumers with a voucher checkbook and an allocation of miles they can use to pay for rides. Depending on how the program is organized, consumers can use these vouchers to access public transit, get rides from volunteer drivers, or use them to reimburse family or friends. Voucher models are a cost-effective strategy for increasing transportation access although current resources for operating and sustaining voucher programs are outdated and under-supported. The toolkit will support the organizational capacity to establish, operate, and sustain a rural transportation voucher program and support the effective use of vouchers by consumers.

Easter Seals' How-To Manual for Building a Rural Transportation Coalition is based on Easter Seals' Accessible Transportation Community Initiative model. The model's

component parts include: the development of a community-wide coalition representing a diverse cross-section of organizations, all of whom are committed to a long-range approach to address area transportation needs; support for the creation and maintenance of strong and equal linkages among the community stakeholders; attracting and sustaining commitment at the highest levels of organizations to work on systems-change solutions; creation of and continued follow-up on action steps to address identified issues; and the building of and commitment to a sustainability plan long before the initial coalition effort is completed.

Volunteer driving programs can fill gaps in rural communities (Rural Health Information Hub, n.d.). The Rural Health Information Hub's Rural Transportation Toolkit points out that there may be communities where volunteer drivers are the only source of transportation available or where they are the only transportation available on certain days of the week or times of day (for instance, weekends and after normal business hours). In some instances, volunteer drivers may be the only option for a person in need of transportation due to the nature of the trip. For example, agencies providing non-emergency medical transit may be able to provide transportation services to and from medical appointments, but not for tasks like grocery shopping or social engagement activities. MN Moving Forward has funded some Volunteer Driver programs. Selected by NADTC as a best practice (National Aging & Disability Transportation Center, n.d.), Shared Mobility, Inc. partnered with the Volunteer Transportation Center Western New York (VTC) to provide volunteer transportation. VTC uses volunteers and mobility management to fill transportation gaps to health care and critical needs destinations.

The toolkit identifies organizations that have developed promising programs designed to improve transportation in rural communities:

- Compass IL (formerly the Center for Independent Living for Western Wisconsin) administers the New Freedom Transportation Program. This program allows persons with disabilities and older adults to access transportation services for medical, shopping, and recreational trips. It utilizes a call center, which is staffed by transportation specialists who coordinate travel for clients. Services are provided by either volunteer drivers who are reimbursed for their miles, or a voucher program that reimburses clients who provide their own drivers.
- Living Independence Network Corporation's Magic Valley Transportation program in Twin Falls, Idaho is a voucher program that provides low-cost, local transportation to older adults and people with disabilities. The program provides trips for health care appointments, grocery shopping, recreation, and employment. Riders of the program receive a LINC Transportation Card they can use to keep track of their rides and book rides with approved transportation providers. Transportation providers include a provider with wheelchair accessible vehicles, a provider that runs on Saturdays by appointment, and a local cab service that runs 24/7.
- Ride Connection provides transportation services to residents of rural Clackamas, Multnomah, and Washington counties in Oregon. The program serves primarily older adults and people with disabilities. Ride Connection provides information referrals,

training on how to use public transit, door-to-door rides, and a community connector deviated-route service. The door-to-door rides are provided by volunteers and paid drivers using insured volunteer-owned vehicles, Ride Connection-owned lift-equipped mini-vans, 14-passenger lift-equipped mini-buses, and a network of local private transportation providers.

- Driver recruitment is one of the primary challenges of the volunteer driving programs. Research by AARP (Lynott et al., 2020) suggests that the reality or the perception that a volunteer's insurance costs will increase or that their volunteer work is not covered makes recruitment more difficult. AARP provides recommendations for state legislation and program operations to address these challenges.

8D: Emerging transportation topics

Microtransit is an evolving transportation mode, with agencies exploring its potential to improve service flexibility, particularly in rural areas.

- A study of public agencies in North Carolina that have implemented microtransit systems (Bardaka & Monast, 2023) includes systems serving rural areas. The study discusses existing challenges related to funding availability, meeting the demand under cost constraints, ADA compliance, banking and technology-related barriers, virtual stops and access to vehicles, driver shortage and training, and data ownership. The study report also presents the lessons learned from North Carolina‘s microtransit implementation, including the implications of service delivery model selection, service provider selection, and marketing. The authors hope the findings of the study and the lessons learned from the North Carolina experience will assist planning and transportation agencies to plan and design successful microtransit systems.
- “On-Demand Alternatives to Dial-a-Ride Services and Unproductive Coverage Routes” (National Academies of Sciences, Engineering, and Medicine, 2025) explores whether and how on-demand microtransit service can be effective in a rural context. The authors conducted a literature review and an exploratory survey of 27 transit providers. The agencies responding to the survey ranged widely in terms of ridership, with between 55 and 9,625 passenger trips per month, with all but one agency providing at least 500 passenger trips per month. In addition, the synthesis contains seven case examples of transit agencies that have implemented microtransit in rural settings. These case examples provide insights on services provided, key challenges, notable practices, and lessons learned, and the report concludes these can be delivered effectively in rural areas although many design and funding challenges exist.
- A 2020 study of the barriers and opportunities for paratransit users to adopt on-demand microtransit (Miah et al., 2020) found that the most prevalent barrier was the required use of credit cards and smartphones for payment and reservations; many low-income older adults and people with disabilities lacked credit cards, smartphones, or both. Communities hoping to encourage paratransit riders to move to microtransit services may realize greater success if they offer alternative payment options, such as cash or vouchers. Previous research suggests that older adults with

disabilities may be concerned for their personal safety, especially when traveling alone. Thus, walking to and from the pickup and drop-off locations required by some models may hinder use for some paratransit riders.

Autonomous vehicles offer great potential for people with disabilities and seniors who cannot drive, especially in locations where programs may be limited by the lack of drivers or available funding, such as rural areas. GoMARTI is Minnesota's Autonomous Rural Transit Initiative, a pilot program that is operational in Grand Rapids, Minnesota. GoMARTI project goals include advancing and informing the technology in rural and winter conditions; researching and providing accessible mobility options; engaging with the local community and building trust in self-driving shuttles; and providing workforce and economic development opportunities. Through December 2024, GoMARTI had 18,698 riders, 1,088 wheelchair-accessible rides completed (~6%), and 93% repeat riders. Other projects to watch include EASI RIDER at Purdue University, designed in response to the U.S. Department of Transportation (DOT) Inclusive Design Challenge focused on developing an innovative solution for accessible automated driving system-dedicated vehicles (ADS-DV). This design won first place but is still only a prototype.

While autonomous vehicles hold promise for expanding transportation options for people with disabilities and others, it is important to note that surveys conducted annually by the American Automobile Association (AAA) have found that while the public appreciates new technology that makes driving safer, the vast majority of the public is skeptical and distrusting of autonomous vehicles. More data and experience will be needed to either confirm or change these perceptions.

Key Informants & Subject Matter Experts Consulted on Transportation & Olmstead Planning

Key Informant or Subject Matter Experts Interviewed	Date & Venue/Modality	Topic(s)
Gerri Sutton, Assistant Director, Metropolitan Transportation Services, Met Council	May 23, 2025	Overview of Met Council roles and responsibilities, divisions, disability-related activities, *Olmstead* strengths and challenges
Kristie Billiar, ADA Program and Policy (Title II) MN Department of Transportation	June 26, 2025	Overview of MnDOT roles and responsibilities, divisions, disability-related activities, *Olmstead* strengths and challenges
Ken Rodgers, Inclusion Consultant	MnDOT: June 24, 2025; Met Council: June 30, 2025	MnDOT and Met Council *Olmstead* strengths and challenges

Key Informant or Subject Matter Experts Interviewed	Date & Venue/Modality	Topic(s)
Kevin Pone, Inclusion Consultant	June 24, 2025	MN DoT *Olmstead* strengths and challenges

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