Appendix C

August 10, 2015
Olmstead Plan

Resource Documents

This packet is a compilation of reports and documents referenced in the August 2015 Olmstead Plan. The reports were either required by the Olmstead Plan or related to and utilized in the development of the August 2015 Plan.

Documents Related to Olmstead Plan Implementation (alphabetically listed)

Title of Report/Document	Plan page	Plan Topic Area	Author	Date	Appendix C page #
ADA Transition Plan	64	Transportation	MnDOT	January 2015	5
A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report	44, 49	Housing Services, Employment	DHS	September 2014	75
A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools	76	Positive Supports	MDE	February 2015	119
Crisis Prevention/Intervention Training Programs	76	Positive Supports, Crisis Services	MDE	June 2015	193
Crisis Triage and Handoff Process	82	Positive Supports, Crisis Services	DHS	February 2015	199
Delivery System for Oral Health	71, 72	Healthcare & Healthy Living	DHS	February 2015	223
Greater Minnesota Transit Investment Plan	66	Transportation	MnDOT	January 2011	237
Health Care and Community Supports Administrations Overview of Behavioral Health Homes	71	Healthcare & Healthy Living	DHS	January 2015	299
Home and Community-Based Supports and Services Waiver Waiting List Report	59	Waiting List	DHS	March 2015	325
Minnesota Employment First Policy	49	Employment	Olmstead SC	September 2015	345
Minnesota Oral Health Plan	73		MDH	January 2013	349
Minnesota Transit Funding Primer Technical Report	64	Transportation	MCOTA	January 2015	405
Minnesota's Olmstead Plan Quality of Life Survey Pilot Study	35, 96	Person Centered Planning, Quality Assurance	Improve Group	December 2015	415
Olmstead Benchmark Report (Barriers in Transitioning Youth to Adult Health Care)	71	Healthcare & Healthy Living	MDH	October 2014	493
Olmstead Community Engagement Plan	88	Community Engagement	OIO	March 2015	503
Olmstead Dispute Resolution Process Work Plan	97	Quality Assurance	OIO	February 2015	535
Olmstead Plan Baseline Data for Current Care	71, 72	Healthcare & Healthy Living	DHS	January 2015	541

Title of Report/Document	Plan page	Plan Topic Area	Author	Date	Appendix C page #
Olmstead Plan: Work and Benefits Family Outreach Plan		Employment	DHS, DEED, MDE	July 2014	595
Olmstead Transportation Forum Final Report	64	Transportation	DHS, MnDOT	June 2014	615
Positive Support Transition Plan Instructions	79	Positive Supports	DHS		711
Postsecondary Resource Guide – Successfully Preparing Students with Disabilities	55, 57	Lifelong Learning & Education	MDE, MNSCU	2014	731
Recommendations for Improving Oral Health Services Delivery System- February 2014	71	Healthcare & Healthy Living	DHS	February 2014	775
Report on Program Waiting Lists	59	Waiting List	DHS	December 2014	853
Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports	76, 79	Positive Supports	DHS, MDE	October 2014	869
The Status of Oral Health in Minnesota	71	Healthcare & Healthy Living	MDH	September 2013	955

ADA Transition Plan

Minnesota Department of Transportation

www.mndot.gov/ada

We all have a stake in A to B

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Minnesota Department of Transportation
395 John Ireland Boulevard
Saint Paul, MN 55155

January 20, 2015

Dear Citizens of Minnesota,

I am pleased to share with you the revised ADA Transition Plan for the Minnesota Department of Transportation. This plan demonstrates MnDOT's ongoing commitment to providing accessibility and continued collaboration between MnDOT and citizens, stakeholders, and partners throughout Minnesota. In addition to establishing a baseline of the accessibility of the State's transportation system, the plan tracks MnDOT's progress to ensure that transportation is accessible to all users.

As Minnesota's transportation leader, Mn/DOT will uphold the vision and policies presented in this plan. The success of making our transportation system fully accessible depends on the coordinated efforts of all levels of government, the public, and the policies and strategies outlined in this plan. Mn/DOT will continue to look for opportunities to involve citizens, stakeholders and partners in the implementation of this plan, future updates to the plan, and in policy decisions affecting accessibility. Together, we can realize a shared vision of an accessible, safe, efficient, and sustainable transportation system.

Sincerely,

(Original signed)

Susan Mulvihill P.E.

Deputy Commissioner/Chief Engineer

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Mn/DOT
ADA Transition Plan

Minnesota Department of Transportation

1/20/2015

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Table of Contents

Introduction

MnDOT Vision

This document is intended to serve as a guide to further the vision, mission and core values for the Minnesota Department of Transportation (MnDOT) by outlining key actions for making the transportation system in Minnesota accessible. The Vision, Mission and Core Values for MnDOT are as follows:

Vision

Minnesota's multimodal transportation system maximizes the health of people, the environment and our economy.

Mission

Plan, build, operate and maintain a safe, accessible, efficient and reliable multimodal transportation system that connects people to destinations and markets throughout the state, regionally and around the world.

Core Values

- Safety
- Excellence
- Service
- Integrity
- Accountability
- Diversity and Inclusion

Transition Plan Need and Purpose

The Americans with Disabilities Act (ADA), enacted on July 26, 1990, is a civil rights law prohibiting discrimination against individuals on the basis of disability. The ADA consists of five titles outlining protections in the following areas:

- Employment
- State and local government services
- Public accommodations
- Telecommunications
- Miscellaneous Provisions

Title II of ADA pertains to the programs, activities and services public entities provide. As a provider of public transportation services and programs, MnDOT must comply with this section of the Act as it specifically applies to state public service agencies and state transportation agencies. Title II of ADA provides that, "…no qualified individual with a

disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." (42 USC. Sec. 12132; 28 CFR. Sec. 35.130)

As required by Title II of ADA, 28 CFR. Part 35 Sec. 35.105 and Sec. 35.150, MnDOT is conducting a self-evaluation of its facilities and developed this Transition Plan detailing how the organization will ensure that all of its facilities, services, programs and activities are accessible to all individuals.

Transition Plan Management

MnDOT's transition plan is a living document that will receive routine updates. Updates are scheduled to occur on a four year cycle. To streamline plan updates and keep the document current and relevant, appendices will be updated annually if new information is available and does not alter the intent of the transition plan. When an appendix update is found to alter the intent of MnDOT's Transition Plan the appendix and affected section(s) will be opened for public review and comment. The update schedule may be altered at the discretion of MnDOT based on changes in guidance from the United States Access Board, Federal policy, and MnDOT policy. MnDOT's Transition Plan is available for continual public inspection through MnDOT's website.

Relationship to Other MnDOT and State Plans

The transition plan does not function as an independent document and informs several planning documents owned by the Minnesota Department of Transportation, including but not limited to the our 50 year vision: Minnesota Go, our 20-year Statewide Multimodal Transportation Plan, and our 20 year investment plan MnSHIP. The development of the plans and their relationship to accessibility is an iterative process led by the goals of the transition plan. As MnDOT's long range plans have been developed they take into account the role of accessibility in meeting multimodal goals, creating livable communities, and identifying investment needs.

In addition to MnDOT's planning and investment documents the transition plan supports the outcomes of Minnesota's Olmsted Plan which focuses on ensuring that individuals with disabilities are living, learning, working, and enjoying life in the most integrated setting of their choice. The Olmstead Plan was published in 2013 and is part of a legal settlement with the state. As part of the eight agencies named to develop and implement the Olmsted Plan MnDOT is focused on how the needs of the Olmstead population affect the prioritization and delivery of our transportation system particularly in the area of Greater Minnesota transit.

Title II of ADA is companion legislation to two previous federal statutes and regulations: the Architectural Barriers Acts of 1968 and Section 504 of the Rehabilitation Act of 1973.

The Architectural Barriers Act of 1968 is a Federal law that requires facilities designed, built, altered or leased with Federal funds to be accessible. The Architectural Barriers Act marks one of the first efforts to ensure access to the built environment.

Section 504 of the Rehabilitation Act of 1973 is a Federal law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any Federal department or agency. Title II of ADA extended this coverage to all state and local government entities, regardless of whether they receive federal funding or not.

When addressing accessibility needs and requirements, it is important to note that ADA and Title II do not supersede or preempt state or local laws that may offer equivalent or greater protections, such as the Minnesota Human Rights Act.

Under Title II, MnDOT must meet these general requirements:

- Must operate their programs so that, when viewed in their entirety, the programs are accessible to and useable by individuals with disabilities (28 C.F.R. Sec. 35.150).
- May not refuse to allow a person with a disability to participate in a service, program or activity simply because the person has a disability (28 C.F.R. Sec. 35.130 (a).
- Must make reasonable modifications in policies, practices and procedures that deny equal access to individuals with disabilities unless a fundamental alteration in the program would result (28 C.F.R. Sec. 35.130(b) (7).
- May not provide services or benefits to individuals with disabilities through programs that are separate or different unless the separate or different measures are necessary to ensure that benefits and services are equally effective (28 C.F.R. Sec. 35.130(b)(iv) & (d).
- Must take appropriate steps to ensure that communications with applicants, participants and members of the public with disabilities are as effective as communications with others (29 C.F.R. Sec. 35.160(a).
- Must designate at least one responsible employee to coordinate ADA compliance [28 CFR § 35.107(a)]. This person is often referred to as the "ADA Coordinator."

The public entity must provide the ADA coordinator's name, office address, and telephone number to all interested individuals [28 CFR § 35.107(a)].

- Must provide notice of ADA requirements. All public entities, regardless of size, must provide information about the rights and protections of Title II to applicants, participants, beneficiaries, employees, and other interested persons [28 CFR § 35,106]. The notice must include the identification of the employee serving as the ADA coordinator and must provide this information on an ongoing basis [28 CFR § 104.8(a)].
- Must establish a grievance procedure. Public entities must adopt and publish grievance procedures providing for prompt and equitable resolution of complaints [28 CFR § 35.107(b)]. This requirement provides for a timely resolution of all problems or conflicts related to ADA compliance before they escalate to litigation and/or the federal complaint process.

MnDOT's Compliance History

Following the passage of ADA on July 6, 1990, MnDOT took initial steps to identify and address Title II requirements. In December of 1991 MnDOT received direction from the local Federal Highway Administration (FHWA) division to complete a curb ramp assessment and transition plan to comply with the new law. Based on direction from the FHWA and the requirements of the final rule passed on July 26, 1991 MnDOT developed the parameters to identify curb ramp needs and an investment plan which would be fully implemented by January 31, 1995. MnDOT records show that each district had completed a curb ramp inventory by December of 1992 and identified funding and a construction timetable that was to be completed by January 26, 1995.

During the same timeframe, the Minnesota Department of Administration conducted an assessment of all state owned and leased properties to identify barriers to be corrected by the individual agencies. According to available MnDOT records, all employee occupied buildings were retrofitted to meet the ADA requirements outlined in 1990 and all subsequent new construction has followed Minnesota Building Codes which meet or exceed ADA requirements. Construction plans and a timetable were developed in 1994 for barrier removal and accessibility improvement for all Class I and II rest areas with work to be completed at the end of 1995. MnDOT had begun barrier removal on rest areas when it was determined that funding administered by the Department of Administration could not be used on rest area improvements. A list of current barriers at MnDOT rest areas can be found in Appendix D.

From 1995 to 2001 MnDOT's ADA efforts were largely decentralized, focusing primarily on reasonable accommodation for employees and transit, with compliance and

oversight falling on individual offices and programs. In general, MnDOT had completed the retrofit requirements identified in ADA and was meeting compliance with new construction and reconstruction projects. During this time MnDOT did not maintain a centralized transition plan.

In 2001 ADA became a point of focus with the Access Board's issuance of the draft rules for public rights of way and the expiration of the moratorium on detectable warning surfaces. MnDOT provided comment to the draft rules in October of 2001, but only became aware of the detectable warning requirement in July of 2002 through an FHWA memo. A revised standard plan with truncated domes was issued in 2003 and has been required in new construction, reconstruction and alterations since 2003. In 2005 the Access Board issued a revision of the draft rules, titled Public Rights of Way Accessibility Guidance (PROWAG), to be utilized as best practices. The lifting of the detectable warning surfaces moratorium and the publication of PROWAG was the first new guidance affecting public rights of way since the initial passage of ADA in 1990.

In September 2006, MnDOT's Affirmative Action Office was asked to assess agency Title II compliance and determine needs in this area. As a result of the assessment, MnDOT took the following actions:

- Designated an ADA Coordinator.
- Drafted a Notice of Non-Discrimination to provide information about the rights and protections of ADA to employees and applicants, as well as participants and users of MnDOT services, programs and activities.
- Established a grievance/complaint process to address or correct user concerns related to inaccessible pedestrian and transportation facilities under MnDOT's jurisdiction.

In 2007, an internal MnDOT ADA Advisory Council was formed. The primary function of this council was to assess and determine accessibility program needs and provide guidance to MnDOT administrators. The group includes key staff from Technical Support, Design, Investment Management (Planning), Construction, Traffic Operations, Maintenance Operations, Transit, Aeronautics and State Aid.

Also in 2007, MnDOT updated its policy and procedures to more effectively respond to requests for Accessible Pedestrian Signals (APS). The policy and procedures require the installation of APS at every signalized intersection and at every pedestrian crossing in new and reconstruction projects.

MnDOT launched its ADA web pages for public use in the spring of 2008. The pages include MnDOT's Non-discrimination Notice, links to accessibility guidance and

information and an online grievance process for users to voice their concerns regarding barriers preventing access to MnDOT facilities, programs and services.

In 2008 MnDOT formed a standing external stakeholder advisory group, made up of citizens with disabilities and advocates for key disability groups in Minnesota. This committee provides important feedback and invaluable real-life experience regarding how persons with disabilities use MnDOT's facilities, programs and services. They also serve as a voice for members of Minnesota's disability community.

Technical Memorandum 08-13-TM-05 Pedestrian (Curb) Ramp Guidelines was adopted and issued by the Deputy Commissioner in 2008 to clarify pedestrian curb ramp installation requirements to MnDOT staff and city and county engineers.

In 2008, MnDOT contracted with an independent consultant to conduct an objective evaluation of the organization's current policies, procedures and practices regarding ADA and Title II. The evaluation analyzed the impact of MnDOT policies, procedures and practices on accessibility within our state, and how accessibility impacted people with disabilities. The report identified policies, procedures and practices potentially did not comply with Title II requirements. Please see Appendix E for the list of policies, procedure and practices and the action taken to address each.

MnDOT's Office of Affirmative Action, Office of Technical Support and Office of Transit began conducting ADA Title II training in 2008. The training provides an introduction to ADA Title II requirements and is offered to local partners and MnDOT engineers/employees in maintenance, design, construction and planning.

In 2009, as a part of the development of MnDOT's Transition Plan, MnDOT Issued Technical Memorandum 10-02-TR-01 *Adoption of Public Rights of way Accessibility Guidance* to MnDOT staff, cities and counties. The memo makes Public Rights-of-Way Accessibility Guidelines (PROWAG) the primary guidance for accessible facility design on MnDOT projects. MnDOT is currently beginning the integration of PROWAG into the Road Design Manual and other technical guidance.

Since the adoption of the transition plan and PROWAG guidance MnDOT has conducted numerous trainings for MnDOT staff and its contractors to raise awareness and provide specific technical knowledge on providing accessibility in the public right of way. The primary training was conducted in 2011 and 2012 for MnDOT employees, cities, counties and consultants to provide an overview of the ADA, MnDOT's compliance direction and design training. Over 600 individuals participated in the training which has provided a more universal understating of ADA needs and Title II obligation. In subsequent years MnDOT has run classes for its construction inspectors

improve the quality of accessibility features which MnDOT routinely provides on all projects that meet or exceed that alterations threshold.

Program Location and Staffing

Managing and implementing the MnDOT ADA Transition Plan requires a multidisciplinary approach encompassing policy development, outreach, technical support and oversight. These responsibilities, required by 28 CFR 35.107, are be managed by two peer positions: the Title II Coordinator/ADA Implementation Coordinator, and ADA Design Engineer in MnDOT's Operations Division

The Title II Coordinator/ADA Implementation Coordinator is responsible for addressing complaints as they are received and tracking the overall progress of the implementation of the MnDOT Transition Plan. The Title II coordinator is also responsible for the investigation of all formal grievances made against MnDOT. To ensure the obligations of ADA and the Transition Plan are met the Coordinator develops policy and procedures to integrate Title II requirements into MnDOT practices The Implementation Coordinator also functions as chair of the Internal ADA committee, the co-chair of ADA Stakeholders group, and the agency lead for implementing Minnesota's Olmstead Plan.

The ADA Design Engineer works with the ADA Implementation Coordinator to develop policy and provide technical support for design and construction at a project level. The position also oversees three full time staff that provides support and direction for project scoping and development, design, and construction oversight when necessary. Specifically, the unit works with districts to scope their projects for accessibility and conducts design review prior to final signature. In addition to providing support for projects, this position will also be available to assist districts in implementing design options that address accessibility complaints.

Please refer to Appendix B for contact information.

Committee Structure

Overview

Due to the far reaching and ongoing implications of the ADA, collaboration is an important tool for MnDOT to identify issues and solutions that reflects the needs of the agency and users. To ensure that stakeholders are represented MnDOT has established three committees, one external and two internal, to assist and advise on ADA policy development. The committees function independent of each other to, but their input is coordinated by ADA Implementation Coordinator who a co-chair on all of

the committees. Detail on the roles and membership of the individual committees follows.

MnDOT's ADA Accessibility Advisory Committee

The MnDOT ADA Accessibility Advisory Committee (MAAAC) was created in 2008 to begin a constructive dialogue on accessibility issues and advise MnDOT on compliance with Title II of the ADA. Since MAAAC's inception, the advisory role has expanded from a focus on achieving Title II compliance to providing input on prioritizing funds for ADA projects, design feedback and communication tools. The committee's current representation was identified and established by the Title II Coordinator. MAAAC's membership is composed of individuals with differing disabilities, MnDOT representatives from the Bicycle and Pedestrian section, the Commissioner's Office, and the Office of Policy, Analysis, Research and Innovation, and representatives from the Minnesota State Council on Disability and the Metropolitan Council Transportation Advisory Committee.

The MAAAC meets monthly in working session type meetings to provide feedback on policy development, including the Transition Plan, and learn about MnDOT operations and advise on accessibility issues. Meetings are co-chaired by the ADA Implementation Coordinator a member elected from the external representation. MnDOT is not a voting member of the committee. MAAAC is currently re-evaluating its structure to identify and recruit a broader cross-section to represent more types of disabilities and provide geographic balance. Expected outcomes of the re-evaluation include an application process for membership and an annual work plan.

Americans with Disabilities Act Advisory Committee (ADAAC) -Disbanded

In 2007 MnDOT convened an internal advisory committee with representation from a cross section of functional areas to assist in the development of policy and practice to integrate ADA into MnDOT project delivery and operations. ADAAC met on a bi-monthly basis, with additional meetings called as needed. The committee focused on issues with programmatic impact and identifies key resources for resolution. The ADA Implementation Coordinator was the ADAAC chair. Committee membership included the following offices and sections:

- Affirmative Action
- Aeronautics
- Maintenance
- Transit
- Traffic, Safety and Technology
- State Aid

- Information Resource Management
- Bridge
- Bicycle and Pedestrian Section
- Construction
- Pre-Construction
- Maintenance
- Technical Support

In 2010 it was determined that ADA integration was largely under way and that representation of the above groups would be met through other standing committees and ADAAC was no longer needed

ADA Implementation Committee – Disbanded

The ADA Implementation Committee was identified as a need during the development of the transition plan as an interim approach to develop and expand the agency's knowledge base and information sharing for ADA design and policy. The committee comprised of one design or traffic engineer from each MnDOT district and staff from the Office of Traffic Safety and Technology, Geometrics, Program Delivery and the Bicycle and Pedestrian Section and was co-chaired by The ADA Implementation Coordinator and the ADA Design Engineer. The members functioned as points of contact and were responsible for tracking ADA requests in their district, providing technical support for projects and providing feedback to ADA policy and practice. The committee met from in January 2010 until January 2011.

Grievance Procedure

Under the Americans with Disabilities Act users of MnDOT facilities and services have the right to file a grievance if they believe MnDOT has not provided reasonable accommodation.

The Grievance Procedure required by 28 CFR 35.107 can be found in Appendix A of this report or on MnDOT accessibility website provides details on how to file a complaint. Under the Grievance Procedure, a formal complaint must be filed within 180 calendar days of the alleged occurrence. MnDOT will act or respond only to complaints made through the grievance process identified in Appendix A.

Communications

Under Section 35.160(a) of ADA, "...A public entity shall take appropriate steps to ensure that communications with applicants, participants, and members of the public with disabilities are as effective as communications with others." This means that

MnDOT is required to provide equally effective communication to individuals with disabilities. Equally effective communication can be provided by offering alternative formats, auxiliary aid(s) and/or services upon request. For example, interpreters are hired as requested for the hearing impaired and text materials that are accessible by screen readers are made available to users.

Website Communications

Background

State Law requires that all of the State of Minnesota's information systems comply with the 2009 MN Law to incorporate Section 508 of the Rehabilitation Act and the Web Content Accessibility Guidelines 3.0.

Minnesota IT (MnIT) is responsible for the development and dissemination of standard state processes, tools, and guidelines in place. This will enhance end user accessibility to state information systems, and make sure that all Minnesota citizens have access to the information they need.

MnDOT will fully comply with or exceed the standards set by MnIT regarding compliance with this law. MnDOT is participating in a committee to set the state standard, and will participate in future committees advising on needs for training and oversight. We anticipate that MnIT will set the standard at WCAG 3.0, compliance level AA.

Current compliance actions

Several years ago MnDOT redesigned its internal and external Web templates to improve their overall accessibility. For example, templates are now controlled by style sheets and styles are set for headers and subhead navigation items. All Web editors are required to use these templates for new and revised pages.

Our Rules for the Web include several items relating to accessibility. For example, all images much include "alt tags" and blinking or scrolling script is not allowed. All Web editors are required to follow these rules; however, we know that some older pages are not in compliance.

We also have an internal Web site that includes additional resources for Web writers and developers, including links to the WCAG 3.0 standards and our Rules for the Web.

Communications is developing training for word processing and other staff about preparing accessible Word and PDF documents. We are also working with contractors to ensure that documents prepared as part of a contract with MnDOT are compliant.

We have developed an external page www.dot.state.mn.us/ada that includes a variety of information about MnDOT and the ADA. This includes our transition plan, a way to file complaints with MnDOT, links to other transportation-related resources and tips about how to use our pages. A link to this page is included in the footer of every MnDOT Web page.

2014-2018 Goals

- Develop contract language and training for our consultant contracts to ensure that accessible documents are a required part of the deliverables.

- Review the Rules for the Web and the templates for compliance with WCAG 3.0 and make revisions as necessary. This step includes educating Web writers and developers about changes to the current standards.

- Develop and implement a plan for spot checking and ensuring compliance with WCAG for all new or redeveloped pages.

- Continue to work provide training for those who develop content that is posted on the web, with the highest priority being given to those who develop content that is seeking comment form the public.

Public Involvement

MnDOT recognizes that broad public participation is essential to the development of Minnesota's transportation system. As required by the ADA and MnDOT's public participation guidance Hear Every Voice, any public meeting, hearing, or comment period held by MnDOT is accessible. MnDOT provides qualified interpreters upon request and will provide documents in an accessible electronic format or other alternative formats, such as large print or Braille. All public notices shall contain contact information for accommodation requests.

Public meetings, trainings, programs and other events must be in an accessible location and indicated on the meeting notice. Project managers and other MnDOT staff are directed to use the Department of Justice Guide to Conducting Accessible Meetings to assist in planning public meetings.

Self-Evaluation

MnDOT, as required by Title II of ADA, must conduct a self-evaluation of physical assets and current policies and practices. MnDOT has identified seven areas that will need to have and maintain inventories. As inventories are updated, they will be the transition plan will be updated accordingly.

Fixed Work Sites

MnDOT owns and leases numerous buildings throughout the state. MnDOT has identified 46 buildings that are routinely accessed by the public. The 46 buildings were re-evaluated in 2013 for potential accessibility improvements. The buildings have been divided into two categories; Priority One and Priority Two. Priority One buildings are those buildings that have employee use and a high potential for public use. Priority Two buildings are those buildings that employees use and have moderate potential for public use. The evaluation of the worksites found that there are no major barriers to public access however there are numerous recommendations for minor accessibility improvements as ongoing maintenance work and renovations are conducted.

The status of the individual worksites can be found in the district breakdowns in Appendix C

Rest Areas

All rest areas and their associated elements are required to adhere to the 2010 ADA Standards. Minnesota State Building Code, Chapter 1341 also includes specific requirements related to accessibility. Some State accessibility requirements in Chapter 1341 are more restrictive than the 2010 ADA Standards.

In addition to the 2010 ADA Standards, the Code of Federal Regulations (CFR) includes regulations related to accessibility that apply to Interstate rest areas and historic rest areas and waysides:

- Interstate Rest Areas: 49 CFR 27.75 requires States to make Interstate rest area facilities accessible whenever the State uses federal financial assistance to improve the rest area or whenever the State uses federal financial assistance to construct, reconstruct or otherwise alter the roadway adjacent to or in the near vicinity of the rest area.
- Historic Rest Areas & Waysides: Several State rest areas and waysides are historic properties listed in or eligible for listing in the National Register of Historic Places or are designated as historic under an appropriate State or local law. 28 CFR 35.151(d) requires alterations comply, to the maximum extent feasible, with Section 4.1.7 of ADAAG.

In 1990, the Minnesota Department of Administration (DOA) contracted with architectural consultants to survey all buildings and facilities owned and managed by the State. The survey included MnDOT rest areas and waysides. Unfortunately, DOA completed the survey before the Federal government finalized ADAAG in 1991. MnDOT staff resurveyed all Class I rest areas by 1994 using ADAAG and recorded actual conditions and identified corrective measures required to comply. (See Appendix D)

In March 1994, the DOA approved a priority listing of MnDOT facilities. Additionally, during FY 1993-04 the DOA distributed $1,700,000 in State funds to MnDOT for ADA improvements to buildings and facilities. Since Travel Information Centers, Class I and II rest areas in the southern portion of the state receive the highest public use, MnDOT considers these facilities the highest priority for rest area accessibility improvements. MnDOT took action to correct then-current deficiencies at the highest priority facilities, except those actions deemed technically infeasible or where MnDOT had identified and scheduled the facility for comprehensive replacement in the near future.

Since 1991, MnDOT has designed and built all new rest area facilities, including buildings, site features and parking areas in compliance with then current ADAAG and Minnesota State Building Codes. Also, since that time, MnDOT has completed rest area rehabilitation and reinvestment projects that included corrective action to bring facilities into compliance with ADAAG and Minnesota State Building Code requirements. MnDOT has not corrected deficiencies at all lower priority facilities.

In 2007, MnDOT retained a consultant to conduct a comprehensive assessment of the physical condition of (49) Class I rest areas. The consultant found accessibility deficiencies at (46) of the rest areas evaluated. MnDOT estimates it would cost $1.9M-2.5M to correct the accessibility deficiencies found at the 46 Class I rest areas.

Accessible Pedestrian Signals (APS)

In 2008, MnDOT completed a statewide inventory of all 1,171 signalized intersections with push buttons that are owned and operated by MnDOT. As part of the inventory each intersection received a rating to determine the priority for conversion to an APS signal. The ranking of the intersections was done utilizing the methodology laid out in the National Cooperative Highway Research Project 3-62 *APS Prioritization Tool.* In general the signalized intersections with higher scores are the ones with the greatest need for conversion to APS, but the rankings are always considered within context so that the greatest needs are served first. Factors outside the ranking that affect an intersection's priority for APS include the number of pedestrians at the intersection, the presence of nursing homes, hospitals, transit, and other public services, and requests for APS. Each district traffic engineer will be responsible for determining which

intersections are priorities in their district, taking the intersection score and other factors into consideration.

MnDOT's policy is to install APS at any eligible intersection where an existing traffic signal has aged to the point of needing replacement. APS is also required for all new signals installed at eligible locations. Based on normal replacement intervals for aging signals, MnDOT expects to achieve 100 percent statewide APS compliance by the year 2030. Since the 2009 publication of the transition plan MnDOT has increased the total number of intersections with APS installations from 120 to 330 or 28 percent of the total system.

Curb ramps and sidewalks

At the time of the 2010 transition plan MnDOT had not completed the self-evaluation for sidewalks and curb ramp. Over the course of three summers each MnDOT district has located and cataloged all sidewalks and curb ramps on MnDOT right of way. The inventory includes both an accounting of the facilities and their condition. The system at the time of this writing consists of 617 miles of sidewalk and 19,324 curb ramps. An analysis of the each system and their condition follows.

Curb Ramps

In determining the compliancy of curb ramps MnDOT inventoried the locations and five accessibility elements for each curb ramp:

- Presence of a landing
- Landing slope – no more than 2% in any direction
- Ramp running slope – 5% - 8%
- Cross slope – no more than 2%
- Presence of detectable warnings

To be compliant under PROWAG a curb must meet all five requirements so even if one element is non-compliant the ramp technically does not meet accessibility requirements even though it may be usable. In reporting on MnDOT's compliance level we include all ramps that meet all five requirements and those that meet all requirements with the exception of having truncated domes. The reason for including both types of ramps is that truncated domes were not introduced as a requirement until 2001 and they are not a retrofit requirement meaning that a compliant ramp built prior to the requirement is still compliant until the alterations threshold is met. Of the 19,324 curb ramps on MNDOT's right of way of those 3543 or 18% are compliant.

Sidewalks

During the summer of 2013 districts completed an inventory of their sidewalks. The total system consists of over 600 miles of sidewalk on MnDOT right of way. The inventory includes an assessment of width, cross slope, barriers, and general condition. The most common deficiency in our network is the violation of cross slope at driveway. The total number of miles of sidewalk in MnDOT's system that is fully compliant is 263.5 miles.

Pedestrian Bridge Inventory

MnDOT owns 170 pedestrian bridges and underpasses throughout the state. Any pedestrian bridge or underpass crossing an interstate or state highway is the responsibility of MnDOT, unless an agreement has been made with a local government agency. The location and condition of all pedestrian bridges within MnDOT's right of way can be found in the district inventory in Appendix C. To be accessible, pedestrian bridges and underpasses must have a ramp leading up to the overpass, the ramp must meet the PROWAG standards for ramps, railings must meet the requirements found in the MnDOT Bikeway Facility Design Manual, the bridges must have a cross slope of no more than 2 % and a running slope of no more than 5%. Those that do not meet accessibility requirements according to PROWAG will be replaced as necessary. Bridges and underpasses that are compliant with the standards in place when they were built will require further discussion to determine the feasibility of compliance with PROWAG and the future of the structure in general.

Greater Minnesota Transit

As the administrating agency for Federal Transit Administration grant programs, MnDOT is required to ensure that grant recipients comply with the Americans with Disabilities Act. Specific transit-related aspects of ADA fall into two distinct categories: (1) ensuring that transit services and facilities are designed to allow access by individuals with disabilities and (2) ensuring that transit vehicles purchased with federal funds meet the accessibility standards of ADA.

With respect to the first function, the Office of Transit has developed tools for MnDOT staff to use to monitor ADA compliance as part of grant oversight. This includes checking that the telephone reservation system is accessible to all; schedulers capture necessary passenger information to ensure that the person's trip needs can be fully accommodated; ADA trip requests in Duluth, East Grand Forks, La Crescent, Mankato, Moorhead, Rochester and St. Cloud are not denied at a higher rate than other trip requests; system advertising and information is produced in a variety of formats; transit facilities are laid out with appropriate clearances and accessibility; etc.

Some older bus garages and administrative facilities are not fully ADA accessible, but the noncompliant elements do not provide a barrier to the services provided to the general public. As facilities are replaced or receive major remodeling they will be required to be constructed to current ADA and Minnesota Building code standards. Reasonable accommodations will be provided at all locations as needs are identified.

With respect to vehicle purchases, the Office of Transit maintains a full array of vehicle specifications – all of which meet the accessibility standards of ADA. All transit vehicles acquired with grants through MnDOT are fully ADA-compliant. Because this policy has been in place for many years, the current fleet acquired through MnDOT is ADA-accessible.

MnDOT's inventory of right of way features will include an assessment of the accessibility of transit stops on MnDOT right of way that have received funding from MnDOT. To be accessible, bus stop boarding and alighting areas must provide a clear length of 8 feet minimum, measured perpendicular to the curb or street or highway edge, and a clear width of 5 feet minimum, measured parallel to the street or highway. Bus stop boarding and alighting areas must connect to streets, sidewalks, or pedestrian paths by a pedestrian access route. The grade of the bus stop boarding and alighting area must be the same as the street or highway, to the maximum extent practicable, and the cross slope of the bus stop boarding and alighting area must not be greater than 2 percent.

In addition to meeting the operations obligations of ADA MnDOT is reaching out to communities in the development of local service plans to ensure that as service is developed and expanded the needs of the Olmstead population are included.

Policies

In 2009, MnDOT contracted with an outside consultant to conduct an audit of its policies and procedures in order to identify areas where modifications may be needed to ensure full compliance with ADA Title II and Section 504. The study involved a review of over 200 policies and procedures that MnDOT uses to provide facilities, services, and programs to the public. Forty-one policies, primarily focused on project development and design, were identified as potentially needing improvement to integrate accessibility more consistently into MNDOT projects and operations. No policies were identified as a barrier to providing accessibility. MnDOT will be developing a systematic approach to ensure long-term compliance with ADA Title II and Section 504 for all policies and procedures. A listing of policies and procedures that MnDOT reviewed and their status can be found in Appendix E.

Maintenance

MnDOT is responsible for the seasonal and structural maintenance of its facilities. As part of the policy review identified in the Transition Plan, MnDOT is examining its current policies and procedures to improve maintenance for pedestrian facilities. MnDOT's Maintenance Office will be leading the policy development and is scheduled to have a policy identified by summer of 2011.

The policy will identify operation guidance for maintaining sidewalks. Guiding the discussion is Federal Code 23 U.S.C. § 116 which obligates a State DOT to maintain projects constructed with Federal-aid funding or enter into a maintenance agreement with the appropriate local official where such projects are located. The discussion will also address snow removal and ice treatment on sidewalks in accordance with 28 CFR § 35.133, which requires public agencies to maintain walkways in an accessible condition for all pedestrians, including persons with disabilities, with only isolated or temporary interruptions in accessibility. Part of this maintenance obligation includes reasonable snow removal efforts.

Correction Program

The Minnesota Department of Transportation is committed to addressing the barriers identified in the self-evaluation. Curb ramp improvements are required on all projects that meet the alteration thresholds. Facilities that are accessible, but do not meet PROWAG standards will continue to be improved through MnDOT's routine construction program. Facilities that are inaccessible and will not be improved in the course of a typical roadway project will be prioritized by districts as part of a separate barrier removal program. The funding and schedule of accessibility improvements that are being made as part MnDOT's routine construction program are determined through MnDOT's Statewide Transportation Improvement Plan (STIP).

Since 2010 MnDOT has improved numerous facilities around the state with a particular emphasis on curb ramps and during the last three construction seasons MnDOT has found that rote application of ADA policy and design does not immediately ensure accessible facilities. Emerging issues in our correction program include the role of right of way in alterations thresholds, the appropriate expansion of scope to ensure the right fix for achieving accessibility, and the quality of construction.

Much of MnDOT's construction program is focused on preserving our existing system and the project that we do typically have a very limited scope focused on working on pavement and working within our existing right of way. Often the improvement of accessible features requires that MnDOT obtain right of way or a temporary easement to construct the facility. Under Minnesota statues the process to obtain right of way

averages around eighteen months often longer than the project development time for the a pavement project. The ADA unit has been working with the districts at a project level to make certain that they are scoping projects with the entirety of ADA needs including right of way so that the proper facility can be built. Ensuring quality construction of accessible facilities is also an area of improvement for MnDOT. Under ADA the specifications provided for a facility do not include construction tolerances so it is important that facilities are built to design and are inspected to ensure that they meet our design requirements. MnDOT has developed contractor requirements and trains inspectors to address this issue, but we are still not at the performance level we desire.

Training

Part of MnDOT's adoption and implementation of Public Rights of Way Accessibility Guidelines and the Transition Plan, included agency-wide training on both design and policy. MnDOT has trained over 600 individuals which included MnDOT staff, cities and counties, and external partners on ADA and Title II in 2012 and 2013. MnDOT is looking at revising and resuming in 2015.

The training is based on policy, mobility needs and design. Modules identified for development and deployment in 2010 include:

- ADA and Title II overview and requirements
- Policy & Procedure
    - Public Involvement
    - Complaint Procedures
- Technical Training
    - PROWAG (Public Right OF Way Accessibility Guidelines)
    - Curb Ramps
    - APS (Accessible Pedestrian Signals)
    - Intersection Geometrics
    - Pedestrian Design & Planning
    - Maintenance, e.g., Inventory, Snow & Ice, Faulting, Maintenance Agreements
    - Bicycle & Pedestrian Planning

In addition to the ADA Overview training MnDOT's ADA Unit provides annual training to inspectors and presents at MnDOT's Signal Certification classes.

Appendix A

How to file a Grievance

The procedure to file a grievance is as follows:

1. A formal written grievance should be filed on ADA Grievance Form. An oral grievance can be filed by contacting ADA Title II Coordinator. The oral grievance will be reduced to writing by ADA Coordinator utilizing ADA Grievance Form. Additionally, individuals filing a grievance are not required to file a grievance with MnDOT, but may instead exercise their right to file a grievance with the Department of Justice.

    - The name, address, and telephone number of the person filing the grievance.
    - The name, address, and telephone number of the person alleging ADA violation, if other than the person filing the grievance.
    - A description and location of the alleged violation and the remedy sought.
    - Information regarding whether a complaint has been filed with the Department of Justice or other federal or state civil rights agency or court.
    - If a complaint has been filed, the name of the agency or court where the complaint was filed, and the date the complaint was filed.

2. The grievance will be either responded to or acknowledged within 10 working days of receipt. If the grievance filed does not concern a MnDOT facility, it will be forwarded to the appropriate agency and the grievant will be notified.

3. Within 60 calendar days of receipt, the ADA Title II Coordinator will conduct the investigation necessary to determine the validity of the alleged violation. If appropriate, ADA Title II Coordinator will arrange to meet with the grievant to discuss the matter and attempt to reach a resolution of the grievance. Any resolution of the grievance will be documented in MnDOT's ADA Grievance File.

4. If a resolution of the grievance is not reached, a written determination as to the validity of the complaint and description of the resolution, if appropriate, shall be issued by ADA Title II Coordinator and a copy forwarded to the grievant no later than 90 days from the date of MnDOT's receipt of the grievance.

5. The grievant may appeal the written determination. The request for reconsideration shall be in writing and filed with the Minnesota Department of Transportation Ombudsman within 30 days after the ADA Title II Coordinator's determination has been mailed to the grievant. MnDOT's Ombudsman shall

review the request for reconsideration and make a final determination within 90 days from the filing of the request for reconsideration.

6. If the grievant is dissatisfied with MnDOT's handling of the grievance at any stage of the process or does not wish to file a grievance through the MnDOT's ADA Grievance Procedure, the grievant may file a complaint directly with the United States Department of Justice or other appropriate state or federal agency.

   The resolution of any specific grievance will require consideration of varying circumstances, such as the specific nature of the disability; the nature of the access to services, programs, or facilities at issue and the essential eligibility requirements for participation; the health and safety of others; and the degree to which an accommodation would constitute a fundamental alteration to the program, service, or facility, or cause an undue hardship to MnDOT. Accordingly, the resolution by MnDOT of any one grievance does not constitute a precedent upon which MnDOT is bound or upon which other complaining parties may rely.

File Maintenance

MnDOT's ADA Coordinator shall maintain ADA grievance files for a period of three years.

Appendix B

ADA Program Contacts

Title II Coordinator

Lynnette M. Geschwind
395 John Ireland Blvd.
MS 200
St. Paul, MN 55155

Ph: 651-366-4717
Fax: 651-366-4155
E-mail: lynnette.geschwind@state.mn.us

ADA Implementation Coordinator

Kristie M. Billiar
395 John Ireland Blvd.
MS 670
St. Paul, MN 55155

Ph: 651-366-3174
Fax: 651-366-4155
E-mail: kristie.billiar@state.mn.us

ADA Design Engineer

Todd Grugel
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MS 670
St. Paul, MN 55155

Ph: 651-366-3531
Fax: 651-366-4155
E-mail: todd.grugel@state.mn.us

Appendix C

Inventory by MnDOT District

District 1 Asset Inventory

Buildings

T7910090221 - Duluth District Headquarters
T7915090143 - Grand Rapids Truck Station
T7915090123 - Virginia Maintenance Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	1755
Number of Non-Compliant Ramps	1445
Number of Compliant Ramps	310
Number of Compliant Ramps without Detectable Warnings	420
Number of Ramps with Compliant Slope and Cross Slope	892
Number of Ramps with Compliant Slope	1329

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
16006	PED-BIKE	TH 61	2009	Compliant
38014	SOIL	PED	2004	Compliant
5953	MN 23	PEDESTRIAN	1941	Excessive Running Grade on Bridge Deck

69122	MILLER CREEK	US 53	2003	Excessive Cross Slope on Bridge Deck and Approach Ramp
Asset Number	**Featured Intersected**	**Facility Carried by Structure**	**Year Built**	**Compliant Issues**
69804	EXCURSION TRACKS	PEDESTRIAN	1989	Excessive Running Grade on Bridge Deck
69805	EXCURSION TRACKS	PEDESTRIAN	1989	Excessive Running Grade on Bridge Deck and Approach Ramp
69811	PED WALK WAY	PEDESTRIAN	1967	Excessive Running Grade on Bridge Deck
69838	I 35	PEDESTRIAN AT 17TH AVE E	1988	Excessive Running Grade and Cross Slope on Bridge Deck
69843	I 35	PEDESTRIAN AT 25TH AVE	1990	Excessive Running Grade on Bridge Deck
69853	KEENE CREEK	PEDESTRIAN	1973	Excessive Running Grade on Bridge Deck and Excessive Cross Slope on Approach Ramp
69855	DITCH	PEDESTRIAN	1973	Excessive Running Grade on Bridge Deck and Approach Ramp
69858	EB I35 RAMP & MICH RAMP	PEDESTRIAN	1989	Excessive Running Grade on Bridge Deck and Approach Ramp
69885	I 35 & TWO RAMPS	PEDESTRIAN AT MESABA	1968	Stairs
69885A	FILL	BIKEWAY AT MESABA	1987	Compliant

Sidewalks

Total Miles of Sidewalks	55.27
Sidewalks < 48" (Miles)	0.38
Cross Slopes > 2% (Miles)	21.96
Condition 1 Sidewalks (Miles) (Best Rating)	0.32
Condition 2 Sidewalks (Miles)	37.77
Condition 3 Sidewalks (Miles)	14.76
Condition 4 Sidewalks (Miles) (Worst Rating)	2.44

Driveways > 2% (Number)	926

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	29
Driveway	0
Hand Hold	1
Hydrant	0
Light Post	29
Mailbox	0
Manhole	1
Minor Gap	2
Narrows to less than 48"	8
Other	5
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	0
Signs	0
Slope Issues	0
Stairs	0
Street Furniture	0
Traffic Poles	2
Trees	6
Utility Cabinet	0
Vegetation	36

Accessible Pedestrian Signals

APS Push Buttons	103
Non-Compliant APS Push Buttons	22
APS Complaint Push Buttons	81
Number of APS Intersections	15
Total Number of Signalized Intersections	83

District 2 Asset Inventory

Buildings

T7920090330 - Bemidji District Headquarters
T7925090530 - Crookston Maintenance Headquarters
T7925090533 - Thief River Falls Truck Station

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	1291
Number of Non-Compliant Ramps	1129
Number of Compliant Ramps	162
Number of Compliant Ramps without Truncated Domes	296
Number of Ramps with Compliant Slope and Cross Slope	776
Number of Ramps with Compliant Slope	949

Pedestrian Bridges

There are no MnDOT owned pedestrian bridges in District 2.

Sidewalks

Total Miles of Sidewalks	58.42
Sidewalks < 48" (Miles)	0.49
Cross Slopes > 2% (Miles)	28.77
Condition 1 Sidewalks (Miles)	17.29
Condition 2 Sidewalks (Miles)	35.87
Condition 3 Sidewalks (Miles)	7.06
Condition 4 Sidewalks (Miles)	2.61
Driveways > 2% (Number)	1009

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	54
Driveway	0
Hand Hold	0
Hydrant	2
Light Post	43
Mailbox	1
Manhole	1
Minor Gap	17
Narrows to less than 48"	4
Other	4
Power Poles	0
Railroad Crossing	3
Sand, Gravel Mud	0
Signs	4
Slope Issues	1
Stairs	1
Street Furniture	0
Traffic Poles	5
Trees	3
Utility Cabinet	2
Vegetation	5

Accessible Pedestrian Signals

APS Push Buttons	34
Non-Compliant APS Push Buttons	20
APS Complaint Push Buttons	14
Number of APS Intersections	26
Total Number of Signalized Intersections	61

District 3 Asset Inventory

Buildings

T7930090443 - Baxter District Headquarters
MnROAD (Monticello)
T7935090735 - St. Cloud Maintenance Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2249
Number of Non-Compliant Ramps	1748
Number of Compliant Ramps	501
Number of Compliant Ramps without Truncated Domes	582
Number of Ramps with Compliant Slope and Cross Slope	1053
Number of Ramps with Compliant Slope	1576

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
6847	MN 23	PEDESTRIAN	1958	Stairs
73029	MN 15	PEDESTRIAN	1987	Compliant
73871	I 94	PEDESTRIAN	1977	Compliant

Sidewalks

Total Miles of Sidewalks	67.71
Sidewalks < 48" (Miles)	1.21
Cross Slopes > 2% (Miles)	24.48
Condition 1 Sidewalks (Miles)	14.48
Condition 2 Sidewalks (Miles)	38.75
Condition 3 Sidewalks (Miles)	12.74
Condition 4 Sidewalks (Miles)	1.34
Driveways > 2% (Number)	937

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	52
Driveway	0
Hand Hold	0
Hydrant	2
Light Post	55
Mailbox	6
Manhole	0
Minor Gap	10
Narrows to less than 48"	11
Other	3
Power Poles	8
Railroad Crossing	1
Sand, Gravel Mud	0
Signs	9
Slope Issues	0
Stairs	4
Street Furniture	6
Traffic Poles	7
Trees	10
Utility Cabinet	1
Vegetation	4

Accessible Pedestrian Signals

APS Push Buttons	318
Non-Compliant APS Push Buttons	136
APS Complaint Push Buttons	182
Number of APS Intersections	67
Total Number of Signalized Intersections	174

District 4 Asset Inventory

Buildings

T7940090616 - Detroit Lakes District Headquarters
T7940090615 - Fergus Falls Truck Station
T7940090658 - Moorhead Truck Station
T7945090820 - Morris Maintenance Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	1381
Number of Non-Compliant Ramps	1151
Number of Compliant Ramps	230
Number of Compliant Ramps without Truncated Domes	324
Number of Ramps with Compliant Slope and Cross Slope	676
Number of Ramps with Compliant Slope	899

Pedestrian Bridges

There are no MnDOT owned pedestrian bridges in District 4.

Sidewalks

Total Miles of Sidewalks	45.71
Sidewalks < 48" (Miles)	0.1
Cross Slopes > 2% (Miles)	26.59
Condition 1 Sidewalks (Miles)	24.42
Condition 2 Sidewalks (Miles)	16.4
Condition 3 Sidewalks (Miles)	3.56
Condition 4 Sidewalks (Miles)	4.68
Driveways > 2% (Number)	861

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	129
Driveway	41
Hand Hold	0
Hydrant	5
Light Post	53
Mailbox	9
Manhole	3
Minor Gap	7
Narrows to less than 48"	22
Other	6
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	0
Signs	11
Slope Issues	0
Stairs	3
Street Furniture	3
Traffic Poles	9
Trees	4
Utility Cabinet	0
Vegetation	0

Accessible Pedestrian Signals

APS Push Buttons	7
Non-Compliant APS Push Buttons	4
APS Complaint Push Buttons	4
Number of APS Intersections	18
Total Number of Signalized Intersections	64

District 6 Asset Inventory

Buildings

Albert Lea Truck Station

T7965091327 - Owatonna Maintenance Headquarters

Wilson Truck Station (Winona)

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2122
Number of Non-Compliant Ramps	1584
Number of Compliant Ramps	539
Number of Compliant Ramps without Truncated Domes	882
Number of Ramps with Compliant Slope and Cross Slope	1404
Number of Ramps with Compliant Slope	1551

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
50802	I 90	PEDESTRIAN	1997	Compliant
55019	US 63	PEDESTRIAN	1963	Stairs
55044	TH 52, FRONT RD	PEDESTRIAN AT 16th ST NW	2004	Compliant
85003	US 14	PEDESTRIAN (ST MARYS)	1963	Stairs
9218	CEDAR RIVER	PEDESTRIAN	1958	Compliant

Sidewalks

Total Miles of Sidewalks	66.54
Sidewalks < 48" (Miles)	0.58
Cross Slopes > 2% (Miles)	24.02
Condition 1 Sidewalks (Miles)	5
Condition 2 Sidewalks (Miles)	32.88
Condition 3 Sidewalks (Miles)	21.2
Condition 4 Sidewalks (Miles)	6.8
Driveways > 2% (Number)	1010

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	30
Driveway	0
Hand Hold	0
Hydrant	0
Light Post	5
Mailbox	0
Manhole	0
Minor Gap	4
Narrows to less than 48"	4
Other	2
Power Poles	0
Railroad Crossing	7
Sand, Gravel Mud	0
Signs	0
Slope Issues	0
Stairs	2
Street Furniture	0
Traffic Poles	1
Trees	9
Utility Cabinet	0
Vegetation	0

Accessible Pedestrian Signals

APS Push Buttons	63
Non-Compliant APS Push Buttons	19
APS Complaint Push Buttons	44
Number of APS Intersections	31
Total Number of Signalized Intersections	102

District 7 Asset Inventory

Buildings

Mankato District Headquarters
T7980091523 - Marshall District Headquarters
T7975091614 - Windom Maintenance Headquarters
T7975032119 - Worthington Scale

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2568
Number of Non-Compliant Ramps	2160
Number of Compliant Ramps	408
Number of Compliant Ramps without Truncated Domes	541
Number of Ramps with Compliant Slope and Cross Slope	1167
Number of Ramps with Compliant Slope	1628

Pedestrian Bridges

There are no MnDOT owned pedestrian bridges in District 7.

Sidewalks

Total Miles of Sidewalks	76.49
Sidewalks < 48" (Miles)	4.76
Cross Slopes > 2% (Miles)	29.84
Condition 1 Sidewalks (Miles)	17.45
Condition 2 Sidewalks (Miles)	45.61
Condition 3 Sidewalks (Miles)	9.63
Condition 4 Sidewalks (Miles)	3.8
Driveways > 2% (Number)	1045

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	33
Driveway	0
Hand Hold	0
Hydrant	1
Light Post	6
Mailbox	0
Manhole	3
Minor Gap	17
Narrows to less than 48"	1
Other	7
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	4
Signs	1
Slope Issues	0
Stairs	0
Street Furniture	1
Traffic Poles	3
Trees	2
Utility Cabinet	2
Vegetation	1

Accessible Pedestrian Signals

APS Push Buttons	105
Non-Compliant APS Push Buttons	20
APS Complaint Push Buttons	85
Number of APS Intersections	18
Total Number of Signalized Intersections	59

District 8 Asset Inventory

Buildings

T7980091030 - Hutchinson Truck Station
T7980091036 - Litchfield Truck Station
T7980091023 - Willmar District Headquarters

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	2019
Number of Non-Compliant Ramps	1801
Number of Compliant Ramps	218
Number of Compliant Ramps without Truncated Domes	390
Number of Ramps with Compliant Slope and Cross Slope	926
Number of Ramps with Compliant Slope	1328

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
43006	US 212	PEDESTRIAN	1971	Stairs

Sidewalks

Total Miles of Sidewalks	58.67
Sidewalks < 48" (Miles)	0.38
Cross Slopes > 2% (Miles)	24.74
Condition 1 Sidewalks (Miles)	34.05
Condition 2 Sidewalks (Miles)	18.17
Condition 3 Sidewalks (Miles)	5.09
Condition 4 Sidewalks (Miles)	1.11
Driveways > 2% (Number)	970

Sidewalk Barriers

Bridge Joint	0
Damaged Panel	10
Driveway	0
Hand Hold	0
Hydrant	4
Light Post	20
Mailbox	0
Manhole	1
Minor Gap	0
Narrows to less than 48"	3
Other	1
Power Poles	0
Railroad Crossing	0
Sand, Gravel Mud	1
Signs	6
Slope Issues	0
Stairs	4
Street Furniture	0
Traffic Poles	3
Trees	5
Utility Cabinet	0
Vegetation	2

Accessible Pedestrian Signals

APS Push Buttons	23
Non-Compliant APS Push Buttons	0
APS Complaint Push Buttons	23
Number of APS Intersections	12
Total Number of Signalized Intersections	52

Metro District Asset Inventory

Buildings

T7906092055 - Aeronautics
T7902092039 - Arden Hills Training Center
T7990092139 - Daytonport Scale
T7990090931 - Golden Valley District Headquarters
T7990091138 - Oakdale District Headquarters
Office of Materials and Road Research
T7900092043 - Plymouth Driver's License
T7990091194 - Waters Edge

Pedestrian Ramps

A compliant ramp must have detectable warnings , a minimum 4 foot by 4 foot landing with a cross slope less than 2% in each direction, a running slope of 8.3% or less, a cross slope of 2% or less, and be at least 48 inches wide.

Number of Ramps	7800
Number of Non-Compliant Ramps	6040
Number of Compliant Ramps	1832
Number of Compliant Ramps without Truncated Domes	2439
Number of Ramps with Compliant Slope and Cross Slope	4596
Number of Ramps with Compliant Slope	6223

Pedestrian Bridges

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
02017	MN 47	PED @ 49th Ave	1967	Stairs
02021	MN 65	PEDESTRIAN	1970	Compliant
02022	MN 65 & Frontage Rd	PED @ 80th Ave NE	1973	Stairs
02044	US 10	Pedestrian	1997	Compliant
10048	US 212	PED/BIKE	2007	Compliant
10531	TH 5	PED	1995	Compliant
19025	US 52	PED @ Lewis St	1973	Excessive Running Grade on Bridge Deck and Approach Ramp

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
27003	I 94, Lyndale & Henn Av	PED at Whitney	1988	Excessive Running Grade on Approach Ramp
27004	Mississippi River	Ped at St Anthony	1883	Compliant
27012	TH 100	Ped at 26th St	1978	Excessive Running Grade on Approach Ramp
27028	TH 77	PED AT 88TH ST	1978	Compliant
27038A	TH 100	Ped Brooklyn Blvd	1976	Compliant
27038B	TH 100	Ped Brooklyn Blvd	1976	Compliant
27061	TH 121	PED at 61st St	1962	Stairs
27105	TH 100 & Vernon Ave	PED at 41st St	1968	Stairs
27135	US 12 & Ridgeview Dr	PED at Ridgeview	1970	Stairs
27202	TH 55 & NB off ramp	PEDESTRIAN	1998	Compliant
27220	TH 610	Pedestrian	1998	Excessive Running Grade on Approach Ramps
27272	TH 12 & BNSF RR	Luce Line Trail	2003	Compliant
27278	TH 12 & BNSF RR	Trail A	2005	Compliant
27284	TH 100	PED at 39th Ave	2000	Excessive Running Grade on Approach Ramp
27407	LEGION LAKE	TRAIL	2008	Compliant
27520	TH 62 & W 64th St	PEDESTRAIN	1963	Stairs
27530	TH 62	PED at 40th Ave S	1966	Stairs
27535	TH 62	PED at 14th Ave	1967	Stairs
27615	TH 100 & SB off ramp	Ped at 59th Ave N	1980	Compliant
27649	TH 100	Pedestrian Bridge	1983	Compliant
27685	TH 252	PED AT 85th AVE	2003	Complaint
27710	I 394	PED @ Pennsylvania	1989	Excessive Running Grade on Approach Ramp
27711	I 394	PED @ Florida Ave	1989	Excessive Running Grade on Approach Ramp
27755	I 394 & 394R Frontage Rd	PEDESTRIAN	1989	Compliant

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
27757	I 394, I394R & Frontage	PED @ Cedar Lake Rd	1988	Excessive Running Grade on Approach Ramp
27864	I 94 & I 694	PED @ Shingle Creek	1980	Compliant
27866	UP RAIL	PED Linden Avenue	1972	Compliant
27868	I 35W NB, TH 65 & STS	PED @ 24th St E	1971	Excessive Running Grade on Bridge Deck and Approach Ramp and Stairs
27908	ELM CREEK	PEDESTRIAN	1973	Compliant
27955	I 94 On/Off Ramps-Huron	PEDESTRIAN	1965	Stairs
27958	I 94	PED @ Seymour	1967	Compliant
27985	I 35W & NB off ramp	PED @ Summer St	1973	Excessive Running Grade on Approach Ramp
27987	I 35W & off-on ramps	PED @ 5th St SE	1971	Excessive Running Grade on Approach Ramps
27B42	US 169	PED-BIKE	2008	Compliant
27R15	MN 610/CSAH 81 railroad	Pedestrian bridge	2005	Compliant
27R17	Wet Lands	Pedestrian TH 610	2005	Compliant
27R30	US 212	PED/BIKE	2006	Compliant
27V57	I 494	PED AT MAYWOOD LN	2005	Compliant
4175	County 101 Minnesota R	Pedestrian	1927	Compliant
5114	TH 7	Recreation Trail	1934	Compliant
62023	Lafayette Rd (US 52)	PED at Winifred St	1969	Excessive Running Grade on Bridge Deck and Approach Ramp
62096	MN 36	PEDESTRIAN	2007	Compliant
62804	I 35E & Thompson St	Ped at Walnut St	1987	Excessive Running Grade on Approach Ramp
62809	I 94 & RAMP 16A	GRIGGS ST PED	2009	Compliant
62822	I 694	RECREATION TRAIL	1966	Compliant
62849	I 94	PED at ALDINE	1966	Excessive Running Grade on Bridge Deck and Approach Ramps

Asset Number	Featured Intersected	Facility Carried by Structure	Year Built	Compliant Issues
62868	I 94, Hudson & Pacific	PED at Maple	1973	Excessive Running Grade and Cross Slope on Approach Ramp
62869	I 94 EB on ramp	PED at Hazelwood	1974	Stairs
62872	I 35E	PED at Bayard Ave	1984	Excessive Running Grade on Approach Ramps
62X02	Ped Trail	TH 35E	2001	Compliant
6402	TH 36	BN Regional Trail	1954	Compliant
6512	I 35E	GATEWAY TRAIL	1960	Compliant
70536	US 169	PED E OF CSAH 17	2002	Compliant
70539	US 169	PED W OF CR 79	2002	Compliant
82012	GORGE	PED	1968	Compliant
82028	US 61, Hasting Ave, 7th	PED	2003	Compliant
82032	US 61 7th Ave BN &CP RR	PED	2003	Compliant
9078	I 494 & N & S Front Rds	PED at 2nd Ave S	1960	Stairs
9600F	Minnesota River	Ped Trail	1980	Compliant
9618	I 35W	PED at 40th St	1965	Compliant
9714	US 10	Pedestrian	1963	Compliant
9736	I 94	PED at Chatsworth	1964	Compliant
9737	I 94	PED at Mackubin St	1963	Compliant
9773	I 94	PED at Grotto	1963	Compliant
9888	I 35W	PED at 73rd Ave	1960	Stairs
9892	I 94	PED at 22nd Ave	1962	Excessive Running Grade on Approach Ramp
9895	TH 100, Frontage Roads	PED at S View Lane	1971	Excessive Running Grade on Bridge Deck
9896	TH 100, Frontage Roads	PED at Windsor Ave	1971	Excessive Running Grade on Bridge Deck and Approach Ramp

Sidewalks

Total Miles of Sidewalks	188.24
Sidewalks < 48" (Miles)	3.79
Cross Slopes > 2% (Miles)	64.61
Condition 1 Sidewalks (Miles)	42.07
Condition 2 Sidewalks (Miles)	115.37
Condition 3 Sidewalks (Miles)	25.96
Condition 4 Sidewalks (Miles)	4.84
Driveways > 2% (Number)	1143

Sidewalk Barriers

Bridge Joint	551
Damaged Panel	3289
Driveway	12
Hand Hold	24
Hydrant	8
Light Post	93
Mailbox	1
Manhole	36
Minor Gap	22
Narrows to less than 48"	40
Other	48
Power Poles	19
Railroad Crossing	13
Sand, Gravel Mud	39
Signs	20
Slope Issues	22
Stairs	13
Street Furniture	17
Traffic Poles	5
Trees	31
Utility Cabinet	5
Vegetation	319

Accessible Pedestrian Signals

APS Push Buttons	1238
Non-Compliant APS Push Buttons	719
APS Complaint Push Buttons	519
Number of APS Intersections	227
Total Number of Signalized Intersections	675

Appendix D

Rest Area Facility Condition Assessment

Facility Location	Cost	System	Correction	Distress	Qty	Unit
Adrian EB						
Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
East Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$4,199	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Damaged	2	Ea
\Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Damaged	1	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$1,017	Fittings	Install grab bars in accessible stall.	Missing	6	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Inadequate	2	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$824	Plumbing Fixtures	Provide protective insulation for exposed piping.	Missing	6	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Adrian EB Total	$64,673					
Adrian WB						
Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$4,057	Slab on Grade	Remove and replace concrete sidewalk, 4" wide	Damaged	100	L.F.
Main Building	$4,199	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Damaged	1	Ea
Main Building	$749	Fittings	Install mirror at accessible height	Inadequate	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage	Inadequate	4	Ea
Main Building	$1,017	Fittings	Install grab bars in accessible stall	Missing	6	L.F.
Main Building	$824	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	6	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea

Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Adrian WB Total	$65,379					

Anchor Lake

Site Features	$5,721	Site Development	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$749	Fittings	Install mirror at accessible height	Missing	2	Ea
Main Building	$2,280	Fittings	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$4,270	Fittings	Provide accessible service counter	Inadequate	14	L.F.
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$6,779	Communications & Security	Replace fire alarm control panel	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Anchor Lake Total	$75,341					

Baptism River

Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$2,880	Fittings	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$6,779	Communications & Security	Replace fire alarm control panel	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Baptism River Total	$63,572					

Beaver Creek

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
East Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Picnic Shelter East	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Picnic Shelter West	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Beyond Useful Life	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Main Building	$1,623	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	40	L.F.
Main Building	$24,345	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	600	L.F.
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Beaver Creek Total	$80,641					

Big Spunk

Site Features	$3,136	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	2	Ea
Site Features	$31,527	Pedestrian Paving	Construct & provide ADA conc. ramp and steps	Missing	40	L.F.
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
Main Building	$1,425	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Auto Parking	$607	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Inadequate	100	L.F.
Big Spunk Total	$93,944					

Blue Earth EB

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
East Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Blue Earth EB Total	$11,561					

Blue Earth WB

North Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
South Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$1,171	Communications & Security	Replace public telephone	Inadequate	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Blue Earth WB Total	$8,087					

Burgen Lake

East Picnic Shelter	$1,623	Slab on Grade	Remove and replace concrete sidewalk 4' wide	Damaged	40	L.F.
West Picnic Shelter	$1,623	Slab on Grade	Remove and replace concrete sidewalk 4' wide	Damaged	40	L.F.
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Beyond Useful Life	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea

Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Burgen Lake Total	$47,302					

Cass Lake

Site Features	$3,136	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	2	Ea
Main Building	$1,190	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Cass Lake Total	$4,326					

Central Minnesota TIC

Site Features	$1,623	Slab on Grade	Remove and replace concrete sidewalk 4' wide	Damaged	40	L.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$1,566	Fittings	Replace directional signage	Inadequate	25	Ea
Main Building	$2,880	Fittings	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$4,270	Fixed Furnishings	Provide accessible service counter	Inadequate	14	L.F.
Central Minnesota TIC Total	$14,432					

Clear Lake

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
West Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$886	Plumbing Fixtures	Provide protective insulation for exposed piping	Inadequate	8	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Clear Lake Total	$68,935					

Dayton Port

Main Building Lobby	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building Men's Room	$8,497	Toilet Partitions	Replace toilet partitions	Damaged	3	Ea
Main Building Women's Room	$16,994	Toilet Partitions	Replace toilet partitions	Damaged	6	Ea

Dayton Port Total	$27,293

Des Moines River

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
North Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
NW Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
South Picnic Shelter	$3,351	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
Main Building	$4,199	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Beyond Useful Life	2	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$2,880	Plumbing Fixtures	Provide protective insulation for exposed piping	Inadequate	8	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Des Moines River Total	$56,306					

Dresbach TIC

Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Main Building	$1,624	Fittings	Toilet partitions laminate clad-overhead braced	Inadequate	1	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$13,004	Plumbing Fixtures	Replace drinking fountain	Inadequate	5	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$641	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	3	Ea
Auto Parking	$3,655	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Inadequate	910	L.F.
Dresbach TIC Total	$56,366					

Elm Creek

Site Features	$10,486	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	5	Ea
Patio Terrace	$6,524	Brick and Tile Plazas	Remove and replace asphalt sidewalk, 4' wide	Damaged	10	L.F.
Patio Terrace	$2,724	Brick and Tile Plazas	Replace expansion joints in concrete pavement	Damaged	50	L.F.
Main Building	$34,880	Slab on Grade	Mud jack floor slab.	Failing	500	S.F.
Main Building	$2,673	Exterior Doors	Repair aluminum frame and door	Inadequate	2	Ea
Elm Creek Total	$57,287					

Enfield

Site Features	$12,584	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	6	Ea
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
Main Building	$15,279	Exterior Doors	Automatic door opener on existing door	Missing	2	Ea
Main Building	$1,498	Fittings	Install mirror at accessible height.	Inadequate	4	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Enfield Total	$31,301					

Enterprise

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$2,291	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Enterprise Total	$36,038					

Fishers Landing

Site Features	$1,568	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	1	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,186	Fittings	Install grab bars in accessible stall.	Missing	7	L.F.
Main Building	$406	Fittings	Replace accessible restroom signage.	Inadequate	2	Ea
Main Building	$24,395	Floor Finishes	Replace quarry tile floor	Damaged	800	S.F.
Main Building	$720	Plumbing Fixtures	Provide protective insulation for exposed piping	Inadequate	2	Ea
Main Building	$4,270	Fixed Furnishings	Provide accessible service counter	Inadequate	14	L.F.
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Fishers Landing Total	$92,638					

Forest Lake

Site Features	$5,704	Site Development	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Main Building	$15,379	Exterior Doors	Automatic door opener on existing door	Missing	2	Ea
Main Building	$3,105	Identifying/ Visual Aid Specialties	Renew System	Beyond Useful Life	1	Ea
Main Building Lobby	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Forest Lake Total	$25,890					

Frazee

Main Building	$1,650	Exterior Doors	Repair aluminum storefront door	Damaged	3	Ea
Frazee Total	$1,650					

Fuller Lake

Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$15,709	Exterior Doors	Replace 3'-0" x 7'-0" aluminum door, incl. vision	Beyond Useful Life	2	Ea
Main Building	$899	Fittings	Install mirror at accessible height	Missing	2	Ea
Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$2,439	Floor Finishes	Replace quarry tile floor	Damaged	80	S.F.
Main Building	$720	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Fuller Lake Total	$58,778					

General Andrews

Site Features	$6,292	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$275	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	2	Ea
Auto Parking	$2,413	Parking Lots	Re-Align & Re-stripe Parking Space for ADA Access	Inadequate	800	L.F.
Auto Parking	$2,204	Parking Lots	Replace Metal Reserved Parking Sign and Post	Missing	3	Ea
General Andrews Total	$11,184					

Goose Creek

Site Features	$4,704	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$6,086	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Inadequate	150	L.F.
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Inadequate	1	Ea
Main Building	$2,155	Identifying/ Visual Aid Specialties	Renew System	Beyond Useful Life	1	Ea
Main Building Lobby	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Auto Parking	$1,060	Parking Lots	Realign & Re-stripe Parking Space for ADA Access	Inadequate	264	L.F.
Goose Creek Total	$23,660					

Gooseberry Falls

Site Features	$3,217	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	1	Ea
Main Building	$730	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Damaged	12	L.F.
Auto Parking	$3,956	Parking Lots	Re-Align & Re-stripe Parking Space for ADA Access	Inadequate	1120	L.F.
Gooseberry Falls Total	$7,906					

Hansel Lake

Site Features	$2,164	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Inadequate	200	S.F.
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building.	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Hansel Lake Total	$55,892					

Hayward

Site Features	$413	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	3	Ea
East Picnic Shelter	$507	Site Earthwork	Remove & Replace Concrete Sidewalk, 4' wide	Damaged	10	L.F.
West Picnic Shelter	$507	Site Earthwork	Remove & Replace Concrete Sidewalk, 4' wide	Damaged	10	L.F.
Main Building	$5,665	Fittings	Replace toilet partitions	Inadequate	2	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Hayward Total	$59,011					

Heath Creek

North Picnic Shelter	$10,052	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	15	C.S.F.
Main Building	$609	Fittings	Replace accessible restroom signage.	Inadequate	3	Ea
Heath Creek Total	$10,661					

High Forest

Site Features	$2,705	Pedestrian Paving	Replace Concrete Sidewalk 4" Thick (SF)	Missing	250	S.F.
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
High Forest Total	$38,114					

Kettle River

Site Features	$8,389	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	4	Ea
Auto Parking	$2,204	Parking Lots	Replace Metal Reserved Parking Sign and Post	Missing	3	Ea
Auto Parking	$2,413	Parking Lots	Realign & Re-stripe Parking Space for ADA Access	Missing	800	L.F.
Kettle River Total	$13,006					

Lake Iverson

Site Features	$6,872	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	3	Ea
Main Building	$5,231	Exterior Doors	Replace 3'-0" x 7'-0" aluminum storefront doors	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$25,492	Fittings	Replace toilet partitions	Damaged	9	Ea
Main Building	$812	Fittings	Replace accessible restroom signage	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Lake Iverson Total	$84,059					

Lake Latoka

Picnic Shelter East	$2,029	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	50	L.F.
Picnic Shelter West	$2,029	Site Earthwork	Remove and replace concrete sidewalk, 4' wide	Damaged	50	L.F.
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Lake Latoka Total	$5,860					

Lake Pepin

Site Features	$6,086	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Inadequate	150	L.F.
North Picnic Shelter	$1,420	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Inadequate	35	L.F.
South Picnic Shelter	$923	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Inadequate	35	L.F.
Auto Parking	$1,060	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Missing	264	L.F.
Lake Pepin Total	$9,489					

Middle Spunk

Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall.	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea

Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$4,704	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$2,434	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Inadequate	60	L.F.
Auto Parking	$607	Parking Lots	Realign and Re-stripe Parking Space for ADA Access	Inadequate	100	L.F.
Middle Spunk Total	$66,281					

MN Valley

Main Building	$15,279	Interior Doors	Automatic door opener on existing door	Inadequate	2	Ea
Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$1,017	Fittings	Install grab bars in accessible stall.	Missing	6	L.F
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$2,880	Plumbing Fixtures	Provide protective insulation for exposed piping.	Missing	8	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
MN Valley Total	$58,162					

Moorhead

Site Features	$1,845	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	1	Ea
Moorhead Total	$1,845					

New Market

Main Building	$609	Fittings	Replace accessible restroom signage.	Inadequate	3	Ea
Site Features	$3,275	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
West Picnic Shelter	$10,052	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	15	C.S.F.
New Market Total	$14,074					

Oak Lake

Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Missing	1	Ea
Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$1,186	Fittings	Install grab bars in accessible stall.	Missing	7	L.F
Main Building	$2,439	Floor Finishes	Replace quarry tile floor	Damaged	80	S.F.
Main Building	$720	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	2	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea

Site Features	$3,136	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	2	Ea
East Picnic Shelter	$811	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Damaged	10	L.F.
Oak Lake Total	$47,914					

Oakland Woods

Main Building	$863	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$4,367	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	4	Ea
Oakland Woods Total	$58,737					

Rum River

Main Building	$2,339	Identifying/ Visual Aid Specialties	Renew System	Beyond Useful Life	1	Ea
Main Building	$1,042	Cabinets & Counters	Renew System	Beyond Useful Life	1	Ea
Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Main Building	$7,639	Exterior Doors	Automatic door opener on existing door	Inadequate	1	Ea
Main Building Men's Room	$5,665	Toilet Partitions	Replace toilet partitions	Damaged	2	Ea
Main Building Women's Room	$11,330	Toilet Partitions	Replace toilet partitions	Damaged	4	Ea
Main Building Women's Room	$6,479	Plumbing Fixtures	Replace lavatory vitreous china	Inadequate	8	Ea
Site Features	$6,292	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
Site Features	$4,057	Pedestrian Paving	Remove and replace concrete sidewalk, 4' wide	Missing	100	L.F.
Rum River Total	$46,278					

St. Croix TIC

Main Building	$1,435	Exterior Doors	Repair aluminum door	Damaged	2	Ea
Site Features	$10,486	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Inadequate	3	Ea
St. Croix TIC Total	$11,921					

Straight River NB

Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$6,779	Communications & Security	Replace fire alarm control panel	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Main Building	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea

East Picnic Shelter	$6,006	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	10	C.S.F
West Picnic Shelter	$8,828	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	10	C.S.F
West Picnic Shelter	$3,483	Slab on Grade	Remove and replace concrete sidewalk, 4' wide	Damaged	10	L.F
Straight River NB Total	$60,911					

Straight River SB

Main Building	$406	Fittings	Replace accessible restroom signage	Inadequate	2	Ea
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Site Features	$138	Water Supply	Replace Exterior faucet handle with ADA lever type	Inadequate	1	Ea
East Picnic Shelter	$3,003	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	5	C.S.F
West Picnic Shelter	$6,006	Slab on Grade	Replace unfinished concrete floor unfinished	Damaged	10	C.S.F
Straight River SB Total	$12,154					

Thompson Hill

Main Building	$13,556	Fittings	Install grab bars in accessible stall	Missing	80	L.F.
Main Building	$2,601	Plumbing Fixtures	Replace drinking fountain	Inadequate	1	Ea
Main Building	$1,802	Communications & Security	Replace public telephone	Inadequate	1	Ea
Main Building	$30,828	Special Purpose Room	Remove one fixture and create accessible stall.	Inadequate	2	Ea
Site Features	$2,097	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Missing	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Thompson Hill Total	$51,098					

Watonwan

Main Building	$812	Fittings	Replace accessible restroom signage.	Inadequate	4	Ea
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$1,092	Pedestrian Paving	Replace Concrete Curb Cut with ADA Curb Cut	Missing	1	Ea
Site Features	$3,289	Water Supply	Install Domestic Water Faucet Piping and Drain	Missing	1	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Watonwan Total	$57,861					

Worthington TIC

Main Building	$431	Exterior Doors	Repair aluminum door	Damaged	1	Ea
Main Building	$2,033	Fittings	Install grab bars in accessible stall	Missing	12	L.F.
Main Building	$749	Fittings	Install mirror at accessible height.	Missing	2	Ea
Main Building	$3,660	Fittings	Provide accessible service counter	Inadequate	12	L.F.

Main Building	$812	Fittings	Replace accessible restroom signage	Inadequate	4	Ea
Main Building	$25,492	Fittings	Replace toilet partitions	Damaged	9	Ea
Main Building	$1,073	Plumbing Fixtures	Provide protective insulation for exposed piping	Missing	8	Ea
Main Building	$3,604	Communications & Security	Replace public telephone	Inadequate	2	Ea
Main Building	$51,705	Special Purpose Room	Construct Single-User Toilet Room	Missing	1	Ea
Site Features	$4,581	Water Supply	Replace Exterior Drinking Fountain; ADA Accessible	Inadequate	2	Ea
Auto Parking	$214	Parking Lots	Install ADA "Van Accessible" Parking Sign	Inadequate	1	Ea
Worthington TIC Total	$94,354					

Grand Total	**$1,942,175**

Note: The following Rest Areas have no ADA Deficiencies: Brainerd Lakes Welcome Center, Albert Lea TIC, and Marion Rest Area

Appendix E

Policies and Procedures under Review by MnDOT

2008 Signal & Lighting Certification Manual	Revised 2010
60% REVIEW CHECKLISTS	N/A
95% REVIEW CHECKLISTS	N/A
Accessibility Grievance Procedure	Revised
ADA Checklist	Revised
ADA IMPLEMENTATION PLAN FOR METRO DESIGN	Revised
D-7 PRESERVATION PROJECT GUIDELINES	N/A
Design Layout Checklist	N/A
GDSU Process of Layout Review	N/A
Guidebook for Minnesota Public Transit Providers	Retired
Guideline for the Application of Tubular Markers and Weighted Channelizers	No impact to accessibility
Guidelines for Changeable Message Sign (CMS) Use	No impact to accessibility
Hear Every Voice (HEV): MnDOT Public and Stakeholder Participation Guidance	Compliant
Hear Every Voice II: Public Involvement Guidance 2008	Compliant
HPDP Accessibility Requirements	Revision in 2015
HPDP Geometric Layouts	N/A
Layout Approval Process	Not found
Maintenance Manual	Revision pending
Minnesota Manual on Uniform Traffic Control Devices (Mn MUTCD) CH 4E	Revised
MnDOT Road Design Manual (RDM)	Chapter 11-3 Revised 2010
MnDOT Traffic Signal Timing and Coordination Manual	
No Passing Zone Workbook	No impact to accessibility
Off-site accessibility checklist	Not found
OLM's Right of Way Manual section 5-491.810	N/A
Scoping and Cost Estimating	Compliant
Scoping Worksheets	Compliant
Standard Plan - Acceleration and Deceleration Lane (Urban) Rigid Design (5-297.210)	No impact to accessibility
Standard Plate 7105C	No impact to accessibility
Standard Plate 7107H	No impact to accessibility
Standard Plate 7108F	No impact to

	accessibility
Standard Plate 7109C	No impact to accessibility
Standard Plate 7113A	No impact to accessibility
Standard Plate 8400E Pipe Railing	Needs revision
Standard Plate 8401 At grade pipe railing	Needs revision
Standard Plate Pedestrian installation	Not Found
Standard Sign Summary	Compliant
Standard Signs Manual	Compliant
Tech. Memo. Minnesota Work Zone Safety and Mobility Policy	Revised 2010
Tech. Memo. Pedestrian Countdown Signals (PCSs) Usage.	No impact to accessibility
TRAFFIC ENGINEERING MANUAL	Revised
Work Zone Field Handbook	Revised

Appendix F

Inventory Attributes for Sidewalks, APS Signals, and Curb Ramps

Below is listing of the data that was collected for determining the accessibility of sidewalks, signals, and curb ramps in MnDOT's right of way.

Sidewalk Attributes

Pedestrian Activity

Sidewalk Width

Sidewalk Material

Boulevard Width

Boulevard Material

Cross Slope

Condition Rating

Signal Attributes

Intersection ID

APS Present

Walk Signal Present

Countdown Present

Pedestrian Phase Activation

Push Button Location

Push Button on correct side

Push Button Landing Area

Push Button Landing Slope

Push Button Landing Location

Push Button Height

Push Buttons 10' Apart

Photo

Curb Ramp Attributes

Intersection ID

Pedestrian Activity

Ramp Type

Location

Truncated Domes

Pedestrian Landing Area

Pedestrian Landing Slope

Ramp Width

Running Slope

Cross Slope

Condition Rating

Gutter In Slope

Gutter Flow Slope

Photo

Appendix G

Glossary of Terms

ABA: See Architectural Barriers Act.

ADA: See Americans with Disabilities Act.

ADA Transition Plan: MnDOT's transportation system plan that identifies accessibility needs, the process to fully integrate accessibility improvements into the Statewide Transportation Improvement Program (STIP), and ensures all transportation facilities, services, programs, and activities are accessible to all individuals.

ADAAG: See Americans with Disabilities Act Accessibility Guidelines.

Accessible: A facility that provides access to people with disabilities using the design requirements of the ADA.
Accessible Pedestrian Signal: A device that communicates information about the WALK phase in audible and vibrotactile formats. Also known as APS.

Alteration: A change to a facility in the public right-of-way that affects or could affect access, circulation, or use. An alteration must not decrease or have the effect of decreasing the accessibility of a facility or an accessible connection to an adjacent building or site.

Americans with Disabilities Act: The Americans with Disabilities Act; Civil rights legislation passed in 1990 and effective July 1992. The ADA sets design guidelines for accessibility to public facilities, including sidewalks and trails, by individuals with disabilities. Also known as ADA.

Americans with Disabilities Act Accessibility Guidelines: ADAAG contains scoping and technical requirements for accessibility to buildings and public facilities by individuals with disabilities under the Americans with Disabilities Act (ADA) of 1990.

APS: See Accessible Pedestrian Signal.

Architectural Barriers Act: Also known as ABA.

Class I Rest Areas: Rest area buildings are open 24 hours per day and offer modern facilities, drinking fountains, display case maps, travel displays, vending machines and public phones. They feature picnic facilities; lighted walkways; and lighted car, recreational vehicle and commercial truck parking lots.

Class II Rest Area: Class II rest areas feature vault toilet facilities with separate facilities for men and women, a water well, picnic facilities, paved parking lots and other site amenities. They are seasonally operated.
Detectable Warning: A surface feature of truncated domes, built in or applied to the walking surface to indicate an upcoming change from pedestrian to vehicular way.

DOJ: See United States Department of Justice
Federal Highway Administration (FHWA): A branch of the US Department of Transportation that administers the federal-aid Highway Program, providing financial assistance to states to construct and improve highways, urban and rural roads, and bridges.

FHWA: See Federal Highway Administration

PROWAG: An acronym for the *Guidelines for Accessible Public Rights-of-Way* issued in 2005 by the U. S. Access Board. This guidance addresses roadway design practices, slope, and terrain related to pedestrian access to walkways and streets, including crosswalks, curb ramps, street furnishings, pedestrian signals, parking, and other components of public rights-of-way.

Right of Way: A general term denoting land, property, or interest therein, usually in a strip, acquired for or devoted to transportation purposes. "Right of way" also may mean the privilege of the immediate use of the highway. (MN 169.01 Subd. 45)

Section 504: The section of the Rehabilitation Act that prohibits discrimination by any program or activity conducted by the federal government.

Travel Information Centers: Travel Information Centers (TICs) and Regional Welcome Centers are Class I rest areas that offer expanded customer services and feature a staffed travel information counter. The TICs offer a broad range of statewide travel information while the Welcome Centers provide more regional travel information.

Statewide Transportation Improvement Program: The Statewide Transportation Improvement Program (STIP) is Minnesota's four year transportation improvement program. The STIP identifies the schedule and funding of transportation projects by state fiscal year (July 1 through June 30). It includes all state and local transportation projects with federal highway and/or federal transit funding along with 100% state funded transportation projects. Rail, port, and aeronautic projects are included for information purposes. The STIP is developed/updated on an annual basis.

STIP: See Statewide Transportation Improvement Program

Uniform Accessibility Standards (UFAS): Accessibility standards that all federal agencies are required to meet; includes scoping and technical specifications.

United States Access Board: An independent federal agency that develops and maintains design criteria for buildings and other improvements, transit vehicles, telecommunications equipment, and electronic and information technology. It also enforces accessibility standards that cover federally funded facilities.

United States Department of Justice: The United States Department of Justice (often referred to as the Justice Department or DOJ), is the United States federal executive department responsible for the enforcement of the law and administration of justice.

Minnesota Olmstead Plan: Demographic Analysis, Segregated Settings Counts, Targets and Timelines

Continuing Care Administration

Children and Family Services Administration

September 30, 2014

For more information contact:

Minnesota Department of Human Services
Disability Services Division
St. Paul, MN 55101
651-431-4262

This information is available in accessible formats to individuals with disabilities by calling 651-431-4262,
Or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

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Contents

Tables of Figures

Olmstead Plan Language

Housing section

Action One: Identify people with disabilities who desire to move to more integrated housing, the barriers involved, and the resources needed to increase the use of effective best practices

- *By September 30, 2014 data gathering and detailed analysis of the demographic data on people with disabilities who use public funding will be completed.*

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 50.

Supports and Services section

Action Two: Support people in moving from institutions to community living, in the most integrated setting

For individuals in other[1] segregated settings:

- *By September 30, 2014 DHS will identify a list of other segregated settings, how many people are served in those settings, and how many people can be supported in more integrated settings.*
- *By September 30, 2014 DHS will review this data and other states[2] plans for developing most integrated settings for where people work and live. Based on this review DHS will establish measurable goals related to demonstrating benefits to the individuals intended to be served and timelines for moving those individuals to the most integrated settings.*

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 64.

Introduction

Minnesota's Olmstead Plan goal is to ensure that Minnesota is a place where people with disabilities live, learn, work and enjoy life in the most integrated setting. Services and supports that enable people to exercise their right of self-determination, to live in the most-integrated settings and to be able to freely participate in their communities will be appropriate to their needs and of their choosing.

To achieve this, the Olmstead Plan sets goals and identifies strategic actions in the following areas: employment, housing, transportation, supports and services, lifelong learning and education, healthcare and health living, and community engagement.

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[1] In the Olmstead Plan, immediately preceding this quoted section, is a list of actions and measures related to certain segregated settings: Intermediate Care Facilities for Persons with Developmental Disabilities, nursing facilities (specifically for people under 65 who are there more than 90 days), Anoka Metro Regional Treatment Center, Minnesota Security Hospital and Minnesota Specialty Health System-Cambridge. The term used here, "other segregated settings", refers to places other than these previously listed five settings.

[2] "In particular, DHS will review plans from Massachusetts, Oregon, and Rhode Island."

This report focuses on moving people on increasing the number of people living in the most integrated settings and decreasing the number of people living unnecessarily in segregated settings.

The State must better align the design and provision of supports and services with these outcomes. The culture surrounding the delivery of supports and services will be based on a holistic approach to supporting people. Many factors influencing quality of life will have to come together, such as expectations and aspirations, skills developed over a lifetime, personal supports, location of one's home and transportation options.

Increasing flexibility and options in all of these areas will require collaboration among divisions within state agencies, across state agencies, with providers, businesses, community organizations and, of course, people with disabilities and their families.

We will know we are making progress towards meeting the goal when we see progress in these population-level indicators:

- Increase in the number of people living in most integrated settings
- Decrease in people living unnecessarily in segregated settings
- Increase in the quality of life as reported by people with disabilities, using indicators described in the Quality Assurance section of the plan
- People will have timely transitions back to their community from hospital care or short-term institutional care

Background Information

People with disabilities in Minnesota receive long-term supports and services either in what we consider an institutional setting or through home and community based services. Home and community based services include home care and personal care assistant services covered through the Medicaid state plan, the Alternative Care program, the Elderly Waiver and the disability waivers.

In state fiscal year 2013, 93 percent of people with disabilities and 68 percent of older adults received their long-term supports and services through home and community based services (83 percent across both populations combined). Of those, 73 percent of people with disabilities and 76 percent of older adults received those services in their own homes.

Related Olmstead actions

This report was produced in conjunction with the Olmstead Plan actions cited on page one. There are several other closely related Olmstead Plan actions. This report includes demographic and baseline data about people receiving services in potentially segregated settings and lays out targets and timelines for moving people to more integrated settings. The related actions are what the state is planning to do, or currently implementing, to achieve those goals.

The plan lays out several actions to promote person-centered practices which identify people who would like to move to a more integrated setting, and those who would not be opposed to such a move. The plan includes actions to support people in more integrated settings and improve the quality of life of people with disabilities.

The plan includes developing and implementing transition protocols to support successful transitions. There are specific, measurable targets for transitioning individuals from Intermediate Care Facilities for

Developmental Disabilities (ICF-DDs), nursing facilities, the Minnesota Specialty Health System facility in Cambridge, the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital.

There are several actions in the plan that will identify people with disabilities who are exiting state correctional facilities, including youth who are leaving juvenile facilities, and connect them with appropriate services and supports upon release.

There are several actions in the plan related to increasing the use of positive practices. The plan also includes actions to increase planning in order to reduce crises and to respond quickly and effectively when crises do occur.

The plan directs the state to change the way prioritization for accessing limited services (waiver wait list) so that those who want to move to a more integrated setting will be able to access the necessary home and community-based supports in a reasonable amount of time.

The plan includes actions to increase flexibility of and access to certain services and supports.

The state has developed plans to provide training and technical assistance to services providers who have business models structured around segregated and non-competitive employment to transition their service delivery model to integrated, competitive employment models.

There are several Olmstead Plan actions related to housing that will facilitate meeting the state's targets and timelines for transitioning people from segregated to more integrated settings. One strategic action is to increase housing options that promote choice and access to integrated settings by reforming the Group Residential Housing (GRH) and Minnesota Supplemental Aid (MSA) Housing Assistance programs. The goal of the reform is to allow income supplement programs that typically pay for room and board in congregate settings to be more easily used in non-congregate settings. It is expected that this change would result in more people with disabilities transitioning from the potentially segregated settings identified in this report to more independent housing.

The plan also calls for increasing the availability of affordable housing. Another is to increase access to information about housing options. And, the plan includes actions to promote counties, tribes and other providers to use best-practices and person-centered strategies related to housing.

HCBS Settings Rule

Simultaneous to Minnesota's Olmstead Plan implementation, the Centers for Medicare and Medicaid Services (CMS) published a rule, effective March 17, 2014, outlining new requirements for states' Medicaid home and community-based services.

The intent of the rule is to ensure that individuals receiving long-term services and supports through home and community-based services programs have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate to meet the needs of the individual. The rule is designed to enhance the quality of home and community-based services and provide protections for people who use those services. The rule defines, describes and aligns requirements across the home and community-based services programs. It defines person-centered planning requirements for persons in home and community-based settings.

States have until March 17, 2019, to bring existing programs into compliance with the rule and must submit a plan to transition their existing home and community-based services waiver programs services

by that date. In Minnesota, this impacts the Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Individuals with Disabilities (CADI), Developmental Disabilities (DD), and Elderly Waiver (EW) programs. New programs under 1915(i), 1915(k) and any new 1915(c) will be required to be in full compliance from the date of implementation. In Minnesota, the new Community First Services and Supports (CFSS) program must meet this requirement.

The new federal HCBS rules require that individuals be afforded a real choice between settings in which they receive services. Minnesota's implementation of these rules will further the state's progress in implementing its Olmstead goals.

Process

Internal work groups

Two groups were convened to work on this project, one to develop the data set for measuring people in potentially segregated settings and another to analyze the data from a policy perspective and set the targets and timelines. The groups included data and policy experts from the Minnesota Department of Human Services Adult Mental Health, Children's Mental Health, Economic Assistance and Employment Support, Disability Services Division, Compliance Monitoring, and Chemical Health Divisions. The Department of Health and the Department of Employment and Economic Development also participated. This work has a direct link to the Olmstead Plan action to develop additional affordable housing and, therefore, included participation by the Minnesota Housing Finance Agency.

How people with disabilities were/will be involved in planning for community integration

Individuals can have significant impact on realizing their personal goals when their preferences as well as their needs are incorporated into assessment and service planning . Minnesota is currently rolling out MnCHOICES, which continues and enhances Minnesota's person-centered approach tailoring services to individual's strengths, preferences and needs. This major reform has been underway for several years and is now in the final stages of its staged roll-out.

People with disabilities also have the opportunity to participate as advocates and planning partners in shaping the future of Minnesota's HCBS system. A series of meetings and input sessions around the state were held as part of the preliminary planning for the HCBS settings rule implementation. Meetings specifically targeted for self-advocates were held to seek input in addition to other forums.

DHS also engaged stakeholders in providing input to the GRH/MSA reform efforts. This effort focused on receiving feedback regarding current housing options and barriers and comments on proposed future directions for this program. For this effort, six listening sessions were held throughout the state with over 450 participants, including people with disabilities and their families.

The Minnesota Department of Human Services conducts a biennial process to gather information about the current capacity and gaps in services and housing needs to support people with long-term care needs in Minnesota. The gaps analysis was originally focused on the needs of older persons but in 2011 the needs of children and adults with disabilities and/or mental illness were added to the study. As part of this process, people with disabilities, people with mental illness, older people and their families participated in focus groups to provide insights about long-term services and supports, based upon their personal experience. For the 2012/2013 study, focus groups were held in 16 communities across the state, with 260 individuals taking part. There were 110 people who participated by completing a short

on-line survey. Twenty-three percent of survey respondents identified as having a disability and 23 percent as parents and caregivers.

As part of the six-year Pathways to Employment initiative, the Department of Human Services, in conjunction with other state agencies, engaged people with disabilities and other stakeholders in a public process to identify what it will take to increase the employment of people with disabilities in Minnesota. Pathways supported three summits which brought together people with disabilities and other stakeholders with one focus—how to make employment the first and preferred choice of youth and adults with disabilities. Pathways also supported a series of events around the state, conversations with various disabilities sub-populations, that yielded nine policy briefs in the following areas: brain injury, mental health, Deaf-blindness, Deaf and hard of hearing, blindness, Autism Spectrum Disorder, intellectual/developmental disabilities, and physical disabilities.

Review of other state's plans (Olmstead Plan item SS 2G.2)

The policy work group that developed targets and timelines reviewed initiatives to reform state employment and day support services in Massachusetts, Oregon and Rhode Island. A chart showing their analysis of those plans is included in Appendix A.

The strategies that are being used by other states informed the development of Minnesota's implementation plans for increasing competitive employment and those plans informed the process for setting targets for competitive employment. The effort to support people to be competitively employed intersects with the targets to support people receiving day services in more integrated settings.

The strategies that Minnesota are pursuing include:

- Adopting an Employment First Policy
- Training and technical assistance to support day service providers to convert their service models from congregate and segregated, "sheltered workshop" day services to more individualized, person-centered approaches of community supports and competitive employment services
- Interagency collaboration to promote promising practices and coordinate services for transition-age youth
- Increasing expectations and work experiences
- Improved data system for tracking employment outcomes for students and adults with disabilities
- Documenting informed choice to enable tracking individuals' decisions and potential barriers to employment
- Service enhancements for people who are seeking competitive employment at minimum wages or higher
- Expanding self-advocacy and peer networks

Minnesota is using earned monthly income ≥$600/month as an indicator of competitive employment.

Our data base contains information about individuals' income, including what is earned income and what is the amount and type of unearned income. We recognize that many people have earned income, but would not necessarily be employed in what we consider "competitive employment"—that is, employment that is part of the regular workforce, not in a segregated setting, and which is compensated at a market rate. Minnesota is setting a relatively high threshold of monthly earned income to separate

those who have jobs that pay sub-minimum wages (more likely to be in segregated settings) from those who have jobs that pay at least a minimum wage.

This is an important distinction to keep in mind, particularly when comparing Minnesota to other states which may be using another benchmark, such as having *any* earned income as an indicator of employment. To illustrate this point, in 2013, 15.8 percent of people on a disability waiver have earned income over $250/month. (This is not the exact same population as used for the rest of our measures, but a number we've been tracking since 2007, and used here just for illustrative purposes).

Methodology

Available data sources

That data that is available comes from existing data systems that were designed for specific purposes. Therefore, there are many shortcomings with the data we have to inform and track our Olmstead implementation.

- Some data can only partially get at some questions
- Some data available for some of the people in the system but not for everyone
- Data fields that could be used, but which aren't reliably used or updated by the people who populate the data base.
- No data available to address some questions or track certain outcomes

MAXIS
MAXIS is a computer system used by state and county workers to determine eligibility for public assistance and health care. For cash assistance and food support programs, MAXIS also determines the appropriate benefit level and issues benefits.

For the purposes of this report, data from MAXIS were used to identify people with disabilities who receive benefits through the Group Residential Housing (GRH) program. This program pays for room and board costs related to living in a licensed or registered setting, as well as services for some people. GRH recipients were included in this report if they reside in one of the following settings: adult foster care, boarding care, board and lodge, board and lodge with special services, homeless shelter, housing with services establishment, or supervised living facility. For settings other than adult foster care, the individual had to be on the program for at least 90 days to be counted. This control sorted out people who are more likely to be living in a segregated setting, rather than passing through one on a temporary basis.

MMIS
Health care providers throughout the state – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in a Minnesota Health Care Program. These programs provide health care services to low-income families and children, low-income elderly people and individuals who have physical and/or developmental disabilities, mental illness or who are chronically ill.

For the purposes of this report, data from MMIS were used to identify people with disabilities who received long-term supports and services typically provided in licensed, and potentially segregated, settings.

Data limitations specific to this project

1. Olmstead Plan does not have measureable definitions or criteria to identify segregated settings
2. Current data bases have limited information regarding the type of settings in which people receive services
3. Current databases do not identify people who want to move to a more integrated setting
4. Current databases lack information required to indicate the type of setting in which the individual is being served (e.g., day/employment services settings). Therefore, it is also difficult, if not impossible, to track movement between settings with current databases.
5. Setting types, as recorded in DHS data systems, represent a wide variety of actual places where people live, and do not necessarily indicate how "integrated" a person in any particular setting is. For example, a person may receive customized living services in an assisted living residence which is comprised entirely of older adults, being in this residence may give the individual more access to community life than the person may have had in their own home.
6. Providers have up to 12 months through MMIS to submit a claim so the claims data for fiscal year 2014 is subject to change through June 30, 2015
7. There is different data kept for people depending on the program they use. For example, people who apply for a Developmental Disabilities waiver will have extensive assessment information in their records. People who are in a nursing facility also have assessment data, but from a different assessment tool with different data points. People who are in the Group Residential Housing program may not have any assessment data.

Data development plan

Because of the data which is currently available does not fully answer questions that could guide us in the process of assisting people move to the most integrate setting, we need to develop additional ways to get information. MMIS and MAXIS are large data bases that are central to the state's operations in administering public programs. The demands upon them are great and changes are not easily made. It is not practical to build additional statewide data systems so we need to work with our existing systems. MnCHOICES is a new assessment system, currently being rolled out, which will provide much more person-centered data in the future.

We are taking short-term and long-term approaches to improving our data. The HCBS segregated settings transition plan will provide the basis for most of the short-term improvements.

1. Develop criteria for measuring a setting's degree of segregation/integration.
2. HCBS waiver providers in potentially segregated settings will complete a self-assessment.
3. Develop a method for rating site-specific "integration-based" criteria using data from provider assessments.
4. Create short-term system for tracking numbers of people who make a move to more integrated setting.
5. Build long-term systems solution for identifying, verifying, collecting and sharing information about degree of integration/segregation.
6. Create long-term system for tracking numbers of people who move from to or from less integrated settings.

Data pull

The baseline and demographic data were compiled using the following process.

1. Data used came from fiscal year 2014 (July 1, 2013 – June 30, 2014).
2. Data included all people, irrespective of age.
3. MMIS data was queried using claim codes of services that are delivered in a potentially segregated setting. Individuals were included in the counts if there was at least one claim meeting criteria within fiscal year 2014. This list included specific waiver services and services commonly accessed by people with serious mental illness or serious and persistent mental illness.
4. Data from MMIS does not include data about Group Residential Housing (GRH). GRH recipients must meet disability criteria to qualify for this program. Therefore, data was pulled from MAXIS to capture people receiving GRH.
5. Some people are only on GRH for a short stay in a temporary setting and therefore would not be considered someone living in a segregated setting. To control for that, we narrowed the MAXIS group, for every setting except adult foster care, to only include people who were in the setting for at least 90 days.
6. We combined the MAXIS group and the MMIS group to arrive at the people that we consider to have been in potentially segregated settings in fiscal year 2014.

List of potentially segregated settings (requires further analysis)

Criteria

There is nothing in current state statute, policy or rule that defines what constitutes a segregated setting in Minnesota. The Olmstead Plan provides the following definition of 'segregated setting', taken from the *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.*[3]

> **Segregated settings:** Segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.

This definition needs to be broken down into measurable criteria, e.g., what constitutes "lack of privacy or autonomy."

The state will develop ways to measure these qualities. In the meantime, we identified settings that are *potentially segregating.* It is important to note that, in addition to developing measurable criteria, data, over and above that currently available to the State, will required in order to identify segregated settings. Additionally, our current data systems do not necessarily identify the setting in which a person receives a service.

In light of these limitations, this is where we are starting the task of identifying people in segregated settings, recognizing that this work will need further analysis, including possibly looking at other settings that weren't included in this first analysis.

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[3] www.ada.gov/olmstead/q&a_olmstead.htm

The group divided settings into residential settings and day/employment services settings. The logic is that strategies for transitioning people to more integrated settings will be similar within those categories and different outside those categories. In other words, a strategy to help people change residence will likely be useful across residential settings but not necessarily in helping people change their day/employment services settings. Likewise, strategies to make day service settings more integrated will likely work across day/employment services but not necessarily with transition out of residential settings.

We included people who are homeless in the count of people living in segregated settings for two reasons. First, according to the U.S. Department of Housing and Urban Development, over 40 percent of America's homeless population is people with disabilities[4]. Second, we consider our goal to be not only decreasing the number of people living unnecessarily in segregated settings but also increasing the number of people living in the most integrated settings. From a quality of life perspective, the people who are homeless have fewer opportunities to participate in community life. Therefore, we chose to look for indicators of homelessness and include people who are likely to be homeless in the counts of being in potentially segregated settings.

The group then developed criteria to use to identify if settings and services in each group will be considered potentially segregated.

Residential – potentially segregated/not integrated criteria

- The setting is controlled by the service provider
  - The exception to this criterion is private family settings (i.e., family foster care)
- There are no limits to length of stay
- A person who is likely to be homeless is considered not well-integrated in their community

Day/employment services settings – potentially segregated criteria

- Services which are often delivered in a provider-controlled setting
- Services which are often delivered in settings with a predominance of other people with disabilities

List of potentially segregated settings

Figure 1: List of potentially segregated settings and services (See Appendix B for definitions)

Residential settings/services delivered in potentially segregated settings	Day/employment services delivered in potentially segregated settings
Adult foster care	Adult day services
Assisted living residence (customized living service)	Day training and habilitation center
Board and lodge (includes homeless shelters)	Family adult day services
Board and lodge with special services	Pre-vocational service
Boarding care	Structured day program
Child foster care	Supported employment services
Children's residential care (children's residential facilities- Rule 5)	
Crisis respite (foster care)	

[4] U.S. Department of Housing and Urban Development, 2013 Continuum of Care Homeless Populations and Subpopulations Report (See www.hudexchange.info/reports/CoC_PopSub_NatlTerrDC_2013.pdf).

Residential settings/services delivered in potentially segregated settings	Day/employment services delivered in potentially segregated settings
Housing with services establishment	
Supervised living facilities	
Supported living services	

Data analysis

Residential services/settings

Figure 2: Residential settings by age and gender, fiscal year 2014

	Setting	Recipient	Age Group 0-13	Age Group 14-18	Age Group 19-26	Age Group 27-35	Age Group 36-64	Age Group 65+	Gender Female	Gender Male
MAXIS	Adult Foster Care	873	-	30	198	161	444	40	413	460
	Boarding Care	521	-	4	63	67	368	19	231	290
	Board and Lodge	3,070	-	36	616	758	1,627	33	765	2,305
	Board and Lodge w/ Special Serv	5,003	-	76	817	1,021	3,017	72	1,207	3,796
	Homeless Shelter	4,715	-	79	890	1,034	2,683	29	1,308	3,407
	Housing w/ Services Establ	2,690	-	21	340	401	1,832	96	920	1,770
	Supervised Living Facility	1,046	-	17	257	257	508	7	371	675
	Unduplicated	**10,562**	**-**	**152**	**1,804**	**2,079**	**6,281**	**246**	**3,132**	**7,430**
Claims	Adult Foster Care	5,318	-	97	910	813	2,821	677	2,255	3,063
	Assisted Living	2,610	-	-	38	62	945	1,565	1,685	925
	Assisted Living w/ 24 Hr Care	8,282	-	-	43	98	1,264	6,877	6,017	2,265
	Child Foster Care	187	55	124	8	-	-	-	62	125
	Crisis Respite	188	34	30	64	25	33	2	56	132
	Children's Residential Care	462	221	241	-	-	-	-	174	288
	Supported Living Services	10,470	45	225	1,510	2,079	5,657	954	4,468	6,002
	Unduplicated	**27,517**	**355**	**717**	**2,573**	**3,077**	**10,720**	**10,075**	**14,717**	**12,800**
Total Unduplicated		**38,079**	**355**	**869**	**4,377**	**5,156**	**17,001**	**10,321**	**17,849**	**20,230**

- A total of 38,079 individuals resided in other potentially segregated setting at some point during fiscal year 2014.
    - Of the GRH-only recipients, the largest group (47 percent) was in Board and Lodge with Special Services facilities. Of those with MA claims, the largest group (30 percent) was in Assisted Living with 24 hour care.
- Of the total, 72 percent were over the age of 35.
- Of the total number in all settings combined, nearly 47 percent were female; however, among the GRH-only recipients 70 percent were male.

Figure 3: Residential settings by race/ethnicity, fiscal year 2014

	Setting	Recipient	Race White	Race Black	Race Am Indian	Race Asian	Race Pac Island	Race Hispanic	Race 2+	Race Unknown
MAXIS	Adult Foster Care	873	697	89	29	25	2	15	6	10
	Boarding Care	521	391	82	12	11	1	14	4	6
	Board and Lodge	3,070	1,858	805	153	45	4	84	50	71
	Board and Lodge w/ Special Serv	5,003	3,048	1,256	324	60	2	133	77	103
	Homeless Shelter	4,715	2,375	1,653	322	51	4	129	90	91
	Housing w/ Services Establ	2,690	1,196	1,207	147	18	1	66	27	28
	Supervised Living Facility	1,046	666	228	59	15	4	27	22	25
	Unduplicated	**10,562**	**6,300**	**2,895**	**599**	**141**	**11**	**271**	**147**	**198**
Claims	Adult Foster Care	5,318	4,533	344	137	91	6	91	38	78
	Assisted Living	2,610	2,263	173	38	59	-	26	6	45
	Assisted Living w/ 24 Hr Care	8,282	7,458	308	69	91	2	54	13	287
	Child Foster Care	187	116	24	13	1	-	14	12	7
	Crisis Respite	188	126	32	5	9	-	7	4	5
	Children's Residential Care	462	278	54	53	2	-	29	31	15
	Supported Living Services	10,470	9,528	424	181	123	1	109	26	78
	Unduplicated	**27,517**	**24,302**	**1,359**	**496**	**376**	**9**	**330**	**130**	**515**
Total Unduplicated		**38,079**	**30,602**	**4,254**	**1,095**	**517**	**20**	**601**	**277**	**713**

- Of individuals residing in other potentially segregated setting, blacks were overrepresented (11 percent versus 6 percent of Minnesota's entire population). This disparity increased in the GRH-only group, where 27 percent were black.
- American Indians were overrepresented among those residing in Children's Residential Care and Board and Lodge with Special Services (11 percent and 6 percent, respectively, versus 1 percent of Minnesota's entire population).

Figure 4: Residential settings by diagnosis, fiscal year 2014

	Setting	Recipient	Acquired Cognitive Disability	Austism Spectrum Disorder	Blind	IDD	Deaf	Hard of Hearing	Mental Illness	SMI	SPMI	Substance Abuse
MAXIS	Adult Foster Care	873	611	111	11	365	5	243	808	245	204	469
	Boarding Care	521	387	14	1	77	1	127	517	190	142	449
	Board and Lodge	3,070	2,017	64	3	157	3	544	2,695	633	447	2,736
	Board and Lodge w/ Special Serv	5,003	3,500	95	11	265	-	979	4,563	944	660	4,540
	Homeless Shelter	4,715	3,286	79	8	191	-	916	4,238	778	493	4,260
	Housing w/ Services Establ	2,690	1,928	41	6	147	-	596	2,432	260	158	2,310
	Supervised Living Facility	1,046	845	52	2	86	-	260	1,037	575	490	967
	Unduplicated	**10,562**	**7,304**	**298**	**28**	**914**	**9**	**2,177**	**9,534**	**1,958**	**1,418**	**9,053**
Claims	Adult Foster Care	5,318	4,675	918	124	2,814	25	2,163	5,180	1,538	1,148	3,164
	Assisted Living	2,610	2,203	77	57	518	13	1,006	2,112	282	193	1,026
	Assisted Living w/ 24 Hr Care	8,282	7,280	119	179	966	17	2,665	6,511	408	277	2,100
	Child Foster Care	187	146	85	6	109	-	79	187	116	93	29
	Crisis Respite	188	134	125	1	186	2	85	181	30	6	24
	Children's Residential Care	462	309	119	1	78	-	165	459	424	414	155
	Supported Living Services	10,470	8,049	3,452	311	10,417	123	5,899	9,762	604	45	1,417
	Unduplicated	**27,517**	**22,796**	**4,895**	**679**	**15,088**	**180**	**12,062**	**24,392**	**3,402**	**2,176**	**7,915**
Total Unduplicated		**38,079**	**30,100**	**5,193**	**707**	**16,002**	**189**	**14,239**	**33,926**	**5,360**	**3,594**	**16,968**

- Individuals with an Intellectual/Developmental Disability were more likely to have an MA claim than were GRH-only recipients (55 percent versus 9 percent).
- Individuals with substance abuse issues were more likely to be GRH-only recipients (86 percent versus 28 percent of those with MA claims).
- Nearly all of the GRH-only recipients living in a Boarding Care facility had some history of mental illness, and 21 percent had a serious mental illness.

Figure 5: Residential settings by mobility, fiscal year 2014

	Setting	Recipient	No Impairment	Walks Aided (i.e. walker)	Uses Wheelchair	Not Mobile	Unknown
MAXIS	Adult Foster Care	873	369	81	30	13	380
	Boarding Care	521	291	15	2	-	213
	Board and Lodge	3,070	362	59	28	7	2,614
	Board and Lodge w/ Special Serv	5,003	655	117	23	5	4,203
	Homeless Shelter	4,715	433	98	20	6	4,158
	Housing w/ Services Establ	2,690	307	117	17	7	2,242
	Supervised Living Facility	1,046	285	30	6	1	724
	Unduplicated	**10,562**	**1,791**	**353**	**88**	**26**	**8,304**
Claims	Adult Foster Care	5,318	3,520	723	576	498	1
	Assisted Living	2,610	833	1,286	327	164	-
	Assisted Living w/ 24 Hr Care	8,282	1,849	3,500	2,137	796	-
	Child Foster Care	187	170	1	15	1	-
	Crisis Respite	188	113	70	4	-	1
	Children's Residential Care	462	81	1	1	-	379
	Supported Living Services	10,470	5,868	3,861	624	110	7
	Unduplicated	**27,517**	**12,434**	**9,442**	**3,684**	**1,569**	**388**
Total Unduplicated		**38,079**	**14,225**	**9,795**	**3,772**	**1,595**	**8,692**

- 40 percent of individuals residing in other potentially segregated setting were assessed to have some sort of mobility impairment (15,162 individuals), indicating a *potential* need for a physically accessible unit.
- Nearly half of the individuals receiving assisted living services were assessed to need assistance with walking.

Figure 6: Residential settings by income source, fiscal year 2014

	Setting	Recipient	Earned Income	Unearned Income	Earned or Unearned Income	Income Unknown	Unearned Subgroup: RSDI	Unearned Subgroup: SSI	Unearned Subgroup: RSDI or SSI	Unearned Subgroup: Other
MAXIS	Adult Foster Care	873	384	614	728	145	421	284	601	50
	Boarding Care	521	87	369	421	100	269	157	366	19
	Board and Lodge	3,070	842	733	1,495	1,575	407	380	656	200
	Board and Lodge w/ Special Serv	5,003	1,075	1,368	2,378	2,625	797	726	1,278	299
	Homeless Shelter	4,715	1,046	995	2,045	2,670	469	600	900	286
	Housing w/ Services Establ	2,690	345	784	1,095	1,595	380	481	700	135
	Supervised Living Facility	1,046	262	479	681	365	272	289	462	65
	Unduplicated	**10,562**	**2,426**	**3,524**	**5,491**	**5,071**	**2,082**	**1,867**	**3,297**	**607**
Claims	Adult Foster Care	5,318	2,197	4,966	5,238	80	3,707	2,049	4,959	229
	Assisted Living	2,610	209	2,503	2,598	12	2,214	598	2,501	93
	Assisted Living w/ 24 Hr Care	8,282	317	7,917	8,256	26	7,478	1,125	7,915	333
	Child Foster Care	187	16	86	119	68	23	73	86	28
	Crisis Respite	188	64	156	170	18	64	117	156	14
	Children's Residential Care	462	12	184	280	182	84	124	184	92
	Supported Living Services	10,470	7,626	10,043	10,430	40	8,025	3,834	10,030	342
	Unduplicated	**27,517**	**10,441**	**25,855**	**27,091**	**426**	**21,595**	**7,920**	**25,831**	**1,131**
Total Unduplicated		**38,079**	**12,867**	**29,379**	**32,582**	**5,497**	**23,677**	**9,787**	**29,128**	**1,738**

- Around one-third of individuals residing in other potentially segregated setting reported some amount of earned income.
- 26 percent (9,787 individuals) reported only receiving income from SSI. The maximum monthly benefit for SSI is $721; hence, people who receive SSI are likely to have limited ability to afford housing in the community.
- An additional 20 percent (10,968 individuals) were General Assistance recipients. This group has even less income. The General Assistance benefit for individuals living in the community is $203 per month.

Figure 7: Residence by region, fiscal year 2014

	Setting	Recipient	1 North West	2 Head-waters	3 Arrow-head	4 West Central	5 North Central	6 South West Central	7 East Central	8 South West	9 South Central	10 South East	11 Twin Cities	Unkn	Frontier
MAXIS	Adult Foster Care	873	2	14	56	18	15	10	241	8	45	133	318	13	4
	Boarding Care	521	3	1	9	4	5	4	70	1	1	25	396	2	3
	Board and Lodge	3,070	4	7	142	65	90	46	159	39	75	336	2,076	31	7
	Board and Lodge w/ Special Serv	5,003	20	19	615	111	129	51	278	54	108	246	3,338	34	29
	Homeless Shelter	4,715	8	18	326	76	44	28	166	13	39	229	3,707	61	9
	Housing w/ Services Establ	2,690	3	9	111	14	39	4	37	1	58	41	2,363	10	1
	Supervised Living Facility	1,046	11	14	68	19	7	29	67	30	32	35	722	12	9
	Unduplicated	**10,562**	**37**	**54**	**833**	**191**	**204**	**100**	**676**	**87**	**258**	**669**	**7,361**	**92**	**44**
Claims	Adult Foster Care	5,318	107	134	470	469	199	231	637	135	261	505	2,166	4	56
	Assisted Living	2,610	105	64	268	230	146	142	170	49	151	234	1,046	5	37
	Assisted Living w/ 24 Hr Care	8,282	134	141	1,162	404	317	235	829	148	489	920	3,499	4	71
	Child Foster Care	187	6	1	26	14	8	8	27	9	14	11	62	1	6
	Crisis Respite	188	1	1	6	8	2	3	18	-	-	7	142	-	-
	Children's Residential Care	462	9	26	103	27	13	24	59	11	41	28	120	1	4
	Supported Living Services	10,470	286	163	920	520	338	505	856	396	587	1,253	4,643	3	174
	Unduplicated	**27,517**	**648**	**530**	**2,955**	**1,672**	**1,023**	**1,148**	**2,596**	**748**	**1,543**	**2,958**	**11,678**	**18**	**348**
Total Unduplicated		**38,079**	**685**	**584**	**3,788**	**1,863**	**1,227**	**1,248**	**3,272**	**835**	**1,801**	**3,627**	**19,039**	**110**	**392**

- Half (50 percent) of individuals residing in other potentially segregated setting were in the Twin Cities Metro Area.
- Of GRH-only recipients, however, nearly three-quarters (70 percent) were in the Twin Cities Metro Area.

Figure 8: Unduplicated provider count by setting/service type (residential), fiscal year 2014

Residential setting/service	Unduplicated provider count
Adult Foster Care (MMIS)	1,074
Adult Foster Care (MAXIS)	491
Assisted living Residence (customized living service)	664
Assisted living Residence (24-hour customized living service)	1,047
Board and Lodge	173
Board and Lodge w/ Special Services	167
Boarding Care	18
Child Foster Care	91
Children's Residential Care (Children's Residential Facilities-Rule 5)	69
Crisis Respite (Foster Care)	18
Housing w/ Services Establishment	992
Supervised Living Facility (SLF)	31
Supported Living Services	708

Day/employment services

Figure 9: Service utilization by age, fiscal year 2014

	Setting	Recipient	Age Group 0-13	Age Group 14-18	Age Group 19-26	Age Group 27-35	Age Group 36-64	Age Group 65+
Day	Adult Day Center	5,782	0	6	119	140	1271	4246
	Day Training & Habilitation	10,135	0	34	1940	2383	5134	644
	Family Adult Day Servcies	46	0	0	2	0	6	38
	Prevocational Services	2,556	0	23	539	461	1464	69
	Structured Day Program	182	0	0	13	39	123	7
	Supported Employment Services	2,827	0	15	719	721	1324	48
	Unduplicated	20,055	0	70	3033	3411	8557	4984

- The data pull included people of all ages and therefore included older Minnesotans using long-term supports and services whose need for those services may have resulted from conditions acquired as they aged and/or conditions that were disabling, independent of their aging.

Figure 10: Service utilization by diagnosis, fiscal year 2014

	Setting	Recipient	Acquired Cognitive Disability	Austism Spectrum Disorder	Blind	IDD	Deaf	Hard of Hearing	Mental Illness	SMI	SPMI	Substance Abuse
Day	Adult Day Center	5,782	4,780	232	129	1,338	32	2,724	5,043	261	160	1,230
	Day Training & Habilitation	10,135	7,302	3,363	287	10,135	124	5,352	9,095	394	13	963
	Family Adult Day Servcies	46	39	-	-	6	-	18	44	3	2	10
	Prevocational Services	2,556	2,175	557	66	1,733	34	1,104	2,449	596	400	1,261
	Structured Day Program	182	181	28	1	121	1	65	177	13	6	100
	Supported Employment Services	2,827	2,195	826	39	2,242	12	1,182	2,645	455	284	1,115
	Unduplicated	20,055	15,461	4,634	497	14,467	194	9,788	18,066	1,466	698	4,084

- Individuals may have more than one diagnosis so these are not unduplicated counts. The service called day training and habilitation is only covered under the Developmental Disabilities waiver, so everyone receiving that service had that diagnosis. Individuals may have had additional diagnoses, as well.

Figure 11: Service utilization by source of income, fiscal year 2014

	Setting	Recipient	Earned Income	Unearned Income	Earned or Unearned Income	Income Unknown	Unearned Subgroup: RSDI	Unearned Subgroup: SSI	Unearned Subgroup: RSDI or SSI	Unearned Subgroup: Other
Day	Adult Day Center	5,782	427	4944	5663	119	2036	3371	4933	717
	Day Training & Habilitation	10,135	8079	9794	10127	8	7395	4165	9785	300
	Family Adult Day Servcies	46	6	42	44	2	19	26	42	2
	Prevocational Services	2,556	2229	2445	2550	6	1839	956	2443	80
	Structured Day Program	182	121	175	182	0	139	65	175	7
	Supported Employment Services	2,827	2483	2669	2824	3	2122	925	2665	94
	Unduplicated	20,055	12008	18666	19919	136	12437	9022	18641	1156

- The chart shows only the source of income, not the amount of income. The 'earned income' category does not distinguish between competitive employment and earnings at sub-minimum wages.
- Individuals could have multiple sources of income so counts are not unduplicated, unless specified.

Figure 12: Service utilization by living arrangement, fiscal year 2014

	Setting	Recipient	Home	Family Foster Care	Corp Foster Care	ICF-DD	NF	Board and Lodge	Housing with Services	Corr Facility	Hospital	Unknown
Day	Adult Day Center	5,782	4,656	119	597	3	80	116	185	-	9	17
	Day Training & Habilitation	10,135	2,879	582	6,549	29	32	2	-	-	-	62
	Family Adult Day Servcies	46	36	-	5	-	1	4	-	-	-	-
	Prevocational Services	2,556	1,022	153	1,147	1	29	92	80	1	10	21
	Structured Day Program	182	36	4	118	-	3	12	9	-	-	-
	Supported Employment Services	2,827	1,423	155	1,090	1	23	53	43	-	6	33
	Unduplicated	20,055	9,427	937	8,814	34	158	248	291	1	25	120

Figure 13: Unduplicated provider count by service type (day/employment), fiscal year 2014

Day/employment services	Unduplicated provider count
Adult day services center (EW) & Adult Day Care	229
Family adult day services setting	14
Structured Day Program	57
Day Training and Habilitation center	246
Pre-Vocational Service	177
Supported Employment Services (SES)	187

Targets and timelines

There are initiatives across the state agencies to support people moving to more integrated settings. While some are smaller in scale and targeted, others are larger and geared to systems-level changes. The systems changes take longer to implement and longer to see results, and will ultimately have a larger impact. The smaller projects will impact the lives of individuals quickly.

The targets given here set a base, but do not limit the number of people that can move. As strategies outlined in the Olmstead Plan, and reforms by DHS are implemented, such as those to promote community living and employment options, shift provider business models, peer mentoring to share their stories of moving to homes of their own or working, manage waiver resources differently, and support experiential learning of options to inform choice, momentum will build, needed community capacity and infrastructure will expand, and increasingly more people every year will seek and obtain community living and employment options.

The ability to transition people to more integrated settings will be affected by the availability of resources to support this work. The DHS will assess progress annually and will adjust targets as necessary to incent movement to the most integrated community living and employment.

These are targets for the settings identified in this report, and do not reflect targets that have been set elsewhere for Anoka Metro Regional Treatment Center, the Minnesota Security Hospital in St. Peter, Intermediate Care Facilities for Developmental Disabilities and nursing facilities.

These are some of the strategies the state is pursuing to reduce the number of people in segregated settings.

Residential interventions

- Continuing moratoriums on development of new ICF-DDs and corporate adult foster care beds
- Reforms to the Group Residential Housing (GRH) and Minnesota Supplemental Assistance (MSA) programs
- Expansion of Housing Access Services
- Technology grants to assist people in developing ways to use technology to support them in the homes and to otherwise meet their needs and goals
- Local planning grants to counties to develop alternatives to corporate foster care
- Providing technical assistance to service providers
- Quality improvement processes
- Transition protocols
- New and modified services
- Changes in payment for services
- HCBS transition plan

Day services interventions

- Working with school districts (Minnesota Department of Education to lead effort)
- Continue to develop and promote the use of Disability Benefits 101 (DB101), a benefits and work planning tool
- Provide technical assistance to providers
- Family outreach

- Develop opportunities for youth work experiences
- New and modified services
- Changes in payment for services
- HCBS transition plan
- Developing standards and managing capacity for day services

Figure 14: Targets and timelines for "other segregated settings"

RESIDENTIAL SETTINGS TARGETS	DAY SETTINGS TARGETS
In SFY 2015 Without additional resources: 50	In SFY 2015 Without additional resources: 50
In SFY 2016 Without additional resources: 125	In SFY 2016 Without additional resources: 150
In SFY 2017 Without additional resources: 300	In SFY 2017 Without additional resources: 200
In SFY 2018 Without additional resources: 350	In SFY 2018 Without additional resources: 500
In SFY 2019 Without additional resources: 400	In SFY 2019 Without additional resources: 500

Appendix A: Analysis of State Plans from Massachusetts, Oregon and Rhode Island

KEY ELEMENTS LEADING TO COMPETITIVE, COMMUNITY SUPPORTED EMPLOYMENT and COMMUNITY-BASED DAY SUPPORT SERVICES:

A Summary of Rhode Island, Oregon and Massachusetts State Reform Initiatives

KEY ELEMENTS LEADING TO COMPETITIVE, COMMUNITY SUPPORTED EMPLOYMENT and DAY SUPPORT SERVICES REFORM	RI Settlement Agreement	OR Governors Executive Order *(Lawsuit Pending)*	MASS Blue Print For Success
Response to U.S.D.O.J. litigation of Title II-ADA, Olmstead.	Y (reactive)	Y (preemptive)	Y (proactive)
Response to CMS' HCBS Final Rule Regulation and Requirements.	Y (reactive)	N	Y (proactive)
Parties Involved in the Plan.	Human Services, VR & Education	ODHS-ODDS, ODE & ODVR	MADDS, MASS ARC MA Provider Org.
Develop and conduct a comprehensive, statewide educational outreach campaign directed at state and local government agencies, providers, schools, people with disabilities and their families.	Y	Y	Y
Close new referrals to congregate, segregated sheltered workshops and facility-based day service programs providers.	Y	Y	Y
Discontinue the purchase of congregate, segregated sheltered workshop services and facility-based day services.	Y	N	Y (within 5 years)
Require providers to convert from congregate, segregated sheltered workshop programs and facility-based day service providers to community-based, competitive employment service providers and day support service providers.	Y	N	Y
Provide comprehensive training, business consultation, strategic planning and technical assistance support to providers on redesigning services and restructuring organizations to convert from congregate, segregated sheltered workshop programs and facility-based day service providers into individualized, community-integrated employment service providers and individualized, community-integrated day support service providers.	Y	Y	Y
Adopt Employment First Policy, and align all provider service and support practices with Employment First Policy.	Y	Y	Y
Create a financial system or service rate structure that incentivizes integrated, community-based, competitive employment services, supports and outcomes.	Y	Y	Y
Develop transition or action plans for people to move from congregate, segregated sheltered workshops and facility-based day service programs to individualized, community-based, competitive employment services and supports or individualized, community-based day services and supports.	Y	Y	Y
Design and implement a community-based, competitive employment services and support plan that gradually phases out special/subminimum wage work and increases minimum wage or higher jobs for people.	Y (Variances are allowable)	N	Y
Construct a comprehensive, compendium of community-based services and supports that produce an individualized employment plan for assessing, exploring, acquiring and maintaining community-based, competitive employment.	Y	Y	Y
Construct a set of community-based services and supports that assist people in other supportive activities such as transportation training, learning independent living skills, teaching personally-effective social skills, recreation and leisure assistance.	Y	N	Y
Identify and implement services and supports for transition age school students and young adults that produce individualized employment plans for assessing, exploring, acquiring and maintaining community-based, competitive employment as well as other supportive activities that assist with life skills instruction.	Y	Y	N
Build a comprehensive employment database system to track community-based, competitive employment and progress on system reforms.	Y	Y	Y

Establish and finance oversight positions that monitor outcomes and quality.	Y	Y	Y
Fund system transformation by converting existing funding, which supports congregate, segregated sheltered workshops programs and facility-based day service, to support individualized, community-based employment service and individualized, community-integrated day support services.	Y	Y	Y
Fund system reform and transformation initiatives with increased state dollars to possibly receive matched by federal financial participation money.	Y	N	Y

RHODE ISLAND

RHODE ISLAND SETTLEMENT

(Rhode Island Consent Decree)

BACKGROUND

On January 14, 2013, the United States Department of Justice initiated an investigation into whether the State has violated Title II of the Americans with Disabilities Act and Olmstead v. L.C. through its administration and operation of its day activity services system, including employment, vocational, and sheltered workshop day services for individuals with intellectual and developmental disabilities.

FINDINGS

1.) Approximately 80 percent of the people with I/DD (about 2,700 individuals)receiving state services are placed in segregated, sheltered workshops or congregate, facility-based, day service programs.
2.) Only about 12 percent (approximately 385 people) participate in individualized, community-integrated employment.
3.) Only about five percent of students with disabilities transitioned into jobs in community-integrated settings.
4.) Placement in segregated settings is frequently permanent:

A.) nearly half (46.2 percent) of the individuals in sheltered workshops have been in that setting for ten years or more, and

B.) over one-third (34.2 percent) have been there for fifteen years or more.

5.) Individuals with I/DD in sheltered workshops reportedly earn an average of about $2.21 per hour.

AGREEMENTS and ACTIONS

1.) Permanently stop placements and funding into sheltered workshops and facility-based, day service programs.
2.) On a scheduled basis, conduct supported employment placements of about 2,000 individuals between January 2015 and January 2024, including:

A.) at least 700 people currently in sheltered workshops;

B.) at least 950 people currently in facility-based non-work programs; and

C.) approximately 300-350 students leaving high school.

3.) Adults transitioning to supported employment services (SES) will receive:

A.) Person-centered career planning process that includes asset-based vocational assessments such as discovery, situational assessments and time-limited, trial work exploration experiences;

B.) Supports Intensity Scale ("SIS") assessment;

C.) Benefits analysis and planning;

D.) Medicaid Buy-In program information and counseling; and an

E.) array of other vocational services and supports to ensure that they have meaningful opportunities to live and work in the community (***Appendix # 1, item # 1***).

4.) School youth in transition (ages 14 – 21 years old), approximately 1,250 students, will receive:

A.) Person-centered, individual learning plans;

B.) Person-centered, school-to-work transition career plans;

C.) Integrated vocational and situational assessments including discovery, vocational assessment, situational assessment and time-limited trial work exploration experiences; and an

D.) array of other transitional services and supports to ensure that they have meaningful opportunities to live and work in the community after they exit school (***Appendix # 1, item # 2***).

5.) SES placement in community integrated employment settings must:

A.) pay at least minimum wage;

B.) allow the person to work the maximum number of hours consistent with their abilities and preferences;

C.) allow the person interact with peers without disabilities to the fullest extent possible;
D.) average 20 hours of work per week in integrated employment settings;
E.) allow access to community-integrated work and non-work day services and supports for a total of 40 hours per week; and
F.) receive transportation and other direct (face-to-face) and indirect (not-face-to-face) employment services and supports.

6.) Supported employment placements cannot be in group job enclaves, mobile work crews and time-limited work experiences.
7.) No vocational or situational assessments shall be conducted in segregated, sheltered workshops and congregate day service program settings.
8.) Employer-sponsored training or provider-subsidized trial work exploration experiences can only occur for 4 – 8 weeks prior to job placement.
9.) Work compensated by any other entity than the employer of record will not qualify as a job placement.
10.) Community-integrated, (non-work) day services and supports shall not be services provided as part of a sheltered workshop, day services facility, group home, or residential program service provider.
11.) Develop an informational outreach campaign for schools and the general public that educates about the benefits of supported employment, and addresses families' concerns about supported employment.
12.) Create an employment first advocacy task force of local stakeholders, advocacy organizations, business networks, individuals with I/DD and family representatives for oversight and monitoring.
13.) Develop Interagency MOU Collaboration Agreements among human services, VR and education.
14.) Adopt an Employment First Policies and presumptions that all people with disabilities can competitively work at jobs in the community given proper services and support.
15.) Variances to SES placements can occur if the eligible person:

A.) makes a voluntary, informed choice for placement in a group work arrangement (e.g., enclaves, crews, etc.), segregated sheltered workshop facility, congregate day services program;
B.) receives one vocational or situational assessment;
C.) receives one trial work exploration experience, except when a documented medical condition poses an immediate and serious threat to their health or safety, or the health or safety of others;
D.) receives outreach educational information and counseling about SES;
E.) receives benefits planning;
F.) annual re-assessment for SES; and
G.) elects an integrated day supports-only placement in lieu of a SES placement.

FUNDING and FINANCING PROJECT INITIATIVES

1.) Establish a Sheltered Workshop Conversion Institute and Trust Fund ($800,000) to assist providers of sheltered workshop services to convert to SES.
2.) Pursue and fund a contract for training and technical assistance vendors to provide leadership, competency and value based training and TA to state staff, employment, sheltered workshop and day service providers.
3.) Reallocate financial resources now spent on segregated sheltered workshop and congregate day service programs to instead fund SE and/or community-integrated day services. Allow funding to follow the person without an increase in cost (maintaining budget neutrality).
4.) Develop and implement performance-based contracts for SES providers to meet goals and objectives.
5.) Provide ongoing funding sources to sufficiently support a competent and qualified system of providers with the capacity to deliver effective SES and Integrated Day Services.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

1.) Identify information and data elements to measure and collect for the U.S. DOJ and the court monitor:

A.) number of individuals in segregated sheltered workshop programs, congregate day services facilities, group job enclaves, mobile work crews and time-limited trial work exploration experiences

B.) number of completed career development plans

C.) number of individuals referred to and receiving SES

D.) number of transition youth exiting or graduating from school with career planning goals, and where they are transitioning to following their graduation or exit from school

E.) number and client capacity of supported employment providers

F.) number of qualified and trained SES professionals

G.) number of qualified and trained vocational counselors and assessment professionals

H.) number of hours worked per week, hourly wages paid, and job tenure in a community integrated employment setting

I.) number and reason(s) for lost jobs and/or terminations from employment along with plans for re-employment

J.) number and client capacity, hours per week, and tenure within community integrated day services providers, including the number of individuals participating in Integrated Day-Only Services

K.) number of variances granted

L.) number of outreach educational information campaign efforts performed

2.) Public reports to the U.S. DOJ and the selected court monitor on identified information and data elements also include:

A.) findings and results of regularly conducted on-site reviews of converting sheltered workshops and day service programs;

B.) identified program service provider deficiencies and required corrective action plans;

C.) employment service and support outcomes and recommendations; and

D.) compliance with the consent decree

Appendix # 1: Services and Supports

1. Vocational services and supports

job discovery and development, job-finding, job carving, job coaching, job training, job shadowing, co-worker and peer supports, reemployment supports, benefits planning and counseling, transportation services, environmental modifications and accessibility adaptations, behavioral supports, personal care services, case management services, assistive technology, social skills training, self-exploration, career exploration, career planning and management, job customization, time management training, self-employment opportunities and supports, adaptive behavior and daily living skills training.

2. Transitional services and supports

career instruction, employment preparation training, school-based preparatory job experiences, integrated work-based learning experiences, business site visits, job shadowing, work skill development, internships, part-time employment, summer employment, youth leadership, self-advocacy, peer and adult mentoring, living skills training, teaching community services, post-secondary school educational opportunities, transportation instruction, benefits planning, and assistive technology.

Appendix # 2: Supported Employment and Integrated Day Services Placements Schedule

Rhode Island Sheltered Workshop and Rhode Island Youth Exit Target Populations

a. By January 1, 2015, the State will provide Supported Employment Placements to at least 50 individuals in the Rhode Island Youth Exit Target Population who left during the 2013-2014 school year.

b. By July 1, 2015, the State will provide Supported Employment Placements to all remaining individuals in the Rhode Island Youth Exit Target Population who left, or will leave, school during the 2013-2014 and 2014-2015.

c. By January 1, 2016, the State will provide Supported Employment Placements to at least 50 individuals in the Rhode Island Sheltered Workshop Target Population.

d. By July 1, 2016, the State will provide Supported Employment Placements to all individuals in the Rhode Island Youth Exit Target Population who left school during the 2015-2016 school year.

e. By January 1, 2017, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.

f. By January 1, 2018, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.

g. By January 1, 2019, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Sheltered Workshop Target Population.

h. By January 1, 2020, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

i. By January 1, 2021, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

j. By January 1, 2022, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

k. By January 1, 2023, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

l. By January 1, 2024, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Sheltered Workshop Target Population.

Rhode Island Day Target Population

a. By January 1, 2016, the State will provide Supported Employment Placements to at least 25 individuals in the Rhode Island Day Target Population.

b. By January 1, 2017, the State will provide Supported Employment Placements to at least an additional 25 individuals in the Rhode Island Day Target Population.

c. By January 1, 2018, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Day Target Population.

d. By January 1, 2019, the State will provide Supported Employment Placements to at least an additional 50 individuals in the Rhode Island Day Target Population.

e. By January 1, 2020, the State will provide Supported Employment Placements to at least an additional 75 individuals in the Rhode Island Day Target Population.

f. By January 1, 2021, the State will provide Supported Employment Placements to at least an additional 100 individuals in the Rhode Island Day Target Population.

g. By January 1, 2022, the State will provide Supported Employment Placements to at least an additional 200 individuals in the Rhode Island Day Target Population.

h. By January 1, 2023, the State will provide Supported Employment Placements to at least an additional 200 individuals in the Rhode Island Day Target Population.

i. By January 1, 2024, the State will provide Supported Employment Placements to at least an additional 225 individuals in the Rhode Island Day Target Population.

OREGON

OREGON EXECUTIVE ORDER
(Oregon Executive Order)

BACKGROUND

On January 25, 2012, the first class action lawsuit case in the nation that challenges sheltered workshops as a violation of the integration mandates in Title II of the Americans with Disabilities Act and Olmstead v. L.C was filed. The case, ***Lane v. Kitzhaber***, was filed on behalf of eight named plaintiffs who are:

1.) stuck in sheltered workshops;
2.) spending years, and often decades in these congregate, segregated settings;
3.) qualified and prefer to work at real jobs in the community; and
4.) often paid less than a $1.00/hour for their labor in the workshops.

The class action lawsuit case is brought on behalf of thousands of similarly situated and qualified persons with disabilities placed in Oregon's sheltered workshop system. The class action lawsuit case seeks an injunction to require the State of Oregon, and its' Department of Human Services, to end the segregation of persons with intellectual and development disabilities, and to assist them in obtaining integrated employment opportunities with supported employment services. The case is pending and proceeding to court, unless a settlement can be reached.

FINDINGS

1.) In October 2011, the United States Department of Justice concluded via a lengthy investigation that the State of Oregon has violated Title II of the Americans with Disabilities Act and Olmstead v. L.C. by funding, structuring, and administering its disability employment services system in a manner that segregates persons with intellectual and developmental disabilities in sheltered workshops.

2.) The U.S. DOJ determined that segregated workshops constitute an ADA violation and a Rehabilitation Act violation, and that the state's employment service system must be reformed in order to expand integrated employment opportunities.

3.) The DOJ claims that Oregon's disability employment service system perpetuates segregation of individuals with disabilities by unduly relying upon sheltered workshops rather than providing employment services in integrated settings, thus causing the unnecessary segregation of individuals who are capable of, and not opposed to, working at jobs in the community.

4.) 2,691 persons receive employment and vocational services. 1,642 – 61% – received at least some of those services in sheltered workshops. By contrast, only 422, or less than 16%, of these persons received services at any time in individual supported employment settings.

5.) The average hourly wage for sheltered workshop participants is currently $3.72. Over 52% of participants earn less than $3.00 per hour. By contrast, the overwhelming majority of persons with disabilities in individual supported employment earn Oregon's minimum wage of $8.80 or above.

6.) The DOJ recommended that Oregon implement certain remedial measures, including the development of sufficient supported employment services to enable those individuals who are unnecessarily segregated, or at risk of unnecessary segregation, in sheltered workshops to receive services in individualized, integrated employment settings in the community.

7.) The DOJ determined that voluntary compliance was not possible after months of negotiations to reach a settlement and avoid litigation.

OREGON GOVERNOR'S EXECUTIVE ORDER (July 1,2013) – AN UNSUCCESSFUL REMEDY

1.) The Oregon Department of Human Services (ODHS) and the Oregon Department of Education (ODE) shall work together to further improve Oregon's systems of designing and delivering employment services to those with intellectual and developmental disabilities.

2.) Oregon will make significant reductions in state support for sheltered work over time.
3.) Oregon will make increased investments in employment services and supports for people with disabilities.
4.) Employment services will be provided immediately to working age people with I/DD who receive sheltered workshop services. Employment services shall be individualized and evidence-based or recognized as effective practices.
5.) Employment services will be provided immediately to transition age young adults (@ 16 – 23). Employment services shall be individualized and evidence-based or recognized as effective practices.
6.) Individualized employment Services shall be based on an individual's capabilities, choices, and strengths.
7.) ODDS and OVRS will provide Employment Services to at least 2000 individuals in the ODDS/OVRS Target Population, in accordance with a schedule (please refer to Appendix 1).
8.) ODDS shall adopt and implement policies and procedures for developing individualized career development plans. The policies will include a presumption that all individuals in the ODDS/OVRS are capable of working in an integrated employment setting. The primary purpose of all vocational assessments shall be to determine an individual's interests, strengths, and abilities, in order to identify a suitable match between the person and an integrated employment setting.
9.) By January 1, 2014, ODDS and OVRS will establish competencies for the provision of Employment Services, and will adopt and implement competency-based training standards for career development plans, job creation, job development, job coaching, and coordination of those services.
10.) By July 1,2016, ODDS and OVRS will purchase Employment Services for people with I/DD only from agencies or individual providers that are licensed, certified, credentialed or otherwise qualified as required by Oregon Administrative Rule. Such requirements for the provision of Employment Services will be competency-based and may include national credentialing programs as the APSE Certified Employment Support Professional exam or a substantial equivalent.
11.) By January 1, 2014, ODDS and OVRS will develop an outreach informational education campaign for all people receiving services from ODDS/OVRS that explains the benefits of employment, addresses family and perceived obstacle concerns to participating in employment services.
12.) Through a developed MOU agreement, ODE will partner with OVRS and ODDS to establish and implement a Statewide Transition Technical Assistance Network to assist high schools in providing Transition Services.

FUNDING and FINANCING PROJECT INITIATIVES

1.) By July 1, 2014, Oregon will no longer purchase or fund vocational assessments for individuals with I/DD that occur in sheltered workshop settings.
2.) By July 1, 2015, Oregon will no longer purchase or fund ***NEW*** sheltered workshop placements.
3.) State agencies will make good faith efforts, within available budgetary resources, to ensure that there are a sufficient number of qualified employment providers to deliver the services and supports necessary for individuals in the ODDS/OVRS system to receive competent employment services.
4.) By January 1, 2014, DHS will financially support new or existing technical assistance provider(s) or use other available training resources to provide leadership, training and technical assistance to counties, employment service providers, support service providers, and vocational rehabilitation staff.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

1.) By July 1, 2014, DHS will develop and implement a quality improvement initiative that is designed to promote Employment Services and to evaluate the quality of Employment Services provided to persons with I/DD.
2.) Starting January 1, 2014, an appointed State Employment Coordinator (as of 10/2013) and a newly formed Policy Review Committee (as of 07/2013) will monitor progress semi-annually through data

collection, data analysis, quality improvement activities and make annual recommendations to the Governor and legislature for performance improvements.

3.) Starting January 1, 2014, and semi-annually thereafter, ODDS and OVRS shall collect data and report to the Employment Coordinator and the Policy Review Committee data for working age individuals that will include:

- **a.** The number of individuals receiving Employment Services;
- **b.** The number of persons working in the following settings: individual integrated employment, self-employment, sheltered employment, and group;
- **c.** The number of individuals working in an integrated employment setting;
- **d.** The number of hours worked per week and hourly wages paid to those persons;
- **e.** The choices made by individuals between integrated work, sheltered work, and not working;
- **f.** Problems or barriers to placement and retaining employment in community-integrated settings;
- **g.** Service gaps;
- **f.** Complaints and grievances.

Appendix # 1: Services and Supports

a. By July 1, 2014, ODDS and/or OVRS will provide Employment Services to at least 50 individuals.

b. By July 1, 2015, ODDS and/or OVRS will provide Employment Services to at least an additional 100 individuals.

c. By July 1, 2016, ODDS and/or OVRS will provide Employment Services to at least an additional 200 individuals.

d. By July 1, 2017, ODDS and/or OVRS will provide Employment Services to at least an additional 275 individuals.

e. By July 1, 2018, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

f. By July 1, 2019, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

g. By July 1, 2020, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

h. By July 1, 2021, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

i. By July 1, 2022, ODDS and OVRS will provide Employment Services to at least an additional 275 individuals.

Massachusetts

MASS. - Blueprint for Success: Employing Individuals with Intellectual Disabilities in Massachusetts

BACKGROUND

In response to recent United States Department of Justice (DOJ) litigation regarding Title II of the Americans with Disabilities Act and Olmstead v. L.C. , and CMS' "HCBS Final Rule" requirements regulating size and settings of non-residential service settings; a group of Massachusetts (MA) disability service providers, advocates, and the Department of Developmental Services (DDS) examined day and employment support service programs for adults with intellectual disabilities (ID). As a result of their analysis, the Massachusetts Association of Developmental Disabilities (ADDP), the Arc of Massachusetts, and the Massachusetts Department of Developmental Services (DDS) entered into a proactive plan to increase community-integrated competitive employment opportunities for people with intellectual disabilities (ID). The plan emphasizes the importance and benefits of having a job and contributing to community businesses through work.

ACTION STEPS

1.) Inform providers that purchasing sheltered workshop services will discontinue within five years.
2.) Require providers to submit business plans on how they are going to increase community-integrated, competitive employment and phase out sheltered workshop services.
3.) Require providers to make concerted efforts to assist people to enter into community-based, supported employment (individual or group), and re-structure their programs into employment services.
4.) Define and align all provider service practices with Employment First Policy.
5.) Develop, establish and implement a new standardized services rate structure that incentivizes integrated, community-based, supported employment (individual or group) services and outcomes (please refer to Appendix 2).
6.) Close new referrals to sheltered workshop programs as of January 1, 2014 as a first step to phase out by June 30, 2015.
7.) During fiscal year 2015, individuals currently in sheltered workshop programs will gradually transition into individual supported employment, group supported employment, and/or community-based day services (CBDS) programs (please refer to Appendix 1). Facility-based, day training and habilitation will only be a service option when it has been determined the most appropriate service option for the person.
8.) Increase the number of people who participate in community integrated individual and group supported employment that pays minimum wage or higher in fiscal years 2016, 2017 and 2018. Gradually phase out group employment settings that pay less than minimum wage.
9.) Expand the scope of CBDS programs to include service options with a career exploration/planning component to serve as a pathway to employment through use of a variety of different volunteer, internships (e.g., Project Search), situational assessments/discovery opportunities, skills training or other community-based experiences. Continue to transition individuals from CBDS into community-integrated work opportunities that pay minimum wage or higher. The CBDS model will also be used to provide complementary supports for individuals who work part-time and need and want to be engaged in structured, program services for the remainder of the work week.
10.) Develop and implement a common framework for a planning and assessment process that allows informed choice as an integral part of the development of a person-centered career plan.
11.) Recruit and fund state advocacy organizations to develop and conduct a comprehensive, statewide educational outreach campaign directed at people with disabilities and their families that includes informational resources, regional forums, family-to-family connection groups and peer support groups.
12.) Create via appointment an Employment First review council to facilitate implementation and monitor ongoing progress of the transition plan.

TRAINING AND SYSTEM DEVELOPMENT

1.) Engage in business consultation, strategic planning and technical assistance to providers on redesigning services and restructuring organizations to convert from congregate and segregated, sheltered workshops into individualized, community-integrated employment services and support provider, including Community-Based Day Services (CBDS).

2.) Develop comprehensive training for employment specialists/job developers with curriculum and field work experiences that are aligned with credentialing //certification entities for employment specialist professionals.

3.) Design educational material and resources for benefits analysis, planning and work incentives.

4.) Produce training on (a) career exploration and discovery approaches; (b) customized job development; (c) systematic instruction techniques, (d) working with specific populations; (e) technology on the job, and (f) other relevant topic areas to be identified.

5.) Create communities of practice that provide in-service learning courses.

6.) Conduct Peer-to-Peer learning sessions for providers to work together on common issues.

7.) Build and fund a coalition of regional employment collaboratives across the state to maximize resources, share best practices, share lessons learned, conduct macro-level job development and provide opportunities for partnership among state agencies, employment service provider organizations and employers. Central Massachusetts Employment Collaborative uncovered over 248 employment opportunities and 136 individuals with disabilities were hired at minimum wage or higher by businesses in the community.

8.) Draft a comprehensive MOU agreement that cooperatively collaborates and coordinates inter-agency responsibilities, resources, services and funding to achieve a unified effort toward getting youth and adults competitively employed in the community.

9.) UMass-Boston ICI will establish a consultant pool consisting of individuals and/or qualified organizations as subject matter experts and technical advisors.

FUNDING and FISCAL STRATEGY (please refer to Appendix #2)

1.)* A total investment of $26.7 million over four fiscal years, from 2015 through 2018 is projected.

2.) Cost analyses are based on the number of people who are receiving facility-based, sheltered workshop services on a full-time basis or part-time basis as of July 1, 2013. The total number of individuals participating in sheltered workshop services is 2,608: 1,251 attend sheltered workshops full-time (typically 30 hours/week) and 1,357 attend part-time (52%).

3.) An investment of new funding is needed to provide resources and opportunities for people to move from sheltered workshop services (rate = $8.42/hour) to individual (rate = $47.96/hour) or group (rate = $13.80/hour) supported employment, and/or CBDS programs (rate = average $12.92/hour). These services have higher rates due to service design and staffing ratio requirements. The incremental infusion of new funding provides a "bridge" to new service options for individuals currently receiving sheltered workshop services.

Important Note: The net cost to the state would only be approximately $13 million dollars due to Medicaid HCBS waiver reimbursement via federal financial participation at almost 50%. for these services.

DATA COLLECTION, MONITORING and QUALITY ASSURANCE

With UMass – Boston ICI, continue to develop and implement an employment outcome data collection system that:

1.) effectively records and reports relevant information and data on new job placements and movement within the service system in order to track and document progress; and

2.) informs the planning processes and transformation initiatives.

Appendix # 1: Services Descriptions

Center-Based Work Services (activity code 3169)
Center-based work services ("sheltered workshops") are essentially work preparatory services that are delivered in segregated settings and that provide supports leading to the acquisition, improvement, and retention of skills and abilities that prepare an individual for work and community participation. Services are not predominantly job-task oriented, but are intended to address underlying generalized habilitative goals, such as increasing a participants attention span and completing assigned tasks, goals that are associated with the successful performance of compensated work. It is intended that the service should be time-limited to assist individuals to move into supported employment options. This service must be provided in compliance with Department of Labor (DOL) requirements for compensation.

Individual Supported Employment (activity code 3168)
An individual receives assistance from a provider to obtain a job based on identified needs and interests. Individuals may receive supports at a job in the community or in a self-employed business. Regular or periodic assistance, training and support are provided for the purpose of developing, maintaining and/or improving job skills, and fostering career advancement opportunities. Natural supports are developed by the provider to help increase inclusion and independence of the individual within the community setting. Employees should have regular contact with co-workers, customers, supervisors and individuals without disabilities and have the same opportunities as their non-disabled co-workers. Individuals are generally paid by the employer, but in some circumstances may be paid by the provider agency.

Group Supported Employment (activity code 3181)
A small group of individuals, (typically 2 to 8), working in the community under the supervision of a provider agency. Emphasis is on work in an integrated environment, with the opportunity for individuals to have contact with co-workers, customers, supervisors, and others without disabilities. Group Supported Employment may include small groups in industry (enclave); provider businesses/small business model; mobile work crews which allow for integration, and temporary services which may assist in securing an individual position within a business. Most often, the individuals are considered employees of the provider agency and are paid and receive benefits from that agency.

Community-Based Day Supports (activity code 3163)
This program of supports is designed to enable an individual to enrich his or her life and enjoy a full range of community activities by providing opportunities for developing, enhancing, and maintaining competency in personal, social and community activities. Services include, but are not limited to, the following service options: career exploration, including assessing interests through volunteer experiences or situational assessments; community integration experiences to support fuller participation in community life; skill development and training; development of activities of daily living and independent living skills; socialization experiences and support to enhance interpersonal skills; and pursuit of personal interests and hobbies. This service is intended for individuals of working-age who may be on a "pathway" to employment; as a supplemental service for individuals who are employed part-time and need a structured and supervised program of services during the day when they are not working, which may include opportunities for socialization and peer support; and individuals who are of retirement-age and who need and want to participate in a structured and supervised program of services in a group setting.

Appendix # 2: Funding and Fiscal Strategy

FY 2014: This is an important planning year to conduct assessments and develop plans with individuals in sheltered workshop programs to determine which alternative service option(s) will best meet their needs.

FY 2015: The largest investment is needed this year to facilitate transition to individual or group supported employment, and/or to CBDS programs for **all** participants in center-based/sheltered workshops. It is expected a majority of individuals will initially move to CBDS programs, which will provide opportunities to explore work-related possibilities. This will enable DDS to reach the goal of phasing out sheltered workshop services and removing the concern of sub-minimum wage payments related to sheltered work programs by June 30, 2015. (Proposed investment: $11.1 million; Net state cost: 5.55 million).

FY 2016: It is expected that a larger number of individuals will move to individual or group supported employment options this year from CBDS programs. In addition, funding will provide participation in CBDS for individuals who work part-time. (Proposed investment: $6.3 million; Net state cost: $3.15 million).

FY 2017: There will be continued movement of individuals from CBDS programs to individual and/or group supported employment services to provide integrated employment opportunities for all individuals who had previously been participating in sheltered workshop programs. (Proposed investment: $8.3 million; Net state cost: $4.15 million).

FY 2018: The final year of investment is used to solidify gains made in integrated employment services for individuals in CBDS and also facilitate movement of individuals to group supported employment earning above minimum wage. (Proposed investment: $1 million; Net state cost: $500,000).

Results

- Ends the purchasing of sheltered workshop services and successfully transition individuals into other employment or service options by the end of fiscal year 2015.
- Eliminates sub-minimum wage payments used by sheltered workshops.
- This funding investment would support individuals to:
  - (a) obtain community-integrated, competitive jobs through individualized supported employment services, and
  - (b) facilitate movement of individuals in group supported employment to earning minimum wages or higher.
- Develops an employment services provider network and system of supports that are more responsive in meeting the needs of people with ID.
- Establishes a system of inclusive employment and day service options that support people with disabilities in competitive, community employment and life pursuits.

Appendix B: Service and settings definitions

Residential Setting/Service	Description
Adult foster care	Licensed, living arrangement that provides food, lodging, supervision, and household services. They may also provide personal care and medication assistance. Adult foster care providers may be licensed to serve up to four adults or five adults if all foster care residents are age 55 or older, have no serious or persistent mental illness, nor any developmental disability. There are two types of adult foster care: Family Adult Foster Care is an adult foster care home licensed by the Minnesota Department of Human Services. It is the home of the license holder and the license holder is the primary caregiver. Non-Family Adult Foster Care (Corporate Adult Foster Care) is an adult foster care home licensed by the Minnesota Department of Human Services that does not meet the definition of Family Adult Foster Care because the license holder does not live in the home and is not the primary caregiver. Instead, trained and hired staff generally provide services. The same foster care license requirements apply to both family and non-family homes. BI, CAC and CADI waiver recipients may use waiver services of adult foster care when the scope of services assessed and identified in the service plan exceeds the scope of services provided through the foster care payment rate paid from the person's assessed resources and the Group Residential Housing rate.
Assisted living residence	Assisted Living residences generally combine housing, support services, and some kind of health care. Individuals who choose assisted living can customize the services they receive to meet their individual needs. To be considered an assisted living residence, the facility must provide or make available, at a minimum, specified health-related and supportive services. Examples include: assistance with self-administration of medication or administration of medication, supervised by a registered nurse; two meals daily; daily check system; weekly housekeeping and laundry services; assistance with three or more activities of daily living (dressing, grooming, bathing, eating, transferring, continence care, and toileting); and assistance in arranging transportation and accessing community and social resources. Every assisted living facility must have a license from the Minnesota Department of Health in order to operate
Board and lodge	Board and Lodge vary greatly in size, some resemble small homes and others are more like apartment buildings. They are licensed by the Minnesota Department of Health (or local health department). Board and lodges provide sleeping accommodations and meals to five or more adults for a period of one week or more. They offer private or shared rooms with a private or attached bathroom. Substance abuse - Board and Lodge can provide housing for up to six months for clients who need stable supportive housing, and strives to provide its residents with additional support services, including Peer Support Services, yet many of these additional services are not currently reimbursable. Often, the client will reside in a "Sober House" while at the same time receive outpatient services from another provider. Homeless shelters are a subset of board and lodge facilities.
Board and lodge with special services	Many Board and Lodge facilities offer a variety of supportive services (housekeeping or laundry) or home care services (assistance with bathing or medication administration) to residents
Boarding care	Boarding Care homes are licensed by the Minnesota Department of Health and are homes for persons needing minimal nursing care. They provide personal or custodial care and related services for five or more older adults or people with disabilities. They have private or shared rooms with a private or attached bathroom. There are common areas for dining and for other activities.
Child foster care	Children under the age of 18 - BI, CAC and CADI waiver recipients may use the waiver service of child foster care when the scope of services assessed and identified in the service plan exceeds both the scope of services provided in the Out of Home Placement Plan and the payment rate that the lead agency is required to cover.
Children's residential care (Children's residential facilities – Rule 5)	Children's residential facilities standards (Minnesota Rules, Chapter 2960) govern the licensing of providers of residential care and treatment or detention or foster care services for children in out-of-home placement. These standards contain the licensing requirements for residential facilities and foster care and program certification requirements for program services offered in the licensed facilities. Statutory language defines "certification" as meaning the commissioner's written authorization for a license holder licensed by the Commissioner of Human Services or the Commissioner of Corrections to serve children in a residential program and provide specialized services based on certification standards in Minnesota Rules. The term "certification" and its

	derivatives have the same meaning and may be substituted for the term "licensure" and its derivatives.
Crisis respite (foster care)	Short-term care and intervention strategies to an individual for both medical and behavioral needs that support the caregiver and/or protect the person or others living with that person. Crisis respite services may be provided: • In-home or • Out-of-home in a specialized licensed foster care facility developed for the
Housing with services establishment	Generally apartment building settings with individual units. Family adult day services must meet standards in Minn. Stat. §245A.143 or Minn. R. 9555, parts 5105 to 6265. If you hold a license as an adult foster care provider and meet the family adult day services standards, DHS does not require you to obtain a separate family adult day services license.
Supervised living facilities	Group home setting serving five or more people with disabilities. SLF provides supervision, lodging, meals, counseling, developmental habilitation or rehabilitation services under a Minnesota Department of Health license to five or more adults who have a developmental disability, chemical dependency, mental illness, or a physical disability.
Supported living services	Developmental disability waiver services provided in a foster care setting are called Supported Living Services (SLS) under Residential Habilitation. Residential Habilitation: Services provided to a person who cannot live in his or her home without such services or who need outside support to remain in his or her home. Habilitation services are provided in the person's residence and in the community, and should be directed toward increasing and maintaining the person's physical, intellectual, emotional and social functioning.
Employment/Day Service/Setting	
Adult day services/Adult day care	Adult day services /Adult day care: Services provided to persons who are 18 years of age or older that are designed to meet the health and social needs of the person. The plan identifies the needs of the person and is directed toward the achievement of specific outcomes.
Family adult day services	A family adult day service program is a program that operates fewer than 24 hours per day and provides functionally impaired adults, none of which is under age 55, have serious or persistent mental illness or people with developmental disabilities or a related condition, with an individualized and coordinated set of services including health services, social services and nutritional services that are directed at maintaining or improving the participants' capabilities for self-care. A family adult day services license is only issued when the services are provided in the license holder's primary residence, and the license holder is the primary provider of care. The license holder may not serve more than eight adults at one time, including residents, if any, served under an adult foster care license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.
Structured day program	Service designed for persons who may benefit from continued rehabilitation and community integration directed at the development and maintenance of community living skills. (Only available through the Brain Injury waiver.)
Day training & habilitation	Licensed supports to provide persons with help to develop and maintain life skills, participate in community life and engage in proactive and satisfying activities of their own choosing.
Pre-vocational service	Services designed to prepare persons for paid or unpaid employment, as reflected in the plan of care.
Supported employment services	Services for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, needs intensive ongoing support to perform in a work setting. The person receiving services must be in a paid employment situation.

Minnesota Department of Education

A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools

Fiscal Year 2015

Report

To the

Legislature

As required by

Minnesota Statutes,

section 125A.0942

COMMISSIONER:

Brenda Cassellius, Ed. D.

February 1, 2015

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2015

Report to the Legislature

As required by Minnesota Statutes section 125A.0942

A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools

Cost of Report Preparation

The total cost for the Minnesota Department of Education (MDE) to prepare this report was approximately $20,000. Most of these costs involved staff time in compiling and analyzing data, staffing the stakeholder group, and preparing the written report. Incidental costs include paper, copying, and other office supplies.

Estimated costs are provided in accordance with Minnesota Statute, section 3.197, which requires that at the beginning of a report to the Legislature, the cost of preparing the report must be provided.

TABLE OF CONTENTS

INTRODUCTION

The Minnesota Legislature tasked MDE with developing a statewide plan "with specific and measurable implementation and outcome goals for reducing the use of restrictive procedures."[1] MDE has submitted reports to the Legislature in 2012, 2013, and 2014, providing summary data of prone restraint and restrictive procedures along with its progress and recommendations for reducing the use of restrictive procedures and eliminating the use of prone restraints.

We commend the reporting school districts for their commitment and candor in their submission of the required data to MDE. For the 2013-14 school year, MDE received responses from all public school districts and charter schools. For the 2012-13 school year, MDE received responses from all but one traditional school district and five charter schools. Data collected for the 2012 and 2013 legislative reports was submitted in varying forms by districts until statutory changes required that districts/charter schools use a form developed by MDE. Thus, data collected and reported after July 1, 2012, represents a consistent reporting format.

2012-2013 Stakeholder Work Group

MDE convened a restrictive procedures work group (2012 stakeholder group) during the 2012-13 school year, as charged by the Minnesota Legislature. The 2012 stakeholder group included representatives from the following legislatively mandated participants: school districts, school boards, special education directors, intermediate school districts, and advocacy organizations. The 2012 stakeholder group met on five occasions between September 2012 and January 2013 to review restrictive procedures data and discuss areas of agreement about how to reduce the use of restrictive procedures.

The statewide plan generated by the 2012 stakeholder group is set forth in the 2013 legislative report available on MDE's website.[2] The 2012 stakeholder group recommended 10 activities in the statewide plan and also recommended legislative changes to the restrictive procedure statutes. During the 2013 legislative session, most of the recommended changes, including extending the date for use of prone restraints to August 1, 2015, were passed by the Legislature. However, the Legislature did not authorize the requested appropriation funds targeted for use with students with disabilities experiencing the highest frequency of restrictive procedures, specifically prone restraints. "Prone restraint" means placing a child in a face down position.[3] As described more fully below, the 2014 Legislature authorized $250,000 in state funds targeted for use with those students.

Summary of Progress toward Implementing the 2012 Statewide Plan

During the 2013 legislative session, safe school levy funds were increased effective fiscal year 2015, and language was added to the levy fund statute to allow its use for co-locating and collaborating with mental health professionals who are not staff or contracted as staff. In

[1] Minn. Stat. § 125A.0942, subd. 3(b).

[2] See 2013 "The Use of Prone Restraint in Minnesota Schools," *available at* http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html

[3] Minn. Stat. § 125A.0941(e).

addition, the 2013 Omnibus Health and Human Services bill expanded the school-linked mental health grants program by $4.5 million for the 2014 and 2015 biennium.

During the 2013-14 school year, MDE provided training throughout the state on the changes to the restrictive procedures statutes and updated the sample forms on the MDE website. MDE also continued to work across the agency to develop a process for and to provide targeted technical assistance. In addition, MDE conducted a survey of school districts and met with the Department of Human Services (DHS) to assist in the development of an expert list. The list was posted on MDE's website in July 2014. Further, MDE continued to coordinate the school-wide positive behavior interventions and supports (PBIS) trainings across the state.

2013-2014 Stakeholder Work Group

MDE reconvened the restrictive procedure work group (2013 stakeholder group) during the 2013-14 school year, as charged by the Legislature. This group was tasked with developing a statewide plan with "specific and measurable implementation and outcome goals for reducing the use of restrictive procedures..."[4] The 2013 stakeholder group included representation from the following legislatively mandated participants: advocacy organizations, special education directors, teachers, intermediate school districts, school boards, day treatment providers, county social services, state human services department staff, mental health professionals, and autism experts.[5]

The 2013 stakeholder group met on four occasions between November 2013 and February 2014 to review the restrictive procedures data and discuss areas of agreement about how to reduce the use of restrictive procedures. The statewide plan that was generated by the 2013 stakeholder group contained eight goals and proposed amendments to Minnesota Statutes section 125A.0942.[6] As set forth in the 2013 statewide plan, the 2013 stakeholder group believed there was a need to continue to meet on a quarterly basis to review prone restraint data, review the annual data for restrictive procedures, review progress in implementing the goals, and discuss any needed changes.

Summary of Progress toward Implementing the 2013 Statewide Plan

During the 2014 legislative session, the Legislature passed the recommended changes, including the requested $250,000 in appropriation funds targeted for use with students with disabilities experiencing the highest frequency of restrictive procedures, specifically prone restraints.

During the summer of 2014, MDE began the process of developing a grant application targeted to seven districts who were using prone restraints and had students with disabilities experiencing the highest frequency of restrictive procedures; specifically prone restraint. Six districts submitted grant applications, and after a review and revision process, six grants totaling

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[4] Minn. Stat. § 125A.0942, subd. 3(b) (2013).

[5] *Id.*

[6] See Appendix A. of the 2014 legislative Report. available at http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html. (last visited Jan. 26, 2015).

$150,000 were approved. Each district is to complete their work under the grant by June 30, 2015. The six districts developed work plans to focus on one or more of the following areas to reduce the use of all restrictive procedures and eliminate the use of prone restraint:

- Consistent training to develop common language and standards for reporting restrictive procedures and clarify expectations;
- Keeping law enforcement calls for service stable as restrictive procedures are reduced and prone restraint is eliminated;
- Building staff capacity in the area of proactive behavior interventions to provide resources and targeted interventions to students with disabilities who have significant behavior challenges and mental health needs who are experiencing a high usage of restrictive procedures and a high usage of prone restraint;
- Increasing capacity related to data collection, understanding student behavior, using preventative and de-escalation strategies more consistently, and implementing interventions with fidelity, and
- Providing crisis services in the school setting to reduce the need for 911 calls and subsequent student hospitalization.

In addition, MDE developed a request for proposal (RFP) for three online training modules to address the three subsets of students with disabilities who experience the highest rate of prone restraint, as set forth in Goal No. 2(c) in the 2013 statewide plan. The RFP application deadline was January 15, 2015, and the MDE review should be completed by January 30, 2015. If MDE approves a RFP application, the three online training modules are to be completed by June 30, 2015.

In July 2014, MDE completed and posted the restrictive procedure expert list, after obtaining input from DHS and special education directors. This was a goal in the 2012 statewide plan and is also a goal in the Revised Olmstead Plan[7]. The list will continue to be edited as additional experts are identified and requests submitted to MDE for inclusion. In accordance with Goal No. 4 of the 2013 statewide plan, MDE collaborated with school districts, advocacy groups, and DHS and facilitated two panel discussions on the reduction of restrictive procedures to provide targeted assistance to districts continuing to use prone restraint. The first panel was held at MDE and the second panel discussion was held at DHS and district staff participated both in person and through a live video stream.

MDE has continued to coordinate the school-wide PBIS trainings across the state and is on track to add a minimum of 40 additional schools by June 30, 2014, and each subsequent year thereafter. At this time, 24 percent of all public schools in Minnesota have completed the positive behavior interventions and supports (PBIS) training. This is in accordance with Goal 6 of the 2013 Work Plan and a similar goal in the Revised Olmstead Plan.

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[7] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_documents. (last visited Jan. 26, 2015).

In addition, MDE updated and posted the "Use of Restrictive Procedures District Summary Form" in accordance with Goal 1(a) and the 2014 legislative amendment to Minnesota Statute section 125A.0942 subdivision 6. Additional Forms were updated and posted and MDE added links to DHS resources on its website. More detail is provided in Appendix A.

2014-2015 Stakeholder Work Group

MDE reconvened the restrictive procedure work group (2014 stakeholder group) during the 2014-15 school year as charged by the Legislature. This group continued to be tasked with developing a statewide plan with "specific and measurable implementation and outcome goals for reducing the use of restrictive procedures..."[8] The 2014 stakeholder group included representation from the following legislatively mandated participants: advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, state human services department staff, mental health professionals, and autism experts.[9] The 2014 stakeholder group met in September 2014 to review the data from the annual summary report for the 2013-14 school year and the prone restraint data for the quarter ending June 30, 2014. The 2014 stakeholder group continues to meet quarterly with meetings scheduled through July 2015 to review the prone restraint data. The statewide plan generated by the 2014 stakeholder group contains nine goals and proposed amendments to Minnesota Statutes, section 125A.0942. The current statewide plan reflects the consensus among the 2014 stakeholder group.

Summary of the Decreased Use of Restrictive Procedures in Minnesota Schools

In reviewing the data school districts submitted to MDE over the last three reporting periods, there has been a decrease in: the number of districts using restrictive procedures (including prone restraint), the number of students with disabilities experiencing the use of restrictive procedures, and the number of total restrictive procedure incidents.

A comparison of the last two reporting periods[10] demonstrates a reduction in the use of restrictive procedures during the 2013-14 school year, and a reduction in the use of prone restraint during the 2014 calendar year as follows:

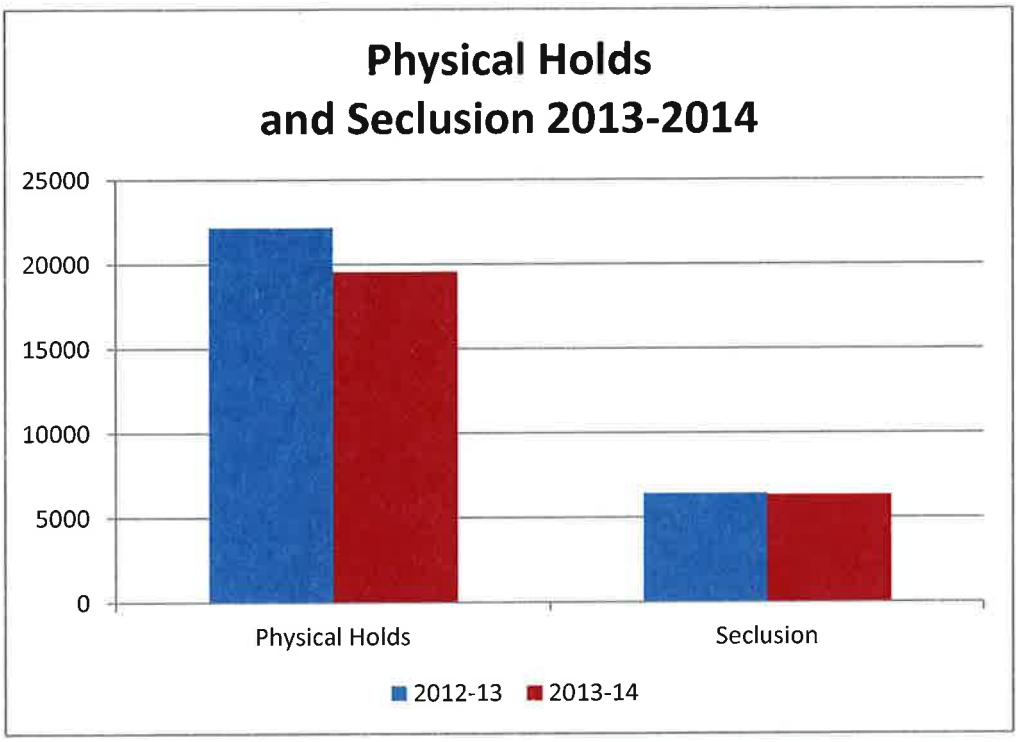
- 34 percent fewer incidents of prone restraint reported
- 12 percent fewer students with disabilities who experienced the use of prone restraint
- 19 percent fewer districts report the use of prone restraint
- 18 percent fewer Black students with disabilities experienced the use of prone restraint
- 9 percent fewer White students with disabilities experienced the use of prone restraint

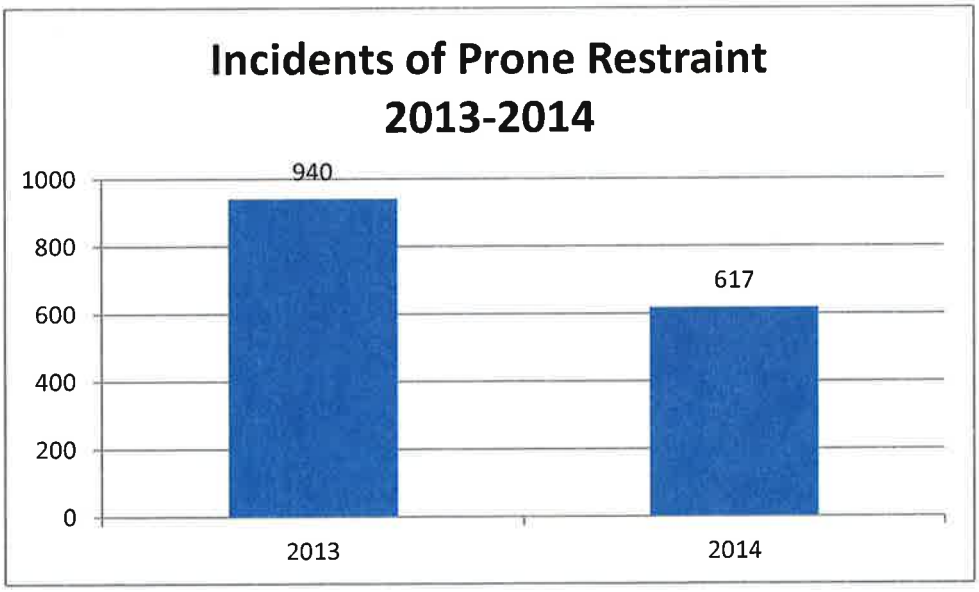
[8] Minn. Stat. § 125A.0942, subd. 3(b) (2014).

[9] *Id.*

[10] The reporting periods for restrictive procedures are 2012-13 and 2013-14. The reporting periods for prone restraint are the 2013 and 2014 calendar years.

- 16 percent fewer incidents of physical holding reported
- 2 percent fewer incidents of seclusion reported





HISTORY OF RESTRAINT IN MINNESOTA

There is an ongoing debate in Minnesota about the legality, morality, and efficacy of using seclusion[11] or restraint on individuals with disabilities. Some are concerned that these procedures are subject to misapplication and abuse, placing students at equal or greater risk than their problem behavior(s) pose to themselves or others.[12]

On February 1, 2012, MDE submitted a report to the Minnesota Legislature detailing the results of data on the use of prone restraint from August 1, 2011, through January 13, 2012.[13] MDE made important disclaimers about the quality of the data presented, which included the short reporting window, the lack of information about the use of other non/prone physical holding and seclusion, and inconsistency in reporting forms, with recommendations for improvements both in data reporting and in clarification regarding the use of restrictive procedures.

During the 2012 legislative session, Minnesota Statutes, sections 125A.0941 and 125A.0942, were amended to include a definition of prone restraint[14] and a revised definition of physical holding.[15] The statute limited the use of prone restraint to "children age five or older," but allowed its use until August 1, 2013,[16] and required districts to report the use of prone restraint on an MDE form.[17] Additionally, the Minnesota Legislature tasked MDE with developing a statewide plan "to reduce districts' use of restrictive procedures."[18] As noted above, MDE continued to collect data on prone restraint, gathered restrictive procedure summary data from districts for the 2011-12 school year, and assembled a group of stakeholders to assist MDE with developing a statewide plan.[19]

In February 2013, MDE submitted a report to the Minnesota Legislature that detailed the results of data collected on the use of prone restraint from January 14, 2012 through December 31, 2012. The report provided summary data on the use of all reported restrictive procedures in Minnesota during the 2011-12 school year and also provided MDE's progress and recommendations for reducing the use of restrictive procedures and eliminating the use of prone restraints.

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[11] Minnesota's restrictive procedures statute defines "seclusion" as "confining a child alone in a room from which egress is barred. Egress may be barred by an adult locking or closing the door in the room or preventing the child from leaving the room. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion." Minn. Stat. § 125A.0941(g) (2014).

[12] U.S. Senate, Health, Education, Labor, and Pensions Committee, *Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficulty to Remedy: A Review of Ten Cases* (Majority Staff Report, issued February 12, 2014), Majority Committee Staff Report. Retrieved from http://www.help.senate.gov/imo/media/doc/Seclusion%20and%20Restraints%20Final%20Report.pdf (last visited Jan. 26, 2015).

[13] For information related to the history of restraint in the educational setting prior to 2012, see 2012 and 2013 Legislative Reports, "The Use of Prone Restraint in Minnesota Schools," *available at* http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html.

[14] Minn. Stat. § 125A.0941(e) (2012).

[15] Minn. Stat. § 125A.0941(c) (2012).

[16] Minn. Stat. § 125A.0942, subd. 3(7) (2012).

[17] Minn. Stat. § 125A.0942, subd. 3(a)(7)(iv). (2012)

[18] Minn. Stat. § 125A.0942, subd. 3(b) (2012).

[19] *Id.*

During the 2013 legislative session, Minnesota Statutes, sections 125A.0941 and 125A.0942 were amended to provide more content specificity for the oversight committee for a district's restrictive procedure plan, clarified requirements for when an individual education plan (IEP) team meeting must be held following the use of a restrictive procedure, clarified that restrictive procedures can only be used in an emergency and not for disciplinary reasons, extended the time period for use of prone restraint until August 1, 2015, tasked MDE with developing a statewide plan to reduce the use of restrictive procedures, included paraprofessionals under the training section, added to the training requirements to ensure school staff are aware of school side positive behavior strategies used by the school and procedures related to timely reporting of the use of restrictive procedures, and required MDE to develop and maintain a list of experts to help IEP teams reduce the use of restrictive procedures.

In February 2014, MDE submitted a report to the Minnesota Legislature that detailed the results of data collected on the use of prone restraint from January 1, 2013 through December 31, 2013. The report provided summary data on the use of all reported restrictive procedures in Minnesota during the 2012-13 school year and also provided MDE's progress and recommendations for reducing the use of restrictive procedures and eliminating the use of prone restraints.

Regulation of Restraint in DHS Facilities

In 2011, DHS entered into a settlement agreement enforced by the federal court in Minnesota, regarding the inappropriate use of aversive and deprivation procedures, including the improper use of seclusion and restraint techniques. As part of the 2011 "METO Settlement,"[20] DHS is currently undertaking a rulemaking process to amend Minnesota Rules, Parts 9525.2700 to 9525.2810 (commonly referred to as "Rule 40"), to reflect best practices regarding the use of aversive and deprivation procedures in facilities that serve persons with developmental disabilities, including through the use of positive behavioral approaches and the elimination of particular restraint practices. On December 24, 2014, DHS published proposed rules.[21] A public hearing on the proposed rules is scheduled for February 23, 2015.

The Rule 40 Advisory Committee issued its final version of "Recommendations on Best Practices and Modernization of Rule 40" on July 2, 2013. To support the recommendations, DHS is holding Positive Supports Community of Practice meetings online on various training topics.[22]

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[20] METO Settlement, Case 0:09/cv/01775/DWF/FLN, Doc. 104/1, Attachment A, p. 5 (2011). Retrieved from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=137925. (last visited Jan. 26, 2015).

[21] Proposed Rules Governing Positive Support Strategies, Person-Centered Planning, Limits on Use of Restrictive Interventions and Emergency Use of Manual Restraint, and Repeal of Rules Governing Aversive and Deprivation Procedures in *Minnesota Rules*, 9525.2700 to 9525.2810; Revisor's ID No. R-04213.

[22] Minnesota Department of Human Services Positive Supports Community of Practice website, available at: http://mn.gov/dhs/partners-and-providers/continuing-care/provider-information/positive-supports/positive-support-cop.jsp (last visited Jan. 26, 2015).

As part of the 2011 Jensen stipulated class action settlement, the State of Minnesota agreed to develop an Olmstead Plan to move the state forward toward greater integration and inclusion for people with disabilities. The initial Olmstead Plan was submitted to Federal District Court (Court) on November 1, 2013. The State of Minnesota submitted Proposed Plan modifications to the Court, most recently on November 10, 2014 (Revised Olmstead Plan). On January 9, 2015, Justice Donovan Frank provisionally approved the State of Minnesota's Revised Olmstead Plan, subject to the Court's review of the State's modifications in accordance with the Order, which must be submitted by the State of Minnesota on March 20, 2015. As part of the Revised Olmstead Plan, MDE is responsible for two activities related to the elimination of the use of prone restraint in the public school setting by August 1, 2015, and reducing the use of restrictive procedures in the public school setting over the time period of June 30, 2015 to June 30, 2019.[23]

REGULATORY DEVELOPMENTS

Recent Minnesota Developments

During the 2014 legislative session, Minnesota Statutes, sections 125A.0941 through 125A.0942 were amended to:

- Provide more content specificity for a district restrictive procedure plan, by including a description of how the school will provide training on de-escalation techniques, consistent with Minnesota Statutes, section 122A.09, subdivision 4, paragraph (k);[24]
- Amend the date the legislative report is due and to make the workgroup ongoing; and
- Require districts to report the use of reasonable force, as defined in section 121A.582, which results in a physical hold as defined in section 125A.0941.25.

Federal Developments

The Keeping All Students Safe Act (H. 1893), legislation aimed at regulating restraint and seclusion on the federal level, was introduced in the United States House of Representatives by Representative George Miller on May 8, 2013, and the bill was referred to the Subcommittee on Early Childhood, Elementary, and Secondary Education.[26]

At a news conference on February 12, 2014, Senator Tom Harkin, Chairman of the Senate Health, Education, Labor, and Pensions (HELP) Committee, released the findings of an investigation into the use of seclusion and restraints. The majority staff report is titled, "Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficult to Remedy: A Review of Ten Cases." The report highlighted cases in which restraint was used as

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[23] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_home. (last visited Jan. 26, 2015).

[24] 2014 Minn. Laws ch. 1X, art. 17, sec. 1.

[25] *Id.*

[26] U.S. Library of Congress website http://beta.congress.gov/bill/113th-congress/house-bill/1893. (last visited Jan. 26, 2015).

a form of punishment or control.[27] At the event, Harkin announced the Keeping All Students Safe Act, a bill to ensure the effective implementation of positive behavioral interventions in the education setting. On February 24, 2014, the bill was introduced in the Senate, read twice, and referred to the Committee on HELP.

Currently, 40 states and the District of Columbia have legislation and/or education agency regulations or policies that prohibit the use of prone restraints or restraints that impede a child's ability to breathe within the school setting. Fifteen states specifically prohibit the use of "prone" restraint in educational settings by state statute, rule, or policy.[28]

Thirteen states specifically prohibit the use of prone restraint in educational settings by state statute, rule, or policy. In addition, 29 states have legislation and/or education agency regulations or policies that encompass all students, rather than only students with a disability. This is in accordance with Principle Four in the U.S. Department of Education, Office of Special Education and Rehabilitation Services (USDE OSERS) guidance document issued May 15, 2012, *Restraint and Seclusion: Resource Document*.[29]

Only four states (Vermont, Massachusetts, Rhode Island, and Minnesota) prohibit the use of restraints that impede a child's ability to breathe and specifically allow the use of prone restraint in limited circumstances. Appendix B contains a citation to and a description of the provisions in place for each state addressing restrictive procedures.

MINNESOTA'S PRONE RESTRAINT DATA

Important Disclaimers Regarding the Data

Reporting Window. School districts have been statutorily required to report to MDE regarding their use of prone restraint since August 1, 2011. As described in the 2012 report, the initial data only covered prone restraint reports received over a five-month period (August 1, 2011 through January 13, 2012). The 2013 report included data from prone restraint reports received January 13, 2012, through December 31, 2012. For the 2014 and 2015 reports, the included data on the use of prone restraint is over a 12 month calendar period (January 1 through December 31), with relevant comparisons to previous years' data. Beginning in September 2012, Districts have been required to use the MDE form for reporting prone restraint and the data has been more consistent since that occurred.

Not the Whole Picture. We acknowledged in prior reports that the use of prone restraint is best evaluated within the context of the statewide use of all other types of restrictive procedures by

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[27] U. S. Senate, Health, Education, Labor, and Pensions Committee, *Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficult to Remedy: A Review of Ten Cases*, Majority Committee Staff Report (Feb. 12, 2014), Retrieved at http://www.help.senate.gov/imo/media/doc/Seclusion%20and%20Restraints%20Final%20Report.pdf. (Last visited Jan. 26, 2015).

[28] Arkansas, District of Columbia, Georgia, Indiana, Iowa, Kansas, Kentucky, Michigan, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, West Virginia, Wyoming.

[29] U.S. Department of Education, Office of Special Education and Rehabilitation Services guidance document, *Restraint and Seclusion: Resource Document* (Issued May 15, 2012), Retrieved *at* https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf. (Last visited Jan. 26, 2015).

Minnesota school districts. Districts are required to maintain data on their use of restrictive procedures, including physical holding or seclusion,[30] and are required to report a summary of this data annually to MDE by June 30 of each year.[31] As summary data, the restrictive procedures data has some limitations not present with the prone restraint data. The summary data necessarily lacks information about the range of numbers of physical holds and uses of seclusion per individual student. The data also lacks information about the length of time students were physically held and secluded and the types of restraints being used.

Limitations in the Restrictive Procedures Data

We received close to or a 100 percent response rate from all public school districts, including charter schools, for the last two school years (2012-13 and 2013-14). It is important to note that the number of restrictive procedure incidents that districts reported in the annual summary may not be aligned with MDE's definition of an "incident" of restrictive procedure, as discussed below. Therefore, incident level comparisons between restrictive procedures incidents and prone restraint report incidents are not likely to be valid. However, as a result of the summary data, we are able to provide policy makers with data to substantiate the percentage of students in the state that have been reported as restricted compared to the data specific to prone restraint.

Outliers. For the 2014 calendar year, one student accounted for 11 percent, or 53 of the 489 reports of prone restraint. Cumulatively, five students account for 24 percent, or 116 of the 489 reports, and 10 students accounted for 35 percent, or 173 of the 489 reports. The remaining 148 students accounted for 65 percent of the reports. These figures are similar to outliers for data collected in prior years.[32]

Of those students who experienced the highest use of prone restraint during the 2014 calendar year, they were found eligible for special education services by meeting state criteria for Autism Spectrum Disorders (five), Emotional or Behavioral Disorders (two), Other Health Disabilities (two) and Developmental Cognitive Disability (one).

Including these unique situations in the overall data counts skews the appearance of the demographic data by incidents. However, this data is important for understanding the issues and potential solutions. The data illustrates that a relatively small number of students underlie the total number of reports and incidents. Though the specific students who make up this group change over time, intensive services targeted to these students are likely to have the greatest impact on diminishing the use of restrictive procedures.

Prone Restraint Data

Districts submitted written prone restraint reports to MDE through a secure website. Individual reports necessarily included personally identifying information related to specific students, and as such constitute non-releasable data under the Minnesota Government Data Practices Act.[33]

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[30] Minn. Stat. § 125A.0942, subd. 3(a).

[31] Minn. Stat. § 125A.0942, subd. 3(b).

[32] See prior Legislative Reports, *available at* http://education.state.mn.us/MDE/Welcome/Legis/LegisRep/index.html.

[33] Minn. Stat. § 13.02, subds. 5, 8a (2014).

MDE prepared and posted a summary of reported data by quarter on its Restrictive Procedures webpage.

Districts that Reported Use of Prone Restraint

District	2014 Reports	2013 Reports
Albert Lea (840)	1	0
Bemidji (31)	0	2
Benton-Stearns Ed. Dist. (6383)	57	72
Brainerd (181)	6	1
Buffalo-Hanover-Montrose (877)	0	2
Cambridge-Isanti (911)	1	0
Goodhue County Ed. Dist. (6051)	2	0
Hendricks (402)	0	2
Intermediate District 287	55	83
Intermediate District 917	137	218
Mankato (77)	23	36
Marshall (413)	0	12
Moorhead (152)	11	15
New London Spicer (345)	1	0
Northeast Metro 916	119	74
Pine City (578)	0	9
Southwest West Central (991)	74	85
Waterville-Elysian-Morristown (2143)	0	1
West Central Area (2342)	0	1
Willmar (347)	2	35
Total Prone Restraint Reports	**489**	**647**

Incidence of Prone Restraint by District

For the purposes of reporting, we consider prone restraint to begin when the child is placed in a prone position by one or more trained staff persons holding onto the child; it ends when the child is no longer being held. That cycle—a hold followed by the release of the hold—is one incident of prone restraint.

In more complex situations related to the same precipitating incident, this hold/release pattern was repeated a number of times before the child was returned to the classroom or other activity. Given that the statutory definition of a "physical hold" is based on the presence or absence of "body contact" or "physical contact," we determined that this situation involved several incidents

of prone restraint, all of which were included on one written report. This explains the difference between the number of "incidents" that occurred (617) and the number of "reports" MDE received (489).

MDE received reports of 617 prone restraint incidents that occurred during the 2014 calendar year, a substantial decrease from the 940 prone restraint incidents reported for calendar year 2013. During the 2014 calendar year:

- 13 districts reported the use of prone restraint, a decrease of 19 percent from 16 during calendar year 2013.[34]
- 158 students were restrained in a prone position by a staff member, a decrease of 12 percent from 180 students during calendar year 2013.

The majority of both prone restraint incidents and reports involved students at one of Minnesota's three intermediate school districts. This is not surprising given that the intermediate districts provide, among other important services, a program of integrated services for special education students.[35] As a rule, the intermediate districts provide services to students with disabilities who have not experienced success at their original district, and a significant percentage of these students exhibit atypical behavioral challenges in a school setting. Two of the three intermediate districts continued to show a decrease in both the number of reports and incidents of prone restraint from the previous legislative report. One intermediate district showed a year-over-year increase, though it was still down substantially from the 2012 report. At the stakeholder meetings, the intermediate districts shared the efforts made to implement data-driven positive behavior strategies and to review the restrictive procedures data on an ongoing basis, as well as staffing and environmental changes.

With the exception of the intermediate district described above and one independent school district, all other districts with reported use of prone restraint in calendar year 2013 showed a year-over-year decrease, some to zero for calendar 2014. In addition, four districts reported use of prone restraint in calendar year 2014, though no use was reported in the prior year. The use of prone restraint in greater Minnesota continues to be mostly reported by special education programs at cooperatives or education districts and districts that are regional centers. In greater Minnesota, these programs and districts function similarly to the intermediate school districts in the Twin Cities metropolitan area, in part, by serving students with the most challenging behaviors.

The following two charts represent the distribution of both prone restraint incidents and reports for the last two annual reporting periods. Statewide, the number of reports submitted, incidents reported, and students involved, and the number of districts using prone restraint during the 2014 calendar year have all decreased compared to the 2013 data, though, on a district level, two districts reported increases.

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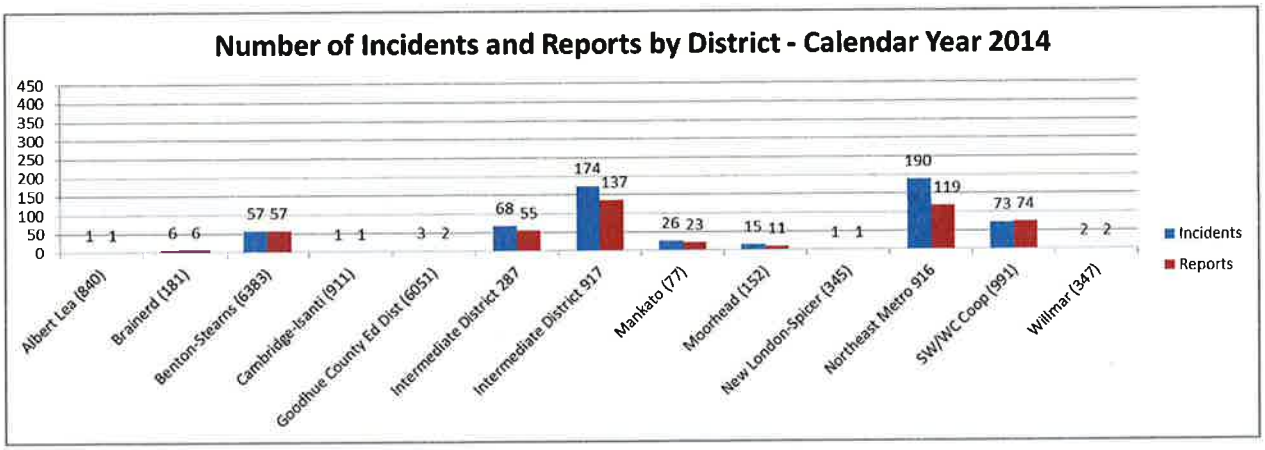
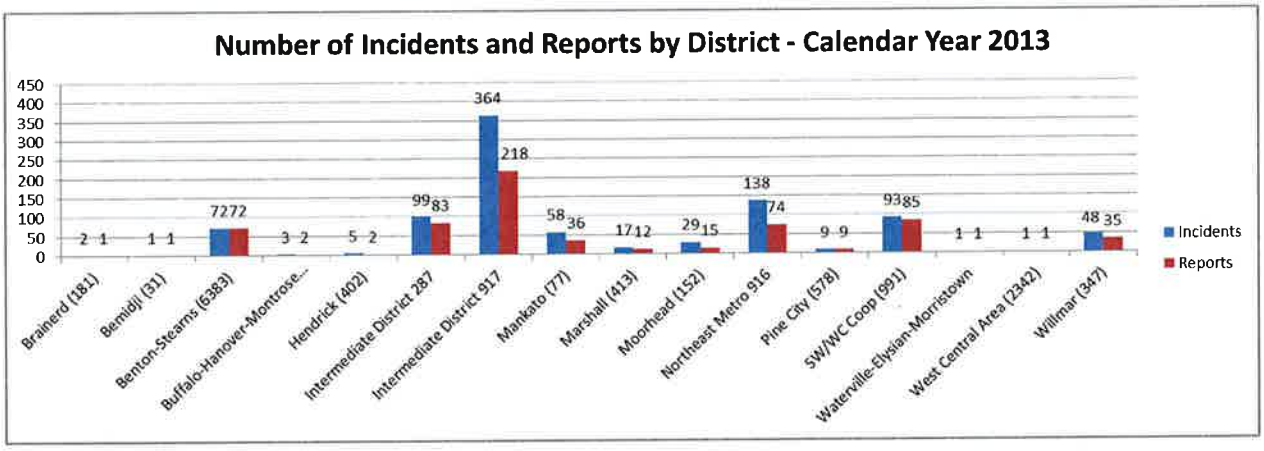
[34] *Id.*

[35] Minn. Stat. § 136D.01 (2014).



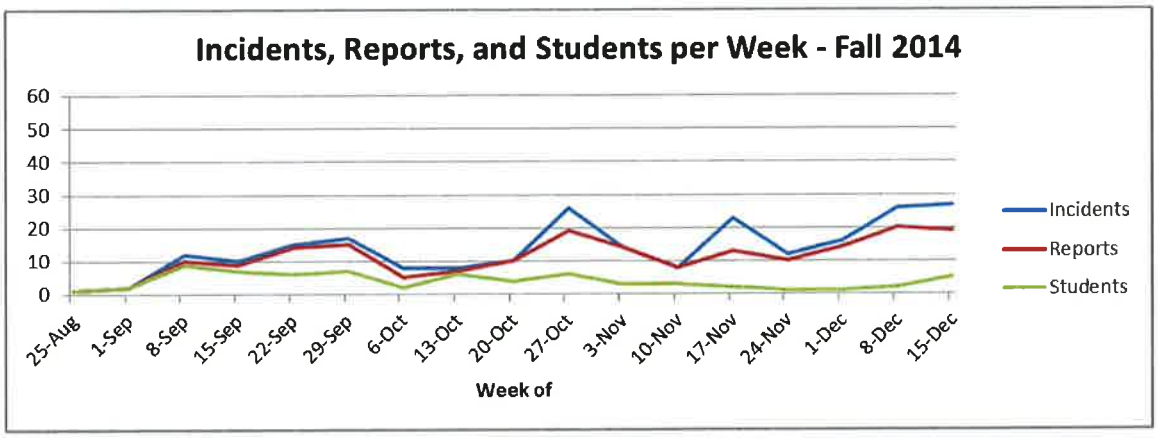


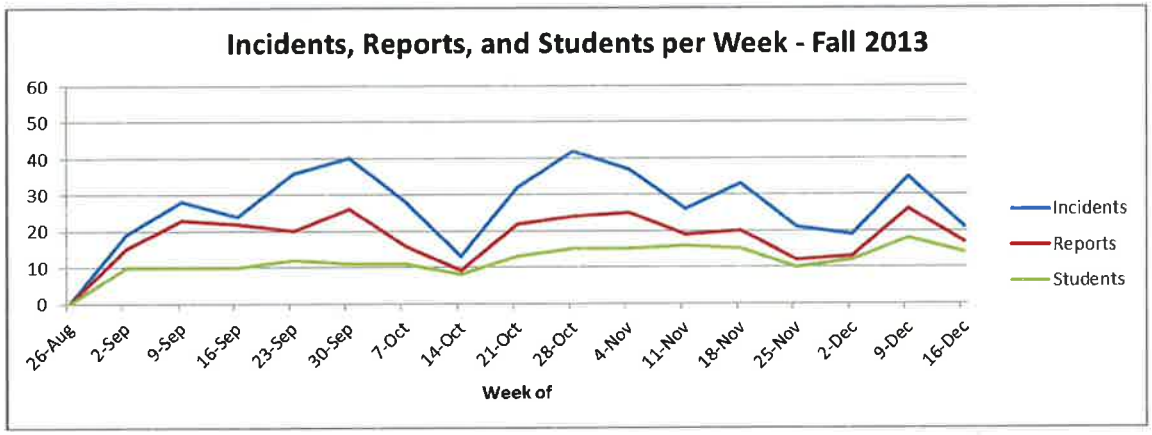
Number of Students in Prone Restraint

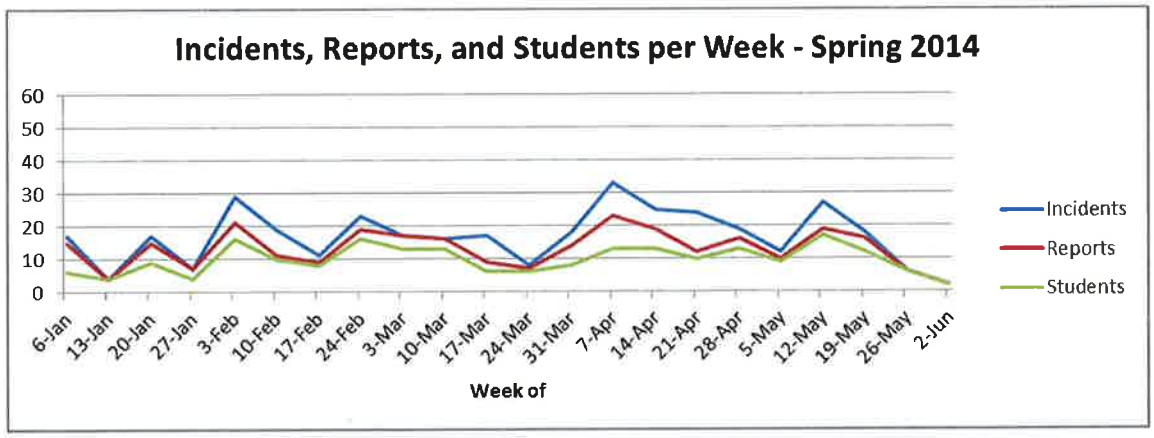
For the 2014 calendar year, districts reported that 158 students with disabilities were restrained using prone restraint one or more times. In comparing individual students who experienced prone restraint over multiple calendar years:

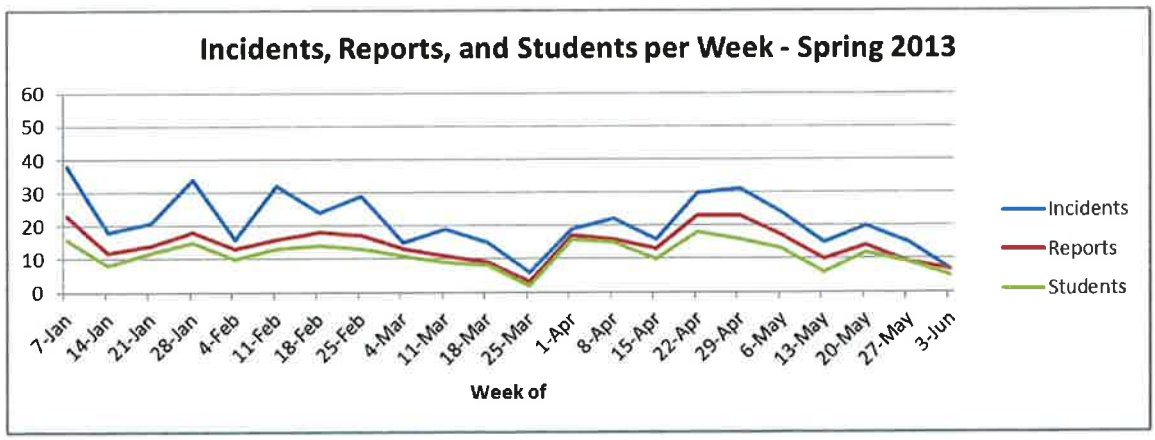
- 62 students experienced prone restraint during the 2013 and 2014 calendar reporting periods.
- 27 students experienced prone restraint during the 2012, 2013, and 2014 calendar reporting periods.
- 6 students experienced prone restraint at least once within all four reporting periods.

The following graphs show the number of incidents, reports, and students per week for comparisons of 2014 and 2013, fall and spring, respectively.


Incidents, Reports, and Students per Week - Fall 2014
60
50
40
30
20
10
0
25-Aug
1-Sep
8-Sep
15-Sep
22-Sep
29-Sep
6-Oct
13-Oct
20-Oct
27-Oct
3-Nov
10-Nov
17-Nov
24-Nov
1-Dec
8-Dec
15-Dec
Week of
Incidents
Reports
Students


Incidents, Reports, and Students per Week - Fall 2013
60
50
40
30
20
10
0
26-Aug
2-Sep
9-Sep
16-Sep
23-Sep
30-Sep
7-Oct
14-Oct
21-Oct
28-Oct
4-Nov
11-Nov
18-Nov
25-Nov
2-Dec
9-Dec
16-Dec
Week of
Incidents
Reports
Students


Incidents, Reports, and Students per Week - Spring 2014
60
50
40
30
20
10
0
6-Jan
13-Jan
20-Jan
27-Jan
3-Feb
10-Feb
17-Feb
24-Feb
3-Mar
10-Mar
17-Mar
24-Mar
31-Mar
7-Apr
14-Apr
21-Apr
28-Apr
5-May
12-May
19-May
26-May
2-Jun
Week of
Incidents
Reports
Students


Incidents, Reports, and Students per Week - Spring 2013
60
50
40
30
20
10
0
7-Jan
14-Jan
21-Jan
28-Jan
4-Feb
11-Feb
18-Feb
25-Feb
4-Mar
11-Mar
18-Mar
25-Mar
1-Apr
8-Apr
15-Apr
22-Apr
29-Apr
6-May
13-May
20-May
27-May
3-Jun
Week of
Incidents
Reports
Students

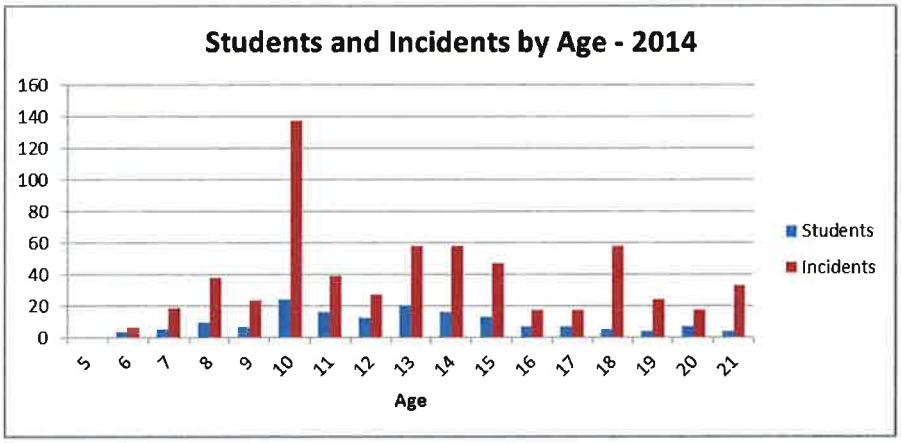
Length of Incident of Prone Restraint

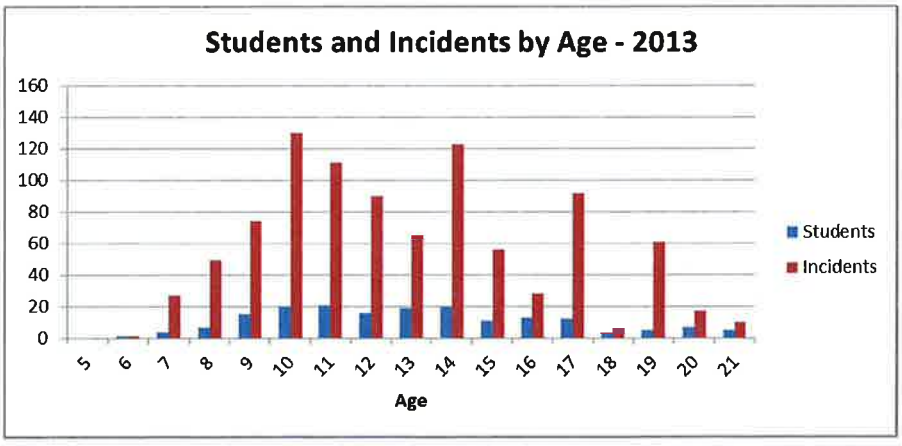
The 2014 data indicates the following:

- 50 percent of the 617 incidents of prone restraint lasted five minutes or less, compared to 56 percent during 2013.
- The number of restraints of five minutes or less also decreased from 525 in 2013 to 310 incidents in 2014.
- Nearly 90 percent of the reported incidents of prone restraint lasted 15 minutes or less.

Age of Students Placed in Prone Restraint

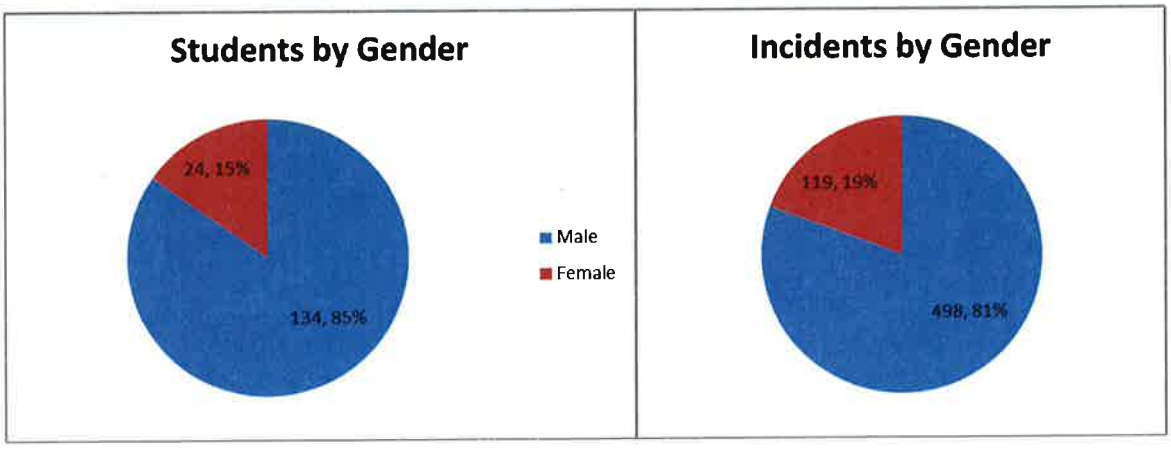
During the 2014 calendar year, prone restraint was used on children as young as 6 years old and as old as 21. This is consistent with prior years. Though the number of students and incidents are again down from the previous reporting periods, the relative peak usage of prone restraint by age, both by number of incidents and number of students, continues to be with middle school students. The peaks of incidents at ages 18 and 21 are due to the skewed effect of the outliers described earlier in this report, whereas the peak at age 10 is more the result of an aggregation: 137 incidents across 24 students.





Gender of Students Placed in Prone Restraint

The 2014 calendar year data shows that boys are more than six times more likely than girls to be restrained in a prone position, which is up from five times more likely in the previous reporting period, though consistent with the 2012 reporting period.

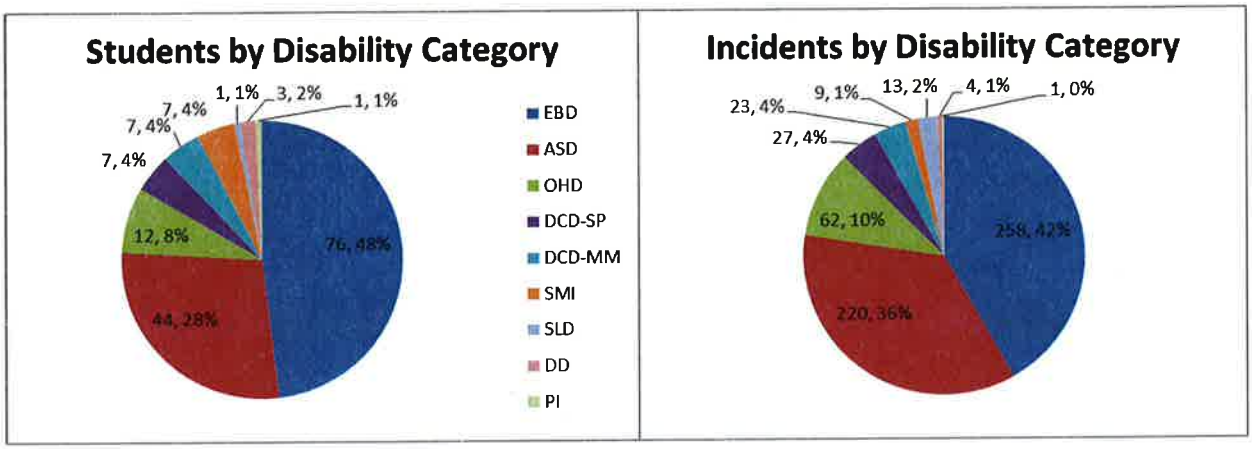


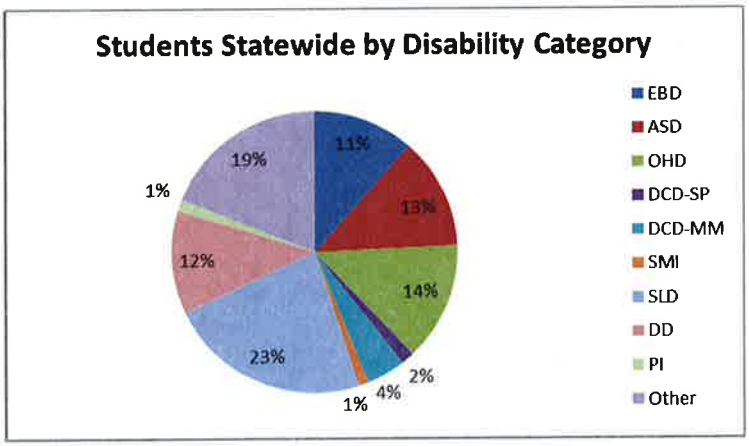
Students and Incidents by Disability Category

Overall, 68 percent of all incidents of prone restraint reported during the 2014 calendar year involved students who were eligible for special education under the following eligibility criteria: Autism Spectrum Disorders (ASD) or Emotional or Behavioral Disorders (EBD). Compared to the 2013 calendar year, this is a decrease from 84 percent of the incidents. Reduced relative usage with students under the ASD category accounts for the decrease.

The first chart below illustrates the number and percentage of students with disabilities subjected to prone restraint. The second chart illustrates the percentage of incidence represented by each specific category. For example, while ASD students represent 29 percent of all students who experienced the use of prone restraint, that same population represents 36 percent of all incidents reported for the same time period. For further comparison, the percentages of these students within the state's total special education population are illustrated in the third chart. For example, the same ASD students who represent 29 percent of all students who experienced the use of prone restraint and represent 36 percent of all incidents reported, are represented in 13 percent of the state's total special education population.[36]

[36] 2014 Child Count Totals by December 1, 2013 by Disability, Race/Ethnicity, and Age, retrieved from MDE Data Reports and Analytics, available at http://w20.education.state.mn.us/MDEAnalytics/Data.jsp.





Key

EBD = Emotional or Behavioral Disorders

ASD = Autism Spectrum Disorders

OHD = Other Health Disabilities

DCD-MM = Developmental Cognitive Disability-Mild to Moderate

DCD-SP = Developmental Cognitive Disability-Severe to Profound

SMI = Severely Multiply Impaired

SLD = Specific Learning Disability

DD = Developmental Delay

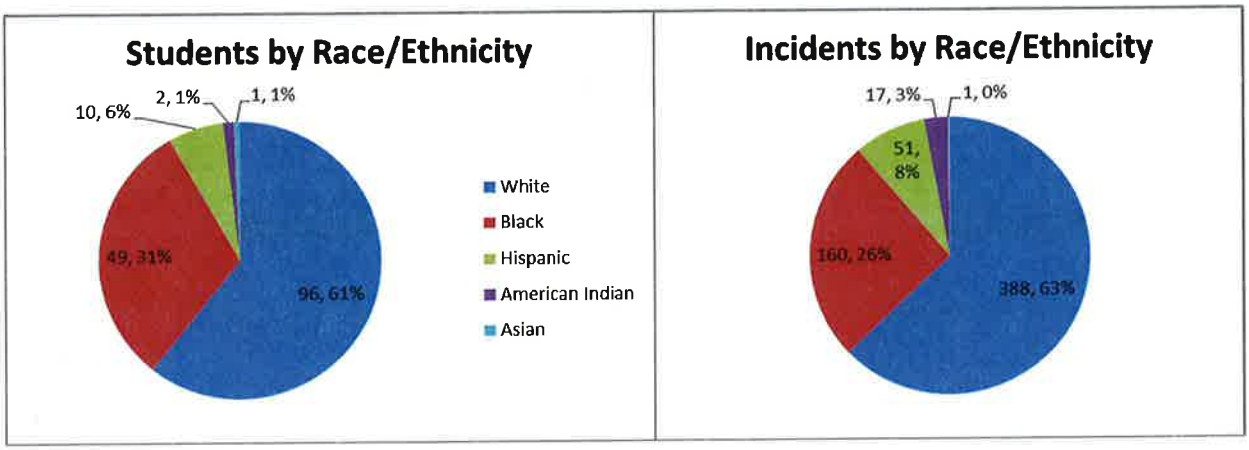
PI = Physically Impaired

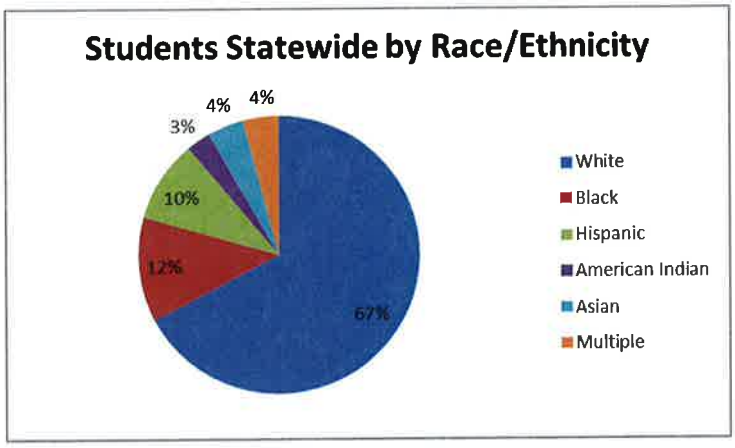
Students Involved In Prone Restraint by Race/Ethnicity

Compared to data from the 2013 calendar year, the proportion of Black students in prone restraint during the 2014 calendar year decreased from 32 percent to 31 percent. The proportion of incidents for Black students also decreased, from 32 percent to 26 percent. At the same time, the proportion of incidents for White students increased from 60 percent to 63 percent, for Hispanic students from seven percent to eight percent, and for American Indian students from less than one percent to three percent.

Much of the change in incidents by race/ethnicity can be attributed to the change in students who fall into the group of outliers described earlier in this report, more of whom were White students during 2014, compared to a larger proportion of Black students in 2013. In comparison

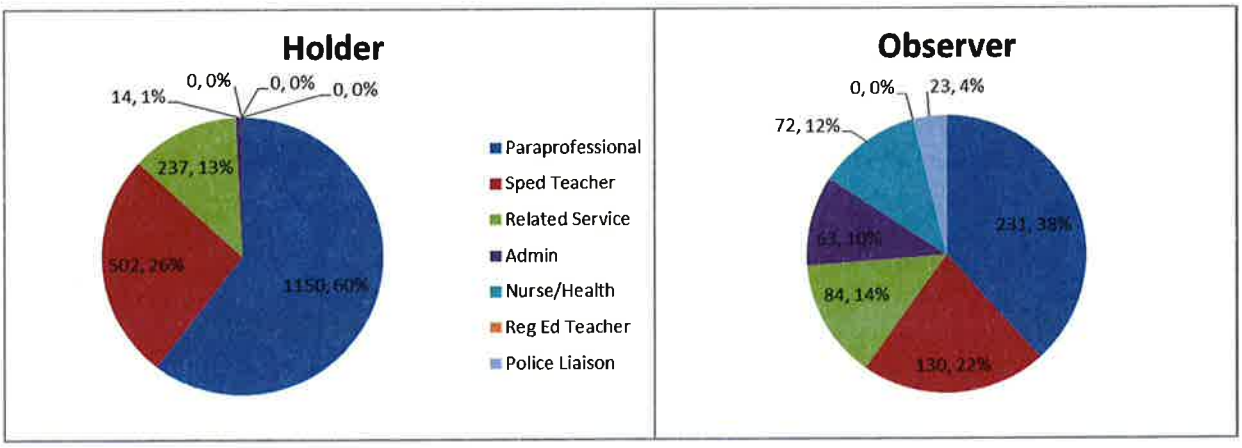
to the statewide population of students with disabilities, Black students continue to be overrepresented in prone restraint by number of students and incidents.





Staff Involved in the Use of Prone Restraint

Approximately 420 staff were involved in the use of prone restraint during the 2014 calendar year, either as a holder or an observer, down from approximately 520 in the previous calendar year. The median number of times a staff person was involved was two times (same as 2013), with a range of up to 48 times, which is down from 70 times in 2013. As in 2013, most reports included at least one paraprofessional as a holder (465 reports) and few reports included only paraprofessionals as holders (97). Across seven reports, 10 education staff were reported as holders and listed as not trained. The chart below shows the percentage of times various staff were holders or observers. For example, paraprofessionals were reported as holders 1,150 times across all reports during this reporting period.



Injuries Related to the Use of Prone Restraint

Across 489 prone restraint reports submitted for the 2014 calendar year, districts reported two student injuries and 24 staff injuries, down from seven and 36, respectively, as reported for 2013. Injury descriptions to staff included strained muscles, scratches, bruises, and bites, which included bleeding. The two reported student injuries were not clearly described; however, neither injury was indicated as necessitating a report to the ombudsman.

RESTRICTIVE PROCEDURES SUMMARY DATA

Following the 2013-14 school year, districts reported summary data to MDE on the use of restrictive procedures, which was due by June 30, 2014. On a form provided by MDE, districts reported:

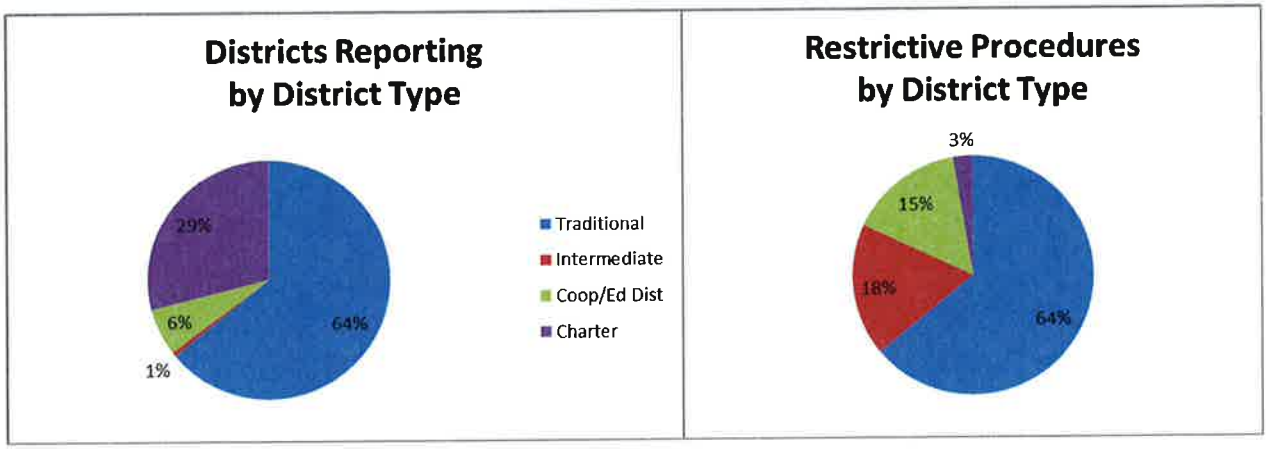
- the total number of students receiving special education services served by the district;
- the total number of incidents of restrictive procedures (includes physical holding, prone restraint, and seclusion);
- the total number of students receiving special education services upon whom a restrictive procedure was used;
- the total number of students receiving special education services upon whom restrictive procedures were used 10 or more school days during the school year;
- the total number of incidents of physical holding (including prone restraint);
- the total number of incidents of seclusion;
- the demographic information for the students (disability, age, race, and gender);
- the number of injuries to students and staff.

MDE received summary data from 522 districts (which includes independent and special school districts, charter schools, cooperatives, education districts, and intermediate school districts). This was a 100 percent response rate, which included district responses of no use of restrictive procedures.

Districts that Reported Use of Restrictive Procedures

Of the 522 districts that reported summary data to MDE, 249 of those districts (compared to 252 districts in 2013) reported use of restrictive procedures, whether physical holding, seclusion, or a combination of both. They include:

- 195 of 335 traditional districts
- 3 of 3 intermediate school districts
- 15 of 33 cooperatives and education districts
- 33 of 151 charter schools



While intermediate districts, cooperatives, and education districts comprise approximately seven percent of the total reporting districts, combined they reported 33 percent of the restrictive procedure use in the state. By contrast, charter schools represent approximately 29 percent of the reporting districts, but reported nearly no use of restrictive procedures. Traditional districts represent approximately 64 percent of the reporting districts and also reported 64 percent of restrictive procedure use. The proportion of restrictive procedures reported for the 2013-14 school year is higher as compared to the 2012-13 data for cooperatives, education districts, and charter schools, with intermediate and traditional districts down slightly.

Of the 249 districts that reported use of restrictive procedures:

- 172 (69 percent) reported use of only physical holding,
- 3 (1 percent) reported use of only seclusion, and
- 74 (30 percent) reported use of both physical holding and seclusion.

While this is consistent with previous reporting, it should be noted that the districts reporting usage changed. Of the 249 districts reporting use of restrictive procedures during the 2013-14 school year, 51 of the districts reported no usage of restrictive procedures the previous school year.

Statewide Data on the Use of All Restrictive Procedures

Across the state, during the 2013-14 school year, districts reported 13,214 physical holds and 6,323 uses of seclusion for a total of 19,537 restrictive procedures. This was a decrease of approximately 11 percent from the 2012-13 school year reporting.

When comparing the data, it should be noted that for the 2011-12 school year, only 474 districts submitted a summary restrictive procedure form, as compared to 513 districts and 522 districts respectively for the 2012-13 and 2013-14 school years.

School Year	Physical Holds	Uses of Seclusion	Restrictive Procedures
2013-14	13,214	6323	19,537
2012-13	15,738	6425	22,163
2011-12	16,604	5236	21,840

Of 138,883 special education students,[37] restrictive procedures were used with 2,740 students with disabilities, which is approximately two percent of the special education population. This percentage is the same as reported in the 2014 legislative report. Physical holding was used with 2,433 students, down from the data reported in the 2014 legislative report (2,604) and seclusion was used with 837 students, also down from the data reported in the 2014 legislative report (957).[38] Compared to the 2013-14 school year, the average number of physical holds per physically held student was 5.4, down from 6.0; the average number of uses of seclusion per secluded student was 7.6, up from 6.7; and the average number of restrictive procedures per restricted student was 7.2, down from 7.5.[39]

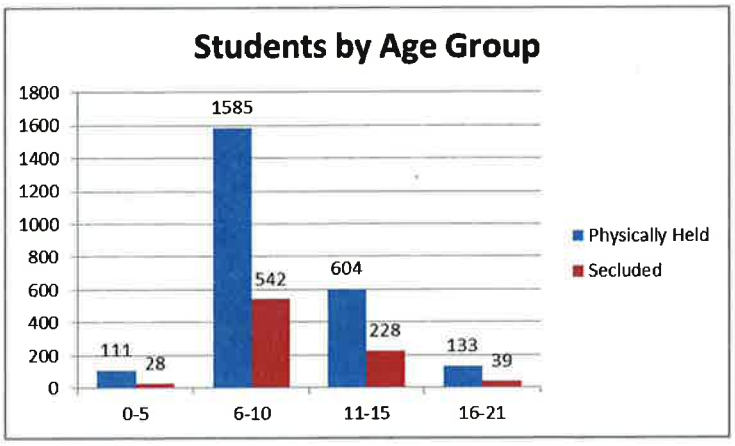
Age of Students in Restrictive Procedures

The majority of restrictive procedures reported for the 2013-14 school year were used with elementary through middle school students, with fewer uses with early childhood and high school students, consistent with the previous legislative reports.

[37] The number of special education students is based on an aggregation of districts' self-reported data in conjunction with the restrictive procedures reporting and may not match exactly with other aggregations by MDE of the number of special education students in the state.

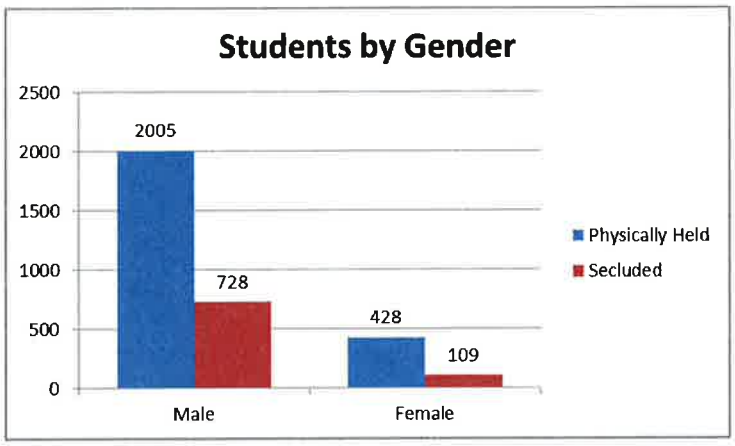
[38] The number of physically held students plus the number of secluded students is greater than the total number of students with whom restrictive procedures were used because a number of students where reported as both physically held and secluded.

[39] As with the previous footnote, the average number of restrictive procedures per restricted student may be higher than the averages for both physical holding and seclusion because of the number of students both physically held and secluded.



Gender of Students in Restrictive Procedures

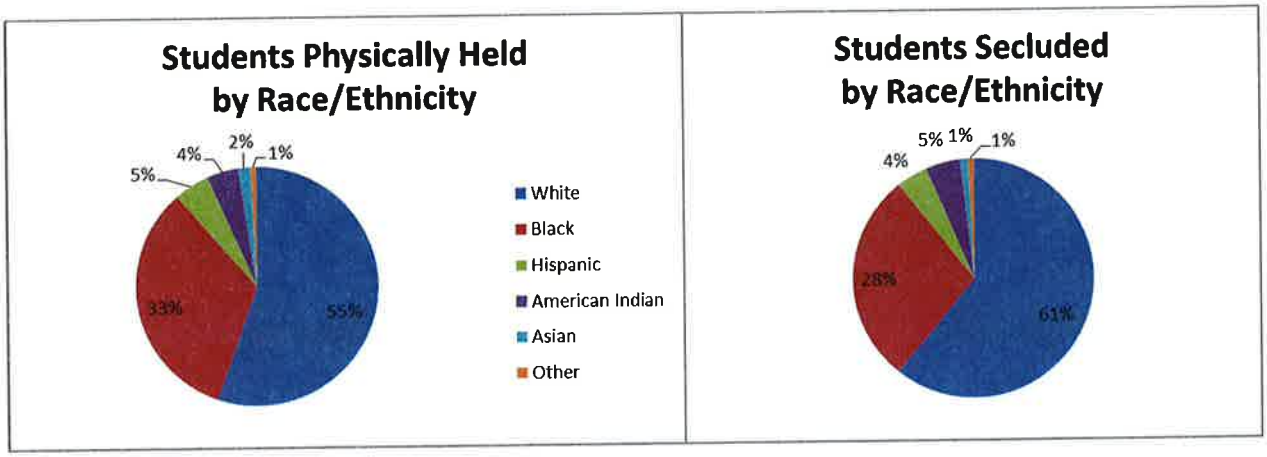
Based upon the data reported for the 2013-14 school year, boys are 4.7 times more likely to be physically held and 6.7 times more likely to be placed in seclusion than girls, consistent with previous legislative reports.

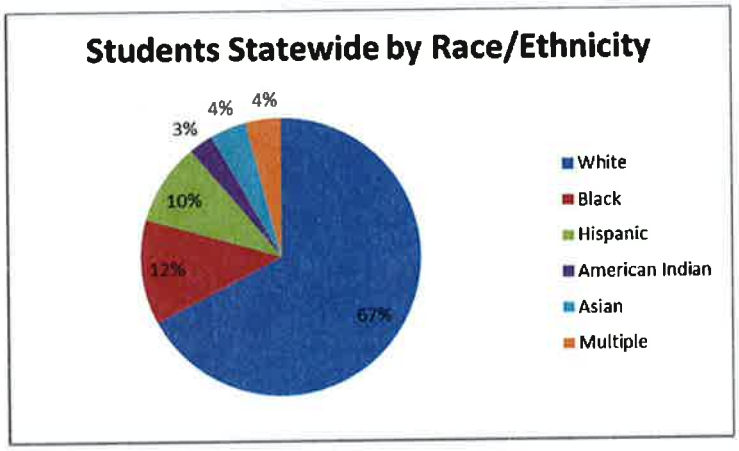


Race/Ethnicity of Students in Restrictive Procedures

Black students, who account for approximately 12 percent of the special education student population,[40] are overrepresented in both the physical holding and seclusion data, consistent with previous legislative reports. American Indian students, who account for approximately three percent of the special education population, are also overrepresented in the physical holding and seclusion data, though not to as great a degree.

[40] 2014 Child Count Totals by December 1, 2013 by Disability, Race/Ethnicity, and Age, retrieved from MDE Data Reports and Analytics, *available at* http://w20.education.state.mn.us/MDEAnalytics/Data.jsp.

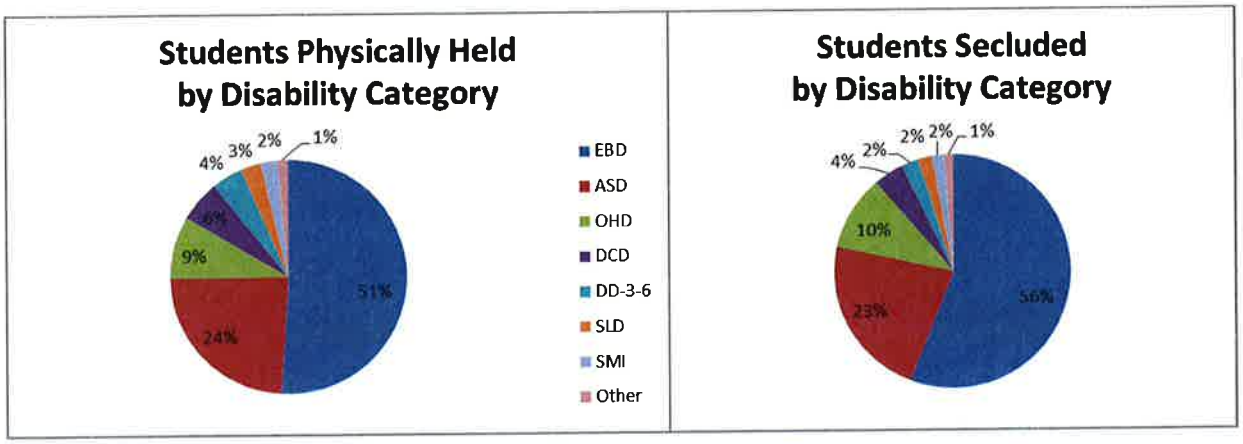




Disability Categories for Students in Restrictive Procedures

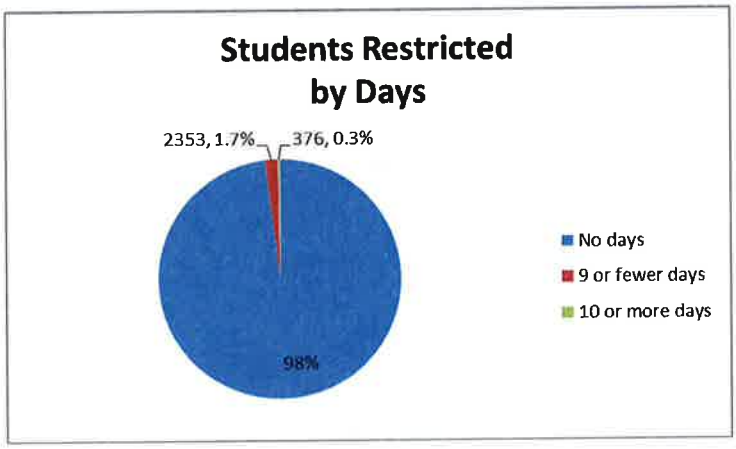
During the 2013-14 school year, students who received special education services by meeting eligibility criteria under the primary disability category of EBD or ASD accounted for three-fourths of the students who experienced the use of restrictive procedures, consistent with previous legislative reports. ASD students make up approximately 13 percent of the special education student population and EBD students make up approximately 11 percent.[41] The remaining one-fourth of restrictive procedures were used on students with Other Health Disabilities (OHD), Developmental Cognitive Disability (DCD), Developmental Delay, ages three through six (DD 3-6), Specific Learning Disability (SLD), and Severely Multiply Impaired (SMI). The categories of disabilities included in the "Other" category are, in order of prevalence: Deaf and Hard of Hearing (DHH), Speech or Language Impairments (SLI), Traumatic Brain Injury (TBI), and Physically Impaired (PI).

[41] 2014 Child Count Totals by December 1, 2013 by Disability, Race/Ethnicity, and Age, retrieved from MDE Data Reports and Analytics, *available at* http://w20.education.state.mn.us/MDEAnalytics/Data.jsp.



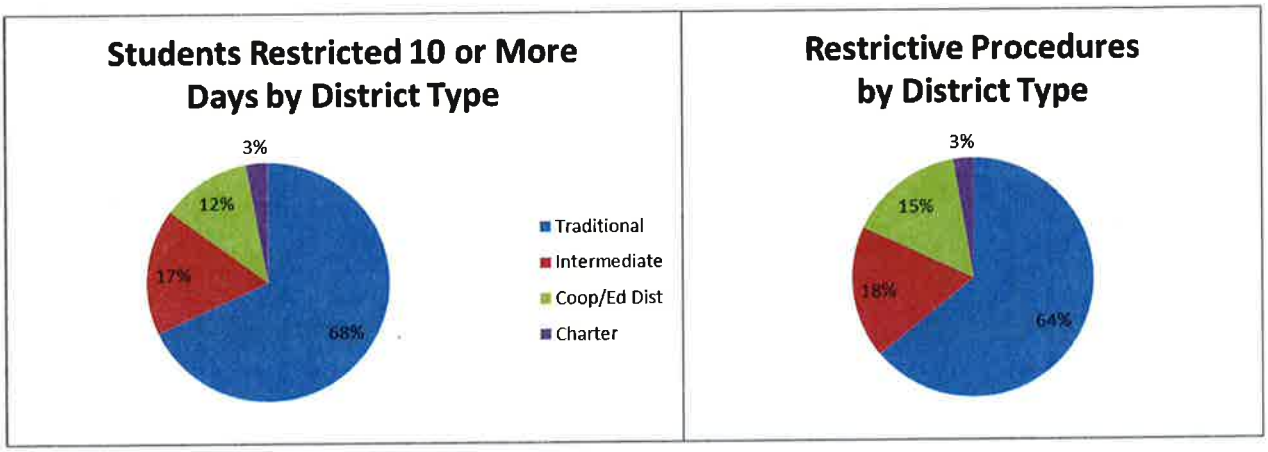
Students Restricted Ten or More Days

New in this legislative report is data on the number of students restricted 10 or more days. As has been noted in the prone restraint data since reporting began, a small number of students account for a large portion of the incidents of prone restraint. A threshold of 10 or more days was chosen for this restrictive procedures summary data point to be consistent with districts' obligation under statute to take additional action when restrictive procedures have been used 10 or more days within a school year.[42] Districts reported that a total of 376 special education students experienced the use of restrictive procedures over 10 or more days during the 2013-14 school year. These students account for approximately 0.3 percent of the special education student population.



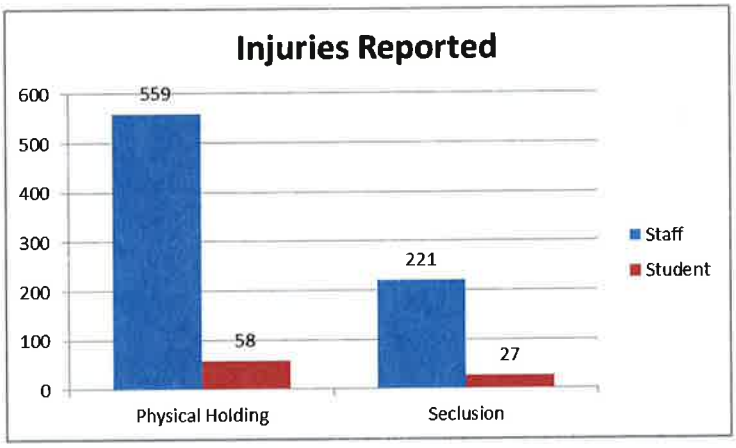
While the restrictive procedure summary data is more limited than individual incident prone restraint reports, the district level data for these outliers in the restrictive procedures population suggest the average number of restrictive procedures may be about 25 incidents of restrictive procedures per student, with 10 or more days of restriction. This would be consistent with the average for the outliers in the prone restraint data. Students who experienced the use of restrictive procedures over 10 or more days across all district types are in rough proportion to the number of incidents of restrictive procedures by district type.

[42] *See* Minn. Stat. § 125A.0942, subd. 2(d).



Injuries Related to the Use of Restrictive Procedures

Data about the number of injuries to both students and staff related to the use of restrictive procedures is reported as increased for all categories, with the exception of injuries related to physical holding for students. However, the data was new for the previous reporting period, so may reflect better reporting more than an actual increase in injuries. As stated in the previous legislative report, there is still some likelihood that injury data is underreported, inaccurately reported, and/or inconsistently reported. Several districts again called to inquire what constitutes an "injury" that should be reported, including questions about the severity and connection to the incident.



STATEWIDE PLAN

MDE is committed to ensuring that all students and all staff are safe in educational environments. We are also committed to working with the Minnesota Legislature and all interested stakeholders, including parents, educators, school administrators, and community leaders, to ensure schools have necessary and effective tools to support student safety while working together to eliminate the use of prone restraint and reduce the use of restrictive procedures. Please refer to Appendix A for the statewide plan, including recommendations and goals.

CONCLUSION

MDE respectfully submits this report to provide the Legislature with objective data to inform its continuing policy discussions regarding restrictive procedures and prone restraint. While the number of students affected by this discussion is small, about 0.1 percent of the special education student population in the case of prone restraint and about two percent for restrictive procedures, it is clear that these students have significant and complex needs.

We anticipate the data provided will result in informed decision-making, promoting safe educational environments. We appreciate the opportunity to inform the Legislature about this important issue and commend the Legislature for its continued commitment to this task.

Appendix A

2014 Statewide Plan to Reduce the Use of Restrictive Procedures and Eliminate Prone Restraint in Minnesota

I. Purpose

During the 2014 legislative session, the Minnesota Legislature tasked the Minnesota Department of Education (MDE) with developing a statewide plan with specific and measurable implementation and outcome goals for reducing the use of restrictive procedures.[43] To assist with developing a plan, MDE assembled a group of stakeholders. The stakeholder group included representation from advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, state human services department staff, mental health professionals, and autism experts.[44] Although invited, the stakeholder group did not have a representative from County Social Services. The group developed implementation and outcome goals that would move the state toward a reduction of restrictive procedures in the educational setting.

II. Stakeholder Work Group Charge

By February 1, 2015, and annually thereafter, stakeholders must recommend to the commissioner specific and measurable implementation and outcome goals for reducing the use of restrictive procedures and the commissioner must submit to the legislature a report on districts' progress in reducing the use of restrictive procedures that recommends how to further reduce these procedures and eliminate the use of prone restraints. The statewide plan includes the following components: measurable goals; the resources, training, technical assistance, mental health services, and collaborative efforts needed to significantly reduce districts' use of prone restraints; and recommendations to clarify and improve the law governing districts' use of restrictive procedures. The commissioner must consult with interested stakeholders when preparing the report, including representatives of advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, county social services, state human services department staff, mental health professionals, and autism experts. By June 30 each year, districts must report summary data on their use of restrictive procedures to the department, in a form and manner determined by the commissioner. The summary data must include information about the use of restrictive procedures, including use of reasonable force under section 121A.582.

Minnesota Department of Education

[43] Minn. Stat. § 125A.0942, Subd. 3(b) (2014).
[44] *Id.*

APPENDIX A

III. Stakeholder Group Members

ARC Minnesota ..... Jacki McCormack
Autism Society of Minnesota ..... Jean Bender
Department of Human Services, Disability Services Division ..... Carol Anthony
Department of Human Services, Disability Services Division ..... Charles Young
Department of Human Services, Children's Mental Health Division ..... Karry Udvig
Department of Human Services, Children's Mental Health Division ..... Nelly Torori
Department of Human Services ..... Richard Amado
Education Minnesota ..... Katy Perry
Paraprofessional, Robbinsdale School District ..... Karen Krussow
Intermediate District 287 ..... Jennifer McIntyre
Intermediate District 917 ..... Melissa Schaller
Minnesota Administrators for Special Education ..... Jill Skarvold
Minnesota Disability Law Center ..... Dan Stewart
Minnesota School Board Association ..... Grace Keliher
National Alliance on Mental Illness ..... Sue Abderholden
Northeast Metro 916 ..... Connie Hayes
Northeast Metro 916 ..... Dan Naidicz
PACER Center ..... Jody Manning
PACER Center ..... Virginia Richardson

IV. Minnesota Department of Education Participants

Director, Compliance and Assistance ..... Marikay Canaga Litzau
Supervisor, Compliance and Assistance ..... Sara Winter
Assistant Commissioner ..... Daron Korte
Compliance Monitoring ..... Ross Oden
Compliance and Assistance ..... Pamela Hinze
Supervisor, Interagency Partnerships ..... Robyn Widley
Supervisor, Special Education ..... Eric Kloos
Special Education ..... Aaron Barnes

APPENDIX A

V. Process

On September 26, 2014, MDE convened the 2014 Stakeholder Work Group (2014 Stakeholder Group) to review the annual restrictive procedures data for the 2013-14 school year. Additional meetings scheduled to review the quarterly prone restraint data occurred or will occur October 27, 2014, January 23, 2015, April 24, 2015, and July 24, 2015.

As set forth in the 2013 statewide plan, the stakeholders chose to meet quarterly and focus on reviewing the data, ongoing implementation efforts of the 2013 statewide plan, and to discuss successes and barriers in reducing restrictive procedures and the elimination of prone restraint.

Stakeholder Group Meetings

MDE staff convened members of the 2014 stakeholder group three times during the time period of September 26, 2014 and January 23, 2015. MDE staff facilitated an exchange of information and stakeholder input through review of:

- Aggregate data from districts' self-reported use of restrictive procedures for the 2013-14 school year;
- Quarterly aggregate data from districts' self-reported use of prone restraint;
- Existing statutory language;
- Strategies employed by intermediate districts to reduce restrictive procedures and eliminate prone restraint;
- Strategies employed by other districts to reduce restrictive procedures and eliminate prone restraint;
- Work accomplished from the 2013 statewide plan as set forth in Appendix A of the 2014 Legislative Report and input on ongoing implementation of that plan;
- The legislative appropriation and the process to utilize those funds to assist students experiencing the highest use of restrictive procedures, specifically prone restraint; and
- The education sections of the Olmstead Plan and status.

During the initial 2014 Stakeholder Group meeting, MDE informed the stakeholders that it had submitted a Form A proposing that the restrictive procedure statute be amended to specifically prohibit the use of prone restraint as of August 1, 2015, in accordance with the implementation requirements from the Revised Olmstead Plan, Education and Life Long Learning Action Item 1D (Proposed modifications July 10, 2014 and November 6, 2014). As set forth in action item 1D, stakeholders will discuss and recommend revisions to Minnesota Statutes section 125A.0942 subdivision 3(a)(8) to clarify that prone restraint will be prohibited by August 1, 2015 in Minnesota school districts, and will apply to children of all ages. Action item 1E requires MDE to report to the legislature on the districts' progress in reducing the use of restrictive procedures in Minnesota Schools and on stakeholder recommendations regarding Minnesota Statutes section 125A.0942 subdivision 3(a)(8). At the initial meeting, stakeholders did not raise any objection, and the meeting focused on a review of the annual restrictive procedures data and prone restraint data for the quarter ending June 30, 2014.

MDE staff and the stakeholders then reviewed the 2013 statewide plan goals and implementation efforts. MDE also provided an update on the $250,000 legislative appropriation.

MDE developed a grant process to target seven districts, including the three intermediate districts with students who experienced the highest usage of restrictive procedures and prone restraint. In addition, MDE was in the process of producing a request for proposal (RFP) for the development of three online training modules addressed in Goal 2(c) of the 2013 statewide plan. During a working lunch, there was a discussion to strategize ways MDE and the Minnesota Department of Human Services (DHS) could leverage services to support students who are experiencing high use of restrictive procedures, specifically prone restraint. MDE staff provided an update on the Olmstead Plan, and stakeholders were given the opportunity to share effective strategies as well as barriers in their efforts to reduce restrictive procedures and eliminate prone restraint.

During the second 2014 Stakeholder Group meeting, MDE sought input from stakeholders on venues for advertising the RFP. Prone restraint data from the quarter ending September 30, 2014 was reviewed. MDE staff provided a summary of the status of the implementation of the goals in the 2013 statewide plan. There was a brief discussion at the meeting about the October 15, 2014 Restrictive Procedures Reduction Discussion Panel (Panel) held to assist the education community in reducing the use of restrictive procedures and eliminating prone restraints in schools by sharing evidence-based best practices and effective strategies and resources. MDE staff, DHS staff, and 2014 Stakeholder Group members who participated on the Panel provided an overview of the training. The 2014 Stakeholder Group discussed what future panel discussions would look like. The 2014 Stakeholder Group also worked on developing questions to gather data about specific students to assist in identifying the students experiencing the highest usage of prone restraint. Ultimately, the 2014 Stakeholder Group chose not to proceed with the questionnaire. Time was again provided for stakeholders to seek ideas and feedback about challenging students.

The 2014 Stakeholder Group focused on the task of eliminating prone restraint and addressing successes and barriers toward reaching that ultimate goal. The stakeholders continued to share a desire to implement and revise as necessary, the 2013 statewide plan to reduce restrictive procedures, including eliminating prone restraint. Based upon a review of the prone restraint data, as well as the discussions held during the restrictive procedures 2014 Stakeholder Group meetings, the stakeholders all agreed on the need to focus resources on those students who experience a high use of restrictive procedures; specifically, prone restraint.

At the January 23, 2015 meeting, the 2014 Stakeholder Group reached consensus to: revise multiple goals, delete one goal from the 2013 Work Plan, add two additional goals, and work toward implementation of the nine goals that should be implemented by one or more state agencies, school districts, or community level entities. A brief discussion on the December 16, 2014 Restrictive Procedures Reduction Discussion Panel: Eliminating Prone Restraint in Schools was also held and included a discussion of future trainings.

In general, the process underscored the stakeholders' desire to reduce or eliminate restrictive procedures. There is shared belief that emergency situations in educational settings could be greatly reduced or eliminated with additional resources – especially mental health services and additional training on positive behavior supports and intervention. Further, that training and an exchange of successful strategies would assist districts in reducing the need for restrictive procedures. For purposes of this report, the goals in the 2013 statewide plan are listed in VI

below with a corresponding update on whether they have been completed or are in progress. The 2014 Stakeholder Group reviewed progress on the eight goals in the 2013 Work Plan and then made recommendations to revise those goals and to add additional goals. The goals in the 2014 statewide plan are listed in VII below.

During the 2014-15 meetings, the stakeholders continued to discuss the barriers to accessing appropriate day and residential treatment. Much discussion centered on the lack of day treatment facilities that worked with students with severe emotional outbursts. Those students are reportedly "kicked out" of day treatment facilities, and many are then enrolled in level three or level four programs. At one of the meetings, a stakeholder described a successful collaboration between the Minneapolis School District and a co-located day treatment center. While the stakeholders did not believe they could adequately address this goal within the next year, it was noted that some stakeholders are currently involved in other work to address these issues.

Finally, the stakeholder group discussed proposed statutory revisions needed to provide clarification or to support the implementation of some pieces of the proposed statewide plan. As set forth in Appendix A of the 2014 Legislative Report, the 2013 Stakeholder Group previously concluded that there was insufficient data to determine the extent to which reasonable force was being used that resulted in the use of a restrictive procedure on a student with a disability. In the fall of 2015, the 2014 Stakeholder Group will review the data collected related to the use of reasonable force on the 2014-15 annual summary report, and decide whether additional statutory changes would be needed to ensure that districts are not using reasonable force to avoid the reporting requirements in the restrictive procedure statute, or increasing removals of students from the school setting.

As indicated by the recommendations of the 2013 Stakeholder Group, the work on a statewide plan to greatly reduce or eliminate the use of restrictive procedures requires ongoing discussion and study to review what is successful, and continue to monitor the data and revise the goals, as appropriate. MDE will continue to collect and report the restrictive procedures data and convene the stakeholder meetings, once in the fall of 2015 and subsequent meetings as needed.

VI. 2013 Statewide Plan and Updates

Goal 1: On or before July 1, 2014, MDE will:

a. Based upon a review of the prone restraint reports received by MDE, MDE will develop a process to identify outliers in prone restraint reporting which will assist MDE in identifying schools and/or school districts that may need targeted technical assistance and thereafter contact and offer technical assistance to the identified schools and/or school districts. In determining whether an outlier exists, and in determining where data is an outlier, MDE will consider whether the prone restraint data is markedly different from other prone restraint data from a comparable school district. MDE has been receiving prone reports since the beginning of the 2011-12 school year.

1a Update: Since the first prone reporting began in August 2011, MDE developed a system to review prone reports within two business days. This review included contacting the district when

the report did not appear consistent or the staff was not trained. MDE staff in the Compliance and Assistance and Special Education divisions met when a high usage of prone restraint was reported on an individual student. During the summer of 2014, MDE staff met to discuss a more formal method to determine where data is an outlier. Beginning with the 2014-15 school year, MDE has identified outliers as any district currently intending to use and rely on the use of prone restraint. As set forth in more detail in goal four below, MDE provided targeted technical assistance by inviting the seven districts still using prone restraint to participate in a December 2014 restrictive procedures panel discussion. Based upon the quarterly report for prone restraint data ending December 31, 2014, five school districts used prone restraint one or more times. Only four districts reported the use of prone restraint during December 2014.

b. Develop a process for school districts to use for state targeted technical assistance related to reducing the use of restrictive procedures, including eliminating prone restraints.

1b Update: In addition to the restrictive procedures reduction discussion panel trainings, MDE provides the following training: Restrictive Procedures Overview for Individual Districts. This is an overview of Minnesota's restrictive procedures statutes pertaining to children with disabilities, including requirements that must be met before using restrictive procedures and the standards for use. This presentation is intended to assist individual districts that have questions about new statutory changes and requires the individual district requesting the training to actively participate in the presentation process along with, and with assistance from, MDE. MDE provided this training on January 26, 2015. MDE will also review training needs identified by districts in the annual summary forms to determine future trainings.

c. Develop and post on its website a Post-use Debriefing form. Developed and posted October 2014.

1c Update.: Completed. Delete 1c.

d. Update the MDE Sample Restrictive Procedures Plan and post it on its website in accordance with Minnesota Statutes section 125A.0942. Update: Original post: November 2011. Edited: April 2012. Edited: January 2014. Edited: September 2014.

1d Update: Completed. Ongoing goal.

e. Amend the MDE Restrictive Procedures Summary Form to allow school districts the option to identify one to two staff training needs, and to review the need to add or amend additional reporting requirements to address the unintended impacts of reducing restrictive procedures. MDE will update the form to clarify that districts must report all incidents involving students with a disability in which a staff member uses restrictive procedures, as defined in Minnesota Statutes, Section 125A.0941.

1e Update: MDE updated and posted the electronic *Use of Restrictive Procedures District Summary Data* form in April 2014. The amendments include a change to the definition of physical holding to include reasonable force covered by Minnesota Statutes, section 121A.6582, when the actions meet the definition of physical holding in Minnesota Statutes, section 125A.0941. Districts are required to report this data beginning with the

2014-15 school year and submit the report by June 30, 2015. In addition, the annual summary form was updated to include a training needs section and gives districts the opportunity to describe areas of training related to the reduction of restrictive procedures summary data reports for the 2013-14 school year, which contained training needs. Districts will again report training needs when they submit their annual reports on June 30, 2015. Completed. Delete 1e,

f. Make publically accessible, in an electronic format on MDE's website, information pertaining to how schools/school districts may access local mental health services for their students including Assertive Community Treatment (ACT) teams and mobile crisis response teams

1f Update: MDE posted the relevant links to the DHS website on June 30, 2014. Completed. Update link as needed

g. Make publically accessible, in an electronic format on MDE website, information and training pertaining to DHS's Positive Support Community of Practice bi-weekly live stream meetings.

1g Update: Posted link to Positive Supports Community of Practice February 2014. Completed. Update link as needed.

Goal 1 Action Items

- **MDE:** Responsible to implement Goal 1, a-g.
- **DHS:** Provide information to MDE related to Goal 1, f and g.
- **School Districts:** Request or utilize offered targeted technical assistance, identify, develop, and implement post-use debriefing and oversight committee procedures and forms based on model examples; collect and report in summary form the use of reasonable force when it results in the use of a physical hold or seclusion on a student with a disability; and to utilize the resources made available on the MDE website regarding accessing local mental health services and the DHS live stream meetings.

Goal 2: Beginning in March 2014, MDE will continue collaboration with DHS by:

a. Supporting implementation of evidence-based practices for positive behavior strategies through the channels already developed by DHS's Continuing Care Administration and Children's Mental Health Division, Positive Support Community of Practice;

2a Update: Goal 2(a) is incorporated in the Olmstead work related to children's mental health and continuing care. Currently, DHS is the lead to develop common definitions and MDE has provided input. An initial report has been completed by Rebecca Freeman, DHS consultant from the University of Minnesota, Institute on Community Integration.

b. Identifying systems for culturally responsive resource identification, consistent with the Positive Support Community of Practice, by collaborating with the Children's Mental Health and Disability Services Division of DHS, including at least the following:

i. Prevention;

ii. quality improvement;

iii. intensive intervention; and

iv. systems collaboration.

2b Update: MDE and DHS have collaborated in the following activities related to Goal 2(b), which are designed to increase awareness of cross agency and community resources and provide enhanced opportunities to work together to address children's and system needs to create the support needed to reduce the use of restrictive procedures:

- Olmstead activity related to mental health crisis,
- Suicide prevention planning workgroup with MDH and DHS,
- Workgroups regarding the development of new mental health benefits for children- e.g. psychosocial education, consultation, new option for psychiatric residential treatment facility (PRTF) setting, and school linked mental health project activities.

c. Researching three cross-expertise training models for statewide use:

i. a continuum of treatment and educational service options for students with a combination of severe mental illnesses and developmental disabilities, including Fetal Alcohol Spectrum Disorder;

ii. in collaboration with emotional and behavioral disorders (EBD) experts and mental health experts, develop an EBD training model that addresses strategies to reduce restrictive procedures used on students with severe aggressive/self-injurious behaviors; and

iii. in collaboration with autism spectrum disorder (ASD) experts, develop an ASD training model that addresses strategies to reduce restrictive procedures used on students with severe intellectual impairments and aggressive/self-injurious behaviors.

2c Update: MDE sent a RFP for development of the three training models in an electronic format. The RFP proposals submission deadline was January 15, 2015. They are in the process of being reviewed, and a final review will take place on January 30, 2015. The work is to be completed by June 30, 2015. If MDE approves an RFP vendor and resulting work product, MDE will then post the trainings for Districts and provide additional training as needed.

d. Identifying options for experts and expert review, funding, and other supports for students in need of long term, systemic, and intensive interventions;

2d Update: MDE and DHS have held statewide training on children's therapeutic services and supports (CTSS) funding that incorporated the (Positive Behavior Interventions and Support (PBIS) tier model, including Tier 3, as a service delivery model. MDE and DHS are working together on the School Mental Health Services Frameworks workgroup where MDE and DHS staff, together with county and school district staff, discuss, develop, and

disseminate integrated frameworks of mental health services delivery in schools (PBIS, CTSS, ACEs, etc.).

e. Supporting the coordinated implementation of the ASD Medical Assistance benefit authorized by the 2013 Legislature with regard to the respective roles of the education, human services, and healthcare systems in providing effective interventions and improving outcomes, including reduction in the use of restrictive procedures;

2e Update: Interagency meetings are held to coordinate services. This particular topic has not yet been addressed.

f. Supporting increased access to mental health treatment, including evidence-based practices, and awareness of mental health services in order to address the symptoms and behaviors of children and youth with mental illnesses, including those with intensive service needs, covered through the (Medical Assistance – individualized education plan (MA-IEP) program, School CTSS program, School-linked Mental Health Grant program, co-located Mental Health Services, and Mental Health in Schools Act.

2f Update: DHS and MDE staff meet on an ongoing basis to discuss different topics. MDE and DHS held a joint CTSS training in October 2014. At the December 5, 2014 Special Education Directors Forum held at MDE, MDE and DHS staff presented on MA-IEP issues, including behavior services and special education transportation. Current discussions between MDE and DHS include a discussion of the interplay between school linked mental health providers, community providers, and the provision of services under a student's IEP.

MDE and DHS staff, along with intermediate district staff, participate in an ongoing DHS work group on the issue of crisis services. The work group has discussed the need to develop a process that includes defining what crisis services are, how to access crisis services, and how to track school district use of crisis services. For purposes of the Olmstead Plan, this activity is focusing on DHS mobile crisis teams, which are funded through MA. Note: Some intermediate districts will continue to set up services with external crisis providers.

Goal 2 involves collaboration between MDE and DHS. Its purpose is to continue the current work and to share expertise for maximum use of resources as the agencies continue to work toward identifying evidence-based practices to address the needs of students with disabilities who are experiencing high rates of restrictive procedures. The 2013 Stakeholder Group provided MDE and DHS with the flexibility to determine the priority and scope of implementing goal number two, based upon resource issues and data demonstrating effectiveness.

Goal 2 Action Items

- **MDE and DHS:** Identify resources and experts external to districts, develop referral lists posted to MDE website, and ensure cultural responsiveness.
- **School Districts**: Provide input to MDE regarding resources and experts.
- **Advocacy Organizations:** Identify resources and experts external to districts and ensure parents are informed of the resource directory.

Goal 3: The Restrictive Procedures Workgroup will provide input to the Mental Health Workforce Summit in order to recommend training to reduce the use of restrictive procedures.

Goal 3 Action Items

- **MDE, DHS and Stakeholder Group:** Participate in listening sessions and planning for the Workforce Summit.

Goal 3 Update: MDE and DHS staff, as well as members of the stakeholder group, participated in listening sessions and planning for the 2014 Mental Health Summit. One stakeholder then attended "HealthForce Minnesota: Mental Health Summit" at Hennepin Technical College on May 28, 2014. No documentation that any training specific to the reduction of restrictive procedures was developed as part of the Summit. The Mental Health Workforce Summit is completed and a legislative report was developed in January 2015.

Goal 4: By August 1, 2014, MDE will collaborate with school districts, including, but not limited to, intermediate school districts, DHS, parent advocacy groups, and community partners to develop a restrictive procedures discussion panel on the legal and practical aspects of reducing the use of restrictive procedures and eliminating the use of the prone restraints to be available to the education community. Panel discussions will be scheduled beginning with the 2014-15 school year.

Goal 4 Update: On July 29, 2014, MDE held a collaboration meeting with stakeholders from DHS, districts, and parent advocacy groups. Subsequently, MDE scheduled and facilitated discussion panels on October 15, 2014 and December 16, 2014. The purpose of the October 15, 2014 discussion panel was to assist the education community in reducing the use of restrictive procedures and eliminating the use of prone restraints in schools by sharing evidence-based best practices and effective strategies and resources. After feedback and input from the 2014 Stakeholder Group, the December 16, 2014 discussion panel's purpose was to share evidence based best practices and effective strategies and resources to remove the barriers to eliminating the use of prone restraints in schools. That discussion panel targeted districts currently using prone restraint, and persons could attend in person or participate through a live stream. The barriers to eliminating prone restraint identified by the registrants were: 1) students with significant behaviors; 2) unintended negative consequences; 3) insufficient support for schools; 4) costs; and 5) lack of clarity about the laws.

Goal 4 Action Items

- **MDE:** Coordinate setting up the discussion panel.
- **DHS:** Participate in the discussion panel about evidence-based best practices.
- **School Districts:** Intermediate and other districts will participate to share effective strategies and resources. School Districts will make staff available to attend the panel discussions.

Goal 5: Consistent with Minnesota's 2013 Olmstead Plan, by June 30, 2015 and each subsequent year, a minimum of 40 additional schools will use the evidence-based practice of PBIS so that students are supported in the most integrated setting. Within this environment of school-wide positive behavior support, districts will train school staff and ensure that compatible school-wide and individual positive behavior approaches align.

Goal 5 Update: MDE is on target to meet this goal. Four hundred eighty-eight (24 percent) of all schools have gone through the PBIS training. Applications for the next PBIS cohort training closed on January 20, 2015. MDE and DHS continue to meet as part of the mental health advisory committee to address PBIS and school linked mental health grants and issues related to mental health. During the 2014-15 school year, the committee will study seven sites that have effective universal PBIS and effective school linked mental health services. The study will include looking at the alignment of school-wide and individual positive behavior approaches.

Goal 6: During the 2014 legislative session, the legislature will consider increasing the general education revenue to allocate state funding for supporting school districts to maintain focus and sustain fidelity of PBIS sites beyond the current two-year support for PBIS implementation. Districts will apply to MDE for state funding through an application process, which will include a requirement that school districts collect and report implementation data. The current cost is anticipated to be $240,000 and will increase as additional school sites complete two years of PBIS training.

Goal 6 Update: The state legislature did not increase revenue for this purpose. There may be proposed legislation during the 2015 legislative session to accelerate the number of schools completing PBIS training each year.

Goals 5 and 6 Action Items

- **MDE:** Provide ongoing technical assistance support and strive to adjust the fiscal burden partially away from special education.
- **School Districts:** Strive to create staff investment in the PBIS culture and make staff available for training.
- **University of Minnesota**: Provide training and technical assistance for Tier 3 level of PBIS.
- **Legislature:** Legislative action to establish a general fund stream to sustain PBIS training in school sites beyond the current two-year training, which is federally funded.

Goal 7: Annually, beginning February 1, 2015, MDE will submit a report to the Legislature summarizing the state's progress on reducing the use of restrictive procedures statewide with recommendations on how to further reduce their use.

As set forth in the prior statewide plan, the continued meetings of the 2013 stakeholder group will allow the group to continue policy work to ensure that positive school outcomes, positive school success for students with mental health and behavior health needs, including the receipt of necessary services and delivery, is reviewed and modified as necessary.

Goal 7 Update: MDE has submitted an annual legislative report related to the use of restrictive procedures in Minnesota public schools beginning on February 1, 2012. Based upon the recommendations in the 2013 statewide plan, the legislature authorized ongoing meetings of the restrictive procedures Stakeholder Group and annual legislative reports. MDE coordinated 2014 Stakeholder Group meetings, which were held in September, October, and January, to review summary restrictive procedures data and individual incidents of prone restraint. At each meeting, stakeholders were given the opportunity to provide input and share strategies and barriers in reducing the use of restrictive procedures and eliminating the use of prone restraint.

At the January 23, 2015 Stakeholder Group meeting, MDE staff reviewed the draft Appendix A for input, discussion, and final recommendations. The data contained in the 2015 Legislative Report has been shared at the restrictive procedures work group meetings. The legislative reports include a summary of progress in implementing the statewide plan, and contain additional recommendations to the Legislature to assist in the reduction of restrictive procedures and the elimination of prone restraint. The reports also include data to inform the Legislature and the public on the use of restrictive procedures in public schools, and to provide data comparisons between reporting periods. Appendix A of each report includes a statewide plan and recommendations for legislative changes to the restrictive procedure statues, and Appendix B provides a summary of other state statutes. This goal will be completed by February 1, 2015.

Goal 7 Action Items

- **MDE:** Submit a report annually and coordinate quarterly meetings of the stakeholder group.
- **School Districts**: Collection and reporting of summary restrictive procedures data and individual incidents of prone restraint.
- **Stakeholder Group**: Meet quarterly to review the data and progress toward goals and to review and revise goals as needed,

Goal 8: During the 2014 legislative session, the legislature will consider establishing a task force to make recommendations on how to integrate planning between the K-12 and post-secondary systems to assist students with disabilities with their transition from school to post-school activities. The task force members would include school district representatives, community based provider representatives, and county social service representatives.

While this goal is broader than the scope of the 2014 Stakeholder Group, the stakeholders wanted to emphasize the need for alignment of resources to allow for a positive transition from K-12 to post-school activities. For students with more significant needs, this planning is essential. The 2013 stakeholder group believes that implementation of these goals will result in the reduction of the use of restrictive procedures in the educational setting.

Goal 8 Update: The Legislature did not create a task force for this purpose.

VII. Goals Recommended by Stakeholder Group

The 2014 Stakeholder Group focused its work on reviewing data and implementation of the 2013 statewide plan. All recommendations by the 2014 Stakeholder Group are intended to reduce school districts' use of restrictive procedures and eliminate the use of prone restraint. As set forth in the 2013 statewide plan, the 2014 Stakeholder Group has provided MDE and DHS with flexibility in determining the priority and scope of implementing goal number two, based upon resource issues and data demonstrating effectiveness.

Goal 1: On or before August 1, 2015, MDE will:

Goal 1a: Based upon a review of the restrictive procedure data, MDE staff will contact the districts using prone restraint, and/or high usages of restrictive procedures, prior to August 1, 2015, to identify the areas of technical assistance needed and then facilitate the provision of onsite targeted technical assistance for individual students as needed. The 2014 Stakeholder workgroup supports legislative proposals during the 2015 Legislative Session for the creation of

PRTF in the Twin Cities, Youth Assertive Community Treatment (ACT) Teams, and reciprocity for teachers from other states as well as alternative licensure options.

Goal 1b: Develop a process for school districts to use targeted technical assistance related to reducing the use of restrictive procedures, and eliminating prone restraint by August 1, 2015. MDE will meet with the Restrictive Procedures stakeholders, including DHS, to discuss training and resources, and also partner with the National Alliance on Mental Illness (NAMI) and other appropriate advocacy agencies regarding parent resources. Targeted technical assistance may include teams from the intermediate districts or other level four programs to help provide expertise, including practical tools. The Stakeholder Group will explore the possibility of developing a video and contacting the regional centers to notify districts of this training opportunity.

Goal 1c: Update the MDE Sample Restrictive Procedures Plan and post it on its website in accordance with Minnesota Statutes section 125A.0942.

Goal 1d: Make publically accessible, in an electronic format on MDE's website, information pertaining to how schools/school districts may access local mental health services for their students including ACT teams and mobile crisis response teams

Goal 1e: Make publically accessible, in an electronic format on MDE's website, information pertaining to DHS's Positive Support Community of Practice bi-weekly live stream meetings.

Goal 1 Action Items

- **MDE:** Responsible to implement Goal 1, a-e.
- **DHS:** Collaborate with MDE for Goal 1b. Provide information to MDE related to Goal 1d and 1e.
- **School Districts:** Request or utilize offered targeted technical assistance, collect and report in summary form the use of reasonable force when it results in the use of a physical hold or seclusion on a student with a disability; and to utilize the resources made available on the MDE website regarding accessing local mental health services and the DHS live stream meetings.
- **All Stakeholders:** Support the Legislative Proposals outlined in Goal 1a.

Goal 2: Beginning in March 2014, MDE will continue collaboration with DHS by:

a. Supporting implementation of evidence-based practices for positive behavior strategies through the channels already developed by DHS's Continuing Care Administration and Children's Mental Health Division, Positive Support Community of Practice;

b. Identifying systems for culturally responsive resource identification, consistent with the Positive Support Community of Practice, by collaborating with the Children's Mental Health and Disability Services Division of DHS, including at least the following:

i. prevention;

ii. quality improvement;

iii. intensive intervention; and

iv. systems collaboration.

At future Stakeholder meetings, MDE will share resources from the PBIS Center that address cultural inequity.

c. Researching three cross-expertise training models for statewide use:

i. a continuum of treatment and educational service options for students with a combination of severe mental illnesses and developmental disabilities, including Fetal Alcohol Spectrum Disorder;

ii. in collaboration with emotional and behavioral disorders (EBD) experts and mental health experts, develop an EBD training model that addresses strategies to reduce restrictive procedures used on students with severe aggressive/self-injurious behaviors; and

iii. in collaboration with autism spectrum disorder (ASD) experts, develop an ASD training model that addresses strategies to reduce restrictive procedures used on students with severe intellectual impairments and aggressive/self-injurious behaviors.

If a Request for proposal (RFP) application is accepted and the training materials are developed in accordance with the RFP, the training will be disseminated on MDE's website and DVDs will be made available as an alternate format.

d. Identifying options for experts and expert review, funding, and other supports for students in need of long term, systemic, and intensive interventions;

e. Supporting the coordinated implementation of the ASD Medical Assistance benefit authorized by the 2013 Legislature with regard to the respective roles of the education, human services, and healthcare systems in providing effective interventions and improving outcomes, including reduction in the use of restrictive procedures;

f. Supporting increased access to mental health treatment, including evidence-based practices, and awareness of mental health services in order to address the symptoms and behaviors of children and youth with mental illnesses, including those with intensive service needs, covered through the MA-IEP program, School CTSS program, School-linked Mental Health Grant program, co-located Mental Health Services, and Mental Health in Schools Act.

Goal 2 involves collaboration between MDE and DHS. Its purpose is to continue the current work and to share expertise for maximum use of resources as the agencies continue to work toward identifying evidence-based practices to address the needs of students with disabilities who are experiencing high rates of restrictive procedures. The 2014 Stakeholder Group provided MDE and DHS with the flexibility to determine the priority and scope of implementing goal number two, based upon resource issues and data demonstrating effectiveness.

Goal 2 Action Items

- **MDE and DHS:** Identify resources and experts external to districts, develop, and update referral lists posted to MDE website, and ensure cultural responsiveness.
- **School Districts**: Provide input to MDE regarding resources and experts.
- **Advocacy Organizations:** Identify resources and experts external to districts and ensure parents are informed of the resource directory.

Goal 3: The Restrictive Procedure Workgroup will provide input to any follow-up meetings related to the Mental Health Workforce Summit in order to recommend training to reduce the use of restrictive procedures.

Goal 3 Action Items

- **MDE, DHS and Stakeholder Group:** Participate in any meetings and planning for a follow-up session to the Workforce Summit.

Goal 4: By August 1, 2015, MDE will collaborate with school districts, including, but not limited to, intermediate school districts, DHS, parent advocacy groups, and community partners to discuss different types of trainings related to the reduction of restrictive procedures to be available to the education community. Stakeholders who will participate in the discussions will include ARC, PACER, and Intermediates 287 and 917.

Goal 4 Action Items

- **MDE:** Coordinate setting up meetings to discuss trainings.
- **DHS:** Participate in the meetings and provide information about evidence based best practices.
- **School Districts:** Intermediate and other districts will participate to share effective strategies and resources. School Districts will make staff available to attend trainings.

Goal 5: Consistent with Minnesota's 2013 Olmstead Plan, by June 30, 2015 and each subsequent year, a minimum of 40 additional schools will use the evidence-based practice of PBIS so that students are supported in the most integrated setting. Within this environment of school-wide positive behavior support, districts will train school staff and ensure that compatible school-wide and individual positive behavior approaches align. During the fall of 2015, the stakeholders will review the data from the MDE and DHS case studies of seven sites with effective universal PBIS and effective school linked mental health services.

Goal 6: During the 2015 legislative session, the legislature will consider increasing the general education revenue to allocate state funding for supporting school districts to maintain focus and sustain fidelity of PBIS sites beyond the current two-year support for PBIS implementation. Districts will apply to MDE for state funding through an application process, which will include a requirement that school districts collect and report implementation data. The current cost is anticipated to be $240,000 and will increase as additional school sites complete two years of PBIS training. MDE will assign a priority for schools where students are experiencing high usages of restrictive procedures.

Goals 5 and 6 Action Items

- **MDE:** Provide ongoing technical assistance support and strive to adjust the fiscal burden partially away from special education.

- **School Districts:** Strive to create staff investment in the PBIS culture and make staff available for training.
- **University of Minnesota**: Provide training and technical assistance for Tier 3 level of PBIS.
- **Legislature:** Legislative action to establish a general fund stream to sustain PBIS training in school sites beyond the current two-year training, which is federally funded.

Goal 7: Annually, beginning February 1, 2015, MDE will submit a report to the Legislature summarizing the state's progress on reducing the use of restrictive procedures statewide with recommendations on how to further reduce their use. The 2015 Stakeholder Group will meet in the fall to review annual summary data from the 2014-15 school year, and will determine if additional meetings are necessary. The purpose of the meeting(s) is to allow the group to continue policy work to ensure that positive school outcomes, positive school success for students with mental health and behavior health needs, including the receipt of necessary services and delivery, is reviewed and modified as necessary.

Goal 7 Action Items

- **MDE:** Submit a report annually and coordinate meetings of the stakeholder group.
- **School Districts**: Collection and reporting of summary restrictive procedures data, and individual incidents of prone restraint until August 1, 2015.
- **Stakeholder Group**: Meet to review the data and progress toward goals and to review and revise goals as needed,

Goal 8: During the fall 2015 Stakeholder Group meeting, MDE staff and stakeholders will review the grantees' work plans and outcome results to determine if there are successful models that can be applied to other districts. During the 2015-16 school year, the stakeholders will discuss ways to share the results.

Goal 8 Action Items:

- **MDE**: Provide copies of the grantees' work plans and outcome results to the 2014 Stakeholder Group at the fall 2015 meeting.
- **Grantees**: Timely provide to MDE outcome results for their work plans and participate in discussions at the fall 2014 workgroup meeting.
- **Stakeholder Group**: Meet to review the grantees' work plans and outcome results and determine if there are successful models that can be applied to other districts. Discuss how to share the results.

Goal 9: During the fall 2015 Stakeholder Group meeting, MDE staff and stakeholders will review the student and staff injury data reported by districts in the annual restrictive procedure summary report for the 2013-14 and 2014-15 school years.

Goal 9 Action items:

- **MDE:** Provide a summary of the student and staff injury data reported by districts on the annual summary form for the 2013-14 and 2014-15 school years at the fall 2015 Stakeholder Group meeting.

- **Districts:** Provide staff and student injury data to MDE on the annual summary restrictive procedure summary form.
- **Stakeholder group:** Review the data at the fall 2015 Stakeholder Group meeting.

VIII. Recommendations

1. Support Stakeholder-Driven Changes to Statute.

The 2014 stakeholder group recommended that the Minnesota Legislature amend Minnesota Statutes, section 125A.0942 to make prone restraint a prohibited procedure, effective August 1, 2015. This recommendation aligns with the Minnesota Revised Olmstead Plan.

The 2014 stakeholder group also recommended that the Minnesota Legislature amend Minnesota Statutes, section 125A.0942 subdivision 3(b) to make the development of a statewide plan permissive. This allows the 2014 stakeholder group to work on the 2014 statewide plan and only make revisions to that plan as necessary.

The 2014 stakeholder group also recommended that the Legislature appropriate $250,000 to be available beginning with the 2015-16 school year, to ensure students can continue to be educated in the least restrictive environment with appropriate behavior interventions, supports, and expertise, and to avoid student placements into more restrictive environments to receive such services. The funds will be used to reimburse expert teams, as described in Goal 1b. The 2014 stakeholder group agreed that the funds are needed to provide training and services to district staff so that students can be educated in the least restrictive environment.

125A.0942 STANDARDS FOR RESTRICTIVE PROCEDURES.

Subdivision 1. **Restrictive procedures plan**. (a) Schools that intend to use restrictive procedures shall maintain and make publicly accessible in an electronic format on a school or district website or make a paper copy available upon request describing a restrictive procedures plan for children with disabilities that at least:

(1) lists the restrictive procedures the school intends to use;

(2) describes how the school will implement a range of positive behavior strategies and provide links to mental health services;

(3) describes how the school will provide training on de-escalation techniques, in accordance with 122A.09 Subd. 4.

(3) describes how the school will monitor and review the use of restrictive procedures, including:

(i) conducting post-use debriefings, consistent with subdivision 3, paragraph (a), clause (5); and

(ii) convening an oversight committee to undertake a quarterly review of the use of restrictive procedures based on patterns or problems indicated by similarities in the time of day, day of the week, duration of the use of a procedure, the individuals

involved, or other factors associated with the use of restrictive procedures; the number of times a restrictive procedure is used schoolwide and for individual children; the number and types of injuries, if any, resulting from the use of restrictive procedures; whether restrictive procedures are used in nonemergency situations; the need for additional staff training; and proposed actions to minimize the use of restrictive procedures; and

(4) includes a written description and documentation of the training staff completed under subdivision 5.

(b) Schools annually must publicly identify oversight committee members who must at least include:

(1) a mental health professional, school psychologist, or school social worker;

(2) an expert in positive behavior strategies;

(3) a special education administrator; and

(4) a general education administrator.

Subd. 2. **Restrictive procedures**. (a) Restrictive procedures may be used only by a licensed special education teacher, school social worker, school psychologist, behavior analyst certified by the National Behavior Analyst Certification Board, a person with a master's degree in behavior analysis, other licensed education professional, paraprofessional under section 120B.363, or mental health professional under section 245.4871, subdivision 27, who has completed the training program under subdivision 5.

(b) A school shall make reasonable efforts to notify the parent on the same day a restrictive procedure is used on the child, or if the school is unable to provide same-day notice, notice is sent within two days by written or electronic means or as otherwise indicated by the child's parent under paragraph (f).

(c) The district must hold a meeting of the individualized education program team, conduct or review a functional behavioral analysis, review data, consider developing additional or revised positive behavioral interventions and supports, consider actions to reduce the use of restrictive procedures, and modify the individualized education program or behavior intervention plan as appropriate. The district must hold the meeting: within ten calendar days after district staff use restrictive procedures on two separate school days within 30 calendar days or a pattern of use emerges and the child's individualized education program or behavior intervention plan does not provide for using restrictive procedures in an emergency; or at the request of a parent or the district after restrictive procedures are used. The district must review use of restrictive procedures at a child's annual individualized education program meeting when the child's individualized education program provides for using restrictive procedures in an emergency.

(d) If the [IEP] team under paragraph (c) determines that existing interventions and supports are ineffective in reducing the use of restrictive procedures or the district

uses restrictive procedures on a child on ten or more school days during the same school year, the team, as appropriate, either must consult with other professionals working with the child; consult with experts in behavior analysis, mental health, communication, or autism; consult with culturally competent professionals; review existing evaluations, resources, and successful strategies; or consider whether to reevaluate the child.

(e) At the [IEP] meeting under paragraph (c), the team must review any known medical or psychological limitations, including any medical information the parent provides voluntarily, that contraindicate the use of a restrictive procedure, consider whether to prohibit that restrictive procedure, and document any prohibition in [IEP] or [BIP].

(f) An [IEP] team may plan for using restrictive procedures and may include these procedures in a child's individualized education program or behavior intervention plan; however, the restrictive procedures may be used only in response to behavior that constitutes an emergency, consistent with this section. The [IEP] or [BIP] shall indicate how the parent wants to be notified when a restrictive procedure is used.

Subd. 3. **Physical holding or seclusion**. (a) Physical holding or seclusion may be used only in an emergency. A school that uses physical holding or seclusion shall meet the following requirements:

(1) physical holding or seclusion is the least intrusive intervention that effectively responds to the emergency;

(2) physical holding or seclusion is not used to discipline a noncompliant child;

(3) physical holding or seclusion ends when the threat of harm ends and the staff determines the child can safely return to the classroom or activity;

(4) staff directly observes the child while physical holding or seclusion is being used;

(5) each time physical holding or seclusion is used, the staff person who implements or oversees the physical holding or seclusion documents, as soon as possible after the incident concludes, the following information:

(i) a description of the incident that led to the physical holding or seclusion;

(ii) why a less restrictive measure failed or was determined by staff to be inappropriate or impractical;

(iii) the time the physical holding or seclusion began and the time the child was released; and

(iv) a brief record of the child's behavioral and physical status;

(6) the room used for seclusion must:

(i) be at least six feet by five feet;

(ii) be well lit, well ventilated, adequately heated, and clean;

(iii) have a window that allows staff to directly observe a child in seclusion;

(iv) have tamperproof fixtures, electrical switches located immediately outside the door, and secure ceilings;

(v) have doors that open out and are unlocked, locked with keyless locks that have immediate release mechanisms, or locked with locks that have immediate release mechanisms connected with a fire and emergency system; and

(vi) not contain objects that a child may use to injure the child or others;

(7) before using a room for seclusion, a school must:

(i) receive written notice from local authorities that the room and the locking mechanisms comply with applicable building, fire, and safety codes; and

(ii) register the room with the commissioner, who may view that room, and(b) By February 1, 2015, and annually thereafter, stakeholders may, as necessary, recommend to the commissioner specific and measurable implementation and outcome goals for reducing the use of restrictive procedures and the commissioner must submit to the legislature a report on districts' progress in reducing the use of restrictive procedures that recommends how to further reduce these procedures. The statewide plan includes the following components: measurable goals; the resources, training, technical assistance, mental health services, and collaborative efforts needed to significantly reduce districts' use of prone restraints; and recommendations to clarify and improve the law governing districts' use of restrictive procedures. The commissioner must consult with interested stakeholders when preparing the report, including representatives of advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, county social services, state human services department staff, mental health professionals, and autism experts. By June 30 each year, districts must report summary data on their use of restrictive procedures to the department, in a form and manner determined by the commissioner. The summary data must include information about the use of restrictive procedures, including use of reasonable force under section 121A.582.

~~(8) until August 1, 2015, a school district may use prone restraints with children age five or older if:~~

~~(i) the district has provided to the department a list of staff who have had specific training in the use of prone restraints;~~

~~(ii) the district provides information on the type of training that was provided and by whom;~~

~~(iii) only staff who received specific training use prone restraints; and~~

~~(iv) each incident of the use of prone restraints is reported to the department within five working days on a form provided by the department.~~

APPENDIX A

Subd. 4. **Prohibitions**. The following actions or procedures are prohibited:

(1) engaging in conduct prohibited under section 121A.58;

(2) requiring a child to assume and maintain a specified physical position, activity, or posture that induces physical pain;

(3) totally or partially restricting a child's senses as punishment;

(4) presenting an intense sound, light, or other sensory stimuli using smell, taste, substance, or spray as punishment;

(5) denying or restricting a child's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the child's functioning, except when temporarily removing the equipment or device is needed to prevent injury to the child or others or serious damage to the equipment or device, in which case the equipment or device shall be returned to the child as soon as possible;

(6) interacting with a child in a manner that constitutes sexual abuse, neglect, or physical abuse under section 626.556;

(7) withholding regularly scheduled meals or water;

(8) denying access to bathroom facilities;

(9) Effective August 1, 2015, prone restraint, and

(10) physical holding that restricts or impairs a child's ability to breathe, restricts or impairs a child's ability to communicate distress, places pressure or weight on a child's head, throat, neck, chest, lungs, sternum, diaphragm, back, or abdomen, or results in straddling a child's torso.

Subd. 5. **Training for staff.** (a) To meet the requirements of subdivision 1, staff who use restrictive procedures, including paraprofessionals, shall complete training in the following skills and knowledge areas:

(1) positive behavioral interventions;

(2) communicative intent of behaviors;

(3) relationship building;

(4) alternatives to restrictive procedures, including techniques to identify events and environmental factors that may escalate behavior;

(5) de-escalation methods;

(6) standards for using restrictive procedures only in an emergency;

(7) obtaining emergency medical assistance;

(8) the physiological and psychological impact of physical holding and seclusion;

(9) monitoring and responding to a child's physical signs of distress when physical holding is being used;

(10) recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding is used;

(11) district policies and procedures for timely reporting and documenting each incident involving use of a restricted procedure; and

(12) school-wide programs on positive behavior strategies.

(b) The commissioner, after consulting with the commissioner of human services, must develop and maintain a list of training programs that satisfy the requirements of paragraph (a). The commissioner also must develop and maintain a list of experts to help [IEP] teams reduce the use of restrictive procedures. The district shall maintain records of staff who have been trained and the organization or professional that conducted the training. The district may collaborate with children's community mental health providers to coordinate trainings.

Subd. 6.Behavior supports; reasonable force.

(a) School districts are encouraged to establish effective schoolwide systems of positive behavior interventions and supports.

(b) Nothing in this section or section 125A.0941 precludes the use of reasonable force under sections 121A.582; 609.06, subdivision 1; and 609.379. For the 2014-15 school year and later, districts must collect and submit to the commissioner summary data, consistent with subdivision 3, paragraph (b), on district use of reasonable force that is consistent with the definition of physical holding or seclusion for a child with a disability under this section.

2. Support Stakeholder Planned Action Items

MDE supports the consensus-based recommendations reached by the 2014 stakeholder group regarding actions that various stakeholders, agencies and the legislature can take to best ensure a reduction in the use of restrictive procedures in the Minnesota education system. As such, MDE recommends the above goals to reduce the use of restrictive procedures and eliminate prone restraints.

3. Strengthen Pre-Enrollment Screening

Pre-enrollment screening for change of placement should be conducted for students exhibiting challenging behaviors in order to pair consequences (both in emergency and in modification) with individual needs. This screening data should include a current (within the past 30 days) functional behavior assessment to ensure that receiving districts are able to design behavior response plans that are specific to the needs of the student.

Very often, intermediate school districts are the receiving districts in these situations. By relying on thorough pre-enrollment screening based on a detailed report of what prior interventions were used and their effect, intermediates and other receiving districts will be better equipped to address student needs. With this data, intermediate districts will have more effective tools for designing individualized and instructional behavior improvement plans that reflect interventions that are least restrictive for students.

APPENDIX B 2015

Legislative Language or **Policy Guidance** Currently in Effect in All States Relating Specifically to Prone Restraint or Restraint that Restricts or Impairs a Child's Ability to Breathe Within the School Setting

State	Citation	Language	
Alabama	Ala. Admin. Code r. 290-3-1-.02(1)(f)(1) (2014)	Prohibits: "(iv) Physical Restraint that restricts the flow of air to the student's lungs—Any method (face-down, face-up, or on your side) of physical restraint in which physical pressure is applied to the student's body that restricts the flow of air into the student's lungs. Use of this type of restraint is prohibited in Alabama public schools and educational programs."	Applies to all children
Alaska	HB 210 amends Alaska Stat. 14.33.120(c) (2014)	"A teacher, teacher's assistant, or other person responsible for students may not ...(3) physically retrain a student by placing the student on the student's back or stomach or in a manner that restricts the student's breathing."	Applies to children with disabilities
Arizona	The Use of Seclusion and Restraint: A Guidance Document on Best Practices Arizona Dept. Of Educ. (2014)	Prohibit some disciplinary procedures including a "physical restraint that places excess pressure on the chest or back or impedes the ability to breather or communicate is prohibited."	Applies to all children with disabilities
Arkansas	Arkansas Dept. of Educ. Advisory Guidelines for the Use of Student Restraints in Public School or Educational Settings, p. 13 (2014)	Prone restraint or other restraints that restrict breathing should never be used because they can cause serious injury or death."	Applies to all children

Appendix B

State	Citation	Language	
California	Cal. Code Reg. tit. 5, § 3052(i)(4)(B)-(C) and (l)(1) and (5) (2013)	(i)(4) Emergency interventions may not include:...(B) employment of a device or material or objects which simultaneously immobilize all four extremities except that techniques such as prone containment may be used as an emergency intervention by staff trained in such procedures; and (C) an amount of force that exceeds that which is reasonable and necessary under the circumstances. (l) Prohibitions. (1) Any intervention that is designed to, or likely to, cause physical pain; (5) "Restrictive interventions which employ a device or material or objects that simultaneously immobilize all four extremities, including the procedure known as prone containment, except that prone containment or similar techniques may be used by trained personnel as a limited emergency intervention pursuant to subdivision (i)."	Applies to children with disabilities
Colorado	Colo. Code Reg. tit. 1, §§ 301-45, 2620-R-2.00 et seq. (2009)	2620-R-2.00(4) defines "positional asphyxia" to mean "an insufficient intake of oxygen as a result of body position that interferes with one's ability to breathe." 2620-R-2.02(1)(a) "the public education program shall ensure that: (i) no restraint is administered in such a way that the student is inhibited or impeded from breathing or communicating; (ii) no restraint is administered in such a way that places excess pressure on the student's chest, back, or causes positional asphyxia."	Applies to all children
Connecticut	Conn. Gen. Stat. §§ 46a-150(4) and 46a-151 Conn. Admin. Regs. §§ 10-76b-510-76b-11	46a-150(4) defines "life-threatening physical restraint" to mean "any physical restraint or hold of a person that restricts the flow of air into a person's lungs, whether by chest compression or any other means." 46a-151 prohibits the use of life-threatening physical restraint.	Applies to children with disabilities

Appendix B

State	Citation	Language	
Delaware	Del. Code Chapt. 41, tit. 14 § 4112F (effective 7.1.14)	(b) Prohibitions and restriction on use. (2) Public school personnel may impose physical restraint only in conformity with all of the following standards: … (b) The physical restraint does not interfere with the student's ability to communicate in the student's primary language or mode of communication; (c) the physical restraint does not interfere with the student's ability to breathe or place weight or pressure on the student's head, throat, or neck; (d) the physical restraint does not recklessly exacerbate a medical or physical condition of the student …	Applies to all children
District of Columbia	57 D. C. Reg. 9457	2818.1 "Nonpublic special education school or program shall not use any form of prone restraint on a District of Columbia student. Use of such restraints as a policy or practice shall be grounds for denying or revoking a certificate of approval."	Applies to children with disabilities
Florida	Fla. Stat. § 1003.573	(4) Prohibited restraint. "School personnel may not use a mechanical restraint or a manual or physical restraint that restricts a student's breathing."	Applies to children with disabilities
Georgia	Ga. Comp. R. & r. 160-5-1-3.5	"(2)(b) The use of prone restraint is prohibited in Georgia public schools and educational programs."	Applies to all children
Hawaii	Haw. Rev. Stat. § 302A-1141[45]	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to children with disabilities
Idaho[46]		No laws or guidance on restraints.	

[45] Provides: No physical punishment of any kind may be inflicted upon any pupil, but reasonable force may be used by a teacher in order to restrain a pupil in attendance at school from hurting oneself or any other person or property, and reasonable force may be used … by a principal or the principal's agent only with another teacher present and out of the presence of any other student but only for the purpose outlined in § 703-309(2)(a)."

Appendix B

State	Citation	Language	
Illinois	105 Ill. Comp. Stat. § 5/10-20.33 Ill. Admin. Code, tit. 23, § 1.285	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to all children
Indiana	Indiana SB 0345 (passed 5.13.13) Commission on Seclusion and Restraint in Schools, Model Seclusion and Restraint Plan[47] (8.1.13)	Requires a commission to adopt rules and model policy pertaining to seclusion and restraint. Model plan provides: IG. "Prone and supine forms of restraint are not authorized and shall be avoided." IH. "Seclusion and restraint shall never be used in a manner that restricts a child's breathing or harms the child."	Applies to all children
Iowa	Iowa Admin. Code r. 281-103.8	"(1) No employee shall use any prone restraints. For the purposes of this rule, "prone restraints" means those in which an individual is held face down on the floor. Employees who find themselves involved in the use of a prone restraint as the result of responding to an emergency must take immediate steps to end the prone restraint."	Applies to all children
Kansas	32 Kansas Register No. 14, 317 (April 4, 2013)	91-42-2(a)(1)(A) "Policies and procedures shall prohibit the following: (i) The use of prone, face-down, physical restraint; or face-up, physical restraint; physical restraint that obstructs the airway of a student; or any physical restraint that impacts a student's primary mode of communication."	Applies to all children

[46] Task force established in Aug. 2010 with proposed rules (IDAPA 08.02.03.160-161) however no action was taken.

[47] Schools are free to adopt a model plan as they see fit. However, any plan adopted by a school must contain, at a minimum, the elements listed in Indiana Code 20-20-40-13.

Appendix B

State	Citation	Language	
Kentucky	704 Kentucky Admin. Regs. 7:160 (2013)	Section 3(2) "School personnel shall not impose the following on any student at any time: ... (d) Physical restraint that is life-threatening; (e) Prone or supine restraint; or (f) Physical restrict if they know that physical restraint is contraindicated based on the student's disability, health care needs, or medical or psychiatric condition."	Applies to all children
Louisiana	La. Rev. Stat. § 17:416.21(C)	(1)"Physical restraint shall be used only ... (c) In a manner that causes no physical injury to the student, results in the least possible discomfort, and does not interfere in any way with a student's breathing or ability to communicate with others;" . . . (3) "No student shall be physically restrained in a manner that places excessive pressure on the student's chest or back or that causes asphyxia; (4) A student shall be physically restrained only in a manner that is directly proportionate to the circumstances and to the student's size, age, and severity of behavior."	Applies to children with disabilities
Maine	LD 243[48] (passed 2013) 05-071 Department of Education, Chapter 33, Section 6	"2. Prohibited forms and uses of physical restraint ... C) No physical restraint may be used that restricts the free movement of the diaphragm or chest or that restricts the airway so as to interrupt normal breathing or speech (restraint-related positional asphyxia) of a student; D) No physical restraint may be used that relies on pain for control, including but not limited to joint hypertension, excessive force, unsupported take-down (e.g. tackle), the use of any physical structure (e.g. wall, railing or post), punching and hitting."	Applies to all children

[48] Revised existing statutory provisions pertaining to physical holding and seclusion.

Appendix B

State	Citation	Language	
Maryland	Md. Regs. Code tit. 13A. § 13A.08.04.05(A)(1)(e)	Provides: "In applying restraint, school personnel may not: (i) Place a student in a face down position; (ii) Place a student in any position that will obstruct a student's airway or otherwise impair a student' s ability to breathe, obstruct a staff member's view of a student's face, restrict a student's face, restrict a student's ability to communicate distress, or place pressure on a student's head, neck, or torso; or (iii) straddle a student's torso."	Applies to all children
Massachusetts	Mass. Regs. Code, tit. 603, § 46.05(3) § 46.05(5)(a)	"Safest method. A person administering physical restraint shall use the safest method available and appropriate to the situation subject to the safety requirements set forth in 603 CMR 46.05(5). Floor or prone restraints shall be prohibited unless the staff member administering the restraint has received in-depth training according to the requirements of 603 CMR 46.03(3) and, in the judgment of the trained staff member, such method is required to provide safety for the student or others present." "Safety requirements. Additional requirements for the use of physical restraint: (a) No restraint shall be administered in such a way that the student is prevented from breathing or speaking. During the administration of a restraint, a staff member shall continuously monitor the physical status of the student, including skin color and respiration."	Applies to all children

Appendix B

State	Citation	Language	
Michigan	Supporting Student Behavior: Standards for the Emergency Use of Seclusion and Restraint, p. 18 Dec. 2006 Michigan Department of Education	"E. Prohibited Practices. The following procedures are prohibited under all circumstances, including emergency situations: … any restraint that negatively impacts breathing; prone restraint: school personnel who find themselves involved in the use of a prone restraint as the result of responding to an emergency must take immediate steps to end the prone restraint." "Prone restraint is the restraint of a person face down." "restraints that negatively impact breathing include floor restraints, facedown position, or any position in which a person is bent over in such a way that it is difficult to breathe. This includes a seated or kneeling position in which a person being restrained is bent over at the waist. Sitting or lying across a person's back or stomach can interfere with breathing. When a person is lying facedown, even pressure to the arms and legs can interfere with a person's ability to move their chest or abdomen in order to breathe effectively."	Applies to all children

Appendix B

State	Citation	Language	
Minnesota	Minn. Stat. §§ 125A.094 - .0942	Minn. Stat. § 125A.0942, Subd. 4(9) prohibits "physical holding that restricts or impairs a child's ability to breathe, restricts or impairs a child's ability to communicate distress, places pressure or weight on a child's head, throat, neck, chest, lungs, sternum, diaphragm, back, or abdomen, or results in straddling a child's torso." Minn. Stat. § 125A.0942, Subd. 3(a)(8) provides "until August 1, 2015, a school district may use prone restraints with children age five or older if: (i) the district has provided to the department a list of staff who have had specific training on the use of prone restraints; (ii) a district provides information on the type of training that was provided and by whom; (iii) only staff who received specific training use prone restraints; (iv) each incident of the use of prone restraints is reported to the department within five working days on a form provided by the department; and (v) the district, before using prone restraints, must review any known medical or psychological limitations that contraindicate the use of prone restraints."	Applies to children with disabilities
Mississippi		No laws or guidance on restraints.	

Appendix B

State	Citation	Language	
Missouri	Mo. Rev. Stat. § 160.263 Missouri Dep't of Elementary and Secondary Educ., Model Policy on Seclusion and Restraint (July, 2010), p. 2	State statute requires all school districts to adopt a written policy addressing the use of restrictive behavioral interventions, including but not limited to definitions of restraint, seclusion, and time-out and descriptions of circumstances under which a restrictive behavioral intervention is allowed and prohibited. It also required the state education agency to develop a model policy. The model policy states that "[t]his policy is not an endorsement of the use of seclusion and restraint. A school district may adopt a policy prohibiting the use of seclusion, isolation or restraint." It further provides that "[p]hysical restraint shall: not place pressure or weight on the chest, lungs sternum, diaphragm, back, neck or throat of the student which restricts breathing."	Applies to all children
Montana	Montana Admin. R. 10.16.3346	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to children with disabilities

Appendix B

State	Citation	Language	
Nebraska	Nebraska Adim. Code, tit. 92, R. 10, § 011.01(E) Nebraska Educ. Dept., Developing School Policies & Procedures for Physical Restraint and Seclusion in Nebraska Schools, (June, 2010), pp. 12, 27, 29, and 34	"Each school system has a seclusion and restraints policy approved by the school board or local governing body." At this time Nebraska does not have any statutes, regulations, or state policies regarding restraint or seclusion but schools are required to have school safety and security committees in charge of developing safety and security plans for each school in order to be accredited. Procedures related to these procedures "could be interpreted as coming under the scope of Nebraska's school safety policies," p. 12. Each school district may choose to format its policies according to its own practices, p. 27. Model policies include the following language: "The only physical restraints to be used are those taught by the approved Crisis Intervention Training Program," p. 29 and "Prone or supine forms of physical restraint are not authorized and should be avoided," p. 34.	Applies to all children
Nevada	Nev. Rev. Stat. §§ 388.521 – 388.5317[49] (1999)	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to children with disabilities

[49] Meaningful protections against seclusion and restraint but no specific prohibitions on prone restraint or restraints that restrict or impair a child's ability to breathe.

Appendix B

State	Citation	Language	
New Hampshire	N.H. Rev. Stat. Ann. §§ 126-U:1 – 126-U:14	126-U: 4 "Prohibition of Dangerous Restraint Techniques. No school or facility shall use or threaten to use any of the following restraint and behavior control techniques: I) Any physical restraint or containment technique that: a) obstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing; b) places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child; c) obstructs the circulation of blood; d) involves pushing on or into the child's mouth, nose, eyes, or any part of the face or involves covering the face or body with anything, including soft objects such as pillows, blankets, or washcloths; or e) endangers a child's life or significantly exacerbates a child's medical condition."	Applies to all children

Appendix B

State	Citation	Language	
New Jersey	New Jersey Dept. of Educ. Guidance Memo 2012-5 (9.18.12)	"The New Jersey Department of Education, Office of Special Education, endorses the use of [the United States Department of Education, Office of Special Education and Rehabilitative Services (USDE OSERS) May 15, 2012, Guidance Document] when developing Individual Education Programs (IEPs) which address the behavioral needs of students with disabilities."	Applies to all children
New Mexico[50]	State of New Mexico Public Educ. Dep't, Use of Physical Restraint as a Behavioral Intervention for Students with Disabilities, Memorandum (March 14, 2006)	Memorandum, pp. 3-4 "Offers the following guidance to IEP teams and building administrators: . . . No form of physical restraint may be used that restricts a student from speaking or breathing."	Applies to children with disabilities
New York	N.Y. Comp. R. and Regs., tit. 8, §§ 19.5(b) and 200.22[51] (2009)	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to all children
North Carolina	N.C. Gen. Stat. §§ 115C-391.1[52]	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to all children

[50] New Mexico does have a Children's Mental Health and Developmental Disabilities Act, which provides, under N.M. Stat. Ann. § 32A-6A-10(I), "In applying physical restraint, a mental health or developmental disabilities professional shall use only reasonable force as is necessary to protect the child or other person from imminent and serious physical harm." Additionally, in 2010, a legislative education study committee was proposed and a Restraint & Seclusion Work Group was created.

[51] New York has meaningful protections against the use of seclusion and restraint, however, such does not include any prohibition on prone restraint or restraints that restrict or impair a child's ability to breathe.

[52] North Carolina has meaningful protections against the use of seclusion and restraint, however, such does not include any prohibition on prone restraint or restraints that restrict or impair a child's ability to breathe.

Appendix B

State	Citation	Language	
North Dakota		No laws or guidance on restraints.	
Ohio	Ohio Admin. Code § 3301-35-15 (Effective Aug. 1, 2013)	(C) "Prohibition on certain practices. The following practices are prohibited by school personnel under any circumstance: (1) prone restraint; (2) Any form of physical restraint that involves the intentional, knowing, or reckless use of any technique that: (a) involves the use of pinning down a student by placing knees to the torso, head, or neck of the student; (b) uses pressure point, pain compliance, or joint manipulation techniques; or (c) otherwise involves techniques that are used to unnecessarily cause pain." (D) "Physical restraint. (1) Prone restraint is prohibited … (2) Physical restraint may be used only if …(b) The physical restraint does not obstruct the student's ability to breathe; (c) The physical restraint does not interfere with the student's primary language or mode of communication…"	Applies to all children
Oklahoma	Oklahoma State Dep't of Educ., Guidelines for Minimizing the Use of Physical Restraint for Students with Disabilities in Oklahoma (May 2010)	"Prone restraints (restraints that position a student face down on his or her stomach or face up on the back) or any maneuver that places pressure or weight on the chest, sternum, lungs, diaphragm, neck, throat, or back must not be used. No restraint that prevents a student from speaking or breathing is allowed."	Applies to children with disabilities

Appendix B

State	Citation	Language	
Oregon	OR Admin. R. 581-021-0550 to -0570 (2013)	OAR 581-021-0553: (1) "The use of a chemical restraint, mechanical restraint or prone restraint on a student in a public education program in this state is prohibited." "Prone restraint means a restraint in which a student is held face down on the floor." OAR 581-021-0550. "'Physical restraint' does not include prone restraint." OAR 581-021-0550.	Applies to all children
Pennsylvania	22 Pa. Code § 14.133(c)(3)	Provides "The use of prone restraints is prohibited in educational programs. Prone restraints are those in which a student or eligible young child is held face down on the floor."	Applies to children with disabilities

Appendix B

State	Citation	Language	
Rhode Island	R.I. Bd. of Regents for Elementary and Secondary Education, Physical Restraint Regulations, 6.2(e) and 7.3(a) (September 1, 2002)	"6.2 Prohibitions: Physical restraint/crisis intervention are prohibited in the following circumstances:... (e) As in a restrictive intervention which employs a device or material or objects that simultaneously immobilize all four extremities, including the procedure known as prone containment, except that prone containment may be used by trained personnel as a limited emergency intervention when a documented part of a previously agreed upon written behavioral intervention plan." "7.3 Safety Requirements. Additional requirements for the use of physical restraint/crisis intervention are: (a) No restraint shall be administered in such a way that the student is prevented from breathing or speaking. During the administration of a restraint, a staff member shall continuously monitor the physical status of the student, including skin color and respiration. A restraint shall be released immediately upon a determination by the staff member administering the restraint that the student is no longer at risk of causing imminent physical harm to him or herself or others. (b) Restraint shall be administered in such a way so as to prevent or minimize physical harm. If, at any time during a physical restraint/crisis intervention, the student demonstrates significant physical distress, the student shall be released from the restraint immediately, and school staff shall take steps to seek medical assistance. (c) Program staff shall review and consider any known medical or psychological limitations and/or behavioral intervention plans regarding the use of physical restraint/crisis intervention on an individual student."	Applies to all children

Appendix B

State	Citation	Language	
South Carolina	South Carolina Dep't of Educ., Guidelines on the Use of Seclusion and Restraint (2011), p. 8	"Prone restraints (with the student face down on his or her stomach) or supine restraints (with the student face up on the back) or any maneuver that places pressure or weight on the chest, lungs, sternum, diaphragm, back, neck or throat are prohibited."	Applies to children with disabilities
South Dakota		No laws or guidance on restraints.	
Tennessee	Tenn. Code Ann. § 49-10-1305(d)	"Any form of life threatening restraint, including restraint that restricts the flow of air into a person's lungs, whether by chest compression or any other means, to a student receiving special education services … is prohibited."	Applies to children with disabilities
Texas	19 Tex. Admin. Code § 89.1053(c)	"Use of restraint. A school employee, volunteer, or independent contractor may use restraint only in an emergency … with the following limitations. (1) Restraint shall be limited to the use of such reasonable force as is necessary to address the emergency… (3) Restraint shall be implemented in such a way as to protect the health and safety of the student and others. (4) Restraint shall not deprive the student of basic human necessities."	Applies to children with disabilities

Appendix B

State	Citation	Language	
Utah	Utah Code §§ 53A-11-805 Utah State Office of Education, Least Restrictive Behavioral Interventions LRBI Guidelines, Positive Behavioral Supports and Selection of Least Restrictive Behavioral Interventions[53]	"Behavior reduction intervention which is in compliance with section 76-2-401 and with state and local rules adopted under section 53A-15-301 is excepted from this part."	Applies to children with disabilities
Vermont	Vt. Code R. §§ 4500 et seq.	4500.3(9) defines prone physical restraint "means holding a student face down on his or her stomach using physical force for the purpose of controlling the student's movement." 4502.1.1 provides "prone and supine physical restraints are more restrictive than other forms of physical restraint and may be used only when the student's size and severity of behavior require such a restraint because a less restrictive restraint has failed or would be ineffective to prevent harm to the student or others." 4501.1(c) prohibits school personnel and contract service providers from imposing on a student "any physical restraint, escort, or seclusion that restricts or limits breathing or communication, causes pain or is imposed without maintaining direct visual contact."	Applies to all children

[53] Utah has guidance found in this document. Nothing that discusses prone or restricts and impairs a child's ability to breathe.

Appendix B

State	Citation	Language	
Virginia	Virginia Depart. of Educ., Guidelines for the Development of Policies and Procedures For Managing Student Behaviors in Emergency Situations in Virginia Public Schools (2009)	No applicable language relating specifically to prone restraint or restraint that restricts of impairs a child's ability to breathe within the school setting.	Applies to all children
Washington	Wash. Admin. Code § 392-172A-03125 (2013)	3(a) "Force and restraint in general. No force or restraint which is either unreasonable under the circumstances or deemed to be an unreasonable form of corporal punishment as a matter of state law may be used. See RCW 9A.16.100 which cites the following uses of force or restraint as uses which are presumed to be unreasonable and therefore unlawful … (iv) interfering with a student's breathing."	Applies to all children
West Virginia	W. Va. Code St. R. § 26-99	"A school employee and/or independent contractor may use restraint in an emergency as defined above with the following limitations: Restraint shall be limited to the use of such reasonable force as is necessary to address the emergency. Procedures and maneuvers that restrict breathing (e.g. prone restraint), place pressure or weight on the chest, lungs, sternum, diaphragm, back, neck or throat, or may cause physical harm are prohibited."	Applies to all children

Appendix B

State	Citation	Language	
Wisconsin	2011 Act 125 Seclusion and Restraint (2012)	Section 2(3)(d) "None of the following maneuvers or techniques are used: 1) Those that do not give adequate attention and care to protecting the pupil's head. 2) Those that cause chest compression by placing pressure or weight on the pupil's chest, lungs, sternum, diaphragm, back, or abdomen. 3) Those that place pressure or weight on the pupil's neck or throat, on an artery, or on the back of the pupil's head or neck, or that otherwise obstruct the pupil's circulation or breathing. 4) Those that constitute corporal punishment."	Applies to all children
Wyoming	Wyo. Stat. § 21-2-202 Wyo. Educ. Rules 42-1 to 42-8 (Jan. 2012)	42-7(b)(i)(B): "Schools shall not utilize aversive interventions, mechanical restraints, or prone restraints at any time"	Applies to all children

Minnesota Department of Education

Note: this is NOT a comprehensive list; as programs are identified and information provided to the Minnesota Department of Education, it will be revised accordingly. "No Evidence" does not indicate the required element is not included in the program; it indicates no available documentation was provided and/or restrictive procedures are not part of the training program. The list will be revised at regular intervals as additional documentation becomes available. The purpose of the list is to assist users to identify existing programs that may inform the development of a more comprehensive Restrictive Procedures Plan outlined in Minnesota Statutes section 125A.0942, Subd. 1. No individual program can address implementation with fidelity, and the creation of a supporting infrastructure to ensure the plan is executed as intended. Contact has been initiated with the Minnesota Department of Human Services as per Minnesota Statutes section 125A.0942, Subd. 5. (b).

Crisis Prevention/Intervention Training Programs

Training Requirements — Training Programs

Training Requirements	*Crisis Consultant Group, LLC*	*Handle with Care*	*Managing Aggressive Behavior*	*Mandt System*
Positive behavioral interventions	No Evidence	No Evidence	No Evidence	Resources
Communicative intent of behaviors	No Evidence	Information	No Evidence	Information
Relationship building	Training	Information	Resources	Resources
Alternatives to restrictive procedures	Information	Training	Training	Training
De-escalation methods	Training	Training	Training	Training
Standards for using restrictive procedures	Training	Training	Resources	Resources
Obtaining emergency medical assistance	Information	No Evidence	No Evidence	Information
Physiological and psychological impact of physical holding and seclusion	Information	No Evidence	Resources	Resources
Monitoring and responding to a child's physical signs of distress	Training	Resources	No Evidence	Information
Recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding used	Training	Resources	No Evidence	Resources
District policies and procedures for timely reporting and documenting each incident involving use of a restrictive procedure	No Evidence	No Evidence	No Evidence	No Evidence
School-wide programs on positive behavior strategies	No Evidence	No Evidence	No Evidence	No Evidence

Minnesota Department of Education

Note: this is NOT a comprehensive list; as programs are identified and information provided to the Minnesota Department of Education, it will be revised accordingly. "No Evidence" does not indicate the required element is not included in the program; it indicates no available documentation was provided and/or restrictive procedures are not part of the training program. The list will be revised at regular intervals as additional documentation becomes available. The purpose of the list is to assist users to identify existing programs that may inform the development of a more comprehensive Restrictive Procedures Plan outlined in Minnesota Statutes section 125A.0942, Subd. 1. No individual program can address implementation with fidelity, and the creation of a supporting infrastructure to ensure the plan is executed as intended. Contact has been initiated with the Minnesota Department of Human Services as per Minnesota Statutes section 125A.0942, Subd. 5. (b).

Crisis Prevention/Intervention Training Programs

Training Requirements — Training Programs

Training Requirements	*NCI (CPI) Non-Violent Crisis Intervention*	*PCMA*	*Positive Behavior Facilitation*	*Right Response*
Positive behavioral interventions	Resources	Information	Information	Information
Communicative intent of behaviors	Information	Information	Information	Information
Relationship building	Information	Information	Resources	Information
Alternatives to restrictive procedures	Training	Training	Information	Training
De-escalation methods	Training	Training	Training	Training
Standards for using restrictive procedures	Resources	Resources	Information	Resources
Obtaining emergency medical assistance	Information	Information	No Evidence	No Evidence
Physiological and psychological impact of physical holding and seclusion	Resources	Resources	No Evidence	Resources
Monitoring and responding to a child's physical signs of distress	Information	Resources	No Evidence	No Evidence
Recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding used	Resources	Resources	No Evidence	No Evidence
District policies and procedures for timely reporting and documenting each incident involving use of a restrictive procedure	No Evidence	No Evidence	No Evidence	No Evidence
School-wide programs on positive behavior strategies	No Evidence	No Evidence	No Evidence	No Evidence

Minnesota Department of Education

Note: this is NOT a comprehensive list; as programs are identified and information provided to the Minnesota Department of Education, it will be revised accordingly. "No Evidence" does not indicate the required element is not included in the program; it indicates no available documentation was provided and/or restrictive procedures are not part of the training program. The list will be revised at regular intervals as additional documentation becomes available. The purpose of the list is to assist users to identify existing programs that may inform the development of a more comprehensive Restrictive Procedures Plan outlined in Minnesota Statutes section 125A.0942, Subd. 1. No individual program can address implementation with fidelity, and the creation of a supporting infrastructure to ensure the plan is executed as intended. Contact has been initiated with the Minnesota Department of Human Services as per Minnesota Statutes section 125A.0942, Subd. 5. (b).

Crisis Prevention/Intervention Training Programs

Training Requirements — Training Programs

Training Requirements	*Safe & Positive Approaches*	*Safe Crisis Management*	*Therapeutic Crisis Intervention*	*Therapeutic Options*
Positive behavioral interventions	Resources	Resources	No Evidence	Resources
Communicative intent of behaviors	No Evidence	Information	No Evidence	Information
Relationship building	No Evidence	Resources	Information	Resources
Alternatives to restrictive procedures	Training	Information	Training	Training
De-escalation methods	Training	Training	Training	Training
Standards for using restrictive procedures	Resources	Training	Resources	Training
Obtaining emergency medical assistance	No Evidence	No Evidence	No Evidence	No Evidence
Physiological and psychological impact of physical holding and seclusion	Resources	Resources	Resources	Resources
Monitoring and responding to a child's physical signs of distress	Information	Resources	No Evidence	No Evidence
Recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding used	Training	No Evidence	No Evidence	No Evidence
District policies and procedures for timely reporting and documenting each incident involving use of a restrictive procedure	No Evidence	No Evidence	No Evidence	No Evidence
School-wide programs on positive behavior strategies	No Evidence	No Evidence	No Evidence	No Evidence

Minnesota Department of Education

In accordance with Minnesota Statute 125A.0942, Subd. 5. (b)., the Minnesota Department of Education (MDE) has published the following list of experts on Reducing Restrictive Procedures. Experts were referred to MDE by schools and other experts in the field. MDE has not evaluated the experts included and the list does not necessarily constitute or imply endorsement, recommendation, or favoring by MDE. Each school seeking training and/or consultation is responsible for determining if the expert meets their needs and criteria. If you have feedback on the experts in this list or have names that you believe should be included, please email us at MDE.RRPExpert@state.mn.us. Thank you.

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Crisis Triage and Hand-off Process

Minnesota Department of Human Services
Community Supports Administration
February 2015

Minnesota Department of Human Services

For more information contact:

Minnesota Department of Human Services
Adult Mental Health Division
St. Paul, MN 55101
651-431-2225

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Contents

Olmstead Plan Language

Supports and Services section

Action Three: Build effective systems for use of positive practices, early intervention, crisis reduction and return to stability after a crisis.

By August 1, 2014, a coordinated triage and "hand-off" process for crisis intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation. Report will be delivered to the Olmstead Subcabinet.

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 66.

Introduction

Crisis is defined as a condition of instability or danger that constitutes a turning point in a person's life. Crises occur where people live and work, in big cities and wide-open spaces, when people are alone or in community, during office hours and in the dead of night. The requirements for reliability across all support systems, ensuring that there is early crisis planning and immediate crisis response, as well as the gravity of the consequences if the response is not provided, demands extraordinary levels of systems coordination, integration, and synthesis.

The overarching goal of crisis services is to provide timely and appropriate support to people who are experiencing significant instability in their lives or are facing eminent danger. The term "crisis" covers a range of situations, such as those prompted by the loss of a caregiver or a significant change in a medical or health condition, that compromise the ability of a person or that person's support system to manage their symptoms or behaviors to such an extent that there is potential for serious harm to the person or others.

A response that is activated only when physical safety of the person or others is compromised is often "too little, too late" or "no help at all" in addressing the root of the crisis."[1] Effective crisis services, therefore, constitute an interconnected network of supports before, during, and after a crisis episode, during which appropriate responses must also meaningfully address the issues underlying the crisis.

Minnesota currently offers crisis services to people with disabilities through different service systems—community-based mental health services, home and community-based services, and state operated facilities. These three systems have different definitions of and responses to "crises." These differences are part of the underlying issues that lead to gaps in the crisis response system.

[1] *Practice Guidelines: Core Elements for Responding to Mental Health Crises.* HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.

Background Information

Current services

A number of existing efforts and planned initiatives are underway to serve people in crisis. There are themes around which these efforts and initiatives can be grouped, as follows:

Case Management: Related services include Community Support Services Crisis Teams; Metro Crisis Coordination Program in the seven county Twin Cities metro area; adult mental health crisis response teams, who routinely see clients in rural hospital emergency departments or jails; and an array of children's mental health services. Crisis response teams are expected to develop regional collaborations with law enforcement, probation officers, schools, case management, and emergency departments for referrals and to know when and how to access crisis services. Case managers are encouraged to develop crisis/relapse prevention plans as part of the individual's Community Support Plans. Crisis plans become part of a person-centered plan that seeks to proactively address both positive as well as challenging behaviors in the community. With the recipient's consent, these plans are shared with the mental health crisis response teams. Adult protective services is a 24/7 county-based common entry point for reporting suspected maltreatment of a vulnerable adult screening for immediate need for protective services or law enforcement, and referral to lead agency to investigate the alleged maltreatment. Additionally, there is a 2015 legislative proposal for enhanced crisis wrap-around services for persons with Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI), and Development Disability (DD) waiver services that had two or more behavioral-related hospitalizations in the previous calendar year.

Mobile Crisis Response Services: The mental health services system includes mobile crisis response teams in 79 counties and one tribe.

Training for Community Capacity: Mental health crisis teams provide community intervention with families and other affected persons; children's mental health services include families and guardians in service design and evaluation; Community Support Services provides training, mentoring, and coaching to clients and others, technical assistance to divert commitments and address crises; and the Minnesota Family Investment Program is developing short- and long-term crisis planning for families with children with mental illness.

Short-term Residential Crisis Stabilization and Respite Capacity: Crisis stabilization beds are available for short-term crisis services for adults; Minnesota Intensive Therapeutic Homes (MITH) Respite offers 30-day crisis return to forensic transitions to prevent revocation of provisional discharge; residential crisis stabilization facilities (licensed as either Intensive Residential Treatment Services or Adult Foster Care) provide structured living for adults who are fragile or are experiencing a crisis; the state-operated Life Bridge program provides housing and support during transitions; currently there are 16 crisis respite beds (≤90 day stay) available statewide for persons with developmental disabilities. There is also in-home crisis respite service available for persons who are on the Developmental Disabilities waiver.

Sustainable and Flexible Funding: A number of services are paid through federal waivers. In addition, services are funded through third-party payer billing, grant funding, county funding, state funding, medical assistance, and the Medicaid State Plan.

Technology-Assisted Consultations: Telepresence is implemented in 18 southwestern counties for Assertive Community Treatment teams, emergency rooms, and psychiatrists for consult; mental health crisis teams are beginning to use telepresence to assist mental health practitioners; Community Support Services Crisis consultation and telepresence is under expansion in the Southern Cities Clinic; and the Phase II Telepresence Option is being planned.

First Episode of Psychosis: A cross-divisional workgroup designed a proposal to strengthen the state's capacity to provide early identification and intensive intervention services for children and adults who have a first episode of psychosis.

Understandable and Accessible Information: The MNhelp.info Network provides objective information to individuals to help them make decisions about services; culturally-specific grants are available to help with outreach to diverse communities. There are recommendations in place for reforming case management to make services more accessible and less duplicative.

Help People Retain Housing: The Crisis Housing Fund provides temporary rental, mortgage, and utility assistance for persons with serious and persistent mental illness while they receive mental health treatment.

Provider Training: Positive support strategies and guidelines on emergency use of manual restraints, and a legislative proposal to provide training between Community Support Services teams, Metro Crisis Coordination Program, and Assertive Community Treatment teams to enhance competency of treating individuals with complex comorbid conditions.

Long-Term Monitoring: Community Support Services Extended Supports provides long-term monitoring for up to 75 individuals with clinical complexity and intellectual disabilities.

Post-Discharge Psychiatric Consultation: Consultation for individuals recently discharged from St. Peter Security Hospital, Anoka Metro Regional Center, and from community behavioral health hospitals where the discharge planning team determines that ongoing post discharge monitoring provided by psychiatrists and psychologists would be essential to successful community placement.

Crisis-related barriers to achieving integration

Although there are a number of crisis-related services, there are a number of barriers that currently exist in access, available services, and follow-up for people in crisis. The examples below help to illustrate the issues that are not yet adequately addressed.

Layering Effect: People with co-occurring conditions, such as those with both mental illness and developmental disabilities, may be treated and stabilized in crisis but end up back in the system because of the complexity of treating the co-occurring conditions. Or, in times of crisis they may not be able to

connect in a timely fashion with providers who have the necessary skills to support them, resulting in what may have been avoidable moves back to more restrictive settings. For example, at times the underlying mental health needs are not adequately addressed by providers of developmental disability services. Similarly, mental health providers may use talk-based therapies that are not well-targeted to the needs of people with developmental disabilities. If the mental health needs of people with developmental disabilities or brain injury are not met as they emerge, there can be further complications such as drug use, homelessness, and chronic physical disease. Another example is, when people are using services from different systems, there can be confusion about where to turn in a crisis. This can be particularly true for people who have recently transitioned from a more controlled setting to a more integrated setting.

Housing for Persons with Behavioral Issues: People with mental illnesses, dementia, developmental disabilities, or other disabilities who have experienced crisis may be admitted to psychiatric inpatient hospital units or other institutional settings without community options for re-establishing housing, or their options for future housing may be limited to sites far from their home communities when they can no longer stay in their former domiciles because of behavioral issues. There may be barriers to reestablishing housing, such as those found when subsidized housing sites screen out individuals with a history of violence or other behavioral issues.

Lack of Experienced, Trained Staff: Direct support workers may not have adequate training, experience, or assistance available to deal with crisis situations. When crisis situations arise, these staff may not be able to address the situation themselves, and also may not have access to someone in their organization with the appropriate skills. Providers may not be aware of the range of services that are available to help them with crisis incidents, and may not be knowledgeable about trauma-informed care, which can help providers identify the triggers of behavior that cause a life crisis.

Crises outside the Home: Crises may occur in the community, such as school, a day service program, or a vocation setting. Most interventions are focused on supporting the person in their home or residential setting.

Measurable Goals

Following are measurable goals that will result from Minnesota's efforts to improve the crisis system for people with disabilities. **These goals are dependent on funding requests currently under consideration in the 2015 legislative session.** *Note: Goal below builds to an increase of 500 people.*

In 2015

- Baseline of 7,045 people will receive crisis services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention.
- Expand DHS data reporting system to include elements for tracking this goal.
- Metro Crisis Coordination Program (MCCP) will begin providing specialty telephone consultation 24 hours a day to mobile mental health crisis teams who are serving people with traumatic brain injury or intellectual disability who are experiencing a mental health crisis.

In 2016

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,170 metro-wide - 125 people over the baseline of 7,045).
- Of the additional 125 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation. (*Note: this is our baseline year. The number will be adjusted as needed.)*
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 38 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2017

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,295 metro-wide - 250 people over the baseline of 7,045).
- Of the additional 250 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 63 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2018

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,420 metro-wide - 375 people over the baseline of 7,045).
- Of the additional 375 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 94 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2019

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,545 metro-wide - 500 people over the baseline of 7,045).
- Of the additional 500 people who will receive a crisis response service, half (250) people will receive immediate face-to-face services and half (250) people will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as safely possible give the traffic and weather.
- 125 people who receive face-to-face services will be able to remain in the community rather than be admitted to a hospital.

Process to Develop Strategic Approach

Community participation

Community members, particularly those who use public services, their families, advocates, service providers, and community partners, such as counties and tribes, all play a critical role in helping shape how public services are designed and delivered.

Within the last couple of years, as the Olmstead Plan was written and implementation began, there have been numerous ways in which the public engaged in processes that contributed to the development of the framework described in this report. The following list highlights some of this work.

- The Department of Human Services conducted numerous focus groups with people who use services, such as those organized through the National Alliance on Mental Illness Minnesota in planning the Minnesota Behavioral Health Homes.
- People who use mental health services and their families meet (typically) monthly to discuss adult mental health initiatives.
- The State Advisory Council on Mental Health consists of stakeholders representing all facets of the mental health system. The Local Advisory Workgroup, a subset of the Council, is made up of individuals with a lived experience of a mental illness, family members, and a county provider. The Subcommittee on Children's Mental Health provides recommendations to the Council. It is comprised of parents, people who presently or formerly used adolescent mental health services, and other stakeholders.
- Certified Peer Specialists quarterly networking
- Offenders with Mental Illness Workgroup
- Mental Health Improvement Workgroup
- ADAD Tribal and Citizen Advisory Council
- Community First Services and Supports and Money Follows the Person Implementation Council
- State Quality Council
- Traumatic Brain Injury Advisory Committee
- Autism Spectrum Disorder Advisory Council
- Home and Community Based Services Settings Rule forums
- Autism public meetings and other input opportunities
- Tribal listening session on people with brain injury and releases from correctional facilities
- Gaps analysis surveys and focus groups
- Olmstead Plan development process, including Olmstead Plan Committee, public meetings, and public comment period

State work groups

State-led work groups contributed to the development of the plan presented here and included people from a broad array of perspectives, including from the following:

- Adult mental health
- Children's mental health
- Disability services
- State-operated services
- County crisis services
- Youth services
- Minnesota Department of Health
- Minnesota Department of Education

In addition to participation in work groups, community subject matter experts contributed feedback and advice.

Strategic Approach to Crisis System

Minnesota is undertaking transformative systems change to achieve the goal of having people with disabilities living in the most integrated settings, being fully engaged in the community of their choice, and pursing their own life goals and interests. This transformation will take years to fully realize, and our wide-reaching, cross-sector approach needs to be strategic to be feasible and successful. The crisis triage and hand-off concept, which is the focus of this report, fits within a broader strategic approach to crisis response and intervention. And, in turn, the crisis strategic approach interlocks with other key strategic focuses, such as building a person-centered culture, effective transitions, increased access to housing, and competitive employment. The barriers identified in the earlier section are addressed in various ways across these strategic focuses as well as in the crisis area.

The three-pronged approach to improving crisis response and intervention services includes: 1) improving crisis triage and hand-off; 2) use of positive supports and person-centered planning; and 3) mental health system reform.

Crisis triage and hand-off

The intent of the statewide crisis triage and hand-off system is to efficiently get people to the best service for them in times of crisis, and to ensure that the hand-off between providers is effective. To do this, the state must develop a statewide, integrated, crisis information, intake, referral, and assessment network model. The intent is to have a centralized point of entry, that people in crisis contact in a crisis, regardless of their diagnosis or what type of services they provide (e.g., community-based mental health services, state-operated services, waiver services).

This is envisioned as a single statewide phone number. The people staffing the phone/portal will provide an immediate response to requests for crisis services statewide with appropriate triage and coordination among crisis services. They will be skilled in crisis assessment and determine both the urgency of the need intervention, and the most appropriate provider for that intervention. They will be well-versed in the services that are available across the state and who they serve.

The access, intake, and processes for service delivery determination and authorization will be seamless to the person. Having a single point of entry, staffed by skilled providers, will decrease confusion, duplication of effort and gaps, resulting in callers getting to the right service in a timely manner. This is crucial as timely, appropriate intervention is the best way to stabilize crisis situations.

In addition to getting the person to necessary services, the intent of the centralized triage system is to ensure that crisis services are delivered in the least restrictive setting possible.

Another key feature of the centralized system is that the triage providers will follow-up with the callers to see it the person actually connected with and received the appropriate service in a timely manner. If there are problems identified, the triage system can work to resolve them, if that is possible, or, at a minimum, record the system failure.

One of the benefits of a centralized system will be the opportunity to track meaningful data that will be used to help us measure the success of the system, identify gaps, and continuously improve the state triage system.

For example, the system will be designed to track data, such as:

- Response times
- Crisis resolutions
    - Resolutions that result in the person remaining in their home, returning home from a medical facility, i.e. ER/urgent care, etc.
- Outcome comparisons by access route, geographic location, population, etc.
- Crisis interventions initiated in psychiatric hospitals, other hospitals and other facilities despite the individual not meeting requirements for those levels of care

While the current system is fragmented, it does have strengths upon which the model can be built. The state will strategically develop this network in phases, using the opportunities and strengths that are available.

Developments in technology in recent years are a great boon to this kind of effort.[2] Some parts of the crisis response system are already beginning to make use of tele-presence technology.[3] Another existing strength is that Minnesota already has pieces of a 'centralized' system for crisis response. Specifically, within the Twin Cities metropolitan area, mental health services are already using a central point of access and triage protocols.

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[2] For example, Minnesota operates technologically integrated systems (i.e., MNhelp.info Network and its Senior Linkage Line, Disability Linkage Line, and Veterans Linkage Line) that support people, help them navigate complex service systems, connect policy and service professionals in 'real time', follow-up with them, and track/measure the effectiveness in achieving meaningful outcomes for people.

[3] Community Support Services (CSS) Crisis Teams, Southern Cities Clinic use telepresence and 18 counties in southwestern Minnesota also telepresence for consultation between Assertive Community Treatment (ACT) teams, emergency rooms, and psychiatrists.

The first phase of developing a statewide triage system is currently underway and expected to last through June 2015. This work centers on defining the roles and responsibilities within the state-operated services and county and provider system of waiver services. These two systems are administered by the Department of Human Services Direct Care and Treatment Administration and the Disability Services Division of the Community Supports Administration, respectively. They support many people with co-occurring conditions, people who are moving from segregated settings to more integrated settings and people who are at high risk of experiencing crises and returning to segregated settings.

Building upon the first phase, also in 2015, the second phase will involve building the statewide triage and hand-off system. This work will center on adding mental health services that are administered through the Adult and Children's Mental Health Divisions of the Community Supports Administration into the project. This phase will include planning and initial implementation. Implementation will begin with realigning currently available resources and continue as resources and opportunities become available.

Also in 2015, there is proposed legislation to build a single statewide number for all mental health crisis services. If this is enacted, it will provide a significant platform upon which to build the single triage system for all disability-related crises (i.e., mental health and/or behavior-related crises).

Positive supports and person-centered planning

Promoting statewide use of positive supports is one of the three-prongs of Minnesota's crisis strategy. The term *positive supports* refer to practices that are person-centered, encourage self-determined behavior, build on social and emotional skills, and take a person's physical, social and mental health into consideration. Positive supports include strategies that teach people productive ways to deal with stress. These supports are essential to eliminate the use of prohibited procedures, avoid emergency use of manual restraints, and prevent physical harm to the individual and others.

The use of positive supports has been proven to be effective in preventing problem behavior and helping a person gain new skills or alternative behaviors to participate effectively in community life. Problem behavior can trigger a crisis situation; the use of positive supports, therefore, is a strategy for avoiding crises.

Person-centered planning is the foundation for positive support practices. Pro-active person-centered planning and assessment anticipates, prevents, and/or responds in a timely way to potential or actual crisis situations, in a way that promotes maintaining individuals in the community, particularly for people with co-occurring conditions.

In October 2014, the Minnesota Departments of Human Services and Education produced a report entitled *Minnesota's Statewide Plan: Building Effective Systems for Implementing Positive Practices and Supports.* The report provides a framework for organizing policies, technical assistance, and resources to ensure people receiving services, are treated with respect, and receive the support they need to live independent, self-determined, and meaningful lives in their home communities. The plan described in

the report will be successful by a) designing and implementing technical assistance that involves teaching organizations to embed the values and vision outlined in the Minnesota Olmstead plan into the everyday actions taken by individuals providing services, and b) working collaboratively with stakeholders who represent people receiving services across the lifespan, family members, caregivers, advocates, practitioners, and community members. The report represents a first step in the state-wide planning process. The plan itself will continue to be refined and updated as it is implemented.

The plan identifies six implementation goals: 1) establishing a technical assistance infrastructure across agencies, 2) designing and implementing strategies for data-based decision making and evaluation, 3) creating a marketing plan for increasing awareness of positive supports across the state, 4) expanding pre-service and aligning in-service training systems state-wide, 5) developing and maintaining an inventory of policies related to restrictive practices and positive supports, and 6) expanding interagency crisis prevention planning. A graphic illustration of the logic model for the plan appears in Appendix A.

Mental health system reform

Minnesota's mental health infrastructure is insufficient with many gaps, poor measurement, and insufficient service availability. Gaps in the system can mean that opportunities for early intervention are missed and crisis situations arise. Gaps in the system can mean that when there is a crisis situation the intervention takes place in a more restrictive setting than is necessary. Sometimes people in crisis go into a segregated setting and, once there, encounter barriers to moving back into integrated settings.

Minnesota has a package of mental health reforms before the Legislature in 2015 that address several of the gaps listed on page 3 in this report. More information about these reforms is in Appendix B.

Prevention and early intervention

- Offer training and consultation for staff at 250 child care centers. Provide assessments and treatment for 1,250-2,500 children with mental health concerns.
- Pilot a new model to help schools support students with mental health and substance use disorders in order to reduce arrests, expulsions and suspensions, while increasing referrals for treatment and services.
- Strengthen the state's capacity to serve youth (16-26) with early signs of psychosis and bridge gaps between children's and adult mental health services.
- Increase availability of mental health crisis services, moving toward a goal of 24 hours statewide coverage for both children and adults.
- Establish one statewide number for all mental health crisis services.
- Improve consistency and quality of crisis services.
- Expand children's mental health respite care grants to serve 500-1,000 additional children and their families.
- Provide training on Adverse Childhood Experiences to 5,000 community partners, parents, and providers. Support local efforts to provide earlier intervention.

Reform and enhance Minnesota's mental health treatment system

- Analyze the state's payment structure for mental health services and develop reforms to stabilize the state's financially fragile mental health system.
- Provide grant funding to stabilize intensive mental health services infrastructure (IRTS/RCS/ACT).
- Provide an immediate rate increase for mobile crisis services to retain current services and promote expansion.
- Enhance the state's community mental health centers, which are the foundation of the public mental health safety net.
- Apply for Federal demonstration project to implement improvements and receive 90 percent federal financial match.
- Implement Behavioral Health Homes to provide integrated psychical and mental health care.

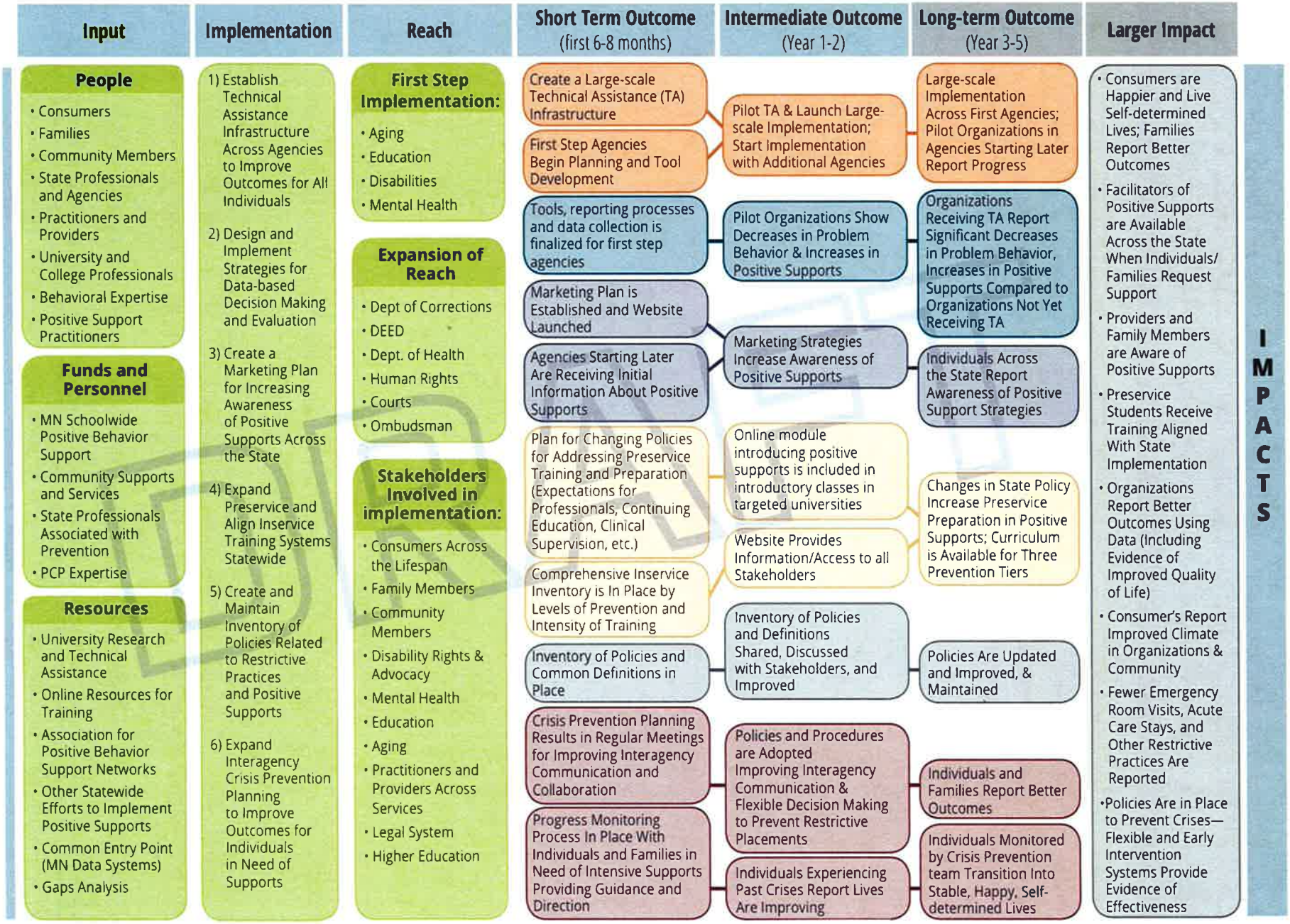
Expand capacity to care for children and adults with complex needs

- Establish Psychiatric Residential Treatment Facilities (PRTF) to support children with very serious mental illnesses who are going unserved.
- Establish extended-stay hospital psychiatric beds, on a contract basis, for youth in need of intensive services on a longer term basis, including those currently served at the Child and Adolescent Behavioral Health Services (CABHS) program.
- Create three new Intensive Residential Treatment Service (IRTS) programs for people transitioning from Anoka-Metro Regional Treatment Center.
- Sustain improvements at MSH including more clinical services, strengthened treatment teams, and increased programming opportunities for patients.
- Create a public psychiatry track in the University of Minnesota's residency program.

Promote and support recovery

- Expand housing with supports grants to serve 1,260 adults with serious mental illness in permanent supportive housing.
- Enhance the quality of current Assertive Community Treatment services.
- Expand high quality Assertive Community Treatment services across Minnesota.
- Develop a Forensic Assertive Community Treatment Team to serve people involved with the criminal justice system.
- Allow greater flexibility to use current funding to help more people exit institutional settings and return to the community.

Appendix A: Positive Supports Implementation Plan Logic Model

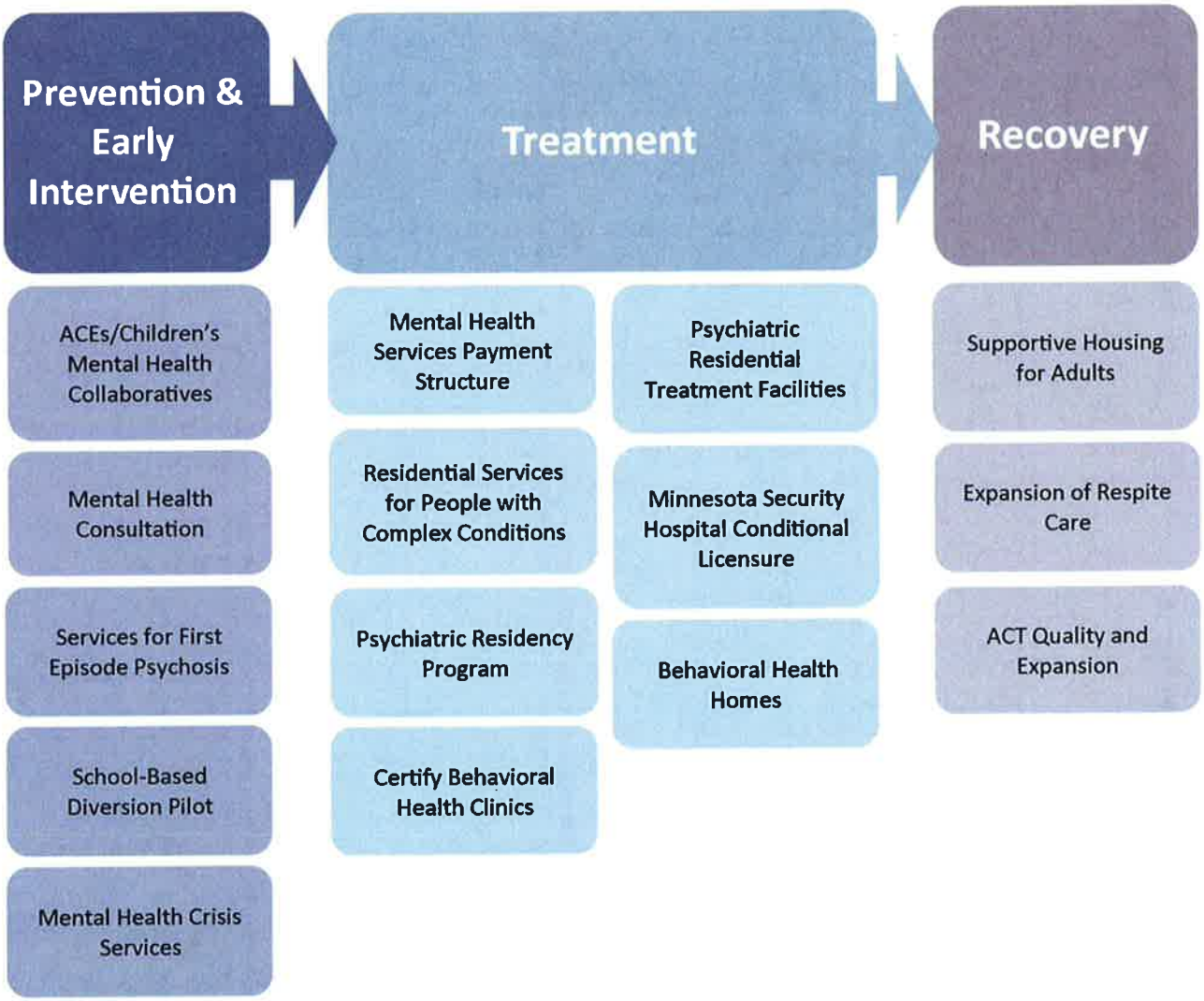


Appendix B: Mental Health System Reform Proposals

2015 Mental Health Reform

The Problem	The Solution	The Impact
Minnesota's mental health infrastructure is insufficient with too many gaps, poor measurement, and insufficient service availability.	A continuum of care that includes: • Mental health promotion and mental illness prevention • Clinical service stability and quality • Community supports	More than 230,000 adults and 75,000 children with mental illness and their families will have the services available they need.

Building a continuum of mental health care for all Minnesotans



Current opportunities

Problem:

Minnesota's Mental Health System is Fragile:

- Residential services are in demand but capacity is shrinking. The Woodlands Center Intensive Mental Health Service (IRTS) closed earlier this year and others are in financially precarious positions.
- Community mental health services are vulnerable. Riverwood Community Mental Health Center, which served some 3,000 clients, closed suddenly in 2014.

Problem:

Existing Community Capacity Does Not Meet Needs:

- Minnesota lacks community-based services for adults, especially those with the greatest needs. Anoka Metro Regional Treatment Center has a waiting list of over 75.
- Intensive children's services are not available in Minnesota. There are between 300-400 children each year with aggressive or self-injurious behaviors whose needs cannot be met.
- Prevention resources are limited. Focus has been on treatment and interventions, leaving prevention and early interventions behind.
- Minnesota has a severe mental health workforce shortage. Most of Minnesota is designated as a Mental Health Professional Shortage Area.
- Employment supports need to be expanded. People with serious mental illnesses in Minnesota have an 80 percent unemployment rate.

Problem:

Housing services are insufficient for those with multiple service needs

- Over 50 percent of children and adults in Minnesota who are homeless live with a mental illness.
- Residential reimbursement rates are inadequate. The average monthly room and board costs for Intensive Residential Treatment Services (IRTS) and residential crisis providers are $1,210 per client. The current monthly group residential housing rate is $876 per client.
- Capital improvements are not covered in current rate structure.
- Lack of treatment services for the most acute children and adults. The system does not have adequate resources for the most aggressive clients.
- Some children's services are not available in Minnesota. We have between 300-400 children each year who would be best served in Psychiatric Residential Treatment Facilities
- There is a workforce shortage. Most of Minnesota is designated as a Mental Health Professional Shortage Area.

2015 Reform Initiatives

Build a More Solid Foundation of Prevention and Early Intervention

Mental Health Consultation for Early Childhood Providers

- Offer training and consultation for staff at 250 child care centers. Provide assessments and treatment for 1,250-2,500 children with mental health concerns.

School-Based Diversion Pilot for Students w/Co-Occurring Disorders

- Pilot a new model to help schools support students with mental health and substance use disorders in order to reduce arrests, expulsions and suspensions, while increasing referrals for treatment and services.

Services and Supports for First Episode Psychosis

- Strengthen the state's capacity to serve youth (16-26) with early signs of psychosis and bridge gaps between children's and adult mental health services.

Mental Health Crisis Services

- Increase availability of mental health crisis services, moving toward a goal of 24 hours statewide coverage for both children and adults.
- Establish one statewide number for all crisis services.
- Improve consistency and quality of crisis services

Expansion of Respite Care

- Expand children's mental health respite care grants to serve 500-1,000 additional children and their families.

ACEs/Children's Mental Health & Family Services Collaboratives

- Provide training on Adverse Childhood Experiences to 5,000 community partners, parents, and providers. Support local efforts to provide earlier intervention.

Reform and Enhance Minnesota's Mental Health Treatment System

Stabilize and Reform Mental Health Services Payment Structure

- Analyze the state's payment structure for mental health services and develop reforms to stabilize the state's financially fragile mental health system.
- Provide grant funding to stabilize intensive mental health services infrastructure (IRTS/RCS/ACT).
- Provide an immediate rate increase for mobile crisis services to retain current services and promote expansion.

Certify Behavioral Health Clinics

- Enhance the state's community mental health centers, which are the foundation of the public mental health safety net.
- Apply for Federal demonstration project to implement improvements and receive 90 percent federal financial match.

Behavioral Health Homes

- Implement Behavioral Health Homes to provide integrated psychical and mental health care.

Expand Capacity to Care for Children and Adults with Complex Needs

Establish Psychiatric Residential Treatment Facilities

- Establish Psychiatric Residential Treatment Facilities (PRTF) to support children with very serious mental illnesses who are going unserved.
- Establish extended-stay hospital psychiatric beds, on a contract basis, for youth in need of intensive services on a longer term basis, including those currently served at the Child and Adolescent Behavioral Health Services (CABHS) program.

Residential Services for People with Complex Conditions

- Create three new Intensive Residential Treatment Service (IRTS) programs for people transitioning from Anoka-Metro Regional Treatment Center.

Minnesota Security Hospital (MSH) Conditional Licensure

- Sustain improvements at MSH including more clinical services, strengthened treatment teams, and increased programming opportunities for patients.

Psychiatric Residency Program

- Create a public psychiatry track in the University of Minnesota's residency program.

Promote and Support Recovery

Supportive Housing for Adults with Serious Mental Illness

- Expand housing with supports grants to serve 1,260 adults with serious mental illness in permanent supportive housing.

Assertive Community Treatment (ACT) Quality and Expansion

- Enhance the quality of current ACT services.
- Expand high quality ACT services across Minnesota.
- Develop a Forensic ACT Team to serve people involved with the criminal justice system.

Increase Flexibility for Transitions to Community Initiative

- Allow greater flexibility to use current funding to help more people exit institutional settings and return to the community.

Delivery System for Oral Health

Health Care Administration

February 2015

For more information contact:

Minnesota Department of Human Services
Health Care Administration
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St. Paul, MN 55164-0984
(651) 431-2202

Legislative Report

Minnesota Department of **Human Services**

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Table of Contents

I. Executive summary

Under the Laws of Minnesota 2014, Chapter 312, article 24, section 47, the Department was required to consult with stakeholders and provide recommendations to the legislature on a new delivery system for oral health and dental services. This report lays out the recommendations resulting from the most recent stakeholder engagement and also previous studies and reports that have examined dental services in the Medical Assistance (MA) and Minnesota Care programs, collectively referred to as the Minnesota Health Care Programs (MHCP).

The three fundamental areas that must be addressed are the base rate payments, administrative burden, and critical access dental payments. Addressing these three areas provides the environment necessary to increase access to dental services, helps ensure the services they provide are of good quality and are fairly compensated.

II. Legislation

Laws of Minnesota 2014, Chapter 312, article 24, section 47:

(a) The commissioner of human services, in consultation with the commissioner of health, shall convene a work group to develop a new delivery and reimbursement system for oral health and dental services that are provided to enrollees of the state public health care programs. The new system must ensure cost-effective delivery and an increase in access to services.

(b) The commissioner shall consult with dental providers enrolled in the state public health programs, including providers who serve substantial numbers of low-income and uninsured patients and are currently receiving critical access dental payments; private practicing dentists; nonprofit community clinics; managed care and county-based purchasing plans; and health plan companies that provide either directly or through contracts with providers dental services to enrollees of state public health care programs.

(c) The commissioner shall submit a report containing the proposed delivery and reimbursement system, including draft legislation to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance by January 15, 2015.

III. Introduction

Minnesota's Medical Assistance program continues to rank extremely low compared to other states on important measures of access to dental services. For example, for several years Minnesota has ranked amongst the lowest group of states in percentage of children receiving a preventive dental service in a year. Over the past few years, several reports, including one specific to MHCP dental rates published by the Office of the Legislative Auditor (OLA) and another more comprehensive study presented to the legislature by the Department last year, have identified a variety of contributing factors that have both hindered access to and have limited the quality of dental services provided to MHCP enrollees. The major contributing factors identified in those previous studies have been confirmed again during recent discussions with stakeholders. The three factors most consistently identified are:

1. The base rates for dental services are too low. The rates are, in large part calculated from a set of base charges that are now more than 20 years old.
2. The administration of the dental program for MHCP is distributed among too many entities, which requires dental providers, most of which are small businesses, to navigate anywhere from three to nine different sets of administrative requirements.
3. The Critical Access Dental (CAD) program is a payment program that has not resulted in increased access. Instead, it creates a disincentive for private practice dentists to participate as public program providers. Furthermore, the CAD program makes payments based on volume without regard for quality or outcomes.

The Department, as part of the previous study provided to the legislature in 2014, interviewed over 75 stakeholders. The 2014 study conducted by the Department is included for your reference. In developing this report, the Department hosted a meeting with all interested stakeholders and the Department of Health to review and discuss the findings and recommendations laid out in the 2014 study. Several stakeholders also met individually with the Department to discuss issues further.

The Department was required to convene a workgroup for this report; however, a stakeholder workgroup was formed by Senator Rosen which took on the work of discussing these issues. As a result, a separate workgroup formed by the Department was not necessary. Through the course of Senator Rosen's workgroup meetings, a fourth item was discussed in addition to the three items noted above. The workgroup discussed whether a value-based payment system could be created to replace the current payment method that pays dental providers by individual service. Similar concepts had been brought up by one or two stakeholders during the Department's 2014 study, but were not identified by a majority of the dental industry as a major barrier to improving access and quality of care across MHCP. Although Senator Rosen's workgroup is continuing to meet, the three main drivers, low base rates, administrative burden, and CAD, remain the primary focus of the workgroup.

Considering all past reports and workgroup input, the Department puts forward the following recommendations which address the three main barriers to dental provider participation that have been consistently identified by stakeholders. Where consensus is lacking amongst the stakeholders for all or a portion of the Department's recommendation, that lack of consensus is noted. The recommendations for each of the three issues are outlined in detail below.

IV. Base Rate Change

The base rate for dental services should be increased. Raising the base rate is consistent with the recommendations in the OLA report and the 2014 DHS study. There is consensus on increasing the base rates; however, there is not full consensus regarding the amount of the increase. Dental providers have suggested an increase that would double the current base rates. The Department favors a more moderate increase of 15% above the current base rate. The 15% increase should be sufficient particularly if coupled with administrative simplification, since reducing the administrative burden will save money for providers, effectively translating into an additional rate increase. In addition, the base rate year should be updated to 2013, which means that rates would be updated to reflect the percentage of 2013 charges necessary to achieve the desired amount of the base rate increase. Updating the base rate year will better align payments with more current provider costs and will make the rate methodology more transparent and easier to understand for both new and existing dental providers.

V. Administrative Simplification

The administrative burden on dental providers needs to be reduced. Reducing the administrative burden resulting from multiple health plans and dental administrators has been noted by several providers to be of equal or even greater importance to those dental providers than the rates, particularly for smaller rural practices. Unlike medical providers, most of whom are affiliated with larger health systems; most dental practices do not have the administrative infrastructure and economies of scale to support multiple administrative rules, requirements, and systems. As a result, the current distributed model for administration translates to significant administrative costs for dental providers. Medicaid staff in other states have indicated that without making it easy for dental providers to do business with the Medicaid program, dental providers will not enroll as participating providers and will continue to refuse to treat Medicaid patients.

There is consensus on the need to ease the administrative burden for dental providers; however, there remains a good deal of debate amongst the stakeholders as to how to best alleviate the administrative burden. The Department, the majority of private practice dental providers and some non-profit providers favor a single administrator model. Under such a model, a single entity is contracted to administer the dental benefit for the entire MHCP population, including fee-for-service and managed care enrollees. The single administrator recruits and enrolls dental providers, pays claims, authorizes services, coordinates with health care services, tracks utilization of dental services, and monitors quality and outcomes. For dental providers, the result is one set of rules which apply to all MHCP enrollees and one method to receive the information necessary to do business, such as patient eligibility, coverage of services, and utilization limitations. As a result of a single point of contact for administrative activity, dental providers could expect to see a reduction in the administrative activities and costs related to MHCP enrollee care. The benefit to enrollees is having one contact for assistance to arrange for dental care and experiencing seamless dental benefits that follow them. Medicaid programs in several states have demonstrated that the single administrator model coupled with fair rates paid to providers is a successful strategy in improving access and health outcomes.

Not all stakeholders prefer the single administrator model. The managed care organizations and their contracted dental administrators along with some of the non-profit providers and many of the safety net dental providers favor an alternative strategy. The proposed alternative strategy consists of ongoing collaboration to reach mutual agreement on how to address the issues that have been raised by providers frustrated by the administrative burden. The Department is willing to work with stakeholders on exploring the viability of a uniform collaborative approach. However, in the absence of specific regulatory requirements the monitoring and enforcement around compliance will be extremely challenging and may not adequately address the concerns of providers.

The Department's conclusions from the 2014 study indicate that based on the success achieved in other states, a single administrator model is the option best positioned to accomplish the goal of administrative simplification. Given the lack of consensus among stakeholders on this particular issue, further discussion and ongoing review of any concrete solutions may be warranted.

VI. Critical Access Dental Program (CAD)

The CAD program needs to be restructured to better align the proportion of the total amount of payment that represents an add-on payment. The current 35% add-on payment is arguably an indicator that the base rate payment is too low. Moreover, if the base rate increases without any corresponding adjustments to the CAD payments, the dollar value of the gap between payment to private, non-CAD dental clinics and CAD clinics grows larger. The significant disparity in payment between CAD and non-CAD providers providing the same services has been identified as an issue that discourages private dentist participation. A realignment of CAD payments should be done in a manner that holds harmless the current CAD providers, but allows the payment gap between CAD and non-CAD to decrease.

In order to hold CAD providers harmless, providers that are both CAD designated and designated community clinics (CC) must be handled differently than CAD designated providers that are not community clinics. Under the current structure, a CAD provider that is also a community dental clinic receives the base rate plus 20% of the base rate as an add-on for being a community clinic and then 35% is added on to that total for CAD payment. The effect is a greater than 35% increase because the CAD add-on payment is also being applied to the CC add-on.

The following describes how the base rate increase and the CAD add-on would be adjusted together for each type of clinic:

- **For non-community clinic CAD providers**, the base rate increase can be made with a proportionate reduction in CAD payments. Therefore, with the 15% increase in base rate the department supports, the CAD rate for non-community clinic CAD providers would be adjusted to 20%. The result is no reduction in overall payment to those non-community clinic CAD providers.
- **For community clinic CAD providers,** the payment structure should ensure that CAD payments take into consideration the effect of the CC add-on and ensure that the combination of the CC and CAD payments no longer cumulatively inflate the total payment. To accomplish this goal, the base rate of 15% should be combined with the 17.4% CAD rate to account for the cumulative effect that results from the 20 % community clinic add on. This would ensure no reduction in overall payments to these providers.

Delivery System for Oral Health

Current State

Dental Provider	Current CC add-on	Current CAD add-on	Total Value of add-on payments
Community Clinic CAD	20%	35%	62%
Non-Community Clinic CAD	0%	35%	35%

Proposed Future State

Dental Provider	Base Rate Increase	CC add-on	Proposed CAD add-on	Total value vs. current payment structure
Community Clinic CAD	15%	20%	17.4%	No change
Non-Community Clinic CAD	15%	0%	20%	No change
Non-CAD dental clinic	15%	0%	0%	15% increase

The OLA report was critical of the multiple payments made to dental providers under the current payment structure, and dental providers have stated that it is difficult for them to track these multiple payments and reconcile them to determine whether they were appropriately paid for a specific patient visit. Furthermore, the CAD payments for services provided to managed care enrollees are calculated quarterly and are paid by DHS through the MCOs. As a result, the CAD add-on payments are delayed by at least 2-3 months from when the service was delivered. Eliminating the CAD add-on payments is probably not feasible in the near term unless and until sufficient dental providers are participating and access is improved. Nonetheless, re-setting the proportionality is at least a step in the right direction toward reducing dental providers' reliance on the separate add-on payments.

The current CAD program has also been criticized as a payment for volume of services provided rather than payment for quality and outcomes. Another frequent criticism is that the criteria for designation are primarily based on non-profit status, affiliation with educational institutions, or ownership by a government entity. Recent provisions now allow private dental clinics to receive CAD payments, but many additional enrollment requirements apply: the private clinics must be located in a dental Health Provider Shortage Area (HPSA); at least 50% of their patients must be public program or uninsured; and they must not place a cap on the volume of MHCP patients they will see. In contrast, many of the non-profit CAD clinics are able to cap their MHCP patient volume to 10% of their total patient population. The CAD program criteria should be modified so that all or a significant portion of the payments are based on outcome measures that promote quality, efficiency, and improved oral health status for patients. Additionally, requirements should be similar for non-profit and private dental providers so that high performing providers are incented to participate in MHCP, regardless of their business model.

VII. Conclusion

Improvement in dental outcomes for MHCP enrollees cannot be accomplished without significant and fundamental changes to the current dental program. Although the stakeholder workgroup has more recently discussed possible large scale payment reforms, the dental provider community generally favors and has built their business models to accommodate payments made based on the services rendered to each patient. The Department welcomes the opportunity to continue discussions about longer-term reforms and how to move the dental community toward more innovative payment models. However, new large-scale innovations and reforms require ample time to adequately develop, test, and expand. In the interim, Minnesota should not wait for those larger plans to evolve - the need is immediate and steps must be taken now. The number of enrollees who want to access dental services is far greater than the currently enrolled providers can serve, particularly in rural Minnesota where dental providers are already scarce. In order to increase access, more private dentists must be willing to provide services to MHCP enrollees. The three fundamental areas that must be addressed immediately are the base rate payments, administrative burden, and critical access dental payments. Addressing these three areas provides the environment necessary for the number of enrolled dental providers to grow, and helps ensure the services they provide are of good quality and are fairly compensated.