MINNESOTA
OLMSTEAD
IMPLEMENTATION OFFICE

Redacted Survey Responses: Transition

These survey responses have been redacted to exclude personally identifying information.

Responses about all transition goals

- I am not a user - but it sounds like a smorgasbord of stuff was included here - from restraints to living settings to specific treatment programs. It is a mess.
- The transition goals appropriately emphasize movement from segregated settings into integrated community-based environments. However, they do not address the importance of preserving the stability of smaller residential homes that already provide integrated placements. Family Residential Services homes are an important part of Minnesota's community-based residential system. When funding structures do not reflect actual support needs, providers may be forced to restructure placements or close homes, which can result in unnecessary transitions for individuals who were previously stable. Supporting funding approaches that maintain the viability of these homes would help prevent avoidable placement disruption and strengthen progress toward the integration goals of the Olmstead Plan.
- Lack of enforceable timelines for assessment, discharge, and transition from institutional settings No accountability framework when individuals remain in restrictive environments due to system delays rather than clinical necessity Insufficient requirement that community-based capacity exist before transitions are initiated, creating risk of “promised but unavailable” services Weak definition of what constitutes “integrated settings,” leaving room for inconsistent interpretation Limited focus on long-term stability after transition, including preventing cycling back into higher levels of care Peer support, workforce input, and policy shaping are included, but not clearly tied to decision authority or measurable system outcomes
- The reality is that for many people, contracted case management does not work. There is too much turnover and lack of training and support. There are some good contracted case managers. However, those are the case managers who apply and are hired to work for the county agencies. I believe Services for all people will improve when contracted case management is eliminated.
- The goals for this Olmstead Plan are simply following the natural trajectory of improvement and are not aspirational. The mission of the Olmstead Plan is supposed to provide actual growth and improvement in the lives of PWD and this plan misses the mark completely. These need to be MEANINGFUL goals. What is provided in this plan are not meaningful.

- Goals don't seem to be integrated in a systemic way. There are treated in isolation rather than analyzed with an end-to-end perspective (ensure pre-requisites are addressed).
- absolutely essential!!!this is the last large institutionalized population in the state. you should also address the racial inequities--more Black people are being sent to these places..
- Why have these goals been placed under the heading “Transition/s”??? They should be the goals for all Minnesotans with disabilities, not only those “transitioning.” And from what to what are the referred transitions?
- Segregated settings should be last resort.
- Will make a goal is NOT a goal.
- The “Anoka Backlog” is a Community Capacity Failure (Goals 1 & 2): The state aims for “fewer people to stay at AMRTC” and “prompt assessments” in forensic programs. This is Administrative Stalling. People are not stuck in AMRTC because of slow paperwork; they are stuck because there is no accessible, staffed housing in the community to receive them. The Olmstead Plan must stop treating this as a “clinical assessment” issue and start treating it as a Housing and Workforce issue. Until the state funds community placements at a rate that competes with institutional costs, the backlog will never clear. 2. Stop “Tracking” Violence and Start Banning It (Goal 5 & Data Goal 6): Goal 5 and Data Goal 6 focus on “less use” of restrictive procedures and “protecting people from increases” in mechanical restraint. This is an unacceptable baseline. “Tracking” the use of mechanical restraints is not a safety strategy; it is a documentation of state-sanctioned trauma. For a state committed to disability justice, the goal must be an Absolute Ban on mechanical restraints and seclusion in all state-funded settings. You cannot “track” your way to safety. 3. Address the “Brain Drain” of Care (Data Goal 3): Data Goal 3 aims for “fewer Minnesotans going out-of-state for services.” This is a public admission that Minnesota's disability infrastructure has collapsed. We are sending our citizens to other states because we refuse to pay a living wage to Direct Support Professionals (DSPs) or build specialized local capacity. This is not a “Data Goal”; it is a Systemic Crisis. The action step must be a massive, immediate investment in the local DSP workforce to bring our people home. 4. The “Provider Neutrality” Mandate for Integrated Housing (Goal 4): Moving to “integrated housing of their choice” is a myth if the person is forced into “Permanent Supportive Housing” where their lease is tied to their service provider. The plan must mandate Provider Neutrality: a disabled person must have the absolute right to fire their care team without being evicted from their “integrated” home. Anything else is just a state-funded institutional annex. 5. Incarceration is Not a Transition Goal (Data Goal 2): Tracking “access to correctional programs” for incarcerated disabled individuals is a baseline ADA requirement, not a “Transition” success. The goal should be Diversion. We must track how many disabled individuals are being funneled into the DOC because the state's mental health and crisis systems failed to intervene. True transition is keeping disabled people out of prison entirely, not making the prison “more accessible.” 6. Move Beyond “Shaping” to “Deciding” (Data Goal 5): Allowing DSPs and disabled people to “shape” the future of Medicaid is a “Knowledge Deficit Fallacy” tactic. It gives the appearance of inclusion while maintaining all decision-making power within the state

bureaucracy. The goal should be Co-Governance. Disabled people and the workers who support them should have a voting seat on the committees that set reimbursement rates and policy, rather than just being "asked for their ideas."

- Data goal 5 is very important. More Inclusion Consultants should be hired, specifically for Medicaid and Waiver Reimagine policy/processes. Data goal 7 - as previously mentioned regarding housing, most of the announcements lately (a. ending HSS; b. ending waiver funding for home mods in provider controlled settings; c. individualized waiver budgets being automatically higher for people receiving residential services, thereby disincentivizing a full range of support services within their own home) seem to decrease options, not increase them. It feels like we are moving backwards from the intention of the Olmstead Plan and not enough advocacy is being done to stop this.
- Transition Goal 6: Some group homes use restrictive procedures better than others. Needs improvement. Transition Data Goal 2 is excellent.
- Disability Systems Change Council (p11 under Measurable goals and strategies) -- there is NOTHING on the home and community based services that make the rest even possible. Under "tracking progress" (p14) they talk about percentages of increase or decrease. Singe digits? Then the claim: "This target reflects changes that DCYF can realistically make." "Discipline" (p18) means suspension longer than 10 days, or expulsion...but not reducing or eliminating restraint. Later on in the document (p22), they refer to "restrictive procedures" -- but do not specifically address restraint. After reading this far, WTF is the Disability Systems Change Council for exactly? Looks like the OIO already decided on everything. Another charade like the WRAC committee, true to (redacted) past behavior. Abuse & Neglect research and goals pertain ONLY to facilities, not home environments and not group homes. NO mention of fortifying Adult Protection to become useful at all and NO mention of the catch-22 in Child Protection when families are not given sufficient funding for the HCBS supports. MDH will "Continue to train health care and other service providers about identifying and reporting abuse and neglect" -- which is absolutely stupid when NOTHING USEFUL ACTUALLY COMES OF IT. The trainers and trainees get more money, but the people get nothing. Housing Universal Design standards (p32) says nothing about those with Chemical Sensitivities who are homeless bc of construction toxins, shared ductwork and previous tenancies destroying the air quality with their substances. Also loans for "improvements" if you already own, but no loan opportunities for NEW home owners. They want us to rent and be under the thumb of landlords. Transportation (start p 34) NO Rideshare access. More unnecessary research for "potential approaches." That money could be spent on ACTUAL RIDES. A whole bunch of "MnDOT is working to confirm targets and baseline data." Why is MNDOT doing it themselves and not surveying the people to see what's needed? And then cost of transportation will go up under this plan with "updated rates would also more closely match the actual cost of providing services." Sounds like the state will not be subsidizing, which means a greater disability tax gap for us to foot. Anoka Metro Regional Treatment Center (AMRTC) p 40 -- NO mention of home and community based supports being a solution. A mention of "Increase access to peer support

across all service areas”...are they going to pay people with disabilities or are they expecting us to do more volunteer work? Crisis service (p48): “DHS recommends that in the future, this goal counts voluntary residential treatment as “staying in community.” They are trying to pawn off an idea that is not, in fact, “in the community.” Community Employment (p50) - “If someone makes $600 or more per month, they are counted as having CIE. If someone makes $599 or less per month, they are counted as having non-competitive employment.” It says NOTHING about the hourly wage or how many hours. This is a stupid way to assess competitve employment. Competitive employment is GETTING A JOB AGAINST AN ABLED PERSON -- COMPETEING WITH AN ABLED PERSON FOR THE SAME JOB. They are passing off a definition that is not correct. They are also talking about allowing “subminium wages” after all the advocacy and new laws. “DHS is working on getting data that will show the number of people who have CIE” (p51) means that we're spending more money on a researcher instead of actually holding these job brokers/coordinators accountable for the already high rates they get. Councils and Advisory Boards (p61): “Minnesota is in the process of redesigning advisory councils to come into compliance with federal regulation (Access Rule). It is reforming the Medicaid Advisory Council and establishing an Interested Party Advisory Council. -- all these councils to pretend like they are engaging stakeholders. It's a ruse. Mechanical Restraints (p62) -- NOT physical restraint, NOT chemical restraint. ONLY “mechanical.” Restraint should be addressed without an adjective/qualifier. Segregated settings to integrated settings (p65) -- again no mention of home settings or group home settings as being “segregated.” If a person can't leave their home or group home in a self-directed fashion, it's segregated. Lots of consultants are being paid! (p66) to do more nothing useful. This money could be used to fund proper levels of care in HCBS settings instead of consultants. Community Engagement -- Telling us what we want to hear, but likely not to deliver bc of history of leadership. “Community engagement is accountable when there is full transparency with participants (p68) , “During engagement, facilitation must fit the needs of the community...We prioritize leading with a spirit of co-creation and honoring the community's feedback.” (p69) -- We are being fed a line of BS right now. I personally won't believe it until (redacted) no longer serves in or for a state agency and until the program designs actually support the people. “Community engagement is core to OIO's work” (p70) and yet, their procedures are exclusive, the agency representatives don't follow through meaningfully with solutions. they say “surveys will focus on quality of life for people in segregated settings...and that doesn't include everyone who is segregated. Agency Connect (p71) “OIO will track state agencies' timeliness and responsiveness” -- but not the quality of the responses. Remove (redacted). Her role on the OIO is a HUGE CONFLICT OF INTEREST to oversee this plan having been the former director of DHS Aging & Disability Services. She threw us under the bus many times during her time at DHS, namely with the Waiver Reimagine's MnChoices Assessment and Budget Methodologies. More: - No mention of Waiver Reimagine even though HSRI's own data projects people facing average $34,644 budget cuts and many will face 50-80% reductions concentrated in home and family living settings. - An independent legal analysis already in the Minnesota Senate record (O'Meara

Wagner, P.A., SF 4512, April 12, 2026) written by the same attorney whose prior litigation CREATED Minnesota's Olmstead Plan identifies Waiver Reimagine as illegal under the ADA, Olmstead, and federal Medicaid law. The 2026 plan does not mention it. - Minnesota is misclassifying 5-6 person congregate settings that meet the DOJ's definition of mini-institutions as participants' "own home." Every community integration statistic the state reports is built on miscoded data and a definition that is wrong. - No budget adequacy standard and nothing requiring that waiver budgets actually be sufficient to sustain community living. - No home care staffing or nursing goals even though nursing and DSP vacancies represent 10-15% of ALL job openings in the state. You cannot access employment, housing, or community life if there is no one to help you perform ADLs in the morning. MN leads the nation in nursing homecare shortages. Goals without access consideration are unattainable. -The public comment process itself routes feedback through a filtered anonymous Formstack survey with text boxes and checkboxes. Also, the Olmstead Plan needs to clearly define what "supports" means. We demanding tangible supports: direct and indirect, formal and informal. Supports should be meaningful to the individual and their family if they choose. Undefined terms create enforcement gaps and leave too much room for narrow interpretation and cost-shifting onto families.

- The transition goals acknowledge important principles, but the plan relies too heavily on broad aspirational language without enough enforceable accountability measures tied to actual service access and prevention of institutionalization. Minnesota should focus on measurable outcomes such as whether people can maintain housing, retain staffing and nursing, avoid hospitalization or institutional placement, and safely remain integrated in the community long term. The state should also recognize that most congregate settings function institutionally per the DOJ's definitions in practice and should not automatically be treated as integrated settings simply because they are licensed as community-based housing. Housing or transition placements that cannot legally or realistically accommodate waiver staffing and supports should not be treated as successful community integration. Preventing institutionalization must remain the foundation of the Olmstead Plan because without stable community supports, individuals cannot meaningfully access employment, education, healthcare, or full community participation.
- These transition goals cannot succeed while Waiver Reimagine is underway—because Waiver Reimagine is precisely what creates the need for transition in the first place. When home-based supports are cut or limited below the level a person with complex needs requires to survive safely in the community, that person is pushed toward more segregated settings. There are not enough group homes to absorb them. Providers are not accepting these participants. Hospitals are not long-term living environments—and many people are sent home because their needs are too complex. There is no hidden safety net. The only net that exists is the system of home-based supports that is already keeping them alive—and that system is in mortal peril. For transition goals to have any real meaning, the Olmstead Plan must explicitly and immediately demand two things. First: that Minnesota adopt and apply the Department of Justice's

definitions for classifying institutional settings—not merely CMS approval—so that transition data reflects reality rather than an illusion of progress. Second: that Waiver Reimagine be halted and reversed, as it is the primary cause of unnecessary institutionalization in Minnesota. We cannot achieve a transition toward integrated settings while simultaneously destroying the supports that make community living possible. We cannot talk about moving people out of institutions if our policies are pushing them into them. We cannot talk about inclusion if people do not survive long enough to be included. You have to be alive to transition. You have to be alive to be integrated. You have to be alive to have a future. Save lives, stop Waiver Reimagine, and adopt the Department of Justice's definitions—that must be the line in the sand.

- Transition objectives assume that the community possesses the capacity to receive participants leaving segregated settings. That capacity does not exist to the necessary extent. There are not enough group homes. ACR and other providers are not accepting many of these participants. Waiver Reimagine threatens to further reduce the supports that enable individuals to remain in the community. A transition toward integrated settings cannot be achieved if, at the same time, the system of supports that makes such integration possible is being dismantled.

Missing Transition Goals

- I honestly don't know what to say - I'm not sure what the difference between a goal and a data goal is - seems to me like the focus should be on people rather than data - and this speaks directly to those moving between segregated settings and community based - and has some very detailed goals around stuff that I know nothing about...as we haven't had to use these services
- One important issue missing from the transition goals is the risk of involuntary placement changes caused by instability in existing community-based residential settings. Recent implementation of the flat-rate funding structure for Family Residential Services is already creating restructuring of one-person homes, staffing reductions, and increased risk of provider closure. These changes are not driven by assessed need or person-centered planning and may result in individuals being required to move from stable placements into larger or more restrictive settings. Transitions should occur based on individual choice and support needs, not funding instability. Addressing the stability of existing Family Residential Services homes is essential to supporting the integration goals of the Olmstead Plan.
- No enforceable timelines for discharge or step-down from restrictive or institutional settings Limited accountability when individuals remain in segregated settings due to system delays rather than clinical need Missing requirement for guaranteed community capacity before discharge decisions are made No clear standards defining what "integrated settings" mean in practice (risk of label-based compliance) Insufficient focus on preventing re-institutionalization after transition to community settings No strong enforcement mechanisms tied to agency performance when transition delays occur Limited attention to individual autonomy in transition planning, including meaningful choice in housing and services Peer support and

workforce input are included, but not tied to decision-making authority or measurable outcomes

- Assistive Technology Assessment, services and equipment is key to transition goals for people with disabilities.
- County case managers need to be a part of the conversation.
- should be a goal around fewer people having guardians, more people exercising supported decision making in accessing services
- While I 100% agree with the goal of “More people will receive supportive services in community-based settings”, it is unattainable without addressing the dramatic shortage in support staff. The gap is growing bigger every year and more people with disabilities are not getting their needs met or are unable to access the community because they do not have adequate support. This issue gets worse as individuals with disability grow older. In fact, solving for the staffing shortage should be a pre-requisite of this goal. It is not just about increasing pay-rates, but it is also about increasing the number of direst support staff (DSP). The reality is there are fewer people opting to follow a care-giving path, because there isn't a formal career pathway. As such I believe the solution should include: - Establishing a formal care-giving profession with options to follow a nursing or medical pathway if desire - Invest in human androids (robotic) as augmentation to human care-giving particularly for adults with disabilities
- Yes, again, many of these challenges are challenges due to lack of capacity from providers due to workforce shortages. While MN is not an NCI State of the Workforce survey state, national numbers indicate that on average, across 27 states, 26.6% of organizations who support adults with IDD had to stop accepting new referrals. This shortage will continue to be challenge over time and without investments to systemic change to fix the workforce challenge, nothing will be able to change.
- Transition goal 5. Include ALL stakeholders, not just support ptofession. Missing is community integration and social goal inclusion
- Better respite services! Peer respite for mental health! Actual peer-run services! Expanding ACT and other comprehensive wraparound services! Repealing sit-lie laws and other modern ugly laws that make it effectively illegal to be visibly disabled or Mad in public!
- No Moving Home MN goals? No goals about delayed hospital discharges due to lack of services - and that's just for people to are eligible for MA-funded services. Most Minnesotan's with disabilities are NOT on MA. We are discharged from hospitals without services in the home to prevent readmission. I was personally discharged with multiple open wounds that needed twice daily packing. No home care, no PDN. A hospital nurse showed my boyfriend what to do. I am forever grateful he became my husband and didn't abandon me. There is no transition planning or assistance for most Minnesotan's with disabilities.
- The “Cliff-Edge” of Transition Funding: Transitioning from an institution to the community is expensive and risky. The plan is missing an “Emergency Transition Fund”-flexible, rapid-response cash that allows a person to instantly secure furniture, a security deposit, and emergency staffing while their regular waivers and benefits catch up. Without this “bridge”

funding, people remain trapped in institutions for months of “administrative churn.” 2. Meaningful Peer-Led Defense (Data Goal 1): While peer support is mentioned, it is usually treated as a “clinical add-on.” We are missing a goal for Independent Peer Advocacy-funding for organizations like the ARC or local CILs to provide transition advocates who do NOT work for the state or the providers. A person cannot “choose” an integrated life if the only person helping them choose is the agency that stands to profit from their placement. This entire Transition section feels like a plan to move chairs around on the deck of a sinking ship. You cannot 'transition' a population into a community that has no workers, no housing, and no reliable transportation. Until the state treats the Workforce Collapse and the Housing Shortage as the primary barriers to transition, these goals will remain performative data-collection exercises.

- More specific action steps - HOW will these goals be met?
- It would be helpful to have an in home counselor who could observe behavior in his current environment and provide guidance to improve behavior management.
- After we were freed from institutionalization and placed in group homes, we still need more supports. Social Security is a major source of support, but they are seeking clarification on how to receive additional support in finding qualified programs to sign up for. Why is Medicare premium so expensive when I am receiving less? There is a stigma against people with mental health disabilities that segregates them from the housing of their choice.
- Unless you take the decision of attending transition schooling after high school-high schools will NOT support sending students to the transition school. Once again it comes down to the district paying for it.
- Ongoing qualitative listening sessions with people especially with the changes in services and resources available to folks during this Federal Administration. Plans need to be flexible to changes
- Need to set realistic targets and make sure infrastructure is in place to bring these goals to fruition. These transition goals should not be unique to AMRTC. There are many individuals social boarding in emergency departments across the state that are dtopped off by group homes, Guardians etc. Their Guardians should be paid and required to stay with people who cant communicate their wants and needs- policy and funding nedds to change on this etc. People should not be admitted to inappropriate levels of care, wrong units and stuck in private hospitals not being able to be discharged.
- Community connectedness is vital for stabilizing families, children and individuals with disabilities. Minnesota had the March 2018 Direct Care Recommendations Report that elevated the direct care crisis. The crisis is five times worse now than it was 10 years ago. It is people who are in crisis and that has to be a major focus of the plan and summary of the plan in the beginning of the document. I was one of the technical writers for the March 2018 approved Direct Care Olmstead Sub-cabinet recommendation report. Is the direct care crisis over? I would conclude that with the current draft report and that is not accurate the draft needs to be suspended until it addresses the constitutional level of human crisis that is real for individuals

from both the disability communities and older adult communities who rely upon direct care services for daily living. .

- One major concern is that the transition goals appear to focus primarily on moving people from institutional settings into community placements, but do not clearly address prevention of institutionalization itself. Under Olmstead and the ADA integration mandate, unnecessary institutionalization is not the only concern. The serious risk of institutionalization caused by inadequate community supports, staffing shortages, inaccessible housing, loss of nursing, service gaps, or failure to maintain existing placements must also be addressed. The plan should include measurable goals related to preventing institutional placement before it occurs, including maintaining adequate home and community-based services, preserving continuity of care, stabilizing community staffing, and ensuring that people can safely remain in their homes and communities long term. Transition should not only mean moving people out of institutions. It should also mean preventing people from being forced into them in the first place.
- The goals are unrealistic.
- What is fundamentally missing from these transition goals is the recognition that Minnesota has its priorities completely backward. The state is focused on moving people *out* of institutions—but it is not focused on preventing them from ending up there in the first place. If we prevent institutionalization, we do not need a massive transition agenda. Prevention must be the number one priority. And the primary cause of unnecessary institutionalization in Minnesota is the lack of sufficient in-home supports—supports that *Waiver Reimagine* is poised to destroy. *Waiver Reimagine* is not merely a threat to inclusion; it is the direct cause of future institutionalization. When the supports that sustain life at home are cut, people with complex needs have nowhere to go—except to hospitals, congregate settings, or out of state. That is exactly what these transition goals claim they want to prevent. Furthermore, the state is fraudulently classifying many congregate settings as "integrated"—leveraging CMS approval to do so—while completely ignoring the definitions established by the U.S. Department of Justice. According to the Department of Justice, any setting where individuals cannot choose their own staff, where meals are regimented, or where daily routines are controlled by the organization rather than the individual, constitutes an institution. Minnesota is counting these very institutions as transition successes. The data is bogus. The progress is an illusion.
- What is missing is an explicit acknowledgment that Waiver Reimagine directly threatens participants' ability to remain in integrated settings. The transition to integrated settings is possible only if in-home supports are sufficient to sustain the participant's life in the community. If those supports are reduced or limited, the transition becomes a crisis—not an achievement. The Plan must include explicit protection of life-sustaining supports as a prerequisite for any transition objective.

Transition Data Goal 1

- We also need more and better peer support services in the community. I have no idea where to get peer support services and as far as I can tell, the only way to get them in the community (for mental health at least) is to be enrolled with an ACT team. There's wellness in the woods and the mental health MN line, but those are all virtual/phone options, which are not accessible for me. ARMHS isn't helpful because ARMHS workers aren't peers, even if ARMHS is supposed to include access to peer support. I can't hire a peer support worker through my waiver because that's supposed to be a straight state plan Medicaid service, even though it's completely inaccessible. We also need peer support services for people with disabilities that aren't mental health focused. MH/SUD peer support is great, but we need to expand the peer support model so that people with other disabilities (eg, IDD, long COVID) can get peer support from other people with those disabilities. Insofar as there are truly peer-run spaces in MN (there aren't! the CSPs aren't, the crisis services aren't! Friggin Wisconsin has us beat because they actually have peer run respites!), these are ONLY mental health/SUD oriented. None of them are geared towards other kinds of disabilities, and the disability programs that do get funded by the state (aside from some of what Advocating Change Together and the Arc do) are very professional-led.
- Again - DCT only population. What about statewide supports? The high level of fraud in peer support programs needs to stop - without stopping the services. The service should require licensure, and billing by treating provider, and inspections and clear guidance. Dump the fraudulent providers and recruit effective, law abiding providers. More than the handful of DCT clients need peer support to stay employed and sober.
- The Peer support should be people with disabilities, potentially similar to person they will serve, who is successfully living in the community

Transition Data Goal 2

- What is DOC going to do to actually make this happen?
- Where is the goal. DOC has really done poorly on their goals!Is
- Qualitative interviews with people what will work for them , does not work and changes needed to access those programs and implement those changes,
- Transition Data Goal 2 is excellent.

Transition Data Goal 3

- More providers need to be developed in the State. In addition, insurance companies need to willing to authorize services in the State. Many insurance companies prefer to refer people to agencies outside of the state.

- We need to better track and report on the number of people, both youth and adults, who go outside of Minnesota for residential treatment, due to lack of appropriate and/or available options here in Minnesota. Our agency has specific concern about this for foster youth, and feel it is important to specifically track this demographic of youth. It would be important to track demographics such as race and ethnicity, age, diagnosis, and reason for pursuing out-of-state placement services. Feedback submitted by Redacted, Office of the Foster Youth Ombudsperson (OOFY)
- Looks good.
- Is the DSP shortage even driving people out of state? Most of the shortages that do that are facility shortages, especially children's facilities. Neighboring states do not offer as much DSP services for MA/Medicaid clients than MN. Moving to SD isn't going to get someone more services. ALSO what about all the people with disabilities who are not eligible for MA/Medicaid and waiver services. Very few Minnesotan's with disabilities are eligible for MA and state paid DSP. Income limits are so far below true poverty. Most of us don't qualify for any DSP help and can't afford private pay rates either.
- Qualitative interviews with people why they had to go out of state, what will work for them , does not work and changes needed to access those programs in state and implement those changes,

Transition Data Goal 4

- The issue is that everyone needs to have an annual MNChoices assessment. Thus, people have to wait months for an initial assessment. Then, it is even longer to start services. I recommend that people be allowed to 'waive' their annual assessment if they are stable. Require in-person assessments every 5 years for those who are stable. If someone's needs change, they can request an assessment. This change would allow more people to get assessed sooner. It is not possible for case managers to send out support plans in the timelines which are expected. It is now much more difficult for people to access personal care services now with CFSS. If the goal was to make services more accessible, CFSS is an epic (and expensive) failure. Remove the new requirement that only people with 'serious mental or physical health issues' be eligible for group homes. That is discriminatory against people with disabilities.
- Need to increase wages and rates for employees to get more in the work force
- I would also add a goal about tracking data on paperwork burden and people who are disenrolled/have services suspended or terminated for purely bureaucratic (eg, forgetting to return a document, mailing a document late) reasons. I also would like the state to require counties to track and report data like “how long does the average person calling about disability services sit on hold before reaching someone from the health care team?” and “what is the average turnaround time between when a person returns their 6-month eligibility paperwork to the county and when that paperwork is processed and entered into the system?”

- DHS will make a goal - that is the goal?!?! Meanwhile in some counties people wait several months for an assessment and several months more for an MA eligibility determination. DSP shortages are only getting worse. It is sad the goal isn't more detailed and also isn't a reach goal. It seems leaders can't even manage meeting the legislatively mandated timeline. Making a goal. isn't going to improve access. Only systemic change will make things better.
- Qualitative interviews with people what will work for them , does not work and changes needed to access those programs and implement those changes,
- These are good things to measure, but making any improvement depends on resources available at the county level, which is outside of DHS control. And there are other dynamics which will make these even more challenging, such as the looming Medicaid cuts from HR1, and the possibility of further withholds from CMS. There will likely be attempts to shift state costs to local government, where budgets are already under stress. Too many times, cuts are made at the expense of people with disabilities.

Transition Data Goal 5

- CFSS is a waste of time and money. Allow people to choose if they want to use CFSS. If they want to keep straight PCA, allow them to do that. CFSS might have been a good idea on paper but it is a horrible idea in practice.
- YES! They have a better understanding of needs.
- Getting PWD/supporters from a range of life experiences -- eg, “I am someone on a waiver with CDCS and I *have to* know and understand all the policy jargon in order to manage the services I need to stay alive” vs “I have a chronic health condition and I receive a few hours of state plan PCA services a week, I don't really understand the policies behind it, but I know a fair amount” vs. “My kid has severe asthma, they're not receiving any kind of in-home services at this point, but we're in the ER at least once a month because of their breathing problems and I'm trying to navigate this all despite English not being my primary language.” With DSPs/other support staff, also looking at a range of life experiences and work tasks. Someone whose primary work is helping a person with cerebral palsy with activities of daily living vs. someone who's an intervener for a DeafBlind person with an intellectual disability, etc. Also considering people who both receive or have received HCBS and have worked or currently work as DSPs or other support staff.
- Again with the “wants to write a goal.” This is mind boggling. How many Olmstead goals are to write a goal?!?!?
- Qualitative interviews with people what will work for them , does not work and changes needed to access those programs and implement those changes,
- Services to people with disabilities are nothing without a reliable, competent direct care workforce. Many direct support staff can barely make ends meet on the low wages our system makes it possible to pay them, and asking for investment of their time in efforts such as this may not be successful. Realizing that it is a requirement under the Access Rule, the state can

check a box without making any impact on the lives of people with disabilities and those that support them.

Transition Data Goal 6

- Must happen!
- Why is ANYONE still subject to mechanical restraints? The Settings Rule made this illegal. EUMR is one thing (that shouldn't happen, either) but mechanical restraints for behavioral reasons are unacceptable.
- You only know about less than 10 people whose providers report they are using restraints. There are many others you don't know about. There were more than 10 people in my mother nursing facility that were under restraint! You need goals about finding, identifying providers that continue to use restraints and forbidding it and training all providers - both MA and private pay - in positive behavioral supports.
- See previous comments Qualitative interviews with people what will work for them , does not work and changes needed to be made and implement those changes,

Transition Data Goal 7

- The moratorium on group homes needs to be removed. Allow people to live in 1 or 2 person group homes. ICS is not a good service.
- There are high percentages of youth in foster care in Minnesota who have disabilities, whether they enter foster care due to abuse and neglect or specifically to access treatment. Foster youth are more likely than non-foster youth to spend significant periods of time in segregated settings where they are not included in their communities, which includes some of the setting listed above, and should also include children's residential facilities (CRF) and PRTF settings. Feedback submitted by Redacted, Office of the Foster Youth Ombudsperson (OOFY)
- You have to actually PUT FUNDING TOWARDS COMMUNITY SERVICES and BE WILLING TO CUT FUNDING FROM INSTITUTIONS. Federal money follows the person demonstrations have been a thing for decades. But also, funneling more money towards institutions in the hope they'll improve is a fool's errand. Maybe try to claw back some of that $1 BILLION the legislature earmarked for expanding the AMRTC to actually invest in community-based mental health?
- “Want to write a goal” is NOT a goal! You have left out all the thousands of segregated group homes! Very few are ICF/DD facilities. They are 4 and 5 bed group homes scattered throughout the state. They are segregated in many ways. Certain towns and neighborhoods have the highest concentrations of facilities because there are NIMBY communities that won't allow them.
- Qualitative interviews with people what will work for them , does not work and changes needed to access those programs and implement those changes More diverse affordable housing with and without services. Bring It Home Subsidy for everyone. Less reliance on the

very expensive supportive housing model which keeps people stuck in that system because of the lack of investment in other diverse housing models people want and need.

- When considering this goal, it is important to understand that while Intermediate Care Facilities are defined as “institutional” settings under federal law, many in Minnesota support 4 to 6 people, and look practically like a community residential group home that serves people on the disability waivers. They are integrated into communities, and often provide community activities to the extent that the individuals can tolerate them, making them less segregated than other institutional settings.

Transition Goal 1

- remove the moratorium on group homes.
- I mean, I think AMRTC should be shut down in the way METO and before that the state hospital system for people with IDD was shut down. If we actually funded community-based services for people with SMI in the way they need, people could actually get help before it rises to the level of AMRTC. Also, warehousing people in huge mental institutions is wrong. It's always been wrong, but if you want a citation for how long we've had published materials saying “this is wrong,” try 1887, when Nellie Bly published Ten Days in a Mad-House. Anyway, FUND COMMUNITY BASED OUTPATIENT CARE AND SERVICES. Including helping people with SMI access waivered services and other “disability” services rather than just mental health services. Stop siloing disability/HCBS services from mental health services. Stop making it an absolute crapshoot whether someone who ABSOLUTELY MEETS the nursing facility level of care due to SMI can get actual HCBS. I know Waiver Reimagine is getting rid of the waiver categories. That is a good time to, you know, make it clear people with SMI can qualify for a waiver (and maybe even expand eligibility criteria to make it easier for people with SMI who don't necessarily need assistance with a ton of ADLs to get services)
- How is appropriately discharging clients a goal. Isn't this business as usual?
- Need more affordable diverse housing options. Qualitative interviews with people what will work for them , does not work and their current housing needs and implement those changes,

Transition Goal 2

- I mean, what's the average time from admission to discharge now? Over 6 years is a LONG TIME for a goal. Who's being referred to FMHP now? On what charges? Is FMHP a competency restoration program or a program for people found not guilty by reason of insanity?
- Need more affordable diverse housing options. Qualitative interviews with people what will work for them , does not work and their current housing needs and implement those changes,

Transition Goal 3A

- The issue is a lack of community providers. There need to be more providers able and willing to provide services in the community.
- EIGHT PEOPLE???? How many people are being diverted now? Why is the focus only on diversion of people who could potentially have been sent to a locked setting? Why are we not focusing on programming that can help people get out of locked settings? AMRTC has like 400 beds! What are we doing to get people out of there?
- A goal for 8 people does not follow the spirit or intent of an Olmstead plan.
- Need more affordable diverse housing options. Qualitative interviews with people what will work for them , does not work and their current housing needs and implement those changes,
- This goal is too limited in its scope. There are many community-based housing options beyond those under the DCT umbrella, including those 245D licensed community residential settings operated by individuals and corporate entities. These should be included in the potential placement options to increase the number of successful diversions.

Transition Goal 3B

- Again, how many people are being moved per year now? 18 seems low. Also, does Community-Based Services (CBS) site mean “group home/state-run facility that is nominally 'in the community' but still a heavily regulated facility”? Or does it mean “person lives in housing of their choice and receives outpatient services through SOCS or another program”?
- Need more affordable diverse housing options. Qualitative interviews with people what will work for them , does not work and their current housing needs and implement those changes,
- Same as the previous goal: This goal is too limited in its scope. There are many community-based housing options beyond those under the DCT umbrella, including those 245D licensed community residential settings operated by individuals and corporate entities. These should be included in the potential placement options to increase the number of successful diversions.

Transition Goal 4

- “Bridging the gap” for PWD who may be able to afford housing on their own but cannot afford *accessible* housing on their own. (E.g., accessible units in apartment buildings cost like twice as much and get labeled as “luxury” units even though things like roll-in showers or visual alert systems aren't luxuries for PWD. Or how most homes in the metro area have so many stairs and if you're lucky enough to find one without in your area, it costs so much more than comparable inaccessible housing.) Leveraging waivered services and eligibility -- with a residential vs non-residential waiver, you can close residential eligibility. Grant programs and partnerships to help people (and organizations) make housing more accessible. Raising the yearly limit on how much waiver budget someone can use for home mods. TA/transformation projects similar to how

MTI helps providers who want to switch from 14c to CIE, aimed at orgs who either a) want to move from segregated group homes to more individual units (where the unit is still a provider-controlled setting, but is an apartment in a larger integrated building) or from providing housing in provider-controlled settings to helping people find/modify housing (similar to some of what Housing Stabilization Services did, but with a greater focus on coordinating accessibility assessments and home modifications). More funding for Technology for Home and better promotion of the program. Ensuring that people are referred to T4H through MNChoices or other routine assessments/points of contact. Expanding transitional services for people moving out of group homes and other provider-controlled settings.

- Where is the innovation? Where is the reach goal? Where is the plan to expand affordable, accessible housing?
- Need more affordable diverse housing options. Bring It Home Subsidies Qualitative interviews with people what will work for them , does not work and their current housing needs and implement those changes,

Transition Goal 5

- Recognize that there are some people receiving services who, whether we like it or not, require use of some restrictive procedures for various safety reasons.
- My thoughts on “positive supports” are the same as my thoughts on PBIS from the education goals. Actual positive supports cannot just be behavioralist stimulus-response antecedent behavior consequence methods. There has to be a real acknowedgement that the person has subjective internal experiences -- thoughts, emotions, reactions. We need actual mental health care that specializes in people with IDD and other disabilities, not just behaviorism.
- Restrictive procedures shouldn't be used on adults or children.
- Qualitative interviews with people what will work for them , does not work and their current housing needs and implement those changes,
- In refining this goal, there needs to be acknowledgement and consideration of the staffing crisis in human services. Restrictive procedures are often used when there are not enough trained staff present to defuse a situation and keep everyone safe. With current legislative and DHS efforts to restrict who can be placed in residential settings, for example, there will be higher proportions of people with more severe behavioral and medical needs, which will further stress the direct care workforce.
- Transition Goal 6: Some group homes use restrictive procedures better than others. Needs improvement.

End of document