

Olmstead Plan stakeholder feedback on June 2013 draft

This document contains all of the feedback received between June 25, 2013 and August 19, 2013 from the Minnesota Olmstead Plan website and email address. Comments included here refer to the June 2013 draft.

Some text has been redacted to protect the privacy of individuals. Please review the Olmstead Plan website's [Use Policy](#) for more information.

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Through June 25, 2013 (Comments 1–3)

Comment 1

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Wednesday, June 05, 2013 4:57 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 6/5/2013 AT 4:57:11 AM

NAME: Anonymous

EMAIL:

REASON:

DESCRIBE YOURSELF: I work for state or local government

COUNTY:

COMMENTS:

Many students need to meet professional education requirements in order to become licensed or certified in their field of study. Interns ,volunteer to work with people at reduced rates to meet these requirements. Interns are also required to be supervised by a professional that meets the educational requirements. I propose that either funding be provided to enhance the ability of families and individuals in the community the ability to access profesional interns. Minnesota should recognize that many professional boards and organizations make it difficult for new grads to obtain certification or licensure. New grads already leave institutions with financial burden of having to get jobs to pay off student loans so any additional fiancial requirements are difficult to attain at the intern rates and the cost of supervision when loans become due and money is scarce. Minnesota should support new graduates in obtaining certification and licensure required by the boards and organizations by giving students scholarship packages to pay for the fees, contract supervision cost and all other cost associated to obtain certification and licensure. For example: a graduate with a masters degree in applied behavioral analysis would have to work 1500 hours of field work and 5 % of 1500 has to be direct supervision for a total of 75 hours which cost between \$3,750 to \$7,500 to obtain their BCBA. This does not count the 1425 hours of field work that must be done and the intern pay rate is 12.00 an hour average or their expected to volunteer on their own time for free. People with disabilities in the community could benefit from student interns in all educational fields if the state of minnesota could create a viable solution that would reduce the new graduate financial burden and increase support in the community in a cost effiecient method.

Comment 2

From: *[Redacted Text]*

Sent: Monday, June 17, 2013 2:17 PM

To: *DHS_OPC Public

Subject: Olmstead input on GRH

Hello,

I would like to submit some comments in regards to **Group Residential Housing (GRH)** funding and the Olmstead act.

I have heard a lot of talk that GRH may be considered or included in the definition of an institution and I think the result of including GRH in that classification would be a grave error.

Chemical Dependency and GRH

As you know GRH covers many areas within Minnesota. One of the areas is **board and lodging for men in recovery from drugs and alcohol**. We have two board and lodges like this that rely on GRH funding. The standard program is 90 days but they can stay longer if they feel their sobriety calls for it. Usually the stay falls between 3 – 6 months but we have had the occasional resident who has stayed for 1 to 1 ½ years. That may seem like a long time but when you are dealing with someone who has 30 years of

addiction, that really is not that long. Also, please remember that is the exception to the rule. As I stated, the average stay is 3 – 6 months.

The guys that come to our type of home are those that choose to do so. We do not accept anyone who is being forced, they must want to stay there. Yes, all the guys are diagnosed as Chemically Dependent (CD) but that does not make it an institution. This is not their permanent housing, and they need and want the support of the other guys in the house to maintain their sobriety. The other men become part of their sober foundation, and when they move out, that foundation continues on with them. They are there because they are like minded in their cause for sobriety and being around someone that may use does them no good.

Each day they are there helps to further equip them to get back out into society but to rush that by having others who may have an occasional drink live with them will create a major stumbling block for them. They do not want to be in the presence of a trigger. They are taught to avoid it at all cost. To think we might reinterpret GRH housing and force them to live with others would end up costing the state a lot of money as the relapse rate would dramatically rise and they would be cycling through treatment at a larger rate.

Please keep this type of housing in mind when discussing the GRH and institution topic. GRH should not be classified as an institution as it serves a purpose in helping those become productive members of society.

Long Term Homelessness and GRH

Another area I would like to address in the GRH funding is the Long Term Homelessness (LTH). I know another concern is the length of stay by some of the people who receive GRH funding. However, please remember GRH serves many people and **sometimes a longer stay is good**. If you bring someone off the street and into an LTH apartment, how long is too long for them to live there? How long does it take a person who has nothing and rebuild their lives to become a productive member of society? Do you think that can happen in 1 year? 2 years? There may be some that could do it in 2 years but not in one. Yes, they can build up material wealth (TV, radios, games, iPods, etc) in a year's time, but does that mean they are now ready to make it on their own? I can almost guarantee you, if we pushed them out in a year or twos time, it would result in them being homeless again. They have to learn how to maintain their lives, how to live in society, new norms, finding and maintaining a job so that it is their job for a long time. This cannot be done by a short term stay.

Again, please keep this type of housing in mind when discussing the GRH and institution topic. **GRH should not be classified as an institution as it serves a purpose in helping those become productive members of society.**

Thank you for your time.

Sincerely, *[Redacted Text]*

Comment 3

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Tuesday, June 18, 2013 10:38 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE
THE FOLLOWING RESPONSE WAS RECEIVED ON 6/18/2013 AT 10:38:24 AM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I am a service provider

COUNTY: Minnesota Kandiyohi

COMMENTS:

We must make sure that client choice is still the priority. Clients and their families should receive the services they want, not the services that we think they should receive.

Through July 1, 2013 (Comments 4–6)

Comment 4

From: Joyce Scanlan *[Redacted Text]*

Sent: Wednesday, June 26, 2013 11:20 AM

To: *DHS_OPC Public

Subject: Comments on Olmstead Plan

Attached are the relevant comments on the Minnesota Olmstead Plan on behalf of the SRC-B Senior Services committee, and the National Federation of the Blind of Minnesota Senior Division presented by Joyce Scanlan, chair of the SRC-B Senior Services Committee and president of the NFB of Minnesota Senior Division.

[Full text of attached file]

COMMENTS TO OLMSTEAD

To: Olmstead

From: Joyce Scanlan, Chair, Senior Services Committee, State Rehabilitation Council-Blind, SRC-B; and president, National Federation of the Blind of Minnesota Senior Division.

Subject: Comments on Olmstead as applied to State Services for the Blind Senior Services

Date: June 25, 2013

The following comments are made on behalf of older persons, seniors, who are dealing with loss of eyesight—many of whom are still interested in employment, and those who may not be interested in employment services but are eager to live independently in their chosen communities.

Today, statistics bear out the fact that Americans are living longer, and as we live longer, problems, such as blindness, are more likely to occur. Whether it is cataracts, glaucoma, macular degeneration, or some lesser-known condition, statistics confirm that as we live longer, we may be faced with a major change in our eyesight. State Services for the Blind (SSB) is the designated state entity with public funding and legally-assigned responsibility for providing effective services to seniors, those over the age of 55, and those who do not seek employment services but wish to remain independent and receive appropriate services.

SSB is not a broadly known public entity in the state of Minnesota and is not the primary resource identified when blindness occurs; SSB and its services to seniors are difficult to find within the Department of Employment and Economic Development (DEED) and a minor, inadequately-funded program within SSB. SSB management needs to do much more to raise its public awareness and visibility so that when blindness comes and the need for services arises, citizens will be better prepared to seek relevant information and services from SSB. While the services are limited by less than adequate funding, there may be helpful information to assist those losing eyesight in maintaining independence and a meaningful lifestyle rather than giving up and seeking out more visible services such as nursing homes and other more custodial programs. As one who has worked with blind people of all ages across a broad economic spectrum over more than forty years, I have become convinced that every person who becomes blind wishes to go on with life, enjoying the same activities, carrying out the same daily tasks, being just as independent and productive as they have been throughout their lives. So the first point that must be demonstrated to them is that there are others who are blind out there in the world living independently and productively as they choose to live, and it is definitely possible for anyone who becomes blind later in life to accomplish the same goals. The question is just how can this be accomplished? And that's where SSB comes in as a service-provider. With better funding and more appropriate visibility in the community, SSB could better reach out to more citizens who could benefit from its services, and thus its improved visibility could increase the likelihood that more seniors would retain their independence and continue to live in integrated communities and not succumb to poor choices or living in a custodial-type setting for lack of more appropriate information. SSB must have greater visibility in the state to avoid being—as it is now—the state's best-kept secret.

According to Minnesota Statute chapter 248.011, ophthalmologists and optometrists identifying a person as legally blind must, after receiving the person's permission, refer the name and address of the individual to SSB officials within 30 days, who, also within 30 days, must contact that person to provide information about the services available, etc. Older persons losing eyesight are far more likely to seek help from their medical doctors, ophthalmologists, etc. rather than from SSB. SSB must partner more directly with these medical professionals who have direct contact with those experiencing vision loss. According to the aforementioned statute, medical doctors, ophthalmologists, and optometrists are required to inform SSB of anyone who becomes legally blind in the state. As far as we know, this statute has resulted in less-than-desired results. In other words, not many referrals have been made to SSB

because of this law. The law has slipped through the cracks with no relevant publicity circulated to assist the medical profession in carrying out the intent of this particular law. We know the numbers of older people losing eyesight are increasing, and SSB's very limited funding prohibits appropriate outreach, and the result is an inability to serve many with need. More people having problems with blindness give up and choose to live in nursing homes where they will no longer receive SSB services for lack of funding. A nursing home is a very segregated and isolating housing arrangement and should not be the choice when appropriate services—related to blindness—should be available. SSB should work cooperatively with the medical profession to assure more appropriate housing is available to seniors facing vision loss. SSB has prepared a cd about its services to help nursing home staff deal with residents who are blind in an appropriate manner with relevant services, etc. However, nursing home staff changes quite rapidly, and the cd with its helpful information becomes lost in the shuffle, and the staff do not have information that could help those residents who are blind. The very sad result is that many nursing home residents who are healthy, except for blindness, are left with less-than-meaningful, and definitely lives without integration.

SSB does take referrals who are seniors. There are approximately seventeen SSB staff who provide meaningful services to seniors; however, as far as I know, there are no staff members providing these services who are blind. Thus, those seeking services have no role models by which to measure their progress or their lives. SSB must do more to employ blind staff to serve seniors. Throughout the entire agency, there are very few blind role models. This is a serious and long-standing problem for all customers, but also for seniors.

We know that in general people respond to blindness in the same way they respond to any other condition or situation they encounter throughout life. Some respond with denial; some with avoidance; some with panic; some with calm. We also know that in general, people fear blindness more than any other condition except cancer. Misconceptions regarding blindness in our society abound. Because the prevalence of blindness in our society is fairly new among our older population, and the number of seniors becoming blind is building, more resources are needed to provide meaningful services to assure seniors that independence is still within the realm of possibility for them. Services can promote independence and positive attitudes toward life. Life is far more than alternative techniques. Proper information and hope can go a very long way in making sure that services available result in a meaningful life. SSB has the wherewithal to serve seniors in a way to bring many years of enjoyment to many customers.

A number of years ago, SSB began offering classes on blindness to seniors. Such classes brought small groups of seniors dealing with blindness together to learn alternative techniques and positive attitudes toward blindness to help them overcome the misconceptions and doubts about what blind people can do. These classes were very successful and assisted many seniors in living independently for many years. We know of many people who continued living totally independently for more than ten years, and several who eventually went into nursing home settings not because of blindness but because of some other health-related difficulty such as a heart attack or stroke. We very strongly recommend the group model for serving seniors who are dealing with blindness. Besides learning from a competent

instructor—especially a competent role model who can demonstrate appropriate techniques and upbeat attitudes toward blindness, seniors can learn much from one another.

In order to provide more integrated services to seniors and independent living customers, SSB should partner more closely with community rehabilitation programs (crps), especially those with a large number of competent role models on staff. Crps could offer role models that SSB currently lacks. We encourage the implementation of the group model or group classes to give seniors who are dealing with blindness a sense of community and the understanding that they can lead full and meaningful lives. Most seniors truly want to go on with life without blindness being a major barrier to their productivity and happiness. The group model of training will persuade them that they can go on with their lives and share the opportunities of the average member of society.

This brings me to the final point toward full integration of SSB into society. SSB must partner more closely with the members of the blind community. Yes, there is the SRC-B with all its committees and legal requirements, etc. SSB has a long-standing record of focusing on its bureaucratic traditions and isolating itself from the broader society of blind people. There are organizations of the blind out in Minnesota with very upbeat and positive philosophies of blindness, which would be a very ameliorating influence on SSB staff. While SSB has made improvements in its approach to blindness over recent years, its staff members have miles to go to make the progress necessary for staff to have as helpful an influence on customers as is needed. The staff must regard integration of blind people into society on a basis of equality as a goal that is possible and achievable; otherwise, SSB will continue to be behind in providing the quality of rehabilitation services necessary to assist blind Minnesotans in reaching their highest potential. Blind people are out there eager to offer their assistance. SSB must open its doors to accepting their help.

Summary of proposed changes to improve possibilities for better integration: In order to better integrate services to Minnesota's population of blind seniors, SSB should: 1. partner more closely with members of the medical profession in order to receive information on seniors who are dealing with loss of eyesight; 2. Employ more staff with personal experience with blindness to serve as role models for customers; 3. Do more effective outreach to improve the visibility of SSB and its services available to seniors; 4. Build working relationships with crps with employed staff who are blind who follow a practice of positive philosophies of blindness in their programs; and 5. Partner more closely with members of the blind community with positive philosophies of blindness who know from personal experiences about resolving issues related to blindness.

Comment 5

From: [Redacted Text]

Sent: Wednesday, June 26, 2013 12:30 PM

To: *DHS OPC Public

Subject: Additional Meeting Session

Would it be possible to add another meeting to the agenda. A meeting for the Bemidji or Thief River Falls region of the state would be good. These areas are hours away from the nearest meetings currently proposed.

[Redacted Text]

Comment 6

-----Original Message-----

From: *[Redacted Text]*

Sent: Wednesday, June 26, 2013 5:02 PM

To: *DHS OPC Public

Subject: INput on person with disabilities

I have a son with schizophrenia, and he lives with his father. He is *[Redacted Text]*. There is very little out there in the area of social integration or recreation for him. There are several places that provide some type of support this way, but the attendance is low and often very sketchy. When he tries to go downtown and socialize, he just runs into people that take advantage of him.

I would like to see some type of really nice social center that plans outing for young adults with mental disabilities and events they can go to in groups, that would be supervised. I would help to be on any committee that plans this.

[Redacted Text]

Through July 8, 2013 (Comments 7-18)

Comment 7

From: *[Redacted Text]*

Sent: Tuesday, July 02, 2013 8:55 AM

To: *DHS OPC Public

Subject: Sign up to speak at Listening Session

Is there any possibility of a listening session being scheduled in SW Minnesota at Marshall or Worthington as examples?

[Redacted Text]

Comment 8

From: *[Redacted Text]*
Sent: Tuesday, July 02, 2013 3:36 PM
To: *DHS OPC Public
Subject: Public Comments

I have heard of these changes and my heart aches for the men fighting for their lives against addiction, whose supportive housing options could close because of the classification of GRH homes as being institutions and needing to separate housing from services. Please educate yourself with the below information. Thank you for your time.

[Email also included the same content as comment 2 regarding Group Residential Housing]

Sincerely,
[Redacted Text]

Comment 9

From: *[Redacted Text]*
Sent: Tuesday, July 02, 2013 3:48 PM
To: *DHS OPC Public
Subject: The Importance of Continuity of Care

To Whom It May Concern:

I am writing today in regards to elements of the Olmstead Act that define GRH facilities as institution and separate Supplemental Services from Housing.

As an Advocate for homeless adults and adults with mental illness, I can attest to the benefits of supplemental services being included in housing programs. By integrating the services that are provided--advocacy, living skills, nursing, home health aides--we are able to provide a greater continuity of care to our clients at a lower cost. Our client's care team communicates with each other, and provides transparency so the client can make decisions for themselves about their care, without having to wait for multiple referrals and adjustments.

Ultimately, Supplemental Service integration only works with housing if the GRH Board & Lodge programs are allowed to continue. These programs are not institutions. There is no guard waiting to lock clients away for "quiet time." Instead, many of these programs encourage independence while providing a safe community to return to. Our clients work, volunteer, and engage with others in their neighborhoods. They attend churches, classes, and concerts. They come and go as they please--while providing us basic details so that we can coordinate care.

Please do not make these Olmstead Act changes! Our clients may live in apartment facilities that run GRH programs, but they provide our clients a sense of community based on commonality. Our staff utilizes supplemental services with clients to help them engage in the neighborhood and the community

at large, while ensuring they have a safe stable home to return to, free of discrimination, and full of compassion and encouragement that our clients are living healthy successful lives.

Regards, *[Redacted Text]*

Comment 10

From: *DHS_Webmaster, DHS
Sent: Tuesday, July 02, 2013 4:43:50 PM (UTC-06:00) Central Time (US & Canada)
Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 7/2/2013 AT 4:43:50 PM

NAME: *[Redacted Text]*
EMAIL: *[Redacted Text]*
REASON:
DESCRIBE YOURSELF: I work for state or local government
COUNTY: Hennepin

COMMENTS:

I work within the criminal justice system, so I am most concerned with DOC's portion of this plan. If actually implemented, this would be a big shift in what I see on a daily basis. My experience is that often agents do not take the time to learn about their clients and seem almost nonchalant about sending someone with disabilities to prison. One simple solution would be for the DOC to consciously hire people/agents with experience working in the community with people with disabilities vs. so much importance placed on having criminal justice backgrounds. In my humble opinion, transition planning, etc. is important, but this simple change would eliminate many of the problems all by itself and keep people who do not belong in prisons or jails out in the first place.

Comment 11

From: *[Redacted Text]*
Sent: Tuesday, July 02, 2013 4:51 PM
To: *DHS_OPC Public
Subject:

[Email included the same content as comment 2 regarding Group Residential Housing]

Sincerely,

[Redacted Text]

Comment 12

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Tuesday, July 02, 2013 7:02 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 7/2/2013 AT 7:02:00 PM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I have a disability

COUNTY: Blue Earth

COMMENTS:

Is there going to be a listening session in Mankato MN.

Comment 13

From: *[Redacted Text]*

Sent: Wednesday, July 03, 2013 5:58 AM

To: *DHS OPC Public

Subject: Public Comments

[Email included the same content as comment 2 regarding Group Residential Housing]

Sincerely,

[Redacted Text]

Comment 14

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Wednesday, July 03, 2013 10:42 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 7/3/2013 AT 10:42:20 AM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I am a service provider

COUNTY: Hennepin

COMMENTS:

I am extremely concerned about the proposal that would no longer allow one company to provide both housing and supplemental services. The clients that I work for do not need more separation of services. The majority my clients have enough difficulty doing things for themselves that most people take for granted. Separating housing and supportive services is unnecessary and does nothing to improve the quality of life for these individuals. I would like to know if this plan includes input from the people it is designed to help.

Comment 15

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Wednesday, July 03, 2013 11:07 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 7/3/2013 AT 11:06:34 AM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Todd

COMMENTS:

I do not have the time to read through the whole document. I would like to have included in this document that persons who are on the waived program and choose CDCS option receive only 70% of the whole budget. The CDCS option makes more use of natural supports than the traditional waiver, so if you choose CDCS, it means you are not as likely using provider supports. If you are not using "providers" your budget is cut to 70%. We are providing round the clock care for my 18 year old son for a very small fraction of what the State would pay for group home or institutionalized care. In discussing the possibility of moving him to group home care, we were told by his behavioral consultant that he would likely be asked to leave many group homes because of the severity of his behaviors. Yet, we receive very little funding through CDCS for his care. This seems contrary to the spirit of Olmstead.

Comment 16

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Wednesday, July 03, 2013 3:17 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 7/3/2013 AT 3:16:40 PM

NAME: *[Redacted Text]*

EMAIL: n/a

REASON:

DESCRIBE YOURSELF: I have a disability
COUNTY: Hennepin

COMMENTS:

I am commenting on behalf of *[Redacted Text]*, who has a disability. He would like to see metro mobility services expanded area-wise (for example, to Buffalo and Andover). Right now he finds it hard to get where he needs to go if he has a trip that requires multiple stops instead of just going to and from one destination. His disability makes it such that he is hesitant to use transfer routes.

Comment 17

From: *[Redacted Text]*

Sent: Friday, July 05, 2013 8:31 AM

To: *DHS OPC Public

Subject: Group Residential Housing (GRH) funding, Supportive Services, and the Olmstead act

Good Morning,

I am writing in regards to Group Residential Housing (GRH) funding, Supportive Services, and the Olmstead act. Basically I am writing to review the main errors in ideas being discussed and drafted that would be a great set back: defining Chemical Dependency Programs as institutions and separation of service from housing.

CHEMICAL DEPENDENCY PROGRAMS DEFINED AS INSTITUTIONS

GRH covers many types of programs in Minnesota. One type being Board and Lodge Programs for those in recovery from chemical and substance abuse/addictions. Below is a brief description of these programs and several reasons as to why they should not be considered institutions:

The standard housing is 90 days, but clients can stay longer if they feel their sobriety calls for it. The average stay is 3 – 6 months, but occasionally clients stay for 1 to 1 ½ years; that may seem like a long time, but when dealing with someone who has 30 years of addiction, it really is not that long.

The individuals participating in the program have chosen to do so. We do not accept anyone who is being forced; they must want to stay in the program.

Although all of the clients are diagnosed as Chemically Dependent (CD), that does not make it an institution.

- This is not their permanent housing.
- The clients have elected to live in the board and lodge setting with others in recovery because they need and want the support of the others to maintain their sobriety.

- If a person is in recovery, that last thing they should do is house with someone who is able and willing to drink. They do not want to be in the presence of a trigger; they have been taught in recovery to avoid it at all costs.
- Each day in a program helps to further equip them to get back out into society.

Reinterpreting GRH housing and forcing these individuals to live with others who are not sober would end up costing the state a lot of money because the relapse rate would dramatically rise, and Chemically Dependent individuals would be cycling through treatment at a larger rate.

Supreme Court case: Oxford ruling allowed people in recovery to live together

- There were a group of guys that wanted to live together and sued to have that right. They took it all the way to the Supreme Court and won!
- City of Edmonds, WA v. Oxford House, Inc. et. al. 514 U.S. 725 (1995). In this case, the Supreme Court ruled in a 6-3 decision that recovering alcoholics and drug addicts were a protected class under the handicapped provisions of the Federal Fair Housing Act Amendments of 1988.

SEPARATION OF SERVICES FROM HOUSING

There may be areas where separating services from housing may be beneficial, but it would not be beneficial for a board and lodge program with special services. A board and lodge facility that provides special services must:

- Have secure and centralized storage of medication
- Give clients reminders and monitor the self-administration of medication
- Support an individual's development, helping to create a medical and social service plan, update the plan, and monitor compliance of the plan
- Provide assistance with setting up meetings, appointments, transportation to access medical, chemical health, and mental health service providers
- Provide 4 hours of nursing to the clients each week

Separating the services from the housing would create chaos in what is currently a stable environment. For example, in a house of 20 clients, you could feasibly need:

Twenty staff, all working for different service providers, on hand for 24 hours a day in order to:

- Give medication reminders
- Monitor the client taking their medications
- Provide transportation assistance
- Assist with setting up meetings
- Providing developmental support

Twenty different nurses who have to provide 4 hours of nursing service to their client each week
 Twenty different lockable storage bins for medication

It does not make sense to separate the housing and services in this manner; there literally would not be room for all the staff to function properly, let alone be productive. It would also be extremely inefficient financially. Even if the clients chose only 5 different service providers, there would still be 5 people waiting around for 24 hours a day and 5 different nurses per week when only 1 staff member and 1 nurse is needed.

Financially it is devastating to separate the two. It would not be feasible for the organization that provided services as well as the organization that provide housing to be profitable. If the separation occurred, an organization that provided special services could not afford to have someone at each facility for 24 hours per day, and provide nursing services 4 hours per week, per individual. An organization that receives only the board and lodge rate would need a facility that houses 40-50 clients in order to break even. Ultimately, the organizations that serve these individuals would either close, or focus on a different population. It is only through the economies of scale in combining housing and services that the board and lodge model is financially viable.

I am sure in theory there are benefits to this plan however, like many great ideas, only in theory. When it comes down to actual implementation it misses the mark and would result in injury rather than improvement. Please realize the actual negative impact this will have on all of the actual individuals and facilities, and in turn, as all things turn back to, the community as a whole.

Respectfully,

[Redacted Text]

Comment 18

From: *[Redacted Text]*
Sent: Friday, July 05, 2013 12:53 PM
To: *DHS OPC Public
Subject: Public Comments: Olmstead Act

[Email included the same content as comment 2 regarding Group Residential Housing]

Sincerely, *[Redacted Text]*

Through July 15, 2013 (Comments 19-27)

Comment 19

From: *[Redacted Text]*
Sent: Tuesday, July 09, 2013 11:07 PM
To: *DHS OPC Public; *[Redacted Text]*
Subject: Accommodations Request Olmstead

To the Lt. Gov. and the entire committee.

Please allow me to reintroduce myself, my name is *[Redacted Text]*. I am *[Redacted Text]* based here in our lovely state and I spoke on the issues of emergency preparedness and disaster relief services for us with physical challenges, and I thank you for that opportunity. I would like to expand on these issues and my idea through how we can work together as state, local and private sector agencies to creating a stronger community that includes all of our citizens with unique accommodation requirements.

Our organization is emergency communications and disaster relief group with a subspecialty of disability services during these environments. My understanding of the Olmstead decision was to promote and facilitate community living with physical challenges. It is my belief, not through data and numbers, but life experience that it ultimately cost more to reintegrate a citizen back into the community from a supported institutionalized stay because in many cases. It requires a minimum of a 30 day stay at the facility. Which this in itself is a complete contradictory of what our ultimate goal is because without programs like ours and others to come it forces institutionalism because of no better options at this time.

I believe a disaster relief program would provide him much needed and more cost effective solution. Our program would allow the traditional 1st responder and disaster relief services to provide services to those that are critical and lessen the load on area trauma centers because they would not be providing services for basic needs to those with physical challenges.

At this time I would like to present some projected data I have been told that based on written medical diagnosis is, it costs 1500 dollars a day to house me in a medical facility, such as a hospital regardless of any additional diagnosis beyond my original disability. This does not include the basics ambulance transportation, for you see, it is difficult for me to sit in a standard wheelchair because I have a custom seating orthotic in my personal wheelchair. So I hope you can see from my illustration and comments at the hearing in which I gave the example that I can run generator on 2 gallons of gas or 8 hours for \$6 would be more effective solution so that a nursing home or facility does not always have to be the answer during disaster environment.

This basic concept would not only be a better solution, but it would show that Olmstead model can be upheld in adverse conditions promoting truly quality.

Thank you for your time.

Sincerely, *[Redacted Text]*

Comment 20

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Wednesday, July 10, 2013 8:47 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 7/10/2013 AT 8:47:28 AM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Sherburne

COMMENTS:

My name is *[Redacted Text]*, I am writing on behalf of my family and my son *[Redacted Text]*, who is *[Redacted Text]* with intellectual and physical disabilities.

I would like to share with the subcabinet a request - when you are looking at employment services please consider people that are very limited in their ability to work. It appeared to me that the planning committee looked at models from states that don't provide day services except those related to employment. In this scenario *[Redacted Text]* would be at home, most likely, all day as he is extremely limited in his ability to work and has personal care needs that require ongoing assistance. This is not a model I'd like to see in MN. Our family is not unique in the fact that we have other commitments and responsibilities that make it difficult to meet the needs of someone like *[Redacted Text]* 24/7/365. If this were to occur we'd no longer be able to keep him at home - and in our area (*[Redacted Text]*) there is only one residential option, including nearby counties, and that's 40 miles away.

I obviously know *[Redacted Text]* well and know that no matter how customized, carved out, or what ever assistive technology is provided, he will be extremely limited in his ability to work.

I hope you will keep *[Redacted Text]* and people like him in mind as you proceed.

Thank you.

Comment 21

[Note: this comment was also submitted using the website form]

From: Koehler, Kurt [mailto:kurt.koehler@CO.RAMSEY.MN.US]

Sent: Wednesday, July 10, 2013 10:47 AM

To: *DHS_OPC Public

Cc: Evenson, Kevin J (DHS)

Subject: Comments on the Minnesota Olmstead Plan

RE: Minnesota Olmstead Plan and Group Residential Housing for Persons with Chemical Dependency and/or Co-occurring Substance Use Disorders and Mental Illness

Please accept these comments (both attached and in text below), submitted today, July 10, 2013 by the Ramsey County Human Services Department, Chemical Dependency Service Team.

If you have any questions or would like additional information please contact:

Kurt D. Koehler, M.S.
Planning Specialist / Contract Manager
Ramsey County Human Services Department
651-266-4113

Kurt.Koehler@co.ramsey.mn.us

Thank you.

[full text of attached document below]

Ramsey County Human Services Department
Chemical Dependency Service Team

Comments on the Minnesota Olmstead Plan and Group Residential Housing for Persons with Chemical Dependency and/or Co-occurring Substance Use Disorders and Mental Illness

Submitted July 10, 2013

We believe the promise of Olmstead and the goals of the MN Olmstead Plan are generally shared by most who work with persons who have disabilities. The ability for one to live with dignity, as independently as possible, within integrated housing of their choosing, and to receive services as they choose, is extremely important. Some of the components that are emphasized in the draft Minnesota Olmstead Plan include access to choice of both housing and service providers – separated if the client prefers, and also the choice to be housed in integrated settings and not only with others who share the same or similar disabilities.

We strongly support these goals for persons with disabilities. However, we have concerns about the Minnesota Olmstead Plan and the effect it may have on the continued availability of Group Residential Housing (GRH) as licensed board & lodges for persons with chemical dependency and those with a co-occurring mental illness in the early stages of recovery.

The MN Olmstead Plan as discussed by the DHS representative Gregory Gray at the Forum in St. Paul on June 19, 2013 suggested that the department's plan may redirect funding from "institutions" to more "integrated" settings. We support this direction, but it is our hope that there also continues to be a continuum of services available that include GRH settings for persons with chemical dependency in order to address the need for onsite services and the benefits of peer and recovery support that occurs in congregate living GRH settings during early recovery.

Congregate living GRH settings play a very important role in the continuum of care for homeless persons lacking income who are coming off the street, out of a detoxification facility, or out of a residential treatment program, as a place to continue their recovery in the early stages and leading to stability and improved health outcomes. Time in transitional living with others who also have a substance use

disorder provides a unique form of peer support and learning in order to avoid the self-isolation characteristic of addiction that so often leads to relapse.

The Olmstead Act applies to persons covered by the Americans with Disabilities Act and while the ADA does not recognize chemical dependency as a disability, the Federal Fair Housing Act does (1988 SCOTUS Oxford Sober House decision). This distinction should be a consideration in the MN Olmstead planning and decision making in terms of providing choice in housing, and in the future of the GRH system that is currently in place for serving persons with substance use disorders.

The U.S. Department Of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) recently released a Treatment Improvement Protocol (TIP) #55, Behavioral Health Services for People Who Are Homeless (First Published in 2013), which clearly describes voluntary congregate living in transitional and supportive housing with services as a needed part of the continuum for homeless persons with a substance use disorder (pages 46-54).

Poverty, health problems, and impairments in functioning often result in homelessness for people who have mental and chemical health disabilities. GRH congregate settings provide transitional housing to people to avoid homelessness and extended lengths of stay (LOS) in hospitals or other institutions. Keeping homeless persons for longer terms in Rule 31 licensed residential chemical dependency treatment settings in order to help them gain a foothold on recovery would certainly be more restrictive, more expensive, and more institutionalizing than moving to a GRH setting where they can begin to work, train for work, attend other schooling, and save money in order to move into independent living.

Authorized lengths of stay in GRH may vary county by county, but evaluation studies have shown that in Ramsey County, and other metro counties, the LOS for most individuals is 90 to 180 days. A length of stay of such a short time can hardly be considered institutionalizing. We believe stability and health outcomes could be negatively affected without these programs. Perhaps uniform policies regarding the LOS and onsite services with required periodic reviews could be instituted statewide to avoid the “warehousing” of people with substance use disorders.

For example, the use of American Society of Addiction Medicine (ASAM) placement criteria in determining LOS (ASAM PPC-2R) would help to monitor and assess client progress through a multi-dimensional assessment process. Placement, continued stay reviews, and transfer to other levels of care could be objectively decided and agreed upon for and by persons with SUD and co-occurring disorders, ensuring lengths of stay are clinically justified for any particular setting. ASAM is broadly accepted and understood nationally as a common language for providers to determine and communicate placement decisions. The ASAM criterion closely resembles the Minnesota Rule 25 assessment for determining proper placement in Rule 31 licensed chemical dependency treatment. However, similar criteria could be used to regulate and monitor placement in congregate living GRH settings licensed as rooming and boarding houses for chemically dependent persons who are experiencing various ranges in stages of change and recovery.

We thank the Minnesota Olmstead planners and the Subcabinet for the opportunity to share our views in this commentary. We believe congregate living GRH programs are needed and could be improved, and we will continue our efforts towards that end.

Comment 22

[Copy of document from listening session, offering public housing perspectives]

Al Hester
Housing Policy Director
St. Paul Public Housing Agency
W. Andrew Boss Building
555 N. Wabasha St. Suite 400
St. Paul MN 55102
Phone: 651-292-6173
Fax: 651-298-4258

[Full text of attachment below]

Comments on Minnesota's Draft Olmstead Plan
Al Hester, Housing Policy Director July 9, 2013

PHA Overview

- 1) The PHA strongly supports the goals of the draft Minnesota Olmstead Plan to maximize opportunities for persons with disabilities to
 - a. Live in integrated settings of their own choosing, and
 - b. Receive the services they need and want, either connected to their housing or independent from it.To achieve those goals and have real options for their housing and services, more persons with disabilities will need income supports and/or housing subsidies. Current subsidies are too few and/or too low. We should not expect new federal resources to be forthcoming.
2. The St. Paul Public Housing Agency (PHA) provides safe, affordable, quality housing to a large number of persons with disabilities, including single individuals, heads of households or two or more, and other household members.
 - a. 43% of 2600 PHA hi-rise residents are single persons who are younger than 62 and who have one or more disabilities, as high as 60% in some buildings;
 - b. 28% of 1700 family households living in public housing are headed by a person who is (or their spouse is) a person with a disability who is younger than 62.
 - c. An unknown number of residents who are 62 or older also have disabilities.
 - d. A significant segment of the residents who are younger than 62 and have disabilities, are persons with mental health issues as their primary disabling condition or a co-occurring condition.
3. The PHA's housing programs include:
 - a. Public housing: The PHA owns, manages and maintains the properties; 4253 rental units with federal subsidies.

- i. 16 hi-rises (2554 units)
- ii. 4 housing developments for families (1296 units)
- iii. —Scattered site single family homes and duplexes (403 units)
- b. Section 8 Housing Choice Vouchers: 4572 federal rent subsidies
 - i. —Tenant-based vouchers : The voucher holder finds a unit in the private market, PHA pays the subsidy if the unit passes inspection and the rent is —reasonable for the unit, and if the property owner agrees to participate.
 - ii. —Project-based vouchers : The PHA has awarded almost 500 Section 8 subsidies to over 20 new or existing housing developments. Over half of those projects and units provide permanent supportive housing with services. Many of those projects are targeted at ending long-term homelessness and many of their residents are persons with disabilities.
 - iii. Special Programs:
 - 1. Homeless Veterans (VASH – Veterans Administration – Supportive Housing)
 - 2. Family Unification Program (FUP)
 - 3. Tenant Protection/Preservation Vouchers
 - 4. Section 8 Moderate Rehabilitation –Single Room Occupancy (SRO) units: Mary Hall, Booth Brown House Foyer.
- 4. HUD funding is inadequate to support current units in public housing and Section 8, with no prospects for significantly increased funding. For the foreseeable future we expect no funding for new public housing units or new vouchers (other than special purpose vouchers like VASH).

Specific PHA Comments on the Draft Olmstead Plan

- 1. Public housing and Section 8 are not the cause of the problem addressed by the court decisions following *Olmstead*, nor are they the solution. We want to continue to be part of the conversations to share our experience with related issues, and to help the State and local agencies move toward solutions where we can.
- 2. Public Housing is an integrated setting.
 - a. All residents have their own lease, private unit with kitchen and bathroom, etc.
 - b. Within the building residents have daily opportunities to interact with other residents who do not have disabilities. PHA Resident Councils (one at each site) demonstrate a good mix of residents with disabilities working side-by-side with those without disabilities, jointly planning and participating in resident activities and governance functions. When Resident Councils plan social outings, they rent buses that are accessible for people with disabilities.
 - c. Residents are free to come and go, so they can and do travel freely in the community and interact with people without disabilities. Like other City residents, hi-rise residents with and without disabilities visit community centers, schools, shopping areas, churches, jobs and volunteer work sites. PHA staff encourage all residents, especially those with disabilities, to get —out and about . Residents with significant mobility impairments often use Metro Mobility to get around.
- 3. Public housing residents choose where they live, subject to the availability of vacant units when they are accepted to public housing. They are not —placed there by another agency.
- 4. Persons with disabilities live in public housing for a variety of reasons including:
 - a. As required by federal statute and HUD regulations, persons with disabilities share top priority with elderly persons for admission to 15 PHA hi-rises that were all constructed as —elderly housing . The 16th hi-rise (777 North Hamline Avenue) has been approved by HUD as —designated housing for elderly residents, so persons with disabilities have lower priority for admission there.

- b. The St. Paul PHA provides —safe, affordable, quality housing (our mission).
 - c. Many PHA units have special accessibility features, and PHA staff are experienced in working with applicants and residents who have disabilities.
 - d. Other affordable housing options are lacking.
 - e. Supportive services are available in or near some public housing locations. PHA Human Service Coordinators can help residents locate services in the community they may want or need.
 - f. Many PHA sites are accessible by public transportation.
 - g. Congressional and HUD funding and program priorities have given persons with disabilities priority access to some special public housing programs. For example, the St. Paul PHA operates the Congregate Housing Services Program (CHSP), a 30-year-old HUD —demonstration program that helps frail elderly persons and persons with disabilities avoid institutionalization by providing affordable housing, some non-medical personal services and links to other community services. A majority of the CHSP participants now are non-elderly persons with disabilities, primarily mental impairments. The five PHA hi-rises that are CSHP sites are among the hi-rises with the highest concentrations of non-elderly persons with disabilities. Services for some CHSP participants are partly paid through MA waiver funding.
 - h. The PHA partners with service providers on other special programs for persons with disabilities, including the Wilder Foundation’s Assisted Living Program and Accessible Space, Inc. both of which provide services to some hi-rise residents.
5. Several Project-Based Voucher (PBV) projects that provide permanent supportive housing are specifically funded to serve people with disabilities. Residents are not —placed there. They voluntarily choose to live there and accept the services offered. (HUD rules require PBV-supportive housing residents to accept the services.) Even though that creates —concentrations of persons with disabilities, those projects should be allowed to continue as they are. Alternative models of subsidized housing and services should also be developed to maximize the choices available to persons with disabilities.
 6. HUD’s recent statement on the —Role of Housing in Accomplishing the Goals of Olmstead specifically states that no requirements of existing HUD programs have changed. For example, the Section 811 program will continue to serve persons with disabilities exclusively, as authorized by Congress.
 7. The HUD statement reminds housing agencies that they are permitted and encouraged—but not required—to give some admission preference to persons with disabilities who are transitioning from or at serious risk of entering an institutional setting are permissible. As explained above, the PHA’s CHSP specifically serves this population in public housing, and some of the Section 8 project-based voucher programs also serve persons with disabilities who are at risk of institutionalization. Any consideration of extending an admission preference to more persons with disabilities would have to weigh the housing needs of other low-income families and individuals in the community.

Thank you for considering these comments. Feel free to contact me (Al.Hester@stpha.org, 651-292-6173) if you would like more information.

Al Hester, Housing Policy Director, St. Paul PHA

Comment 23

[Redacted Text]

[Full text of document from listening session, describing challenges for PCAs].

Human Service Programs: A PCA's Observations

By *[Redacted Text]* M.S., A.B.D.

August 3, 2011

A PCA's Experience

Having worked as a PCA (Personal Care Attendant) off and on for what is now a little over 20 years. I would like to comment on Minnesota's Department of Human Services, budget from the perspective of a PC A. According to Minnesota Department of Employment and Economic Development, roughly 10,000 individuals were employed as Home Health Care Aides or PCAs in 2009 in the Twin Cities area, or 40,000 statewide (Vilsack, 201 0). Further analysis of Department statistics indicates that this was the fourth fastest growing career in 2011. An estimated 2,279 new home health jobs were created in 2011. The Office of Minnesota Budget and Management (2009) stated that \$402 million was budgeted for PCA services in 2009. This would place the annual per capita pay of PCAs at an average of\$10,000, which is below the \$15,000 national poverty level according to U.S. Department of Health and Human Services statistics. Currently Minnesota Statue allows a home health care agency to use 27.5 %of the dollars they receive for administrative overhead. In exchange the agency is required to train, and supervise PCAs. This means that approximately \$110,000,000 of PCA costs is going to home health care provider agencies. The remaining \$290,000,000 is paid as wages to PCAs (Punelli Lemire, 2006).

Why are administrative costs for PCAs set at 27.5%? Compare this to the administrative costs of Medicare and Medicaid, which are estimated by the Centers for Medicare and Medicaid Services (CMS, 2012) at 3% annually. The CMS estimates that administrative costs for private insurance at 12% annually. These figures are disputed by the Center for Policy and Research of AHIP a private health insurance think tank. The research provided by AHIP argues that Medicare and Medicaid true administrative costs are closer to 1 0%. AHIP also argues that CMS includes in its analysis of private insurance administrative costs such things as state sales taxes on health insurance, which can run as high as 3% of premiums. Other costs that are included in private insurance administrative costs in the CMS analysis, which the insurance industry analysis, claim are not included in CMS estimates. Are costs associated with services such as providing consulting nurses. The 27.5% percent being paid to home health care agencies in Minnesota, for administration is more than ten times as high as CMS costs, and twice that of AHIP. If the state were to limit health care providers to 15%, which is more than private insurance or Medicaid receives for administration. Costs to the State of Minnesota would he reduced by \$50 million annually.

A major reason given for this supervision by Home Care Agencies is the prevention of fraud by PCAs. According to testimony provided to U.S. House Judiciary Subcommittee on Crime, Terrorism and Homeland Security on March 4, 2010. By D. Mark Collins Assistant Attorney General Director, Nebraska

Medicaid Fraud Control Unit and President, National Association of Medicaid Fraud Control Units. This testimony cited the following two examples of fraud in the Context of Home Health Care (2010).

"A Minnesota personal care provider agency that provided private duty nursing services and personal care assistant services was owned and operated by a licensed practical nurse. The nurse was providing LPN services without a current registration with the state Board of Nursing. A MFCU investigation revealed that the owner submitted claims for RN services when the services were provided by an LPN. The provider pleaded guilty to theft and was ordered to serve 364 days in jail, to pay Medicaid restitution of \$57,185.56 and to be on supervised probation for five years."

"A family of four was convicted of masterminding an eight-year fraud in Oregon. The four received more than \$230,000 in Social Security disability and Medicaid in-home care payments. Although the state conducted annual in-home assessments, the husband and wife were able to fool investigators into believing that the husband needed around-the-clock care. Surveillance by the MFCU revealed that the husband was not disabled."

Please note that there is no mention of an individual PCA, acting alone in this testimony. The cases involving fraud by a PCA require either collaboration with a Health Provider Agency or the beneficiary of PCA services. This would suggest that most of the problems with home health care fraud do not lie with PCAs, and in the rare case such fraud does occur, PCA's are responsible for only a small part of the fraud problem. It should be further noted that the IRS estimated total costs of U.S. Health Care at \$1.3 Trillion (IRS, 2012). In 2009 fraud was estimated at \$1.3 billion or roughly **1%** of Health Care costs. Admittedly, enforcement of fraud does deter more fraud (2012). However, at some point, dollars spent on enforcement should be considered in context of achieved financial savings, especially given the current state of government budgets, at all levels of governance.

Moving on to a more personal note, I have been a PCA off and on for more than 15 years. I have had various types of clients with varying disabilities and have worked with numerous agencies. Having this experience as a PCA raises several questions. The first being, according to the court's ruling of Wednesday June 29, 2011 my services are considered essential services to the State of Minnesota. If this is the case, why am I denied benefits given to other state employees? The right to health insurance, retirement, vacation, sick leave, overtime, and the right to unionize. I have worked with my current client for over seven years, since 2005. I have had less than a week off that entire time. In 2009 my hourly wage was cut from 12.91 an hour to 12.61. In 2011 it was cut further down to \$12.41. In that same time period the home health care agency supervising my hours actually received an increase in hours for my supervision. The agency that supervises my hours does not provide, or is it required to provide respite, for the PCAs it employees. I would be more than willing to forego any personal benefits if every other Department of Human Service and health care worker in Minnesota were willing to forego theirs as well.

In regard to training I would estimate that after over 10,000 billed hours I have been provided with less than eight hours of training. Even though, I have requested training, to better assist my clients on more than one occasion. My contact with someone from an agency, has not been much more than discussions

regarding billable hours, and a care plan, which I pretty much draw up myself. In all cases my client has trained me to provide their needs, or I have done it myself. My clients have taught me how to assist with catheterization, transfers, monitoring medication, oxygen tanks, and other daily living needs. The agency providing supervision at no time was involved. There was no need, in fact their presence and involvement would have been a hindrance and inconvenience. It would have taken away the little control and dignity, the client has over the most personal aspects of their lives. In addition, the education and training of the personnel that I have worked with from the home health care agencies, is often lacking, and inappropriate for the position.

Just how much supervision does a Personal Care Attendant (PCA) require? Including doctors, nurses, social workers, social service agencies, and nonprofits, there are at least 15 individuals who all are involved in my client's overall care plan. This does not include the Home Care Agency responsible for administration of my hours. I bill for roughly 2000 hours a year, at an hourly wage of \$12.42. How can the agency currently responsible for my supervision justify charging the state an additional 27.5%? If there was a problem that required outside intervention wouldn't the client's doctors, nurses, or other professionals intervene? If so, why is the oversight of a home health care agency needed, to duplicate services already provided by others?

This is a difficult time for Minnesotans as they struggle with solving the state's budget. No doubt there are many possible ways to attack the problem. Working as I do as a Personal Care Attendant one of the fastest growing programs and costs in the state budget. I would suggest the following. Look closely at how PCA services are provided. Since PCAs work directly with children, disabled, and elderly, PCAs should be empowered with the tools and responsibility necessary to accomplish this important job. Rather than depending on and funding a bureaucrat or agency, that is not providing direct care in the home. Fairness, would dictate that PCAs should receive a living wage with the same benefits given to other state employees. If the state cannot afford this it should consider elimination of the program altogether. It is not ethical to expect individuals who provide PCA services, to live at a standard less than others, earning wages near the poverty level.

A few final words, regarding the importance of PCA's, if you believe that this does not apply to you, think again. At any time anyone one of us might become ill, or disabled, requiring the services of a PCA. Wouldn't you want the best and most qualified PCA services available? Do you want someone providing the most personal of your care needs, living near or at the poverty level? How can a PCA be expected to focus on quality care to their client, when they are burdened with the added stress of attempting to live on a low wage, with no benefits? What does this say about our state, and society, if this is the kind of service we provide our states most vulnerable citizens?

-----References:-----

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[Redacted Text]

Comment 24

From: *[Redacted Text]*
Sent: Thursday, July 11, 2013 2:09 PM
To: *DHS OPC Public
Subject: Re: Olmstead Decision

On Thu, Jul 11, 2013 at 12:03 PM, *[Redacted Text]* wrote:

To Whom it may concern:

My name is *[Redacted Text]*. I am writing to express my concern of the impact of the Olmstead Decision on the Drug-Addicts and Alcoholics in our state.

I wish to offer some of my personal experience in my recovery from addiction and the role the Group Residential Housing has had on my ability to be a functioning member of my community.

I suffered from addiction for a very large part of my life. Back in *[Redacted Text]*, I went through the *[Redacted Text]* treatment center in St. Paul. Upon discharge, I entered into the *[Redacted Text]* program *[Redacted Text]* St. Paul. As a GRH funded facility, this half-way house was instrumental to my recovery from addiction.

Congregate living with other alcoholics and addicts laid the ground work for my path back into society and offered a safe environment for me to begin that journey. I have remained in contact with many of the men with whom I shared living space during my time as a resident of *[Redacted Text]*. A good number of them remain sober and have successful lives and attribute their success to Group Residential Housing services and the peer support that comes with it.

Since leaving *[Redacted Text]* as a client, I have found opportunities to serve the members of my community as well as aid in the recovery of others. I wThroughfered a position as a cook for *[Redacted*

Text] early on, I have since worked for several other facilities. I am currently the manager of *[Redacted Text]* and have been witness to the success of many. In my role as manager, I reach out to my peers in other GRH facilities on a regular basis in hopes that through cooperation we might better impact the recoveries of those we serve. My peers have experienced similar success with their residents and also see the necessity of these programs.

It is vital to the state of Minnesota and its residents that such programs remain in tact for those who suffer from alcoholism and addiction. Without them, the state is likely to suffer an increase of homelessness and hopelessness. These organizations that offer congregate living for addicts and alcoholics are safe homes for so many that have no other option and very little chance at success without them. Addiction is a fatal disease that requires intensive lifestyle changes in order to keep it arrested. Peer support as an on-going maintenance of the disease is vital to the success.

Most residents use the congregate living at *[Redacted Text]* for 90-180 days. This is not intended as long term living, rather a short term half-way house program that allows the residents to learn a new way of living. Many go on to finish or continue their educations and become employed while utilizing the skills they have learned from their peer support environment.

Thank you, *[Redacted Text]*

Comment 25

From: *[Redacted Text]*

Sent: Thursday, July 11, 2013 3:31 PM

To: *DHS_OPC Public

Subject: Olmstead plan

Have you looked at the Senior Housing model? In this kind of setting people with disabilities could live independently with support available at need. Community activities would be available as well as community transportation to things like grocery shopping. It's more community integrated than a typical group home situation, yet still not as unsupported as truly independent living.

Taking the model and expanding the age availability means that an aging parent with a dependent adult could both move in and take advantage of the community support, still remaining mostly independent and neither being forced to give up the relationship due to external circumstances. Likewise this kind of facility would be an option for adults with children looking to care for aging parents where entirely independent living is no longer an option but a nursing facility unattractive.

I have a son who "falls through the cracks" in the current care models. I am divorced, aging and his primary care giver. He is *[Redacted Text]*, with physical disabilities as well as some cognitive issues including being a savant. He would benefit from an expanded workforce program where there were built in supports for him to utilize his skills. An emersion school setting would be ideal, but the staffing and funding in those environments make it difficult for them to consider taking him on. I suspect there

are many places through-out government funded agencies and institutions where room could be made to increase placement for transitioning youth. How many legislators have at least one person on staff who came to them through the transition programing? Why not more?

Until you experience this issue personally you will never understand the scope of the problem you are trying to legislate and will likely set up as many barriers as access points. I highly encourage you to approach this legislation from the viewpoint of personal options if you had a parent who became disabled due to a stroke but didn't need constant nursing care, if you had a child who was injured in an automobile accident, if your child suffered brain damage due to a head injury. What services would you like to have available to you and in what kind of setting?

Thank you,
[Redacted Text]

Comment 26

From: *[Redacted Text]*
Sent: Thursday, July 11, 2013 3:33 PM
To: *DHS_OPC Public
Subject: Olmstead public comments

[Full text of attachment below]

Good afternoon – I have taken the time to read the entire Olmstead Plan and would like to thank you for a job well done.

My major concern at this time is the education portion and the fact that most of the plan is geared towards 18 years and up. What about the younger students? We really need to make changes in the system early on in the students' life if we wish to be successful in making changes to the transition age group. If we don't set examples and guidelines early on, it will be much more difficult later in their lives. I would like to see the age reduced to include elementary and middle school children as well.

On page 62 it says "Minnesota has experienced relatively little change over time in the percentages of students with disabilities ages 6-21 in the levels of instructional settings, continuing to offer a continuum of services and maintaining its status as a high inclusion state. Here is my concern. When the report says for example, "Served in regular classroom at least 80% of the day", does that percentage include pull out time? Meaning, are they crediting the full percent even if the child is in the class for only 5 or 10 min?

Last year I shadowed my son at school to get a better idea of what his day was actually like. I'm glad I did. We headed to science class, entered the room and were quickly seated at the back of the room away from his peers. After 5 min in the class, the Para said, let's go kids. We got up, left and headed back down to his special education class room. When I asked why, the Para said, "the stuff that they were going over would be over their heads and they would not understand it".

That week, I meet with the principal and teachers to voice my concern and to let them know I did not want my son pulled out of this class. After a brief back and forth with them, they agreed to follow my wishes.

One week after my son had been in the class full-time, he came home and asked me “mom, where’s my buttocks, my skull, my esophagus”! Then proceeded to show me exactly how your digestive system works.

Another example is when my son was in elementary school. He was not included in mainstream class at all due to budget cuts. They just didn’t have enough Para’s to bring him back and forth to class. One day, I went to school and found that he was in a special education class that had many children that were non-verbal watching movies. It honestly was holding my son back.....and all in all.....every child in that class back! As soon as he was placed in a general education class, his vocabulary really took off. He raised his hand to answer questions more than the general education students.

In addition – while doing a presentation to the elementary school on disabilities, a young girl raised her hand and asked “can I catch a disability from touching someone with a disability”. That’s when I realized we have a lot of work ahead of us.

IDEA doesn’t necessarily mandate inclusion and given the vast discrepancies within the realm of special needs, the “least restrictive environment” is determined on a case by case basis.

Educators and all students (essentially, everybody) benefits through interacting with different people. Integrating students with disabilities into the classroom may also force teachers to leave their comfort zones and learn new techniques to become better instructors.

Adaptation is vital obviously and it comes in two forms: accommodations and modifications. Essentially, they assist students with special needs by compensating for any disability-related obstacles, giving students the tools to excel. After all, a pupil with special needs is unlikely to thrive if he or she is simply dumped into a general education classroom.

Friendships, otherwise unimaginable, form, and these bonds allow kids to understand diversity in ways that textbooks and formal classroom lectures can’t. While not a traditional subject such as math and science, diversity proves important in creating an open-minded society. Throughout their lives, students will encounter others who do not think or act as they do; by learning how to work and interact with these individuals, they gain an advantage not only in the classroom, but also in life in general.

Inclusion can also trigger enhanced collaboration between educators. For example, if a child has a learning disability that makes it difficult to read, his or math teacher may need to confer with other teachers to find a way to help that student with word problems.

Perhaps the most important benefit of inclusion rests in the academic benefits for students with special needs. These students become engaged in their education as opposed to staying unchallenged inside segregated classrooms. In other words, inclusion gives students with disabilities the best chances to thrive academically. There is also a newly developed body of evidence derived from co-teaching, where the special education teacher joins with the general education teacher for areThrough student weakness. The team approach is proving to be possibly one of the best methods of including special

education students, while providing both accommodations and modifications and specially designed instruction.

If we don't start this early, it just gets more and more distant. The chances that our children will be included will diminish greatly.

I think what is important to point out that, we are not asking for them to make changes without proper supports. In order for us to be successful in getting these changes implemented we must assist the service providers to ensure it gets done and done properly.

The struggles and challenges of inclusion is not a disability/disorder issue, it is a human issue.

Thank you for listening!

[Redacted Text]

Comment 27

I have attached some comments and recommendations for the Sub-Cabinet's consideration. Thank you!

[Full text of attachment below]

Dear Minnesota Lt. Governor Prettner Solon and Olmstead Planning Sub-Cabinet Members,

My name is *[Redacted Text]* and I'm self-employed doing business as *[Redacted Text]*. As I shared in my brief testimony on *[Redacted Text]*, I retired on *[Redacted Text]*, following a 40-year career, 36 as a senior manager of employment and workforce development programs supporting job seekers and incumbent workers with a wide array of disabilities. Also, I am a *[Redacted Text]*, a grassroots organization working to promote integrated employment in the workforce at competitive wages and benefits as the first and preferred outcome of Minnesotans with disabilities. Given my strong interest and experience in employment and disability issues, I appreciate this opportunity to offer comment on the draft of Minnesota's Olmstead Plan, and particularly its competitive employment objectives.

First, I would like to congratulate the Committee on its important work to measurably improve the lives of Minnesotans with disabilities to live, learn, work, and recreate in the most integrated setting. And I commend the Committee for acknowledging the pivotal role competitive employment plays as a multiplier and driver of individual choices including self-determination and self-support, expanding housing and supported living options, playing to one's strengths and talents, increasing social integration and inclusion, enhancing life opportunities through higher education, and opening access to fuller community participation. The truth is competitive employment is a gateway to achieving a majority of the foundational goals of Minnesota's Olmstead Plan. And frankly, it would be challenging if not impossible, to realize measurable quality of life milestones without a good job. For this reason, I encourage the Committee to advance a new vision by making competitive employment a clear and imbedded cornerstone of Minnesota's Olmstead plan.

Gandhi once said: “Happiness is when our thoughts, words, and actions are in harmony.” The landmark Americans with Disabilities Act (ADA) of 1990, Section 504 of Rehabilitation Act of 1973, Individuals with Disabilities Education Act (IDEA), Developmental Disabilities Assistance and Bill of Rights Act (DD Act), and Supreme Court’s Olmstead Decision in 1999 assure the civil rights of individuals with disabilities to engage in the most integrated community settings. However, the stated goals of many public policies simply don’t align with current practices and end user outcomes. Despite the best of intent, we’ve managed to create a parallel universe where people with disabilities are now in the community but still largely separated from everyone else.

This fact is no better illustrated than in the area of competitive employment. Stated simply, the pursuit of a competitive job is not a commonly-held expectation of people with disabilities or a clearly defined goal of disability public policy. Stubbornly-held stereotypes, and low expectations about the employability of individuals with disabilities, especially working-age youth and adults with significant disabilities, continue to drive our public investments disproportionately in disability care and safety net programs. The sad truth is working-age youth and adults with disabilities are infrequently valued as potential economic assets; rather, they are more often viewed as a group requiring varying levels of care and long-term public assistance.

Despite public perceptions, research studies continue to document the employability of people with disabilities when high expectations and strengths-based approaches are used. For example, the University of Maryland documented that working-age youth with disabilities in transition from high school were seven times more likely to obtain competitive employment when a family and youth requested this outcome. The same study revealed youth were five times more likely to obtain competitive employment when paid, integrated employment experiences were a fundamental part of his or her individualized education and transition plan (M. Simpson, University of Maryland, 2004). Studies like this one document that the real engine of social change is to increase expectations.

Until Minnesota establishes a clear, written public policy statement on competitive employment as the first and preferred outcome, it will continue to struggle aligning its stated goals with desired results. Too often, existing policies lead to random, directionless service interventions not focused on the primary target—securing a competitive job. And the proof of low expectations is in the results. The competitive employment participation rate of people with disabilities for May, 2013 was only 20.7% according to the federal Department of Labor. Although Minnesota has pockets of excellence supporting job seekers with disabilities, our own data is quite similar to nationally reported statistics for individuals with significant disabilities. For example, Minnesotans with Intellectual or Development Disabilities (ID/DD) who are served in Medical Assistance Waiver funded programs such as Day Training and Habilitation (DT&H) programs are competitively employed at a rate of less than 20% (Source: Minnesota DHS and Ramsey County). Similarly, adults with Serious Mental Illnesses (SMI) who are supported by Minnesota’s Community Mental Health Centers are competitively employed at a rate of only 15% (Source: SAMSHA). We can do far better in increasing the rate of return on Minnesota’s public investment in disability-based programs and services.

The underlying problem with current public policies is a lack of clarity about competitive employment as an expectation and presenting this outcome as merely a “choice.” We need to elevate this conversation! Minnesota must insure people with disabilities and their families are better educated so they can make informed choices and more fully grasp the opportunities and benefits of a working life. As I like to tell people: “You can choose whether or not to work but you don’t get to choose the consequences.” A lifetime of unemployment, underemployment, dependency, segregation, poor physical and mental health, and long-term poverty is too often a resulting outcome of choosing the status quo.

For these reasons, I would like to offer 10 recommendations to Minnesota’s Olmstead Planning Committee to strengthen the employment sections of its draft:

1. Galvanize a fundamental shift in Minnesota’s vision about employment and disability. We need to clearly acknowledge the employability of all Minnesotans with disabilities as well as their ability to contribute as economic assets in the right job in the workforce with the right supports.
2. Establish a written, statewide Employment First Policy. Employment First is the vision, policy, and practices of making integrated employment in the workforce at market rate wages and benefits (with or without supports) the expected and preferred outcome of all Minnesotans with disabilities. This does not mean everyone will choose work but help to attack the roots of low expectations by reinforcing that anyone, including job seekers with significant disabilities, can work with the right goals, practices, supports, and partnership of a willing employer (unless self-employed). The Minnesota Department of Employment and Economic Development (DEED) articulated the importance of Employment First principles in its state agency plan and it’s my hope this language will be adopted as a shared state agency policy for the State of Minnesota.
3. Establish a clear, shared Employment First priority and division of labor among state and local agencies. A written, statewide Employment First policy will redirect priorities and integrate the collective energies, expertise, and resources of state and local agencies by stimulating new partnerships and reinvesting in policies and practices that will result in increased competitive employment outcomes. With everyone moving in the same policy direction, we have the best chances for success.
4. Establish a statewide, uniform definition of employment. The centralized goal of Minnesota’s Olmstead Plan is to support people in the most integrated community settings. So it follows logically that integrated competitive employment in the workforce on the payroll of a business, at minimum or market rate wages and benefits, is the most desired, optimum outcome. The Minnesota Employment First Coalition, therefore, recommends competitive employment is the appropriate standard of measurement Minnesota should use to gauge its performance progress over time. Although other employment approaches are used to support people with disabilities in Minnesota, establishing a competitive employment standard of performance embraces optimal levels of inclusion and natural workforce conditions. This makes the most sense to gauge our state’s progress in promoting employment change and higher levels of inclusion.
5. Establish uniform data collection across all state agencies. Once a uniform definition of employment is established, it’s important to introduce standardized state agency data collection

protocols so Minnesota can measure and document improvements in achieving competitive employment participation goals. A uniform data collection procedure will allow Minnesota to invest its public resources in better ways to gauge employment progress, identify and address unmet needs, and reward employment outcome performance where appropriate.

6. Identify specific employment outcome performance targets. An Employment First Policy is meaningless without establishing specific performance targets to be achieved over time. For example, the Minnesota Disability Law Project offered excellent recommendations for unifying statewide performance with clear annual and incremental goals to be achieved over a five-year period. At a minimum, these performance indicators should include an annual percentage of Minnesotans with disabilities who participate in competitive employment, annual percentage of sub-populations who obtain competitive employment (i.e., adults with ID/DD, SMI, TBI, etc.), percentage of working-age youth in transition from secondary education who obtain competitive employment, and percentage of adults in center-based services who advance to competitive employment. Also, the State of Minnesota, as an exemplary employer, should establish its own targeted hiring goals to increase the employment participation of adults with disabilities within state government jobs over a five-year performance period.

7. Invest in workforce development training for professionals and education for families. It's not enough to develop an Employment First policy and establish performance goals for Minnesota. If our end goal is to find, develop, and create jobs around known interests, strengths, and skills of Minnesotans with disabilities, we will need better trained professionals to introduce new strengths-based employment approaches. This means Minnesota must invest resources in the training, retraining, and skills development of professionals who are engaged in secondary and post-secondary education, adult habilitation and rehabilitation services, and broader community support of Minnesotans with disabilities. Also, Minnesota needs to offer better educational outreach, information, and training for family members so they can assist and support their loved ones who choose a working life. Many families still report not knowing where to turn or how to get the support and assistance they need.

8. Advance from a scarcity model of thinking to one of abundance. Many parts of Minnesota's system of support for individuals with significant disabilities are predicated on a model of long-term intensive services. Current support systems require increasing levels of funding income with very little outcome movement by participants. The present system is not sustainable economically and does little to promote the desired goals of Olmstead. With that said, let's be clear here. A small percentage of individuals with complex, profound disabilities require extensive levels of support. However, many individuals with significant disabilities do have a capacity to work in the labor force with guided supervision from employers and needing only moderate to limited levels of support from professionals. A core question comes to mind—"Why are people with the lowest levels of skill limited to services or work in buildings/programs with the narrowest base of jobs?" It seems logical people with lowest levels of skill would benefit most by having access to a wider base of opportunities to achieve the most effective job match. By focusing on potential partnerships with the entire workforce, Minnesota has the best chance of securing suitable job matches based on the diverse interests and unique skills of its unemployed and underemployed job seekers.

9. Engagement of Business Leaders. Conventional wisdom is business leaders need to be better educated about the abilities of job seekers to change Minnesota's employment landscape and create more job opportunities. Do changed business attitudes really change behaviors? Or do we have this backwards? Does changing business behavior impact new attitudes about hiring people with disabilities? While business education is a worthy goal, past engagement strategies have been ineffective. To illustrate, "hire the handicapped" campaigns are ineffective in changing attitudes because business leaders are not interested in hiring people with disabilities. They are interested in hiring job seekers with interests and skills to contribute to their business bottom line. For this reason, engagement approaches such as apprenticeships, internships, and on-the-job training programs are more effective because they enable business leaders to field-test customized employment principles for themselves. Of course, these approaches also offer contextualized work experiences for job seekers with disabilities, many of whom learn best in natural job settings. "Hands-on" employment development approaches are effective, efficient win-win learning opportunities for both employers and job seekers alike and increase job placement rates. We need to invest more in progressive, cost-effective business engagement strategies!

10. Focus on Youth with Disabilities. Success is intentional. Achieving a tipping point in the competitive employment of Minnesotans with disabilities rests ultimately on changing consumer demand. Many individuals with disabilities and their families are not informed about emerging practices and opportunities to participate in the competitive labor force. For this reason, creative changes in educational outreach, employment planning and support practices, and accountability to outcomes must begin with youth with disabilities. Today, most everyone realizes true success means beginning employment preparation much earlier, insuring youth have opportunities to work in real jobs for real pay before leaving high school, and engaging effective job development supports to increase chances of obtaining competitive employment (or obtaining a post-secondary education outcome).

In closing, I'd like to point out the Employment First movement is gaining strong national momentum as a strategy to improve employment participation outcomes. The National Governor's Association, for example, acknowledged the importance of taking effective action this past year through its initiative called A Better Bottom Line. Also, with the State of Texas passing legislation this past week, over half of the states in our country now (26) have introduced a formal Employment First Policy either through state legislation or a Governor's Executive Order. Minnesota needs to be more decisive so its own policies are better matched to desired outcomes.

All said, Minnesota's Olmstead Plan offers an historical opportunity to improve the lives of our residents with disabilities. I'm anxious to see how the Sub-Cabinet's work will result in new policy improvements so all Minnesotans benefit. Finally, please feel free to call on me if I can support the Sub-Cabinet's work in any way. And thank you once again for the opportunity to contribute my ideas.

Best wishes, *[Redacted Text]*

Through July 22, 2013 (Comments 28–29)

Comment 28

[attached document contained content the same as text in the email]

From: *[Redacted Text]*
Sent: Tuesday, July 16, 2013 1:31 PM
To: *DHS OPC Public
Subject: Our Mental Illness Testimony

Gentlemen or Ladies:

Since I am unable to give our testimony on mental illness personally, I have attached my document to this email. I have also copied and pasted it below in case you are not able to open Open Office.

Thank you very much for reading our story.

Sincerely,
[Redacted Text]

Thank you for hearing my story. Even though mental illness affect one out of five people, it still has not moved completely out of the silent category. As we begin to understand Mental illness and how directly or indirectly, it affect all of us, instead of asking can we afford the cost of treating mental illness as any other serious life-long illness, we will ask can afford not to?

[Redacted Text]

Our journey with mental illness began in May *[Redacted Text]*. Our son, *[Redacted Text]* was *[Redacted Text]* and had high hopes for a bright and productive life. After graduating from the University of Minnesota - Morris, he had a successful career in the computer industry for three years while he and his sweetheart made plans to marry. The wedding, scheduled for May. was not to be. On the day before the big event, *[Redacted Text]* was hospitalized by an unexpected and particularly vicious bipolar episode. We learned about this terrible disease as *[Redacted Text]* struggled painfully and we struggled right along side him trying to support him in his battle.

[Redacted Text] dealt with his disorder with humor, dignity and a strong motivation, never losing his kindly concern for others in the midst of the trials his illness inflicted. His lifelong concern for the “underdog” led him to the University of *[Redacted Text]* and his specialty--public interest law. He graduated in *[Redacted Text]* and moved to Florida to work in the legal field. Unfortunately, he was hospitalized by another attack in 2001 and returned to Minnesota for hospitalization in December 2001.

After treatment he returned to his legal career working at *[Redacted Text]* helping low-income clients with legal issues in the areThrough social security, unemployment, housing and discrimination. We were so happy that *[Redacted Text]* had finally found a medication he could tolerate and that he had been healthy for 3 years and that the corner had been turned on this terrible illness. We felt that he had a handle on his illness and could work with reasonable accommodations. He also passed the bar exam in

Minnesota on his first try in *[Redacted Text]*. However the Minnesota Board of Law Examiners did not admit him to the bar due to his bipolar disorder.

[Redacted Text] appealed and endured two years of the stress of having every area of his private life reviewed by the Board of Law Examiners. Finally, the hearing date was set for *[Redacted Text]*. We admired how he handled the stress during painful process of waiting for the admission decision and then waiting again, for further directions and then waiting for a hearing date and a decision. I have often wondered if you take away a person's dream, which represents hard work and large financial investment and the ability to have a meaningful career, how many of us, with or without mental illness, could have shown the patience he showed?

We always felt our son had potential to be an advocate for this painful, horrible illness. Sadly *[Redacted Text]* died by suicide *[Redacted Text]*. *[Redacted Text]* had many gifts that would have benefited the people he wanted to serve, but his voice has been silenced. During this painful 8-year struggle with my son's illness, we have recognized a serious need: The need for those afflicted with mental illness to be supported with the same care and concern that those afflicted with life-long physical illness are supported. Mental illness is a very lonely illness. There is much less education and awareness of this illness than most physical illnesses.

Yet, as we have learned through *[Redacted Text]* illness, mental illness is physical in that it affects a very important part of our body--the brain. Hopefully with research better medications can be developed to better handle the chemical imbalance and to lessen the side affects. The isolation, which often accompanies those afflicted, can be relieved with education.

We hope positive things can come from *[Redacted Text]* painful experiences. All of us have ability to move Minnesota forward in acceptance of mental illness and appreciation of the gifts and contributions that people with mentally illness can give when treated with fairness and compassion. Let us move Minnesota forward, not backward.

Each of us may have, or some day have, a *[Redacted Text]* in our family. Our hope is that they not be denied what our David was denied--fair and compassionate treatment.

By *[Redacted Text]*

Comment 29

From: *[Redacted Text]*

Sent: Monday, July 22, 2013 8:02 AM

To: *DHS OPC Public

Subject: olmsted

[full text of attached document below]

[Redacted Text]

Comments from a service provider about Group Residential Housing. It is imperative that any changes to the Chemical Dependency program caused by changes to funding resulting from the MN Olmstead Plan} be avoided.

Any decrease in the availability of Group Residential Housing for the Recovering community would have severe unintended consequences. The population of homeless adults struggling with chemical dependency and poverty heavily rely upon this program. For the 25 years that I have been *[Redacted Text]*, I have seen a few thousand individuals make the transition from treatment facilities and sometimes correction facilities to GRH , then on to independent living as contributing members to our community.

Minnesota has developed a very efficient and cost effective model. It directs homeless Chemically Dependent people into treatment programs, after graduation many options are available. The one we offer is Group Residential Housing (often called a halfway house). A stay of one day to six months is offered by the county and state. The average stay for client being about 90 days. This time is used to secure employment and arrange future housing. The social part of this time is spent creating a program to change behavior and develop the tools needed to prevent relapse.

The setting of our GRH offers a safe, serious environment, where the camaraderie of fellow residents is very important in developing a successful recovery plan. Group Residential Housing, for this population, is proof of the adage that there is safety in numbers. There is not an i in recovery, and there is not an INSTATUTION in the way the GRH program operates. The U.S Supreme Court. in the 1988 Oxford House decision, specifically acknowledged this fact as it applies to Recovery from addiction and homelessness.

I do not know how GRH facilities for chemical dependent people was lumped in with the ADA Act. People in recovery do not consider themselves as Disabled. In fact, Most of them realize that without recovery, their health and sometimes behavior will end up with them becoming disabled. By taking GRH funding away we believe that it will create a need for much greater funding for serious disabilities in the future.

Please contact me if you have any questions.

[Redacted Text]

Through July 29, 2013 (Comments 30–38)

Comment 30

From: *[Redacted Text]*
Sent: Wednesday, July 24, 2013 12:14 PM
To: *DHS OPC Public
Subject: Public Comments

Community employment and integration is important for people with disabilities, however, we need to provide options and choice. Do not eliminate options for people that are not able to work in the community and still require habilitative services during the day. It's a wonderful concept, but plain and simple it is unfair to those that cannot work in the community. They can still sustain a meaningful life by being able to leave home and attend a day program.

[Redacted Text]

Please feel free to contact me for anything that may help this partnership be successful.

Comment 31

From: Shands, Rachel A (DHS)
Sent: Wednesday, July 24, 2013 3:59 PM
To: *DHS_OPC Public
Cc: Wood, Jean K (DHS)
Subject: Public Comments from the Minnesota Board on Aging

Dear Olmstead Subcabinet members,

Attached please find comments from the Minnesota Board on Aging regarding the Subcabinet's draft Olmstead Plan.

Thank you,

Rachel Shands
Long-Term Care Systems Consultant
Minnesota Board on Aging
P.O. Box 64976
St. Paul, MN 55164-0976
(651) 431-2272
rachel.a.shands@state.mn.us

[Full text of attachment below]

July 22, 2013

Lt. Governor Yvonne Prettner Solon
Chair, Olmstead Subcabinet Office of the Governor
130 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Dear Lt. Governor,

The Minnesota Board on Aging (MBA) would like to convey its appreciation to you and the other members of the Olmstead Subcabinet for your important work in developing an Olmstead Plan for Minnesota. We are a 25-member Governor-appointed Board whose mission is to ensure that older Minnesotans and their families are effectively served by state and local policies and programs in order to age well and live well. In this role, we wish to provide comments on the draft Olmstead Plan, from the perspective of older adults who are experiencing disabilities.

Many older adults experience disability for the first time in the later years of their lives. These impairments are often due to the progression of chronic illnesses. There are aspects of the experiences of older adult who experience impairments that are unique. In order for older adults to live in the way that they choose, even as their disabilities progress, we must consider their unique needs. We respectfully suggest that the Olmstead Subcabinet consider and include the following issues in the final version of the Olmstead Plan:

- **Information and Assistance.** Information and Assistance, provided by Minnesota's Aging and Disability Resource Center (ADRC), the MinnesotaHelp Network™, helps older adults and their caregivers to make informed decisions about meeting long term service and support needs and remain in the community. This includes all the services offered by the Senior LinkAge Line®: One Stop Shop for Minnesota Seniors, which provides older adults with the simplicity of getting connected and getting answers on many topics and issues by calling one phone number statewide.
- **Support for Family Caregivers.** Family caregivers are the foundation of Minnesota's long term services and support system for older adults who have impairments. By supporting family caregivers we enable them to sustain their caregiving role for a longer period of time and reduce their reliance on more costly forms of care. This includes offering individualized support to caregivers to equip them with the knowledge, tools, and skills to provide care, and helping them navigate complex systems.
- **Ensure access to proven interventions for chronic care management.** The Live Well at Home practice framework, developed by the MBA, provides the aging network with a common approach to identify high risk older adults and help them take action to better manage their chronic conditions and maintain independent living.
- **Ensure access to in-home supports.** Older adults who have impairments must have access to a core set of supports, including caregiver support, chore, homemaker, home-delivered meals, assisted transportation, personal emergency response system and environment modifications, regardless of their pay source. The availability of these supports is necessary in order to ensure older adults with disabilities can live where they choose.
- **Return to Community.** The Return to Community initiative assists nursing home residents who have expressed a desire to return to the community and have the resources and support to assist with the transition. Return to Community facilitates successful transitions from the nursing home by helping to change the mindset that nursing homes are the best long-term residence for older adults with disabilities, and by respecting people's preferences for living and caregiver arrangements.

- Care integration and care transitions. As chronic illnesses progress, older adults' needs for health care services increase, and they often experience care transitions from hospital to home, or nursing home to home. A coordinated system of health care and long term services and supports can more effectively identify high-risk individuals, connect these individuals with needed services, and provide follow-up, improving the overall quality of care people receive.
- Transportation. As people age, a significant and growing number will not be able to or will choose not to drive. These individuals may be at risk of becoming isolated and immobile, because where they live lacks transportation alternatives like public transit and pedestrian-friendly road design. For these persons, transportation systems are needed to enable older adults to continue to live in their community – whether for medical appointments, shopping, church, congregate dining, for family visits or social/cultural events. These systems must include a range of transportation options, and must have a high degree of coordination in order to make most efficient use of existing resources.
- Housing. Many older adults plan to “age in place.” In order for people to continue living in their homes as they experience increasing disabilities, they must have access to a cohesive system of home modification that links the key components. This includes in-home assessment, builders truly knowledgeable about accessible constructions, and access to products needed to modify the home. Older adults with limited incomes may need subsidies in order to make home modifications. Some older adults may wish to or need to move as their needs increase. In those instances, access to accessible and affordable housing is critical.
- Technology. Technology is a type of equalizer for persons with disabilities, because it can remove traditional barriers within physical and social environments. As the population ages and experiences more disabilities, creative use of technology to help individuals help themselves can increase the ability to be independent.

In 2001, the State of Minnesota Long Term Care Task Force issued a report entitled “Reshaping Long-Term Care in Minnesota.” The report documents the task force’s recommendations for Minnesota to address critical long-term care issues, including policy directions and strategy areas. For more than 10 years, these policy directions and strategy areas have guided our work to ensure that older adults in Minnesota can age well and live well, in the manner that they choose, even as their health declines and their disabilities increase. The Olmstead Subcommittee may wish to consider updating the policy directions and strategy areas from that report as part of the Olmstead Plan.

Thank you for the opportunity to provide feedback on the Olmstead Plan. The MBA acknowledges that this important work must be done with an eye toward the resources available to the state. The MBA has a track record of offering interventions and supports that are not only cost-effective, but can actually bend the cost curve. We stand ready to assist and advise in any way that is needed.

Sincerely,

Don Samuelson, Chair

Comment 32

From: *[Redacted Text]*

Sent: Thursday, July 25, 2013 1:41 PM

To: *DHS OPC Public

Subject: Public Comment

Hello,

The committee appears to be heading toward separating housing from services but I would like to remind everyone not to throw the baby out with the bath water. There are certain programs it might need to be done and others that would probably greatly damage the program.

One of the programs it would damage is the board and lodges with special services.

Do we separate those providing treatment from those housing the people in treatment? No, because it makes sense to keep them together, it is part of their treatment. It is the same for the board and lodge with special services; it is a part of the recovery in providing the services and life skills in getting the residents prepared for a life out in the community.

I know it if viewed as a bad thing but the clients like having roommates, it helps to keep them from relapsing because they are not alone at night. When does anyone usually decide to do something wrong? It happens when they are all by themselves. Those in recovery do not want to be alone, they need the extra support. There may be those that want their own room and so we can meet their needs as well, but don't take away once choice in the name of choice itself.

If we separated the services from the board and lodge, what will motivate the board and lodges to be responsible for their residents? They no longer have to worry about their well being. It is not a good decision in this specific area.

Here is a list of requirements within the special services a board and lodge must provide:

- Have secure and centralized storage of medication
- Give clients reminders and monitor the self-administration of medication
- Support an individual's development, helping to create and update their service plan
- Provide assistance with setting up meetings, appointments, transportation to services
- Provide 4 hours of nursing to the clients each week

Separating the services from the housing would create chaos in what is currently a stable environment. For example, in a house of 20 residents, you could easily end up with:

- 10 staff from different service providers, on hand for 24 hours a day in order to:
 - o Give medication reminders
 - o Monitor the client taking their medications
 - o Provide transportation assistance
 - o Assist with setting up meetings
- 10 different nurses who have to provide 4 hours of nursing service to their client each week
- 10 different lockable storage bins for medication

Financially, it costs everyone more money!

- Even if the clients chose only 5 different service providers, there would still be 5 people waiting around for 24 hours a day and 5 different nurses per week when currently only 1 or 2 staff members are on hand 24 hrs per day and 1 nurse for 4 hours per week.
- The state will end up having to pay more money to fund the different service providers
- And the loss of revenue from separating housing with services would not make running a board and lodge worth the effort losing a vital option for people in recovery.

1. If a board and lodge could function without the services, you have effectively removed a desire to make sure the clients within the building are receiving the most effective care. It would no longer concern the Board and lodge.

Please take this into consideration and do not lump board and lodge with special services into the entire pot when discussing separating services from housing.

[Redacted Text]

Comment 33

From: *[Redacted Text]*
Sent: Friday, July 26, 2013 11:01 AM
To: *DHS_OPC Public
Subject: Olmstead Plan

To whom it may concern:

I am writing about the 'Olmstead Plan'

I have a disabled daughter that gains many benefits from her in-house work at her day program and if this program were changed, she would be forced to stay home because she absolutely cannot go out to work in the community. Whoever has come up with the idea that this 'plan' needs to be put in place has never dealt with a disabled individual or they would understand how valuable in-house programs are.

I think serious consideration must be given to the consideration of the disabled person and to the benefits they are gaining.

Stop trying to take the one good thing my daughter has in her daily routine.

[Redacted Text]

Comment 34

From: Steve Heath [mailto:stevieheath@gmail.com]
Sent: Friday, July 26, 2013 11:21 AM
To: *DHS_OPC Public; *[Redacted Text]*
Subject: Olmstead Plan

Our daughter, [Redacted Text], currently attends a day program at [Redacted Text] in the [Redacted Text] facility. She is not a candidate for working in a community based setting. She does piece work at [Redacted Text] that she has the ability do. She functions at a three to four year old level and her behavior that does not qualify her to work in a community setting.

She needs the income from the work she does at Achieve to provide the basic necessities not covered by her government assistance.

It is our hope that this type of work can still be provided. We are continually in contact with the staff at Achieve and are very satisfied with the way they provide for our daughter, [Redacted Text].

Feel free to contact us for more information if desired.

Sincerely, [Redacted Text]

Comment 35

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Friday, July 26, 2013 11:41 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 7/26/2013 AT 11:40:40 AM

NAME: [Redacted Text]

EMAIL: [Redacted Text]

REASON:

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Anoka

COMMENTS:

Recently we received news that the State of Minnesota and the Department of Human Services was considering implementing the Olmstead Plan. While we see the well intentions of this plan it is not reasonable that it could be applied to all individuals. Our daughter suffers from uncontrolled seizures and it is not possible for her to be employed in a community setting. Previous experience has proved this true on many occasions. There are others with similar circumstances. It would be devastating to eliminate her in-house work program. Not being able to work would totally disrupt her life and destroy her quality of life. She loves working with the employees and staff at her sheltered workshop and does a good job. Please recognize that one size fits all definitely does not work for people with disabilities. We urge you to continue the current options so that the needs of all can be met.

Thank you for your time.

[Redacted Text]

Comment 36

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Friday, July 26, 2013 2:58 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 7/26/2013 AT 2:57:47 PM

NAME: *[Redacted Text]*

EMAIL:

REASON:

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Anoka

COMMENTS:

Community employment and integration is important for people with disabilities, however, we need to provide options and choice. Do not eliminate options for people that are not able to work in the community and still require habilitative services during the day.

Comment 37

-----Original Message-----

From: *[Redacted Text]*

Sent: Friday, July 26, 2013 7:45 PM

To: *DHS_OPC Public

Subject: Feedback

Please don't eliminate options for people with disabilities who are unable to work in the community. Please continue to have "in-house" production available for those that need it as an option instead of forcing those with disabilities unable to work in the community to remain at home.

[Redacted Text]

Comment 38

From: *[Redacted Text]*

Sent: Monday, July 29, 2013 8:10 PM

To: *DHS_OPC Public

Subject: MN Olmstead Plan Comments

To whom it may concern:

As co-guardians and family members of a man who has tried several times to work in the community, we are concerned that employment in habilitative services in day programs continue to be available for people with disabilities. Habilitative day services have provided employment for my brother between community jobs that are not always permanent. He enjoys the work that he does with contracts provided by his day program. Due to the nature of his disabilities, work out in the community is not always appropriate or available.

PLEASE do not eliminate his basic human right to have the option of work where he is productive whether that is at habilitative day services or in the community. Keep his employment options open.

Sincerely, *[Redacted Text]*

Through August 5, 2013 (Comments 39-46)

Comment 39

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Tuesday, July 30, 2013 2:34 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 7/30/2013 AT 2:33:52 PM

NAME: *[Redacted Text]*

EMAIL:

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Anoka

COMMENTS:

I am am concerned that this bill now tries to fit all the people who need supervised employment in to another box, instead of making decisions for individuals. Not everyone could work in a job in the community, even with supports. This would also not prevent all abuse of these individuals. In fact my children (adopted through foster care, with disabilities of different levels) are more likely to be taken advantage of in the community by "normal" people. This has happened already. They need much more supervision than they would get in the community. My one son needs constant reminders to stay on task, don't visit, do not give away things or accept things or worse take them. He needs to be protected from *[Redacted Text]*. He would have to be at home for his own protection. Can legislators ever get beyond "one size fits all" mentality, so when a part of a program is not appropriate for some people, everyone has to change their program and suffer. We NEED in-house programs to keep some adults in the "community" at all. Frankly, I prefer to not expose my son to ridicule and teasing he does not understand. Also he would be encouraged to "do" things by the more able, just for their fun with no realization or concern for the consequences for him. In-house programs have to stay. In fact I think they need to be expanded to include life skills and relationship and social skills classes. These skills

would go a lot farther toward making my children independent and safe members of society, than scrubbing toilets or floors.

Comment 40

-----Original Message-----

From: *[Redacted Text]*

Sent: Wednesday, July 31, 2013 3:39 PM

To: *DHS OPC Public

Subject: Public Comment

If you really want feedback, why haven't you scheduled any evening sessions? Obviously some disabled people work. I care for my grandson and am not able to attend any metro meeting during the day.

[Redacted Text]

Comment 41

From: *[Redacted Text]*

Sent: Thursday, August 01, 2013 10:36 AM

To: *DHS OPC Public

Subject: Olmstead Subcabinet

To The Olmstead Subcabinet,

We are writing in regards to the 'employment' part of the Olmstead Plan that is being developed. Our son, *[Redacted Text]* and daughter, *[Redacted Text]* have special needs. They are fortunate to receive services and work through *[Redacted Text]*, in *[Redacted Text]*, MN. Our daughter has been able to successfully work in the community for over 25 years. Our son, however, has tried, at times to work in the community without success, but had been given the option to work within *[Redacted Text]*. He has enjoyed working and participating in programs at *[Redacted Text]* and it has been the best fit so far. We are so thankful that he has the option to continue to go to "work" everyday with out the pressures of being put in the community.

We feel that it is important to integrate people with special needs into the community, however, it is extremely important that they are allowed options and a choice if they are not capable of working in the community. Places, such as *[Redacted Text]* provide that option for people that are more comfortable working and contributing in a "day service" workshop along with finding jobs within the community. *[Redacted Text]* has not only given them opportunities for work, they have given them a safe environment with peers and staff that give them the sense of community and importance.

We truly hope that people with special needs are continued to be given the option/choice to be employed in both the community and in-house production and non-work related programs.

Sincerely, *[Redacted Text]*

Comment 42

From: *[Redacted Text]*
Sent: Thursday, August 01, 2013 2:15 PM
To: *DHS_OPC Public
Subject: MN Olmstead Plan

Please see attachment re the MN Olmstead Plan as dictated by *[Redacted Text]*.
[Full text of attached file]

My name is *[Redacted Text]*. I have 2 daughters, *[Redacted Text]* and *[Redacted Text]*. Re: the Olmstead Plan. Not everyone is capable of working in the community. My daughters have multiple physical and emotional handicaps. The day program at *[Redacted Text]* is the program that best fits their needs.

Respectfully, *[Redacted Text]*

Comment 43

From: *[Redacted Text]*
Sent: Thursday, August 01, 2013 4:35 PM
To: *DHS_OPC Public
Subject: Public Opinion Olmstead

[Unformatted text from file attached to email]

- Minnesota already has in place the knowledge and tools to create person centered plans for persons with disabilities. It was strongly suggested that these plans begin being written with the individual and their family/circle of friend when the individual begins their middle school years.
- If used these plans could be used to give true "Meaningful" services, concrete commitments to increase integration with specific and reasonable timeframes.
- Nine different State agencies are working as part of the Olmstead Subcabinet.
- Having nine different State agencies working in collaboration The Olmstead plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the Olmstead Plan's goals.
- There are 5 placements mentioned and 2 services mentioned a total of 7 very important items.
- This plan is written in nine different points of view [9 different State agencies] instead of one voice and one Plan.
- Without One Voice/One Plan it is Not clear: how each agency will follow their mandates, perspectives, resources and work collaboratively to support the individual with disabilities and their families.

How will these items be addressed?

1. Waiting lists,
 2. St Peter,
 3. Cambridge ,
 4. Anoka, DT&H and
 5. community rehab programs,
 6. 4 person adult foster homes,
 7. Nursing homes
- According to Braddock there are 10745 people with Developmental disabilities living with caregivers in Minnesota; this is an opportunity to avert 10745 placements into institutions by training the work force to work with families in the community.
 - Allowing “no individual supports” and not allowing providers to provide supports for families with aging caregivers and with young adults that have behavior needs is allowing the progress Minnesota has made slip back into one of our darkest hours and could trigger 10745 Olmstead complaints.
 - Minnesota has rewritten its rule 40 and Statute to improve it to “Best Practice . This is a community practice that has always been in place now it will be in Statute and Rule.
 - Goals are not written with people with disabilities as being the guiding force - which leaves the disabled people standing on a precipice of generality instead of individuality and self-direction.
 - There are no education goals drafted? This leaves open a back door to allow ‘prone” restraint to be used by educated persons that do not understand behavior and its communicative nature.
 - There is no goal for Healthcare and Healthy Living – There is entirely too much current research that has already been done not to have these last two goals addressed.
 - The rewriting of Rule 40: “. This will affect all other agencies especially the Department of Education which is still using prone restraint instead of positive behavior interventions until Aug. 2013.
 - Having an Olmstead plan opens the doors for opportunities for Minnesota to lead our Nation as MN leaders have done before us.
 - Using Person Centered Plans we can be ahead of the Nation in understanding and supporting persons with disabilities in the most integrated settings using our supporting work force in the same way we started to in the early 2000’s.
 - It is an opportunity to put back into place a system that was working well for families and persons with disabilities.
 - This will allow persons with disabilities to hire fiscal agency /PCA etc., from their community whether they live in a rural/suburban/or urban environment.
 - As a State we are still moving too slowly away from the medical model of services this is not to say those in need of “medical services” should not receive them. But the delivery of services for Living, Learning, working, and enjoying life in the most integrated setting should not be based on a professional’s opinion or a “status Quo”, or this is how we do it and have done it for years, kind of attitude.
 - This can leave persons with disabilities in the chasm of “well intentions”, “good intentions”.
 - The most horrifying living situations that have ever been done in human history were based on good/well/honorable intentions and after they passed away they weren’t even afforded a name on their grave only a number.
-

Comment 44

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Sunday, August 04, 2013 2:12 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/4/2013 AT 2:12:00 PM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: anoka

COMMENTS:

Please, please re-consider Minnesota's Olmstead Plan. My son is *[Redacted Text]* years old, has Down's Syndrome and verbal apraxia (unable to speak). He works at *[Redacted Text]* working on site. He is unable to work out in the community. He is happy where he is. They provide other services such as occupational therapy and assistance with going to the bathroom. Without center-based programs, my son would have to stay at home with his retired parents and stagnate. He would lose the assistance, socialization, and ability to work and feel self-worth. Please do not take away his life.

Comment 45

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Monday, August 05, 2013 11:12 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/5/2013 AT 11:11:37 AM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Hennepin

COMMENTS:

You are spot on about living in the community. The trouble we have with our son, *[Redacted Text]*, who is *[Redacted Text]* and has Down Syndrome, is that he does not have a waiver. So all of the new innovative ideas coming down the pike are not economically feasible. And there are a LOT of us out there. How will the Olmstead act help impact this problem?

Comment 46

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Monday, August 05, 2013 1:16 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/5/2013 AT 1:16:25 PM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

DESCRIBE YOURSELF: I work for state or local government

COUNTY: St-Louis

COMMENTS:

Just a comment I have heard from a few of my clients that have Cerebral Palsy or another disease requiring a wheel chair. I have 2 clients that have worked hard and gotten their degrees only to find if they start to go to work they will lose their medical assistance and their PCA assistance that they need on a daily basis. There needs to be a way these people can feel like productive citizens without being penalized for it.

Through August 12, 2013 (Comments 47-54)

Comment 47

From: *[Redacted Text]*

Sent: Monday, August 05, 2013 6:21 PM

To: *DHS_OPC Public

Subject: Olmstead Plan

When I received information regarding the Olmstead plan I was taken back to the passing of Public Law 94-142. At first look the idea of avoiding the least restrictive environment seemed to be the IDEAL answer to the hopes and prayers for people with disabilities. Reality set in when I realized that the least restrictive environment could not possibly be the same for everyone. One person's least restrictive environment could very well be another person's prison.

My hopes for my daughter were dashed when the special education team at her school told me that the best option for her future would be placement in a sheltered workshop because mainstreaming wasn't working for her, they assumed they were correct so no other options were explored. Fortunately a teacher friend suggested having her reassessed at a different school, whose opinion was much more varied and positive. She transferred there and made significant progress. Three years later upon completion of high school (*[Redacted Text]*) (*[Redacted Text]*) accepted her into their program. In a very short time she was working in the community then after a couple of years the good people at *[Redacted Text]* offered her the opportunity to become the first person to work For *[Redacted Text]* County

Human Services. It worked out so well that many other *[Redacted Text]* clients joined her and she is still working there and still getting the opportunity to learn new and increasingly challenging tasks.

Through the years I have done a lot of volunteer work for various organizations that serve persons with disabilities. I have seen many of the people served go on to jobs that a few years earlier would have been considered "the impossible dream" SO FAR SO GOOD but there are many other individuals who have physical, emotional or developmental issues are unable to find their "comfort zone" in the community. These people are being well served by places like the Achieve where they are involved in meaningful jobs or activities IN HOUSE. To my way of thinking, these clients are in their least restrictive environment, and have been given feelings of purpose and pride.

The purpose of this history is to point out the variety of services provided by places like the *[Redacted Text]* are vital ones. These REALISTIC options must remain in place so that the people with a VARIETY of special needs have the opportunity to find their IDEAL niche. A "one size fits all" method would leave no options to the people currently working in house, they would end up remaining at home which often would be the MOST restrictive possible,

PLEASE allow them to find their niche, let them make their contribution, let them feel the pride of a job well done - even if that job seems menial to some, to them it may seem enormous.

Comment 48

July 30 letter re Olmstead to the Lt. Governor. (Forwarded to Olmstead email account on 8/6/13)

[Text from attached document below]

Minnesota Association of Centers for Independent Living

July 30, 2013

Honorable Yvonne Prettner Solon

Office of Lieutenant Governor

State Capitol

75 Rev~ Dr. Martin Luther King, Jr. Drive

St. Paul, Minnesota. 5 5114

Dear Lieutenant Governor:

We are writing to you today in your role as Chairperson of the Olmstead Sub Cabinet, appointed by Governor Dayton. Many representatives of Minnesota's Centers for Independent Living (CILs) were in attendance at the Olmstead Sub Cabinet Listening Session on Tuesday, July 9, 2013, held in 200 of the State Office Building. David Hancox, the Executive Director of the Metro Center for Independent Living, was present to represent the Minnesota Association of Centers for Independent Living, (MACIL). We were pleased to see such a large attendance representing a wide variety of individuals and organizations

with ties to the disability community. MACIL has composed this letter today to offer some observations to the Sub Cabinet related to the draft plan.

First, as I am sure you and other members of the Sub Cabinet are aware, Centers for Independent Living (CILs) have been providing meaningful consumer directed services in Minnesota for over 30 years. All Minnesota's CILs provide a wide array of Independent Living services that assist people with disabilities to live as independently as possible. All CIL services are consumer directed and community based. One primary goal of the 8 Minnesota CILs is to prevent unnecessary out-of-home placements of people with disabilities, and to ensure that individuals have the resources and supports to live self directed lives in the community of their choice.

The operational philosophy of CILs nationwide and in Minnesota directly mirrors the intent of the Olmstead Decision. With this in mind, the members of MACIL offer their support for the efforts of the MN Olmstead Sub Cabinet's Olmstead Plan, and would respectfully offer the following observations and recommendations.

1. The MN Olmstead Plan should have, as its core, the intent to change the historical assumptions that see individuals with disabilities as helpless, needy and incompetent. We should be reminded, as Ed Roberts, founder of the IL movement once said, that "disability can make you very powerful." More importantly, until we reverse this assumption and replace it with a more accurate perception, people with disabilities will always be seen in a subordinate and disadvantaged light.
2. The CIL philosophy permeates the entirety of the sub cabinets proposed plan and goals, i.e. consumer self-direction, choice, self determination, self advocacy, and the use of Peer Mentorship as a means of achieving many of the stated goals.

We would respectfully inform the sub cabinet that in Federal Fiscal Year 2012, Minnesota's 8 CILs:

A. Assisted in the relocation of 240 Minnesota citizens with disabilities from nursing homes, other institutional settings, and into homes of their choice in the community. These successful relocations not only produced a greater quality of life for these individuals, but also saved the taxpayers of Minnesota more than \$20 million in projected institutional costs.

B. Provided Peer Mentor services statewide to more than 725 individuals,

C. In collaboration with the Minnesota Department of Economic Development/Rehabilitation Services, CILs provided "right now" availability of IL services within Minnesota's Workforce Centers. By collaborating to provide simultaneous IL and VR services, we serve more than 2000 individuals per year, and have seen a better than 60% success rate for positive employment goal outcomes for customers. In the metro area Workforce Centers, the success rate has been an incredible 77.9%.

D. In recent years, the MN CILs have engaged in active outreach to Minnesota veteran's with service related and other disabilities. In Hennepin County, the Metro CIL is a partner in the Hennepin County Veteran's Court program, a Peer Mentor and instructional effort designed to provide first offenders the opportunity to avoid incarceration through participation in remediation activities. The CIL in Marshall,

MN has a contract with Mankato River Agency on Aging to provide assessments and case management for the Department of Veterans Affairs Veterans Directed Home and Community Based Services; providing qualifying veterans the opportunity to stay at their home and avoid institutionalization.

E. Provided a wide array of IL core services, i.e. independent Living Skills, Peer Mentorship, Information and Referral, and Systems and individual Advocacy. These core services have been available for more than 30 years, and are meeting many of goals being set forth in the sub cabinet's proposal.

MACIL would respectfully remind the sub cabinet of the existence and the availability of these valuable services, provided by MN CILs. We would suggest that the Olmstead Plan place emphasis on strengthening the existing resources in the state rather than spending significant amounts of time and resources reinventing the wheel.

3. We would echo the sentiment expressed by our colleagues from the Jewish Social Services to focus on "inclusion", not integration. Not merely as an exercise in semantics, but rather as a desire to more effectively and clearly communicate our ultimate expectations, i.e. "integration" creates a presence for people;" inclusion" connotes an active participation.

4. We would encourage the Olmstead Plan to aggressively pursue an end to the institutional bias that exists in so many of the current funding and resource distribution models. We still spend so much more on institutional care and settings that we do on cultivating meaning community supports and consumer self direction.

If you or the sub cabinet would like to hear more about the work and successes of the MN CILs, and how these efforts are already contributing to the intent of the Olmstead Decision, we would be happy to meet with you to provide content or respond to questions. MACIL appreciates the efforts of the Olmstead Sub Cabinet, and wish you continued success.

Sincerely,

Roberta Cich, Co-Chairperson MACIL
David Hancox, Vice Chairperson
Steve Thovson, Co-Chairperson
Nate Aalgard, Treasurer
Randy Sorenson, Secretary
Vicki Daile Molle, Member
Cara Ruff, Member
Alan Augustine, Member

Comment 49

From: Steve Piekarski [*Redacted Text*]
Sent: Thursday, August 08, 2013 11:02 PM
To: *DHS OPC Public
Subject: Public Comments

Attached is my comments on the draft Olmstead Plan.
Steve Piekarski, Board President Minnesota APSE

[Text of Attachment below]

Date: August 6, 2013

Lt. Governor Prettner Salon, Commissioners, and Department Representatives

Minnesota Association for People Supporting EmploymentFirst is a membership organization exclusively focused on integrated employment and career advancement opportunities for individuals with disabilities. Our goals are to promote employment opportunities for all people, through local, regional, and national networks, help establish and expand equitable employment opportunities for individuals with disabilities, and advocate with state and local officials in promoting integrated employment. Minnesota APSE is also a member of the Minnesota Employment First Coalition, a grassroots organization working to promote integrated employment in the workforce at competitive wages and benefits as the first and preferred outcome of Minnesotans with disabilities. Because of Minnesota APSE's focus on integrated employment and our relationship with the Employment First Coalition we have a strong interest in Minnesota's Olmstead Plan, and particularly its competitive employment objectives.

Minnesota APSE believes that the Olmstead Plan is a step in improving the lives of Minnesotans with disabilities by giving people to live, work and recreate in the most integrated setting. We also are encouraged by the emphasis on the role of competitive employment will play in the lives of Minnesotans. We believe that without employment in the mix it is difficult to achieve many of the goals of the Olmstead Plan. Employment drives individual choices in supported housing options, and builds upon ones strengths and talent, which increases community inclusion.

Minnesota APSE commends the sub-cabinet's extensive and difficult work, and even though employment plays an integral part in the Olmstead Plan, Minnesota APSE believes that there are areas that could be strengthened in the employment section of the draft.

- **Respond the broader interpretation of the ADA's integration mandate.** Recent U.S. Department of Justice (DOJ) actions (Lane v Kitzhaber in 2012 and United States v State of Rhode Island and City of Providence in 2013) has shown that ADA's integration mandate is applicable beyond residential services and includes employment services for transition-age youth and adults with disabilities provided by state or local entities. Recent DOJ enforcement activities highlight the evolution of legal and public perception of institutional care to also include sheltered work. Minnesota relies heavily on segregated work environments in transition and adult day services. Without adequate planning to increase integrated employment services and decrease segregated employment services, the Olmstead Plan will not achieve its intended integration outcomes. Specifically, the current Olmstead Plan does not explicitly identify segregated work settings as being institutional like, nor does the Plan adequately address how integrated services will be expanded.

- **Establish a statewide Employment First Policy.** Employment First is the vision, policy, and practices of making integrated employment in the workforce at market rate wages and benefits (with or without supports) the expected and preferred outcome of all Minnesotans with disabilities. This does not mean everyone will choose work but help to attack the roots of low expectations by reinforcing that anyone,

including job seekers with significant disabilities, can work with the right goals, practices, supports, and partnership of a willing employer (unless selfemployed).

Included in an Employment First Policy should be the clear expectation of the roles among state and local agencies. This will allow for expertise and resources of state and local agencies to focus their energies on encouraging new models of supports and making changes to outdated policy and practices that will increase competitive employment outcomes.

- **Establish a uniform definition of employment and data collection.** Minnesota APSE believes that Minnesota should adopt a standard definition of employment across all state and local agencies so performance can be measured consistently across the spectrum of employment services utilized by individuals with disabilities.

Once a uniform definition of employment is established, it will be critical to introduce a standardized data collection process so progress can be measured and documented so effectiveness of the different types of employment supports available can be compared. By having a standard data collection process funding can be directed to the practices and supports that improve employment outcomes.

- **Focus on youth and their families.** It is critical that the Department of Education is engaged in ensuring individuals with disabilities and their families are informed of all the employment options that are available. In our experiences too often families and individuals with disabilities are not aware of the array of employment supports available and are often steered toward supports that a professional believes is the most appropriate. Individuals and families need to be educated in all the options available so they can make informed decisions when it comes to employment opportunities. To accomplish this, the education system must be engaged in the process of ensuring individuals and families are aware and educated in opportunities to guarantee individuals with disabilities can achieve competitive employment.

Minnesota APSE is excited by the framework of the Olmstead Plan and the opportunities it provides to individuals with disabilities. The members of Minnesota APSE will continue to follow the work of the Sub-Cabinet and how employment will play an integral part in achieving the goals that Minnesota has laid out in the plan. Please feel free to call me with any questions my number is [Redacted Text] or by email at [Redacted Text]

Comment 50

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Friday, August 09, 2013 4:07 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/9/2013 AT 4:07:28 PM

NAME: [Redacted Text]

EMAIL: [Redacted Text]

DESCRIBE YOURSELF: I work for state or local government

COUNTY:

COMMENTS:

We would like to provide some information to help the development of the Olmstead Plan for the Healthcare and Healthy Living goal and advancement of this goal. From the handout provided at the Olmstead Plan Subcabinet Meeting and Listening Session entitled: Overview of Minnesota's Draft Olmstead Plan June 2013 Putting Olmstead's Promise into Practice. Within the Healthcare and Healthy Living topic area in the "What this means" section it addresses: "Healthy living includes having support to be active every day, to eat healthy foods, and to use medicine safely". After review of the "What we'll do" section it is noted that increasing activity every day and eating healthy foods is not addressed. To make sure this area is not overlooked we want to provide information that can help in the development of this goal.

The Centers for Disease Control and Prevention (CDC) report that obesity rates for adults with disabilities are 58% higher than for adults without disabilities and for children with disabilities the rate is 38% higher. Overweight and obesity increases the risk of coronary heart disease, type 2 diabetes, cancer, high blood pressure, lipid disorders, stroke, liver and gallbladder disease, sleep apnea and respiratory problems and osteoarthritis. Annual health care costs of obesity related to disability are estimated at approximately \$44 billion. By being proactive in increasing physical activity and healthy eating will help to reduce chronic illness and assist in lowering health care costs.

Regular physical activity provides important health benefits for people with disabilities. Evidence shows the benefits include improved cardiovascular and muscle fitness, improved mental health and a better ability to do tasks of daily life. Individuals with disabilities have many barriers that they experience that make it difficult to eat healthy, control their weight and be physically active. Initiatives that can be taken to address these barriers include education on healthy food choices, accessibility and assistance to receiving local and healthy food choices, accessibility to environments that can enable exercise and providing opportunities that allows an individual's interests to help guide them to being more physically active.

Another area that has not been addressed is reducing tobacco use and exposure. The CDC released an issue of Morbidity and Mortality Weekly Review that discussed the high rate of smoking among adults with disability, 25.4% compared to 17.3% of adults who report having no disability. Smoking cigarettes kills almost one in five adults each year. Due to the higher prevalence of smoking among adults with disabilities means that this population is at increased risk of death and disease. Initiatives that can be taken to reduce tobacco use and exposure include educational materials geared towards individuals with disabilities, adapting tobacco cessation materials to include people with disabilities who may not be receiving these messages through existing campaigns and current programs, train Quitline and cessation staff to assist individuals with specific disabilities, and develop policies to protect individuals with disabilities from second and third hand smoke.

Through our program *[Redacted Text]* with funding from the Statewide Health Improvement Program and a Community Transformation Grant we have developed an innovative Health Equity Initiative. Our focus is to work with organizations that serve populations within communities that experience greater health inequities due to poverty and low socio-economic status, high rates of obesity, and/or tobacco

use and exposure, high rates of chronic disease, and racial and ethnic populations that experience health inequities. The goal of this initiative is to create policy, system and environmental changes to increase physical activity, healthy eating and reduce tobacco use and exposure. We are available to assist in any way to provide information and help move this goal forward for the increased health of people with disabilities.

Comment 51

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Saturday, August 10, 2013 7:09 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/10/2013 AT 7:08:36 AM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

DESCRIBE YOURSELF: I am an interested citizen

COUNTY: Wright

COMMENTS:

Thank you for the opportunity to express opinions about the Draft Proposal of the Minnesota Olmstead Plan. While it may look good on paper to some, the reality is that it continues to ignore that the people who are most affected have no ready and meaningful way to evaluate and/or oppose those in government positions who are not in full compliance with the premise and word of the Olmstead Act. In other words:

1. the reality is that the assessments of the person for services continue to lie with the case manager and his/her supervisors regardless of what the statutes say for guardian powers and authority. If the guardian does not agree with the case manager, then the matter can be taken to appeal.....at the expense of the guardian and/or person while the case manager enjoys full legal representation of the County Attorney's office and the AG's Office.
2. There is no meaningful measure for the consumer to evaluate the work of the agents and/or even register a complaint. A Byzantine Labyrinth exists wherein a complaint on a county agent is heard by no one. the county agency claims they do only what DHS tells them to do. DHS claims they are acting only on what the county agency tells them. And a complaint to DHS on the actions of an agent only gains a referral to the County Human Services Board comprised of the County Commissioners who have somehow been convinced that they have no authority over the agents OR they readily admit that they know little about the workings of this agency that claims so much of the budget because of the private nature of their work so just have to assume that the agents know what they are doing. While the Olmstead Act is to operate on the premise of power and choice granted to the consumer, the consumer has little power when thrown into the Byzantine Labyrinth of the unending power of the agency.

3. The reality is that those consumers/guardians who stand to uphold the rights of the consumer, under the premise and word of the Olmstead Act, then gain a "target" on their backs, with the reality of the full force of the agency coming down upon them.

4. The reality is, there is little or no reinforcement for providers of services to comply with the Olmstead Act or the Plan, as written. It would mean that those consumers who are yet "stuck" in the least integrated systems of group living and sheltered work would "fly the coup" so to speak, leaving that provider without the income garnered from that consumer AND would possibly leave that provider exposed to having to take someone whose needs were even heavier. No incentive there to help the consumer to be less dependent. None.

From Commissioner Lucinda Jensen's commentary in the first set of minutes from this committee,

" The Olmstead Decision said that public entities must provide community based services to this broad group of people with disabilities where the services are appropriate and where the affected people don't oppose them."

There is no ready and meaningful way for the consumer/guardian to oppose what the agency and providers are doing....not without having to face an appeal against an agency that has built in legal representation.....There is no meaningful way for a consumer/guardian to assess the work of the agency...to even register a complaint. None.

Thank you for listening and I hope that this will lead to another look at the Plan...a look that will really give clear power to the consumer for choice afforded by the Olmstead Act, not just lip service.

Respectfully, *[Redacted Text]*

Comment 52

From: *[Redacted Text]*

Sent: Sunday, August 11, 2013 5:34 PM

To: *DHS OPC Public

Subject: Comments on Olmstead Plan for MN

One area that is missing from the plan so far is any plan for INCREASING employment of individuals living with disabilities. There needs to be an identified and specific program to increase employment of individuals with disabilities in State agencies.

There can be PILOT PROJECTS identified IN EACH AGENCY, SPECIFIC NEW DISABILITY focused internship programs IN EACH AGENCY, and even perhaps a short two week volunteer work rotation option IN EACH AGENCY for those who may not know what they could do if given an opportunity or to develop an understanding of what kinds of supports may be needed. All these programs need to be focused within STATE AGENCIES first!

These introductory type programs need to then feed into competitive employment within state agencies. The State of Minnesota needs to become the MODEL EMPLOYER in Minnesota BY DESIGN AND PLAN. DEED, and specifically VRS could be best-equipped to organize the framework for such programs but these need to be housed in EACH AND EVERY STATE AGENCY! Then, and only then will public employers understand this is the norm to follow.

Without a specific plan WITH PERFORMANCE MEASUREMENTS for increasing employment for individuals with disabilities within state agencies, Minnesota is missing a huge chunk of opportunity to lead in the right direction.

[Redacted Text]

Comment 53

From: Wieck, Colleen (ADM)
Sent: Monday, August 12, 2013 11:01 AM
To: *DHS_OPC Public; Bibus, Beth (MMB); Vollmar, Rosalie (DHS)
Subject: Aug 7, 2013 Council Mtg Olmstead Input.doc

I want to make sure this input is received and so I sent to the general mail box as well as Beth and Rosalie individually.

Thank you.

Colleen

Colleen Wieck
MN Governor's Council on Developmental Disabilities
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St. Paul, MN 55155
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[Full text of attached file is below]

INPUT FOR THE OLMSTEAD PLANNING DOCUMENT

MINNESOTA GOVERNOR'S COUNCIL ON DEVELOPMENTAL DISABILITIES

AUGUST 7, 2013

On August 7, 2013, *[Redacted Text]*, *[Redacted Text]*, led a participatory exercise to gather input from members of the Minnesota Governor's Council on Developmental Disabilities. The following input comes

from twenty-five individuals with developmental and other disabilities, family members, advocates, professionals, and others. The individual input has been grouped into the main goals of the Olmstead Subcabinet. The final set of statements includes items that do not fall under one of the main goals.

I. Supports and Services:

Support workers are not appropriately trained nor do they understand needs. There are things to help direct support staff--why aren't we as a state doing that?

My son is 19 and the most important issue to us is the constant staff turnover. We need to keep good people. The rate of pay is a huge part of that. We have trouble keeping staff when the pay is \$17-\$18 an hour. It is an isolating job, physically hard, emotionally hard. It is a job that people do not want to do. The incontinence of a 19 year old is different than a 3 year old. I don't know what the answer is. It is important because how else do we keep him at home.

Relationship building must be a stronger piece of supports and services. People with disabilities need opportunities to meet others.

There is a lack of staff and a lack of quality staff.

The right services and supports are essential to promote and buttress independence, self sufficiency, self esteem and confidence. It is a bedrock for inclusion.

Supports and services feed into other areThrough life. Without services and supports then living life is difficult.

II. Housing:

Why are there mandates for 4 people per home? There should be individualized living arrangements rather than just 4 person group homes. People should live with those who have similar interests.

Today's housing options are not what is needed. There is nothing outside of Activities of Daily Living. There are some options, but they haven't changed in decades. People need to be active members of the community.

Housing options are not what they envision to be there. There is nothing outside of activities of daily living.

An individualized apartment is a model for one person on the autism spectrum.

Housings--not all settings are safe or desirable. If the housing is poor then other areThrough life suffer.

There are poor housing choices--institution settings or group homes or the family. Parents are worried about what happens when the parents pass away. NOT high quality of life in group homes--I would not want to live there.

Residential providers focus on money and not on the person or the quality of life.

Housing is a foundation for everything else.

Our family member has a long term plan to live in his own home in northwestern MN. The family would like him to choose a roommate with the same interests and desires. BUT the family has to create this because the county and the state simply tells us what is available. The county and the state should be helping.

There is real inconsistency in the quality of residential providers--they should be graded on a regular basis. There is no information about quality.

What happened to the consumer bill of rights? It seems to be forgotten by the residential providers.

Residential providers are making individuals with disabilities earn their way to participate in community activities--you have to be good in order to go into the community.

There is a moratorium on foster care/group homes and so what is the future for my son? If he owns his own apartment, then we rely upon 24 hour help coming into the apartment. How can we be sure of quality?

There is no respect in group homes. There are 50 year old residents and young staff are dictating how individuals must feel and behave. I am worried that staff will not do everything that needs to be done.

III. Community Engagement:

Our family member will be voting in 2014 because he does know the legislators. However, we anticipate the stares and the protests that he should not be voting. We will deal with that.

We live in a small town and there is a segregated mentality. The church seems to be the only place to volunteer so there just aren't many activities. The community seems unaware, there is still a stigma about disabilities. Peers (young people) are much more open. Individuals with disabilities should be able to volunteer and serve on boards.

I work with many individual advocates and they want more educational programs and classes and fun things to do in the community.

Many individuals with developmental disabilities have aged and need more options for older individuals.

We need far more advocacy and human rights training classes--how to stand up for themselves, how to be assertive, how to understand their rights, and individuals with developmental disabilities need to be the presenters and/or co-presenters.

How do we empower people with disabilities--what is the avenue? How do we develop a culture so that providers include and understand what their customers want?

Community engagement is a vague and limited goal. What about friendships?

Friendship building should be part of the community engagement goal not just client-staff relationships. Community engagement is also linked to where you live. Friends are the best antidote against abuse and increase safety when someone cares about you.

Community engagement is important because when people with disabilities are seen in non-stereotypical environments that helps educate the community members on the importance of inclusiveness.

Stigma must go away, everyone deserves a chance.

Community engagement is important because people with disabilities must have opportunities to connect with church and volunteering. Volunteering might lead to employment.

People without socialization skills will struggle with moving ahead--they will tend to remain in poverty. People need to show the desire to learn.

The current plan does not acknowledge the level of abuse and neglect currently experienced.

IV. Education and lifelong learning:

The special education teacher removes ___ from the classroom as soon as he becomes noisy. The classmates are terrific and engage with ____. He is a social person related to his Syndrome so why remove him from class? He did go to the prom and on a band trip because of his peers and his family NOT the school.

We need full integration of 18-21 year olds and not segregation. One good example is Project SEARCH.

There are not enough programs for people with disabilities that enable me to find a job in supported employment. The county does have any programs to help me or my roommate get a real job. I want to learn more about advocacy. I also want to teach others about advocacy. There are no educational programs for adults.

Lifelong learning is my top priority because--Education opens doors and provides people with skills and teaches self advocacy.

Lifelong learning must include postsecondary education for employees with disabilities. This is important to take the emphasis from the system to the client. People should not be denied opportunities because of lack of money.

School inclusion is missing; disability should be part of all diversity. Acceptance requires association. There is token inclusion. Exposure leads to new attitudes. There is no systemic or structural change toward inclusion. Inclusion in schools will lead to real change faster.

Lifelong learning means that adults with disabilities need a chance. Just because you have a disability does not mean you cannot do it such as attend college.

Lifelong learning and education leads to independence and empowerment. It should be no different for a person with a disability than it is for citizens without disabilities. Education should provide opportunities to be welcomed and engaged and then onto college.

MnSCU must be part of this plan.

V. Employment:

The plan must embrace employers--there must be active engagement of employers in order to make this plan work.

Employment is important because of motivation, self-sufficiency, and self-esteem.

Employment is important to daily life and the value of quality of life is affected.

Our family member wants to begin his own small business. He wants a business plan and our new case manager is all in favor. This is quite a breakthrough.

Employment is my top priority. I want to contribute--nothing else matters. With employment you get lifelong learning. Employment allows more housing options. There is a natural rhythm to life from school to employment to housing.

Instead of going to a traditional day program where I got paid \$2.00 a week, now I am making about \$200. a week.

Shutting the doors to sheltered workshops and DT&H programs could be detrimental to people without a plan in place for employment search, procurement of a job, support on the job and transportation.

The current plan includes an Employment First statement. Please consider whether or not this is a statement that ALL people with disabilities choose. Many people with significant disabilities need to be asked. If they choose to say no to employment do they receive nothing? OR do people who say no to employment receive less support or less community connections?

Employment is a top priority because when someone can work and contribute to society then not only does the individual prosper but so does the community. When we all do better, we all do better.

Computer technology must be taught to all people with disabilities for future jobs. Don't forget start up groups such as Specialisterne which helps individuals on the autism spectrum to be software testers.

Employment is a top priority because they are not enough opportunities and it would benefit the entire state. Any campaign must be statewide; the current providers may not be able to do it all such as 1 to 1 job coaching (if 1 to 1 coaching is necessary). We need more employment services.

People with disabilities want more opportunities for better jobs because employment gives freedom and financial resources open opportunities.

VR needs to support youth at a younger age. Parents need to understand the importance of this.

Employment is important because of the level of poverty and it affects all other issues including social time, friends, happiness, access to better housing and it is the area that needs the greatest improvement.

How do we maximize potential and address societal piece --not just one person getting a job. You must use an individualized approach--change the silo programs; use person centered plans.

State agencies must hire people with disabilities and so should counties.

Employment is important so that you can pay for the things you need to live. They need a chance to get out of sheltered workshops.

VI. Health:

Rural physicians are dropping patients because of high costs of care and low reimbursement. Fewer doctors have more patients.

Our family member has full access to health care but not to a national specialty center for his Syndrome. The Minnesota health care providers insist on keeping him here and not letting him go to Boston.

Current health services are limited and with an aging population; those with disabilities will be competing for resources. Cutting costs will be an important consideration with the aging population. Disability does not have the lobbying numbers or as strong a voting bloc as aging.

There are some individuals with disabilities who have chronic health conditions. All person centered planning must take into account the many health conditions and issues.

VII. Transportation:

Transit systems must be available 24/7 in order to allow for full participation in the community.

Effective transportation is needed for employment. The transportation must be effective and timely. The problem with Metro Mobility is that individuals have to leave their job 30 minutes before the shift is over. More flexibility should be given to allow PCAs to provide transportation.

There is NO transit system in Greater MN. When planning for improved transportation services, please do not forget about the rest of MN.

As people age, disabilities become part of life and that can become isolating. We need simple ways for people to get where they want to go. Transportation allows for education, employment and flexibility to live where they want. There must be a better way to integrate transport systems to allow PCA and home health aides to get to consumers.

People cannot get to jobs in rural areas.

OTHER:

Technology/AT:

Our family member used an iPad at school but it was loaded with over 400 apps. The family purchased an iPad for him and a family member created a communications app just for him. The school saw that it worked when it was personalized for the family member.

We must have self-determination become the overall goal. We have to make sure self-determination is implemented to ensure that people have informed choice. If people are in charge of their own money then they will need better choices. People are stuck--there are no choices and no place to go. The future is not good.

We must ask the people directly about what services they have now that are good and what is making people happy.

There must be more resources or none of the goals will be achieved. Where will the funds come from? Everything needs money.

Remember that ALL individuals with disabilities include a wide spectrum of abilities and includes people who need significant supports.

The plan must recognize direct support professionals. It is a struggle to find good help. There must be training for those who work with people with disabilities.

The plan does not address opportunities in the political space--getting the voice into the legislative arena is really important. Are there ways to join forces with others that are more organized--aging, the deaf community?

The plan must have a place for minority communities and immigrant communities.

The plan must address aging services for people with developmental disabilities. There is no provider network and so there is a fear of institutionalization.

Colleges--there is a real inconsistency in how students with disabilities are treated. At one college a deaf woman was not provided with a sign language interpreter. She passed the course because of her classmates. At the same college, a professor will share notes with a student who has a learning disability.

The plan needs to speak to all not just people eligible for public programs.

The plan does not mention recreation, physical activity and social engagement activities.

A strong section about rights is needed. Don't forget the problems with guardianship experienced by people.

Comment 54

From: *[Redacted Text]*

Sent: Monday, August 12, 2013 12:39 PM

To: *DHS OPC Public

Subject: *[Redacted Text]*

Minnesota Olmstead Plan... Attached you will find a letter regarding our son, *[Redacted Text]*. Please let me know that you received this and can open the PDF file.

Thank you,
[Redacted Text]

[Full text of document is below. PDF also contained photos.]

[Redacted Text]

When the little silver car pulls into the driveway in the afternoon, all you need to do is look at the expression on *[Redacted Text]* face to know how happy he is to see his dad get home from work.

When his sister, *[Redacted Text]*, comes to visit, there is no mistaking the laughs and excitement, the abundant joy that those most familiar to him bring. His quality of life is enhanced in ways that words aren't necessary to express.

[Redacted Text] was born in *[Redacted Text]* with an unspecified severe disability that limits his communication and physical mobility. He also has epilepsy, which became life threatening in *[Redacted Text]*, when he developed aspiration seizures. He was hospitalized a dozen times in *[Redacted Text]*. Since *[Redacted Text]*, a very dedicated team of individuals have kept *[Redacted Text]* alive and free of aspiration seizures due to a strict eating/sleeping schedule he must adhere to.

A key player in this team has been his day program, *[Redacted Text]*, in *[Redacted Text]*. *[Redacted Text]* attends *[Redacted Text]* on Monday – Friday where he spends his day in the work room. *[Redacted Text]* participates in several jobs brought in from the community including shredding paper, assembling gadgets, etc..... *[Redacted Text]* is allowed to work at his own pace and receives a small paycheck based on the physical weight of the jobs he is able to complete. Some days he has the stamina to stay on task for a long period of time, other days he isn't as strong. But, in either case, he is given the opportunity to complete the tasks at hand to HIS ability.

Attached are some photos of *[Redacted Text]* working on one of his jobs at *[Redacted Text]*. All you need to do is look at his face to recognize how pleased he is when a specific job is complete.

While at *[Redacted Text]*, *[Redacted Text]* also receives non-work related programs, such as occupational therapy and opportunities to maneuver his walker or wheel chair throughout the facility to strengthen his muscles. He is given the self-help care needed to maintain his strict eating/sleeping schedule and meet his significant habilitative care needs.

Once a month, *[Redacted Text]* utilizes his paycheck from *[Redacted Text]* to take his family out for pizza. Before working at *[Redacted Text]*, *[Redacted Text]* had never been able to earn enough money to do this. Below are some photos from his *[Redacted Text]* birthday party which he was able to host for himself.

As the Olmstead Plan studies the needs of people with disabilities in the State of MN, please remember *[Redacted Text]*. I can't think of a setting more appropriate to meet his needs than what the day program at *[Redacted Text]* affords him. Please do not eliminate the option of a day program for medically fragile individuals, like *[Redacted Text]*. The choices we make for *[Redacted Text]* are significant for his quality of life, but, also allow us to literally help keep him alive and healthy.

When his mother's little blue car pulls into the parking lot at *[Redacted Text]* in the morning, all you need to do is look at the expression on *[Redacted Text]* face to know how happy he is to see the buses arriving to bring his friends to work along side him, the abundant joy that those most familiar to him bring. His quality of life is enhanced in ways that words aren't necessary to express.

Sincerely, *[Redacted Text]* parents

Through August 19, 2013 (Comments 55–108)

Comment 55

From: Derek Nord [mailto:nord0364@umn.edu]
Sent: Tuesday, August 13, 2013 9:45 AM
To: *DHS OPC Public
Subject: Olmstead Plan Comments

To whom it may concern,

Please accept the comments (attached) aimed at providing feedback for the draft MN Olmstead Plan. If you have any questions, please don't hesitate to contact me.

Thank you, Derek

Derek Nord, Ph.D.
Research Associate
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Institute on Community Integration,
Research and Training Center on Community Living,
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[Full text of attached file below]

August 13, 2013

The Honorable Lt. Governor Prettner Solon
Chair of the Olmstead Plan Subcabinet

Thank you for the opportunity to respond in writing regarding the Minnesota Olmstead Plan, currently in draft form (Through June, 13, 2013). We appreciate the work of the Subcabinet and recognize the substantial undertaking this has been. We have been actively engaged in this planning process and am dedicated to seeing an effective and visionary Olmstead Plan that can drive Minnesota forward with respect to achieving the full integration of Minnesotans with disabilities.

We commend the Subcabinet for recognizing the importance of competitive employment for Minnesotans with disabilities by identifying this area as an overarching goal of the Plan. Employment is a core aspect of community life that should be supported. Despite this recognition, the Plan does not adequately address the employment support system and overlooks three main points related to employment.

1. Integration mandate - Recent U.S. Department of Justice (DOJ) actions (Lane v Kitzhaber in 2012 and United States v State of Rhode Island and City of Providence in 2013) have shown that ADA's integration mandate is applicable beyond residential services and includes employment services for transition-age youth and adults with disabilities provided by state or local entities. Recent DOJ enforcement activities highlight the evolution of legal and public perception of institutional care to also include "segregated sheltered workshops" (DOJ, Findings Letter to Oregon, 2012). The DOJ has made their Olmstead interpretation clear, segregation early in life stunts quality and personal growth for a lifetime. "When the expectations that public entities have for students with disabilities are unjustifiably low, significant negative consequences are often imposed up such young people. For example, many students with I/DD [intellectual and/or developmental disabilities] experience a permanent restriction on the quality and trajectory of their adult lives" (DOJ, Rhode Island, p. 3).

Minnesota relies heavily on segregated work environments in transition and adult day services. Recent data show that 83% of the 13,546 Minnesotans receiving day and employment services from DHS are working in segregated settings (Butterworth et al, 2011). Without adequate planning to simultaneously increase integrated employment services and decrease segregated employment services, the Olmstead Plan will not achieve its intended integration outcomes. It is recommended that the current Olmstead Plan conform to DOJ interpretation and explicitly identify segregated work settings as being institutional like and clarify its values related to segregated work settings. Additionally, the Plan must identify the need and strategies to expand integrated employment services while simultaneously decreasing the use of segregated sheltered work.

2. Shift resources to reflect dedication to integration mandate – Due to wide use of segregated employment across different state agencies and the substantial resources spent on support services to continue the segregation of people with disabilities. A 2011 survey of Day Training and Habilitation services (via DHS) an investment of \$81 million on segregated employment (\$68.3 million Medicaid and \$12.7 of other funding). In comparison, individual employment services received an investment of just \$15.5 million.

The draft Plan does not identify the large existing investment as a barrier to achieving its overarching competitive employment goal. Resources must shift to build capacity among employment providers. In addition, the Plan does not identify a strategy to reduce its investment in segregated employment and shift resources to community employment settings that are more likely to achieve the employment goal.

3. Clear State and agency values related to segregated employment – The draft Plan and listening session presenters are giving mix messages regarding the use of segregated employment. At the heart of the Olmstead decision and the Governor’s Executive Order 13-01 forming the Subcabinet is integration of Minnesotans with disabilities. Minnesota has taken a clear stand on institutional residential settings and does not provide people this segregated institutional residential service choice; the policy decisions have resulted in steep declines in institutional and segregated residential service use over the last 20 years. The State’s values and related policies regarding segregated work are unclear in sections of the Plan. Despite the strong language regarding competitive employment in the overall goal, state agencies that rely heavily on segregated work services have not adequately responded to how they will reduce this reliance beyond providing a choice, thus allowing segregation if people choose to be segregated. This approach will not ensure segregation is reduced. The values of the State and state agencies related to segregated employment services should be clarified and consistent throughout the Plan.

Additionally the Plan does not address the need for stable, reliable direct support workforce that is available to provide support to people with disabilities in integrated settings. For decades research has shown higher turnover rates in community integrated services when compared to institutional services. Many factors influence the challenges faced by the community workforce. Predicators of turnover include: wages, access and take up of health and retirement benefits, adequate supervision and support and career opportunities. It is an oversight of the Plan not to include strategies to promote the development of a community direct support workforce and support to caregivers. We urge the addition to a specific recruitment, retention and training program in Minnesota that promotes the direct support workforce.

Again, we would like to applaud your extensive work in developing the comprehensive plan and thank you for the opportunity to provide written comments. We look forward to reviewing the Subcabinet’s next iteration. In the event you have questions related to this letter, don’t hesitate to contact us.

Sincerely,

Amy Hewitt, Ph.D.
Derek Nord, Ph.D.

Comment 56

-----Original Message-----

From: *[Redacted Text]*

Sent: Tuesday, August 13, 2013 12:22 PM

To: *DHS_OPC Public

Subject: OLMSTEAD PLAN

I am the guardian for my sister *[Redacted Text]*, age *[Redacted Text]*. She has been fortunate to have attended *[Redacted Text]* for thirty four years. Her disability is Down Syndrome/retarded and she is semi-retired from *[Redacted Text]* day service program. Due to her disability and aging, the importance of continuing her participation in the day program schedule is paramount to her emotional well being.

Following is a quote from *[Redacted Text]*: "community employment and integration is important for people with disabilities, however, we need to provide options and choice. Do not eliminate options for people that are not able to work in the community and still require habilitative services during the day."

Minnesota has always been a leader in programs and service to our disabled citizens; please do not eliminate day service programs.

Sincerely, *[Redacted Text]*

Comment 57

From: *[Redacted Text]*
Sent: Tuesday, August 13, 2013 2:34 PM
To: *DHS_OPC Public
Subject: Pope County Needs

Some of the areas I would like to see addressed are:

- Employment options for individuals with disabilities increasing in rural communities. We have very few employers and it takes many of my Adult Mental Health clients over a year to find a placement with Department of Rehabilitative Services.
- Improved/increased transportation access for rural residents with disabilities. We have the Rainbow Rider here which is only able to offer volunteer drivers for some of our very rural clients and it is often difficult for volunteer drivers to be accessed.
- Emergency programs for homeless individuals with disabilities who are not stable enough or are too high of needs to be at a homeless shelter and are not on disability or waiver eligible even though they have severe needs.
- Ensure that the MNChoices evaluation thoroughly evaluates mental health symptoms as the LTCC only asks 3-4 questions relating to the most debilitating issues in my client's lives!

[Redacted Text]

Comment 58

From: *[Redacted Text]*
Sent: Wednesday, August 14, 2013 10:18 AM
To: *DHS_OPC Public
Subject: Troubling aspects of Minnesota's Olmstead Plan

To Whom it May Concern,

This communication is being written with respect to the Olmstead Plan. I must admit I have not studied the plan to its fullest but do think I have an overview of the vision.

We have a daughter who is involved in a well thought out and productive program. One she thoroughly enjoys and provides her with the security and daily programming necessary for her to enjoy life at the best of her capabilities. She is not one who could be employed in a community setting. If she were not able to be in a protected environment (and who will guarantee that protection in a community setting) her life would take an unforgiving down turn. Worse yet, because she is *[Redacted Text]*.

As I understand the Olmstead Plan, in a general view, our daughter would be employed in community settings only and would not be in the protective environment she currently enjoys. For her this will not work. She did work in a community setting for a short time a number of years ago but it almost become a disaster. The people she was working with had no idea her needs and their patience was not a virtue needed for individuals with disabilities.

Most new ventures look good on paper but the hidden unintended consequences can be very troubling and it those features, individuals like my daughter, must endure. Everyone involved needs to take a long long careful look before sending our most vulnerable citizens down a path which, in the long term, will produce negative results.

I thank you for your time.

Sincerely, *[Redacted Text]*

Comment 59

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Wednesday, August 14, 2013 11:16 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/14/2013 AT 11:15:41 AM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I work for state or local government

COUNTY: Anoka

COMMENTS:

I am a *[Redacted Text]* employee with a disability and I applaud your dedication, compassion and time that everyone has made so far into the Olmstead plan. While this is an enormous undertaking and at times may be challenging, everyone in Minnesota, with or without a disability, will benefit by this plan. In my current position at *[Redacted Text]*, I make sure *[Redacted Text]* forms are written at a 7th grade

reading level and that our forms are accessible. I recommend that any documents coming out of the Olmstead plan and really all documents be made accessible to all. This includes web pages, brochures, forms, reports, text message and any future technologies that arise.

Comment 60

From: *[Redacted Text]*

Sent: Thursday, August 15, 2013 2:15 PM

To: *DHS OPC Public

Subject: Olmstead Plan feedback

I am the mother of two children with disabilities. Both are adults now. Professionally, I am the *[Redacted Text]*. I would like to make a couple comments on the proposed draft of the Olmstead Plan.

My youngest son is *[Redacted Text]* and was born with Down syndrome. When he was in the transition phase of his education, the job experience he wThroughfered included things like folding towels at a hotel, cleaning, and small assembly or piecing tasks at businesses. He repeatedly told us that he did not like the jobs, he wanted to work in an office. He also repeated his dislikes and likes at conferences. We helped him advocate for his stated preferences. Yet, each time they changed his job, it would be more of the same. I can appreciate the difficulty of schools in locating job opportunities for their students. However, the limited range of placements was not acceptable. If I back up to talk about the expressed expectations for my son, they were also very limiting. Anytime most of the people who my son had contact with expressed expectations, they were very limited. Things such as “group home” and “a job at McDonalds” or “a job cleaning” were frequent messages.

Today, my son works in an office. He works for the *[Redacted Text]*. He does light clerical support and has a list of duties that number about fifty. Of course not all of these are daily. Some are weekly, some are occasional, and then there are the regular daily responsibilities. When I occasionally run into these same professionals in the community and they ask about him and I share what he is doing. I continue to see looks of shock on their faces as this is so far from what they EXPECTED of him. Thankfully we connected with people early on who helped us understand independent living. It changed the way we thought about his life and the opportunities he might have. It changed our expectations and the way in which we presented opportunities to him. At a young age we introduced decision making. Do you want to wear the jeans or the sweatpants today? Do you want a sandwich or soup for lunch? He had little spoken language during these early years but we used a combination of sign language, pictures, and pointing to make sure he could express his choices.

Recently I had phone call from the mother of a young woman that my son went to school with. I hadn't spoken to her since our children graduated. She was in the process of moving her daughter from one DT & H to another. She wasn't sure which choice she wanted to make and was asking which one we had used and how our experience had been. During the conversation she said she doubted her daughter could work more than maybe an hour a week. There are no adequate words to express my shock at this

statement. In addition to knowing her daughter through my son, I also know her daughter from having worked with her as a paraprofessional during her school years. I would whole heartedly agree her daughter has many challenges medically, physically, and cognitively. However, she is also a young woman who is very social and has the ability to do many things. She would clearly not be able to sustain a 40 hour work week. However, from what I know about her, she certainly could work more than an hour a week. The critical piece would be finding a job for her that fit her capabilities, interests, and desires.

Additionally this mother spoke about a living situation for her daughter. She was very interested in an effort going on with a group of parents that would essentially build a facility for their children. The closest descriptor would be think assisted living for older adults but instead with children with disabilities. I was happy that she couldn't see the look of shock on my face at that moment. Building an institution is very far from the core of independent living. Yet this mother liked the idea because her daughter would be in her opinion safe and happy to be with other individuals with disabilities.

My reason for sharing this story is that unless families have the opportunity to learn about independent living they will probably make choices on behalf of their children that do not encourage them to make decisions for themselves. They are also less likely to make decisions on their behalf that lead them to lives of independent living.

Somehow, this plan must lay out some way in which any professional who works with individuals with disabilities and their families learns about independent living and its benefits to anyone with a disability. These professionals include but are not limited to teachers, County social workers, Occupational or other therapists, doctors, nurses, etc. Coursework must be a part of their degree or certification requirements. Parents need multiple opportunities to learn about and understand independent living. They need to hear positive expectations for their children as they grow up so when these young people are looking at jobs, they can help make choices. And as part of their parenting they need to see the relationship between early opportunities and developing the skills to be self determined and interdependent.

I'm looking forward to seeing the next draft of the Olmstead Plan and hope this helps you in its development. Thank you.

[Redacted Text]

Comment 61

From: Sheila Grisim [mailto:Sheilag@fraser.org]
Sent: Thursday, August 15, 2013 3:23 PM
To: *DHS OPC Public
Subject: Olmstead Public Comment, Fraser / Sheila Grisim

Dear Olmstead Sub-Cabinet,

Attached, please find my comments in regards to the Olmstead Draft Plan for Minnesota. Thank you in advance for your time and consideration of my concerns.

Sincerely,

Sheila A. Grisim, M.A.

Director, Home & Community Supports

Fraser®

6328 Penn Avenue South

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www.fraser.org

Fraser: Special Needs - Bright Futures

Visit us on Facebook at www.facebook.com/FraserMN

[Full text of document attached to email]

Dear Olmstead Sub-Cabinet Committee,

Thank you all for your contributions to the Olmstead Plan development and for your long-term commitment to assuring that people with disabilities have robust service choices in Minnesota.

My name is Sheila Grisim and I am the Director of Home & Community Supports at Fraser. Fraser is a local, non-profit organization founded in 1935 by Louise Whitbeck Fraser, a parent of a child with special needs. Fraser serves thousands of children and adults with autism and other disabilities each year in healthcare, housing, and education. In addition to my professional experience working in disability services, I have lifelong personal experience with *[Redacted Text]* who has special needs. *[Redacted Text]* has a developmental disability, autism, multiple mental health disorders and epilepsy. She faces numerous challenges on a daily basis that she addresses with both formal services and natural supports.

Fraser is a champion of meaningful community inclusion and I think each of us should have the right to choose our community. My husband and I chose our neighborhood because there were other families with young children like ours. Likewise, I want *[Redacted Text]* to have the same meaningful choices and not be restricted by arbitrary percentages or head-counts; as though people with disabilities need to be separated from one another in the community. *[Redacted Text]* has many friends who also have special needs but others who do not. I believe strongly that there is equal value in the time she chooses to spend or “interact” with each of her friends, regardless of their disability status. It would be disappointing to see the Olmstead decision, that was based upon increased choice, actually limit with which of *[Redacted Text]* friends she could choose to live, based on a concern over “concentration” of adults with disabilities. While none of us want to return to the days of institutions, my definition of an institution is when a person is forced to live somewhere they do not want to be; which is what the

Olmstead decision was based upon. Forced integration would not be tolerated with any other minority group and should not be considered for people with disabilities.

Part of my role at Fraser is to oversee our HUD-subsidized (Prac 811) Independent Living apartment buildings for adults with developmental disabilities. The most recent apartment we opened in 2010 has 14 units and we received over 70 applications; I think this demonstrates that no one is being forced to live in this highly sought-after housing option. The overwhelming majority of the 56 adults with disabilities who were not able to move in to our Fraser Hopkins Court are stuck living at home with aging parents, who counted on Minnesota's promise to support their children in the community when the large institutions were closed. At this time, these parents are expected to continue to care for their adult children with disabilities indefinitely until a crisis arises. I cannot imagine the hardship it would have caused my family if my sister still had to live at home with my parents while her peers, without disabilities, moved out of their family homes. Limiting housing options in a system that is already experiencing an extreme shortage of safe, affordable housing seems quite counter-productive for Minnesota.

All five of the Fraser Independent Living apartment buildings are completely full and, due to excessive wait times caused by very low tenant turnover, all of the waitlists are closed. Each tenant has their own apartment, lease, keys, and is not required to receive any services from Fraser. In our 2013 tenant satisfaction survey, over 97% of the adults with developmental disabilities, indicated that they enjoy living at Fraser apartments and understand that it is their choice to live there. Although all of the tenants have disabilities, these apartments in my opinion are quite distinct in numerous ways from any institution. This housing model is quite similar to senior housing and I fail to understand why this would be a valid housing choice for older Minnesotans but not for adults with disabilities.

[Redacted Text] is on the waitlist at three of our apartment buildings and I cannot imagine having to tell her or any of the other dozens of people on the waitlists for this public housing that we cannot accept their housing application because our "quota" of adults with disabilities in the building is full or they need to give up their waiver funding to move in. *[Redacted Text]* struggled with making friends her entire life and has been the victim of financial exploitation and *[Redacted Text]* due to her vulnerabilities. If she feels safer and less socially isolated living with other vulnerable adults who she considers her peers, I do not see why any of us would want to restrict her from making that informed choice. As *[Redacted Text]*, I urge you to help me protect her choices in housing to help her remain living safely and successfully in the community.

Sincerely,

Sheila A. Grisim, M.A.
Director, Fraser Home & Community Supports
6328 Penn Avenue South
Richfield, MN 55423
Ph. 612-767-5170
Fax 612-767-5176
sheila.grisim@fraser.org www.fraser.org

Comment 62

-----Original Message-----

Sent: Thursday, August 15, 2013 3:43 PM

To: *DHS OPC Public

Subject: State Advisory Council on Mental Health comments on Olmstead Plan

See attached letter from the State Advisory Council on Mental Health with comments on the Olmstead Plan.

[full text of attached document below]

August 7, 2013

Minnesota Olmstead Subcabinet

P.O. Box 64988

St. Paul, MN 55164-0988

Dear Members of the Subcabinet,

The State Advisory Council on Mental Health respectfully submits the comments below on the draft Minnesota Olmstead Plan. These comments focus on the "Housing; Olmstead Plan Goal." The goal as stated in the draft is stated as: "People with disabilities will choose where they live, with whom, and in what type of housing."

While the Council supports this goal, we believe that it does not address the very significant marketplace dynamic of decreasing availability and affordability of rental housing in Minnesota.

Locating and renting a safe and affordable housing unit is usually the largest barrier for a person with a mental illness as they search for a home in the community. According to the Minnesota Housing Partnership (MHP), the vacancy rate for apartments in the Twin Cities for the first quarter of 2013 was only 2.8%. For apartments under \$1,000/month, the rate was 2.4%. A vacancy rate of 5% is considered "balanced." The MHP's '2 x 4 'Report:Quarterly Housing Indicators is available at: http://www.mhponline.org/images/stories/docs/research/2x4/mhp2x4report_q113_full.pdf

While the State Advisory Council recognizes that resources are limited, a goal to meet the housing need should recognize the most significant barrier to successful community integration: the availability of safe and affordable housing. Otherwise, effectiveness of the Olmstead Plan is likely to be diminished.

We encourage the Subcabinet to include the dimensions of the Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Practice - Permanent Supportive Housing in its final plan. The dimensions consist of: choice in housing and living arrangements; functional separation of housing and services; decent, safe, and affordable housing; community integration and rights of tenancy; access to housing and privacy; and flexible, voluntary, and recovery-focused services.

Thank you for your consideration, Alison M. Wolbeck

Comment 63

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Thursday, August 15, 2013 4:51 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/15/2013 AT 4:50:48 PM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Hennepin

COMMENTS:

In my experience as a caregiver, disability rights advocate, parent of a child with a disability, and executive director of The Youth Legacy Foundation, which engages youth with disabilities in the community around volunteer service, leadership, mentoring, and peer mentoring, I have observed a lack of support and opportunities for people with disabilities. I am a huge proponent of inclusive education, more accessible higher education, and better workplace accommodations. People with disabilities are not well represented in higher education and employment due to a lack of accessibility and adequate preparatory opportunities. I support the Olmstead Plan. We need to more fully include people with disabilities in the community and ensure greater access to the same opportunities afforded people without disabilities. I believe that the Olmstead Plan will help strengthen our democracy because it will promote greater community inclusion, access, and participation for people of all abilities.

Comment 64

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Thursday, August 15, 2013 5:27 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/15/2013 AT 5:27:25 PM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I am an interested citizen

COUNTY: Blue Earth

COMMENTS:

I appreciate the Minnesota Plan's inclusion of integration within the community. We need all kinds of people working, living, playing, and participating in the life of all Minnesota Communities. This, I believe creates strong, diverse communities. I am a long time ally in the Minnesota Self-Advocacy Movement. I think self-advocacy plays a key role in assisting people with disabilities in the development of confidence and their access to community. My work with Self-Advocates Minnesota or SAM has shown me even more how self-advocacy helps people discover and develop their gifts and talents. There are people living in our State who do not have access to participation in self-advocacy. People tell me that they can't get rides or can't go "out of town" for events. I have even had staff tell me in various parts of our State that they don't want people to learn more about their human and civil rights because it causes "trouble". This is troubling to me. People must have full access to learn about their basic civil and human rights. Self-Advocacy can help people access this information. I love seeing how people grow and discover their inner strength when they are part of self-advocacy communities. It is inspiring and that is why I continue my work as an ally- I see the difference it makes. Thank you for your efforts on this plan. I love how it reads so far and would love to see more language around self-advocacy and self-advocacy playing a key role in the implementation of the plan in the future.

Comment 65

From: Carol Rydell [*Redacted Text*]
Sent: Thursday, August 15, 2013 6:03 PM
To: *DHS_OPC Public
Cc: Carol Rydell; Jon Alexander
Subject: Public Comments

Attached are comments from the Employment First Coalition on the draft of the Olmstead Plan.

[full text of attached document]

Comments Submitted by the Employment First Coalition Via Email on August 15, 2013

Dear Lieutenant Governor Prettner Solon and the Olmstead Plan Subcabinet:

The Minnesota Employment First Coalition appreciates your commitment to the inclusion of Minnesotans with disabilities to live, work and enjoy community living as do Minnesotans without disabilities. We also appreciate the opportunity to provide comments on the June 2013 draft of the state's Olmstead Plan on employment.

The Minnesota Employment First Coalition was founded by Minnesota APSE in 2006 as a grassroots, cross-disability movement of employment champions from a broad range of disability advocacy organizations, federal, state and local government agencies, self-advocates, employment and disability service providers, and educational institutions. Since 2007, the Coalition has hosted four statewide

employment summits. The Coalition has partnered in the planning and running of two statewide employment and disability conferences, published Employment First summary progress reports, and has championed initiatives with specific recommendations to encourage changes in employment policies and practice for Minnesotans with disabilities.

83% of the 13,546 Minnesotans receiving day and employment services from DHS are working in segregated settings. The state invests \$81 million for segregated Day Training and Habilitation Services, compared to \$15.5 million in individual employment services. Minnesotans with disabilities have the capacity to be employed in the regular workforce just as they have the capacity to live in typical neighborhoods and participate fully in community life. The data on segregated employment above does not reflect those capabilities. It reflects the low expectations about what Minnesotans with disabilities can achieve in employment and the consequences of policies that support those low expectations.

The draft Olmstead Plan's employment goal is on target – "People with disabilities will have choices for competitive, meaningful, and sustained employment in the most integrated setting" and we support many of the activities detailed in the Plan. However, to make substantial progress, the Plan must go further. An individual competitive job (with or without supports) on the payroll of a business, at minimum or market rate wages and benefits is without question, the "most integrated" employment outcome for Minnesotans with disabilities and should be the clear goal of the final Olmstead Plan. Much of the Plan's language on "employment" does not reflect that standard. Minnesota, like other states, has an excess of unaligned definitions related to employment and the draft plan needs to clarify that "competitive employment" is the standard for the Plan. The US Department of Justice in its recent action in Rhode Island provides support for the standard of individual, not group or crew, jobs. Page 3 of the "Rhode Island Supported Employment and Day Services Interim Settlement Agreement Fact Sheet" indicates that supported employment placements are to be "individual placements."

The Employment First Coalition recommends the following changes to the draft Olmstead Plan to ensure that Minnesotans with disabilities have access to competitive employment:

The State of Minnesota (not just the representative agencies of the Olmstead Subcabinet) should adopt an Employment First Policy. An Employment First policy would articulate that the state recognizes the value of competitive employment as the preferred outcome of Minnesotans with disabilities as it does for all of its citizens. Minnesotans with disabilities, like other citizens, can choose other options, but the state would realign its policies and resources to substantially increase access to competitive employment. An Employment First policy affecting all state agencies would also be consistent with the recommendation by the Governor's Workforce Development Council (in "All Hands on Deck") for the state to become a model employer of Minnesotans with disabilities.

Adopt a statewide definition of "competitive employment" and make it the clear goal of Minnesota's policies and practices. Competitive employment is by definition "integrated." It is individual employment (with or without supports) on the payroll of a business, at minimum or market rate wages and benefits. It is employment as it is understood and accessed by typical citizens.

Adopt specific performance measures of progress that challenge the state to change its employment policies and practices. The Coalition supports the performance measures proposed by the Minnesota Disability Law Center as a minimum standard of a 10% increase per year for five years for transition-aged youth and adults moving into competitive employment. We also support a 10% increase per year in the number of providers skilled in Individual Placement Services –Supported Employment (IPS-SE) services for individuals with a mental illness.

Ensure that state agencies work together to provide Minnesota’s youth with disabilities employer-paid work experiences, not merely “work experiences” as a goal. Most young adults without disabilities have “employer-paid work experiences” (otherwise known as “jobs”) while they complete their education. Those jobs are often part-time and temporary in nature, but they provide critical experiences for future employment. Research indicates that having a job while in school significantly increases competitive employment outcomes for individuals with disabilities. Participants in listening sessions conducted by the Minnesota Employment Policy Initiative (MEPI) in 2009 and 2010 also identified the importance of competitive jobs while attending school both for choosing and for achieving future competitive employment. Youth who have a job while in school are unlikely to choose less integrated options.

Ensure there is collaborative outreach by state agencies to families and individuals with disabilities with the primary emphasis on informing them of the many benefits of competitive employment (and of available work incentives) to address concerns about competitive employment with a secondary emphasis on resources available to achieve competitive employment. The state needs to have a common message about the value of competitive employment to Minnesotans with disabilities to ensure that individuals and their families can make an “informed choice” about their employment options.

Ensure that DEED’s goal to revise the EE Rule is aligned with employment priorities for DHS. In the past when the EE Rule was changed to support “community-based employment”, many individuals with disabilities remained in segregated employment programs by switching to DTH funding.

The Minnesota Department of Education should clarify to local school districts that a primary goal for students with disabilities is to have a job or be enrolled in post-secondary education when they graduate from public school education, and MDE should measure those outcomes upon graduation. Too many students graduate from schools without a job or enrollment in further education. Often, special educators “hand off” students to adult employment services with the expectation that employment occurs after graduation. Research confirms that youth that leave school services without a job, often never have a job. The transition years provide the best opportunity for collaboration and sharing of resources between the schools and adult employment services toward the common goal of competitive employment or to “try out” post-secondary education and identify additional needed competencies or accommodations for successful completion of post-secondary educational programs.

The Department of Health can have a critical role in increasing competitive employment outcomes.

The health care community has a natural link with many individuals with disabilities who are unemployed or underemployed. Unfortunately, that community remains poorly informed about how competitive employment can support and contribute to recovery from a mental illness and other disabilities. The Department of Health is positioned to better inform the health care community about the many benefits of competitive employment and the available resources to achieve it and to encourage health care professionals to share that information with individuals with disabilities.

The Department of Human Rights should ensure that the affirmative action policies that support employment and economic opportunities for women and minorities are also available to individuals with disabilities. The state utilizes numerous opportunities through contracting and purchasing to support economic development for women and minorities, but not for individuals with disabilities. The federal government has proposed regulations extending affirmative action policies for individuals with disabilities and the state should take similar action.

We appreciate the opportunity to provide comments on the state's draft Olmstead Plan, and we look forward to seeing a next draft which moves more forcefully to ensure more Minnesotans with disabilities experience the positive benefits of having a competitive job.

Submitted on the behalf of the Employment First Coalition,

Carol Rydell
Kaposia, inc.
380 E. Lafayette Freeway South
St. Paul, Minnesota 55107
Phone: 651-789-2815

Jon Alexander
Kaposia, inc.
380 E. Lafayette Freeway South
St. Paul, Minnesota 55107
Phone: 651-789-2817

Comment 66

From: *[Redacted Text]*
Sent: Friday, August 16, 2013 11:10 AM
To: *DHS OPC Public
Cc: *[Redacted Text]*
Subject: Public Comments

1. I am concerned that the Olmstead Plan does not address the needs of persons with mental health diagnosis, particularly those with dual diagnosis. There is a small but very intense population who is currently being served in jail because there are not enough beds in the community to meet their mental health needs. Since the Regional Treatment Centers closed, at least in rural MN the services

for persons with intense needs have declined. The central intake system is not consumer-friendly. We have often had to contact upper level DHS staff and/or have families contact consumer advocates in order to get the treatment necessary for our consumers.

2. In regards to people who are eligible for the CADI/BI or Developmental Disability waivers, how does the Olmstead Plan integrate with DHS's recent effort to decertify adult foster care beds? There is always going to be an ebb and flow of persons entering and leaving adult foster care homes, this also occurs in nursing homes, hospitals, etc. Counties have been notified that beds may be decertified in the future as soon as a bed opens. This allows no time for consumers and their families who are seeking community placement to visit a home with a new opening or to make transition plans.

Is it part of the Olmstead Plan and/or DHS' plan to move back to placing persons with disabilities into nursing facilities? Because that is what will eventually occur if counties have no open beds in small, four bed adult foster care homes especially if there was a need for imminent care because a caregiver experiences a health emergency.

We often use community based adult foster care homes for respite. This allows the person with a disability to remain living in their family home as long as that is their wish, but also allows for a smooth transition when a placement out of the family home is needed. Counties are under the impression that respite beds will not be available in community settings any more, but will be decertified as to DHS they appear unused.

3. I have a brother with developmental disabilities who receives Waivered Services and I have worked with disability services since the RTC's were closed. I'm very concerned that recent changes have us going back to the limited option of nursing facility placements for people who need assistance, rather than moving forward as we have been doing for the last 20+ years.

Thank you for the opportunity to comment.

[Redacted Text]

Comment 67

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Friday, August 16, 2013 12:49 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/16/2013 AT 12:49:11 PM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Hennepin

COMMENTS:

I am the parent of a *[Redacted Text]* year old son with fetal alcohol syndrome, which includes a "borderline" intellectual disability and significant behavioral, mood, and sensory difficulties. It is nearly impossible to access the appropriate housing and support services for him. If he is not in the middle of a major crisis, he will not receive a waiver. He needs more help and support than the current options provide. The only other option for him is an ICF-DD, which is what Olmstead is trying to avoid. We parents are in the position of keeping him at home with the lack of independence and a feeling of neediness, or buying him a townhouse and trying to piece together all of the supports ourselves, through PCA services, which is not specialized enough for him, along with him being ISOLATED even though he would be in a neighborhood.

We need a greater variety of options for those individuals who should not be in an ICF but who also may not be best served being fully integrated into a community (due to isolation). We also need a much better system for waivers.

It should not be the case that if you live in Dakota county, for example, you may get a waiver but WITH THE SAME NEEDS AND DISABILITIES if you live in Hennepin county, you will not get a waiver.

I believe that our waiver rules and systems are set up exactly the same way as organ transplants: you may have a high need, and be on an imaginary "list," but each time a new waiver opportunity--or a new organ in my example--is available, someone else may always be seen as needier than you and be put at the top of the list ahead of you. We who are advocating for our disabled family members should not be competing with each other to demonstrate that our need is the greatest. A need that is unmet is still an unmet need, regardless of the possibility that someone else also has an unmet need. It is not a want: it is a NEED.

A person should not have to be literally IN CRISIS before getting their needs (not wants) met. That is like saying the person with heart disease needs to already have a heart attack before being allowed to have the known life-saving medication. Or the person with diabetes needs to already have an amputation before being given the insulin that is known to help.

The waiver system needs to be fixed, and there need to be far more realistic options for those people who will not easily just fit into a community neighborhood setting.

Comment 68

From: Moccia, Kim (ADM)

Sent: Friday, August 16, 2013 1:54 PM

To: *DHS OPC Public

Cc: Tom Reed

Subject: Olmstead Plan - Comments from MN Assisitive Technology Advisory Council Chair

Attached for your consideration is a letter from the Minnesota Assistive Technology Advisory Council submitted by its chair, Tom Reed. This advisory council provides consumer-driven advice to STAR, Minnesota's federally-funded Assistive Technology Act program. Information about the advisory council and its council members is available on STAR's website. Please let us know if you have questions regarding this letter or would like additional information about assistive technology, the STAR program, and its advisory council.

Regards,

Tom Reed, MN Assistive Technology Advisory Council Chair (treed@tjreed.com)

Kim Moccia, STAR program coordinator (kim.moccia@state.mn.us)

Kim Moccia

Program Coordinator

Minnesota STAR Program | 358 COB, 658 Cedar Street | St Paul MN 55155

651-201-2297 direct dial | kim.moccia@state.mn.us |

Website: <http://www.starprogram.state.mn.us>

Device Exchange: <http://www.mnstarte.org>

Twitter: @MNStarProgram

[full text of attached document]

August 15, 2013

Minnesota Olmstead Sub-Cabinet

P.O. Box 64988

St. Paul, MN 55164-0988

Re: Olmstead Plan Comments

On behalf of the Minnesota Assistive Technology Advisory Council, I am submitting the following recommendations for your consideration. This advisory council provides STAR, a division of the Department of Administration and Minnesota's federally-funded Assistive Technology Act program, with consumer-responsive and consumer driven advice. A majority of council members use assistive technology (AT) and know from personal experience the importance of AT.

For Minnesotans with disabilities, assistive technology provides the tools they need to function independently at home, school, work, and in their communities. With a growing number of AT choices, it is more important than ever that individuals are able to see and compare features of similar devices and have an opportunity to try a device prior to purchase to ensure that the device meets his or her needs. The STAR program partners with organizations around the state to provide Minnesotans of all ages and disabilities access to assistive technology demonstrations and device loans free of charge.

It is our understanding that the main goal of the Olmstead Plan is to make Minnesota a place where people with disabilities live, learn, work and enjoy life in the most Integrated setting. For these reasons, we recommend:

- Partnering with STAR on assistive technology-related Issues
- Identify STAR as a resource for assistive technology demonstrations and device loans
- Include consideration of assistive technology across all goals outlined in the Plan

Sincerely,
Tom Reed
Chair

Comment 69

From: *[Redacted Text]*
Sent: Friday, August 16, 2013 2:13 PM
To: *DHS_OPC Public
Subject: MNSILC Response

The Minnesota Statewide Independent Living Council (MNSILC) wishes to thank the Olmstead Sub-Cabinet for its hard work and commitment to drafting Minnesota's Olmstead Plan. MNSILC needs to provide some critical feedback to the Sub-Cabinet on this draft plan. It would be impossible to lay out every item we felt was productive or limiting in this draft plan. We will try to make some general comments and give some examples where it seems helpful.

We appreciate your efforts to gather information and data from various groups like MNSILC and the state departments that provide and oversee services and supports for individuals with disabilities. Trying to fully understand all of what is currently in place and how it can support or hinder implementation of a plan is no small task. Additionally attitudes and perspectives vary greatly in the disability community, just as the range of disabilities is widely varied.

The current draft plan lays out a number of key items. There is a clear description of what currently is in place for individuals with disabilities, in most cases. Barriers are also well discussed and laid out, overall. The way in which the document is laid out makes understanding each departmental area easier. We were particularly appreciative of the recommendations by the Department of Employment and Economic Development that include making nursing home relocation a fifth core service for Centers for Independent Living in Minnesota and more fully funding those Centers. Both are key areas MNSILC has talked about and supports. Activities in our new State Plan for Independent Living also work towards this end.

This plan needs to have a section of definitions and one that details acronyms. Unless a person is very well versed in the disability community and has a broad range of experience in many areas, there are terms and acronyms used that make this plan more like reading a foreign language. Some departments use similar acronyms with different meanings. A quick reference section would greatly improve the readability.

While the plan is largely arranged by departments and that gives the reader the opportunity to more readily understand what the department does and what its areThrough strength and challenges are, it does complicate the reader understanding what is being proposed in a given area. The plans for transportation or employment are laid out in a number of departments.

Overall the plan does not address specific steps Minnesota will take to ensure that people with disabilities are able to choose how they wish to be supported in the community. This is concerning. In several places, such as on page 24, in the "Description of overall plans to reduce or eliminate these

barriers” section, the third bullet refers to a diversion plan. Nowhere does it describe what this might entail. Further it hints at a reduction in options for individuals with disabilities. Will all non-community based options be eliminated or will access become very restricted? While we agree that community based employment at a wage commensurate with the work being done by others is the goal, a wide range of disabilities exist. In the case of some individuals with significant mental health needs, the level of expectations, constant change, and high demands may make work in a community based setting too daunting, at least as a place to start. Then would they just not to work because there are no other options? A lack of reasonable options for a person with that description is no more acceptable than our current situation: community based options that are not the stated expectation for many people with disabilities. Minnesotans need to understand exactly what will happen and how, in order to understand if this Olmstead Plan is good for them. Any given person with a disability may be able to tell you that they need an affordable, accessible place in their community to live with supports A, J, and Q coming into their home to assist them. But if affordable, accessible housing does not exist in their community, and/or they can only access support J because no one provides A and Q, then what will happen? How will this plan help them to achieve their stated choice? How will Minnesota improve to make more affordable, accessible housing available? Or how will this person access additional funding to make finding a place to live more possible? How will Minnesota increase access to needed services? How will Minnesota approach the current funding shortage issues to move this plan along? The disconnect between desired choices and availability is daunting. What is going to change?

The philosophy of Independent Living (IL) is foundational to Olmstead. Yet sections like “Progress Measures” on page 9, contain an individual choice statement that is buried in the middle of a bulleted list. The tenth bullet on this page states, “Percent of assessed (MnCHOICES) individuals who say, ‘My plan supports what I want’.” Choice is central to the discussion. The individual with the disability needs to be able to choose and that is how progress should be measured. Independent Living is an issue of civil rights. All disabilities, all age groups, and all individuals must be considered.

The entire plan must use person first language. Any document coming from the State of Minnesota needs to carefully screen to ensure that appropriate language is used. This is a matter of respect. Look at page 43 as an example. The fourth paragraph uses the words, “disabled people”, rather than the correct usage of “*people with disabilities*”. The next paragraph states, “disabled offenders”, rather than “*offenders with disabilities*”. We noted a number of places throughout the document where language was an issue.

One of the keys to the success of this plan is how Minnesota approaches implementation. Many people in the state who have a disability, their family members, and service professionals really know very little about what exactly Independent Living really means. This affects what choices they may make. Key professionals such as educators, County social workers, therapists, or medical staff need to have a requirement in their training programs that includes coursework on what IL is and why it is important for all individuals with disabilities. In addition, a marketing program that targets increased awareness in the general population would be beneficial to all Minnesotans with disabilities. Attention to the different broad topic areas listed in the document at times appears limited. Here are several examples.

Housing: Nursing Home Relocation (NHR) is mentioned in several places regarding housing. Housing is a broad issue that includes not only NHR, but challenges such as affordability, accessibility (see MNSILC’s newly released Home Accessibility Needs Assessment Report at [mnsilc.org](https://www.mnsilc.org)), more choices in types of

housing available, choices about who to live with, how to help adults transition from home to community living, housing for families with a member who has a disability, etc.

Transportation: Metro transportation can be a challenge to access, dependability can be an issue, and so on. Outside the metro, getting transportation at the time when you need it, outside the 8-5 window or on Sunday when it is not available—is an issue. Further if transportation exists, it probably will not cross County lines, meaning that if you can get a good job in a city a short distance away that is just across the County line, you are out of luck because no transportation to that community exists. Getting to and from a medical appointment may be an issue because of the times those appointments are available or the length of the appointments and the hours a transportation system runs. This of course does not address the many areas that lack any sort of access to transportation for the person with the disability.

Life-long learning: What currently exists in Minnesota is not addressed. Further there is no plan for expanding on what is available. New Jersey, as an example, has a four year integrated college program for individuals with cognitive disabilities. Minnesota does not have anything like this. What training programs might be available for an individual with a cognitive disability that wants to do clerical work? They would certainly be more likely to succeed if they could further their education in a post-secondary option or training program.

MNSILC cannot emphasize enough the critical role that Centers for Independent Living play in our Minnesota communities for people with disabilities. They provide critical support for independent living skills training, advocacy, peer mentorship, and information and referral. In addition each Center functions under the IL model which ensures that each Center is staffed by a majority of individuals who have disabilities themselves and is directed by a board that also includes at least 50 % individuals with disabilities. They are doing the work of ensuring that Minnesotans with disabilities have access to supports and services that promote Independent Living. An Olmstead Plan for Minnesota needs to take advantage of this already existing, highly effective, and well organized resource as a key part of moving forward in the promotion of Independent Living for Minnesota.

Again we thank you for your considerable efforts to develop this plan. We hope our comments are productive in helping you finalize the plan that will be submitted for approval.

Respectfully,
Mickey Kyler
MNSILC Chairperson

Comment 70

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Friday, August 16, 2013 2:38 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/16/2013 AT 2:38:29 PM

NAME:

EMAIL:
REASON:
DESCRIBE YOURSELF: I am a service provider
COUNTY: Rice

COMMENTS:

Hello,

I work for a DT&H which as a large amount of people working at job sites in community settings. Many of these people are able to work due to the special wage they earn and support of a job coach. If this sub minimum wage is no longer available many of these people will no longer be able to work. They will not only loose the ability to earn money but will loose the community connections they have made with business people, other employees and customers. They will loose self worth. Our program strives to place people in independent employment whenever possible but there will always be some individuals who need higher levels of support or have productivity levels that are below what would be tolerated by an independent employer. I think there is no "one size fits all" approach to this matter and that by having more options for people they will be able to live more productive and happier lives.

Comment 71

From: *[Redacted Text]*
Sent: Friday, August 16, 2013 4:57 PM
To: *DHS OPC Public
Subject: olmstead plan

In regard to this matter, community employment and integration is very important for people with disabilities, however, we need to provide options and choice. Please do not eliminate options for people that are not able to work in the community and still require habilitative services during the day.

Comment 72

From: Moccia, Kim (ADM)
Sent: Friday, August 16, 2013 4:57 PM
To: *DHS OPC Public
Cc: Bibus, Beth (MMB)
Subject: Public Comments

On August 13, 2013, the Minnesota Assistive Technology Advisory Council took part in a participatory exercise to gather input on the Olmstead Plan from its council members. Attached is a summary of the input received during the exercise. Please let me know if you have any questions.

Regards,
Kim

Kim Moccia
Minnesota STAR Program | 358 COB, 658 Cedar Street | St Paul MN 55155
651-201-2297 direct dial | kim.moccia@state.mn.us |
Website: <http://www.starprogram.state.mn.us>
Device Exchange: <http://www.mnstarte.org>
Twitter: @MNStarProgram

[full text of attached document]

Input for the Olmstead Planning Document
Minnesota Assistive Technology Advisory Council

August 13, 2013

The Minnesota Assistive Technology Advisory Council provides consumer-driven advice to the STAR program, which is Minnesota's federally-funded Assistive Technology Act program. On August 13, 2013, the Council took part in a participatory exercise to gather input from its council members. The following input comes from individuals with disabilities, family members, advocates, and professionals. The individual input has been grouped into the main goals of the Olmstead Subcabinet. The final set of statements includes items that do not fall under one of the main goals.

I. Supports and Services

Help with Activities of Daily Living (ADL) was identified as a priority as was assistance with getting out in community.

II. Housing

Council members identified the *shortage* of accessible housing as a barrier to obtaining appropriate and affordable housing.

III. Transportation

Need to increase access to affordable public transportation in rural areas through the state, as well as, increasing statewide public transportation routes/options.

Currently there is a lack of transportation options in rural areas and options available in the Metro do not always meet people's needs and can also be very expensive.

Good public transportation varies across the state. Without affordable public transportation it may be difficult or impossible for some people with disabilities to get to work.

IV. Employment

Many people with disabilities are not self-sufficient and there are not a lot of employment options for them to pursue. Employers are not educated on what people with disabilities are capable of.

Many people with disabilities live below the poverty line and have substantial living expenses, which is why increasing employment options for people with disabilities is so important.

V. Healthcare

Without good healthcare nothing else happens.

Son is totally dependent on care.

Topics Listed as Missing from the List:

-
- Assistive Technology – consideration of and access to assistive technology across all topic areas (e.g. employment, learning, support and services) is essential
 - Advocacy: provide opportunities to help shape policy and create change
 - Education: need more specific education/training for employment
 - Lifelong learning separate from education – different from formal education
 - Important to reach out to diverse populations to ensure that they are included in the planning process

Tally of Group’s Responses: What was the most important topic to them?

Topic and Number of participants

- Healthcare = 2
- Housing = 1
- Employment = 2
- Transportation = 1

Tally of Group’s Responses: What was the second most important topic to them?

Topic and Number of participants

- Employment = 3
- Transportation = 2
- Supports and Services = 1

Demographics of group:

(Participants were given the option to identify with more than one group; therefore, numbers below do not equal the number of participants responding to this survey.)

Demographic and Number of Participants

- I am a person with a disability = 4
- I am a family member of someone with a disability = 1
- I work for a government organization = 2
- I am a service provider = 3
- I am an interested citizen = 4
- I work in higher education = 1
- I am a legal or other advocate = 2

Comment 73

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Saturday, August 17, 2013 4:13 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/17/2013 AT 4:13:23 PM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Hennepin

COMMENTS:

As parents of a son who has developmental disabilities, we encourage the Olmstead Sub-Committee to provide choices to individuals with disabilities that will meet their individual physical, emotional and social needs. The State of Minnesota has already developed an array of options that we believe provide some choices to meet the many unique needs of this population. For example, the ability for persons to live in a home setting with two or three other individuals as roommates and friends, receiving the support according to their needs has been a wonderful option for individuals. Also, creating apartment settings where individuals can live independently yet also have emergency people available in the building if a health or other issue arises has also provided a wonderful opportunity for independence but in a safe environment. In fact, we wish that there was more flexibility for individuals beside SILS apartments and 3-4 person group homes. We think it would be great to have 6 to 8 person facilities with congregant dining, individual apartments and ability to share social experiences while being staffed according to the needs of that setting. You get some cost efficiencies and the clients get to have more people to interact with. The point is there should be options. We are very concerned that the state may be moving away from these types of supported living options by beginning to eliminate the designated beds that have been given to providers. The Planning Committee appears to be condemning providers who were asked to create a variety of options with family input and calling these options institutional.

We are concerned that some advocates of the disabled want to force everyone into "individual" housing settings when that is not necessarily the best setting for the individual. The Olmstead case was about two women who were mentally ill, were judged after treatment to be able to live on their own, yet were kept in institutions. That is wrong. But to then say that everyone should or can live independently is not living in reality. Our son could not live like that unless there were many support staff involved in his care. And the reality is that even if that type of support was provided in an apartment, he would be a very lonely person. Going to an apartment where there is no one there but a care attendant is not our idea of happiness nor is it our son's idea of happiness. Social companionship is particularly important to everyone and there should be many ways to address these needs without being excessively restrictive or by insisting that all people should live by themselves.

Please continue to give many choices to individuals with disabilities. And by the way, our son is not served by any provider. He lives with us and has an active social life with friends and family. Someday, as we become too old to care for him, he will need some other choices of housing and support. We would like to know that he will have choices that fit his needs and that the state will not react by creating one-size fits all solutions. Frankly, our state doesn't have enough money now to meet the needs of our citizens who are disabled whether in housing, transportation or work. This proposal could isolate rather than integrate people. Please use common sense!!!

Comment 74

From: *[Redacted Text]*

Sent: Sunday, August 18, 2013 11:03 AM

To: *DHS_OPC Public

Cc: Ltgovprettnersolon (GOV)

Subject: Olmstead Testimony

[Redacted Text]

8/13/2013

To Lieutenant Governor Pretterner Solon and Olmstead Sub-Cabinet:

My name is *[Redacted Text]*. I grew up in Duluth. I was diagnosed with mental illness as a child and have received SSI for the past 26 years.

I am here to address what my doctors, advocates and I view as disability related discrimination in the areas through medicine, social services and housing. There is disability related prejudice and denial of essential supports which create overwhelming barriers to those attempting to live independently.

I am here to address what the U.S. Supreme Court Olmstead Decision describes as follows:

“Knowledgeable professionals tell us that our society, and the governments which reflect its attitudes and preferences, have yet to grasp the potential for treating mental disorders, especially severe mental illness. As a result, necessary resources for the endeavor often are not forthcoming.”

The statute further states the purpose is “to develop and implement, through research, training, services, and the guarantee of equal opportunity, comprehensive and coordinated programs of vocational rehabilitation and independent living, for individuals with handicaps in order to maximize their employability, independence, and integration into the workplace and the community”

I am diagnosed with PTSD in part due to the 16 years of appeals and denial of medically necessary treatment and supports. Without family support and persistent self advocacy my doctors and advocates believe it is likely I would have been institutionalized for life, perhaps from the age of 19 - thus becoming a major economic burden on the state at a cost of millions.

Obama Care's universal access does nothing for me. I am still excluded. Most of my medical expenses will still be unpaid by Medicare and Medical Care insurance. I Depend on the MSA (Minnesota Supplemental Assistance) special diet food supports to pay for most of the medical treatments for my psycho-physical mental health disability.

What is a psycho-physical mental health disability?

My doctors find that we must treat my immune system in order to heal my nervous system and brain. My medical team recognizes that I have a "dual diagnosis", both psycho-neurological and "physical". My body is constantly inflamed with multiple chemical sensitivities.

Very few of my treatments are paid by Medicaid and Medical Assistance. I have called the Minnesota Medical Assistance office and they have said "What is your problem? Do you have allergies? Medical Assistance does not do well with allergies."

Because I have not received adequate medical supports I have been unable to participate in vocational rehabilitation and thus work. I am no longer able to volunteer in mental health advocacy as I had for many years. For most of my life it has been a struggle to survive.

CADI Waiver (Community Alternatives for Disabled Individuals)

I live in a small Minnesota county with limited population and have tried to move to Duluth for 13 years but have been unable to due to lack of affordable disability accessible housing and the non-transferability of my CADI waiver which is granted to the county for my benefit. CADI waivers do not follow the person thus trapping me in a county that has demonstrated for over a decade firm determination to not service my CADI waiver. The county daily practices passive abandonment in a highly aggressive manner.

[Redacted Text] had represented me in two major CADI appeals which resulted in denial of services (by the same judge). Disability law finds that both denials reflected bias and discrimination towards my environmentally induced mental illness and disability. The representation I required in order to file a District Court appeal was not available.

Legal Aid of Minnesota said that the state Appeals Division was apparently unwilling to acknowledge the scope of my disability issues. Thus trying to wash its hands of a highly complex and rapidly expanding disability category.

For 14 years I have had a CADI waiver. For the past 9 years I have received no CADI services once the state allowed counties to pool their CADI funds. This pooled-committee process means I have never met the real decision makers. The committee system means there is no viable county accountability. It means the county is authorized to ignore my medical request and medically necessary need.

My state licensed CADI planning specialist reports that after having facilitated over 500 CADI plans from 50 Minnesota counties over an 8 year period my service plan proposal is reasonable and conventional.

He reports that no other service plan has been rejected in total as have my plans. The county has denied all services and then terminates the CADI waiver because the waiver is unused.

CADI is the only potential source for treatment support for my type of disability. It matters not to the county that my doctors indicate there are no emergency or institutional services available for my type of disability. CADI supports are firmly blocked by the county and now the DHS appeals division. I have never had a CADI service plan as is mandated by CADI policy even though I have been found eligible for CADI supports for the past 15 years. This is discrimination.

The Obama administration recently made food allergies in children an ADA civil right. Immune related issues have reached epidemic level and still Minnesota is rejecting the necessity of addressing this crisis.

The county attitude is that “the best thing we can do for you is to give you a one way bus ticket to the county line”.

The county director said to me that “you should live where you get the services you need. ... If we can deal with you we can deal with anyone in the county.” This comment was coupled with firm intent that I should know that I have been a topic of discussion at the county board. These statements were obviously intended to intimidate.

Very little changes from one social service director to another. It appears that county policies are set by the county board and the powers that be within the county. Each administration gets similar directives. The county would try one strategy after another until the state appeal division put a stop to that form of harassment.

The county has tried to deny all services including food stamps, even sending the county attorney to my annual food stamp evaluation. Staff from other counties as well as state administrators tell me that they dread dealing with my county. The situation is awful.

HRA HOUSING

Due to my disability I received HRA section 8 housing for 21 year. Suddenly in 2011 HRA cancelled my Section 8 voucher with no prior notice. They accused my family and me of criminal and fraudulent behavior. HRA’s Office of Investigative General and the State Financial Fraud Division found no basis on which to pursue an investigation thus leaving me in housing limbo - essentially homeless/ an environmental refugee.

In addition my records and legal documents and procedures have been part of State Medical Assistance Appeals, reviewed by Legal Aid, the County attorney, our family attorney, disability financial advisor and HRA’s own attorney. These authorities have approved the financial instruments we use yet HRA charges fraud and imposed over \$50,000 in penalties.

The HRA penalty’s continue to be imposed. Some of the penalties will continue to discriminate against me and my family for life.

HRA claims they are not subject to the ADA. A claim Legal Aid said they would fully prosecute but HRA avoided a confrontation.

This is discrimination and it is not because of HRA's ignorance of disability issues. I have met with HRA's architect, building contractor, HOPE Six housing development team and their attorney as well as the Section 8 supervisor. They are very informed.

The State must enforce discrimination law and the ADA with greater commitment.

Housing

For the past 16 years I have tried to find accessible housing appropriate for my. I have met with the Minnesota Finance Agency, Duluth's HRA Hope Six Project (which promised to build 6 accessible units but cancelled all due to the complexity and cost), The Human Development Center in Duluth and every other possible option. My environmental physician has directed my family and I to check out possible living options throughout the United States. We have not found any other viable options for environmentally accessible housing because of financial, environmental, social service and medical barriers.

Environmentally accessible housing factors such as the quality of air, water, light and even food are critical to maintaining health and wellbeing for all disabled. The Olmstead Plan must address what is medically necessary to achieve quality of life standards which will sustain life for all disabled individuals. Standards must be set to provide healthy housing for all. Housing that includes "intentional housing" communities such as are popular in Europe. Housing that is appropriate for meeting the medical need of the individual - including those with compromised immune systems.

DHS may recall the health crisis they incurred in their own office building in St. Paul when they "remodeled" in the 1990's forcing some staff to work from home. Duluth's Social Service building is widely known for its illness producing construction. The University of Minnesota Duluth has had struggles maintaining the health of its buildings. Five minutes in a Duluth nursing home environment put me in an hospital emergency room. The problem is epidemic and completely disabling for me.

Increasingly the medical community is realizing that these toxic exposures are an underlying cause of disability in children and adults. For instance even slight expose to lead in children is known to cause attention deficit disorder. Second hand smoke is now banned from all public buildings because it's unhealthy. HUD has done extensive research on the health impact of environmentally toxic housing - yet they deny responsibility for their role in this crisis.

Staff at University of Minnesota Duluth indicate parents increasingly select schools where food services are allergy aware and provide supportive nutritional services. In Duluth the Essentia hospital system has gone to the use of hypo-allergenic cleaning supplies.

My psychiatrist as well as my entire medical team take the view that medicine and public policy can no longer deny the fact that environmental factors are severely impacting mental and physical health and

compounding disability issues. This is especially true of the disabled who are already weakened. My doctors claim the evidence is too strong to be longer ignored.

Minnesota Department of Human Rights

After HRA canceled my section 8 support I contacted the HRA regional section 8 office (Dana Kitchen) who approved of action taken by the Duluth office. I contacted Senator Frankin who referred the situation to the HRA congressional liaison (Peter Bass) who refused to discuss the situation with me and terminated any contact. Calls to the regional HRA office were not returned. Legal Aid looked into the case and for unknown reasons refused to communicate with me even after I made numerous phone calls and emails.

HRA issues can not be appealed beyond their in-house staff. There is no independent review. Access to District Court is almost impossible to obtain. Finally Representative Dill suggested I contacted the Minnesota Human Rights Office.

It took roughly 20 months for the Human Rights office to conduct an investigation. I call it a non-investigation since they did not contact my witnesses. I had submitted a 19 page history of my 21 year relationship with HRA. I wonder if the Human Rights office even read it. They did not contact me for clarification. Their decision seemed to ignore the facts which I presented. I wonder if my case is too complex to be adequately investigated by the Human Rights Office with their limited resources.

The Human Rights office indicated to me that they are severely under staffed. Apparently they had relied only on HRA records and HRA's legal council which seemed to repeat whatever HRA wanted them to say. A previous HRA staff attorney has reported to me that he felt obligated to resign from the Duluth HRA office for ethical reasons. They were asking him to take legal positions which were unacceptable.

Requests for a Human Rights reassessment were made by Representative Dill and Lieutenant Governor Prettner Solon. A phone call from the Human Rights Office to me confirmed that my request was received on time. A reconsideration decision was made *[Redacted Text]*. I have been too traumatized to read the decision.

I have heard from advocates and attorneys that the Duluth HRA office as an agency run amok. I understand that in past years Minneapolis HRA housing supervisors have provided significant assistance to individuals in similar situation to my own (per. *[Redacted Text]*- disability financial advisor, *[Redacted Text]*- attorney).

It appears that action taken by the Duluth HRA office was in line with a federal directive as approved by the HUD regional office. Perhaps because of the agency's concern that they are not providing environmentally safe housing. Increasingly building contractors and perhaps HUD itself has been found negligent by the courts. Perhaps after 21 years of section 8 support they were directed to discriminate against my type of disability and have me removed from the program.

Providing safe, disability accessible housing is critical to keeping the disabled in the community. It is nearly impossible to provide medical and social service supports without adequate housing and in my case without an environmentally accessible home. Employment is not achievable for the disabled if adequate housing is unobtainable.

APPEALS

I have had constant state Medical Assistance appeals for 16 years. The Minnesota State Ombudsmen hands are tied, unable to help for lack of funding.

[Redacted Text] continues to represent and advocate for me. Legal Aid services have been with drawn without explanation after 15 years of intensive representation.

County Commissioners and staff have lied, altered county hearing records, and prompted a forward thinking commissioner to resign after witnessing their treatment of me and herself.

I cannot tell how destructive it is when the county social service director says in so many words “I think I got you” after an appeal hearing, using the appeal process as a competition to get me. Another county social service director suggested that I just go to work so I wouldn’t have to deal with a hostile disability system. I was shocked. I was so sick could barely get into the court house.

My county’s stated policy is to send all disagreements to appeals. They do so over and over until they get a judge who will agree with them. Then, no matter what the appeals division orders the county has the authority and ability to get around the order. The county has essentially neutralized the state’s authority as it relates to Medical Assistance appeals. For the county it is a game where the spoils go to the winner, where I am a hunk of flesh to be disposed of!

I pray that there will finally be a thorough investigation of the county’s function and the effectiveness of the appeal process.

RESOLUTION

The care I need is not alternative to the area of my disability. What I ask for saves the state money and meets the need of a rapidly increasing segment of the disabled population.

This conflict and denial of services kills my spirit and deepens the severity of my disability.

Senator Sam Solon tried to help but I was too ill and my family too over whelmed to follow through with the referral he arranged with the DHS commissioner. The intent was to find some way to help pay for my out of pocket prescribed medical expenses which are approximately \$500 per month. It’s nearly the entire amount of my monthly SSDI check.

Having served for 8 years on the *[Redacted Text]* I am aware that it has been DHS policy to use the appeal process to clarify controversial policy. In my experience the adversarial process for resolving disability service issues does not work. It is an outdated, ineffective and costly conflict resolution process as it relates to disabilities. A modernized conflict resolution process must be capable of

addressing issues of discrimination and prejudice as well as determining the highest and best use of public funds.

As *[Redacted Text]* attorney says, “the denial of services does not make the person or the problem go away”. Services are denied but the individual’s disability issue remain. It resolves nothing. The state must devise an arbitration process that resolves medical disputes and brings solutions to pain and suffering.

The Minnesota Medical treatment model emphasizes evidence based medicine that further denies treatment for many disabilities which have no established treatment protocol.

Doctors tell me they fear losing their license if they try to do the right thing.

It is standard policy during a medical/hospital intake to ask if one is experiencing abuse. When I report I am regularly violated by licensed professionals and county administrative staff my report is ignored. I doubt if any record is made. There is never followup. Likewise a case manager (not from my county) reported that during a county meeting professional staff (mandatory reporters) criticized me by name in a hostile manner. It was shocking to the case manager (and to me) to experience this violation. I keep wondering how much more chronic hostility I can take.

By state law the mentally ill are promised a complete physical as part of the diagnostic process. This does not happen. When a causative diagnosis is found there is generally no funding for treatment (as has been the case previously for diabetics who were diagnosed as mentally ill). This leads to undo suffering. Thus the state funds treatments (perhaps for a life time) that don’t work.

For instance psychotropic medications repress mental health symptoms but do not treat the underlying condition.

In Minnesota there is a major increase in dialysis among the chronically mentally ill who have been taking psychiatric medication for decades. Dialysis is costing the State a quarter million per person per year. That’s roughly \$2,000 per treatment. This crisis was largely predictable and avoidable because of lifetime use of prescribed psychotropic meds.

Representative Tom Huntley has acknowledged to me that the extreme cost of dialysis for such a large disabled population is “a real problem”.

In my case I must leave Minnesota for another state to receive medical treatment. I go where the doctor patient relationship is protected by law and doctors do not fear losing their license as they care for the medically abandoned.

The only way Minnesota can have an effective and sustainable disability system is for what Medicaid refers to as Money Following the Person (MFP). The effectiveness of this has been demonstrated successfully at the Village Integrated Service Agency in Long Beach, CA which I have visited, the CARE programs in Florida, Pennsylvania and elsewhere. It is a significant part of the new Affordable Care Act.

It has been over a decade since legislators expressed interest to my suggestion that the state pilot an MFP type of model ... but as a founder and board president of the Minnesota Mental Health Consumer Survivor Network (C.S.N.) I was too disabled and without sufficient medically necessary supports to carry the plan forward.

The bottom line is that many of us lack access to disability appropriate medical care and support. Medical and social discrimination and disfunction is embedded in outdated state policy and procedures.

Thank you for your concern and desire to improve our Minnesota disability experience by bringing it out of the dark ages of the 19th century.

P.S. My health did not permit presenting an outline of this testimony at the Duluth session on August 13, 2013. I trust that the concerns I identify will result in meaningful solutions. Solutions that will make it possible for disabled individuals such as myself to participate. I look forward to the progress we can make as we learn to integrate public policy with biology.

Comment 75

From: Steve Larson [mailto:stevel@arcmn.org]
Sent: Sunday, August 18, 2013 11:42 AM
To: *DHS_OPC Public
Subject: Public Comments

Steve Larson
Public Policy Director
The Arc of Minnesota
800 Transfer Road
Saint Paul, MN 55114
Office - 651 523 0823 Ext. 115
Cell - 651 334 7970
stevel@arcmn.org

[full text of attachment]

Olmstead Testimony
by Steve Larson, Senior Policy Director
August 19, 2013

Today I want to discuss employment and housing for persons with disabilities.

First Employment - The Arc United States Employment Position Statement states: "For all people with intellectual and developmental disabilities, publicly funded employment programs should first explore employment alongside people without disabilities at comparable wages, with comparable benefits, before considering other options in the community." (The Arc United States Employment Position

Statement October 27, 2012). I think this clearly states that Minnesota should become an Employment first state. A key measurement in the Olmstead Plan needs to be the rate of employment for persons with disabilities.

The Arc Minnesota recently celebrated its 60th Anniversary and this has given us some time to reflect on how far we have come. Our history includes substantial efforts by The Arc Minnesota, its chapters, members and allies to address the needs of individuals with disabilities in large congregate settings. Minnesota was successful in closing down all of its regional centers for persons with intellectual and developmental disabilities in 2001. However we have found it necessary to be continually vigilant so that we avoid the creation of new congregate settings because our system is not meeting the needs of individuals with disabilities in the community. The METO lawsuit reinforces our need to be vigilant on this issue.

The Department of Justice has provided us with guidance on how to move forward with housing for persons with disabilities. They state:

The “most integrated setting” is defined as “setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible...”

Evidenced-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings include, but are not limited to (1) congregate settings populated exclusively or primarily with individuals with disabilities¹

Unfortunately thousands of Minnesotans with disabilities still live in large congregate programs. Together we now have an opportunity to rectify this situation.

In 2009 The Arc Minnesota with a grant from the Minnesotan Department of Human Services started its Housing Access Services program. Through June 30th 751 individuals with disabilities across the state have moved into places of their own with their name on the lease. Of these 751 individuals:

- 121 moved out of congregate care settings
- 138 were homeless
- 502 were diverted from having to move into a congregate care setting

All are eligible for medical assistance and as necessary receive their supports through home care or waived services.

Some keys to making this happen are the availability of transition dollars to help with deposits and furniture. The DHS grant provides these transition dollars. Minnesotans with disabilities are forced into poverty in order to access Medical Assistance so these transition dollars have been vital to the success of this program.

Housing Access Services has demonstrated that focused efforts with dedicated staff can achieve substantial results using a person centered process that meets the needs of individuals’ one person at a time.

Minnesota is poised to make a quantum leap in giving persons with disabilities control over their housing. A few of the tools in place are the Moving Home Minnesota federal grant, the availability of MSA Housing Assistance dollars, and moving more towards self direction in our waiver and home care programs through the initiatives in Reform 2020.

Our housing challenges include addressing the issues created by the moratorium on corporate adult foster care.

We believe MnCHOICES and other assessment tools will show that a percentage of individuals living in corporate foster care could benefit from a more integrated setting. When individuals are asked during their assessment “if they want to move to a more integrated community setting or make changes in their living situation” we need to have easily accessible person centered planning for them and a comprehensive system in place to help them achieve their dreams and goals.

Thank you for this opportunity to testify.

Comment 76

From: Sue Abderholden [mailto:sabderholden@namimn.org]
Sent: Sunday, August 18, 2013 12:54 PM
To: *DHS_OPC Public
Subject: Olmstead Comments

Attached are the comments from NAMI Minnesota.

Sue Abderholden, MPH
Executive Director
NAMI Minnesota
800 Transfer Road, Suite 31
St. Paul, MN 55114
651-645-2948 Ext. 105
612-202-3595 Cell Phone
1-888-NAMI-HELPS
www.namihelps.org

[full text of attached document]

August 14, 2013
To Olmstead Subcabinet:

On behalf of the National Alliance on Mental Illness of Minnesota (NAMI Minnesota) we are submitting these comments regarding Minnesota's draft Olmstead plan released June 13, 2013. NAMI Minnesota is a statewide grassroots organization dedicated to improving the lives of children and adults with mental illnesses and their families. Nearly 100% of our board and staff either live with a mental illness or have a family member with a mental illness.

This work will have far reaching implications for members of our community and we have a number of concerns with the draft plan. There has been very little engagement with mental health community throughout the Olmstead planning process and we are worried that people with mental illnesses will not be well served by the recommendations.

Many of the proposals in the draft plan seek a one-size-fits-all solution but people living with mental illnesses don't fit neatly into the definition of "disabled." Time and again we have seen services and supports designed from the perspective of serving people with developmental or physical disabilities fail to meet the needs of people living with mental illnesses, often with quite detrimental effects. Our community faces a unique set of challenges which require a distinct approach. We urge you to create a separate section of the Olmstead plan dedicated to people with mental illnesses that is based on input from the mental health community.

With the proper treatment and supports people with mental illness can recover. While some people will live with the symptoms of their mental illness for much of their lives, for many, the right treatment and support can reverse the disabling effects of their illness or prevent it from becoming disabling in the first place. This concept of "recovery" - that people can and do get better - needs to be an integral part of any recommendations related to people with mental illnesses.

The mental health community has been striving to move our system away from a "fail first" model where people must be overwhelmed by the symptoms of their illness and cycle in and out of the hospital, homelessness, the criminal justice system, etc. before receiving intensive services. Instead we are working towards a system that provides comprehensive treatment services earlier to prevent people from having their lives significantly disrupted. Unfortunately, this focus on "early intervention" is not reflected in the plan.

We are also concerned that the plan, in assessing both what services are currently available and what services are needed, overlooks many successful programs, including numerous evidenced-based practices, which are enabling people with mental illnesses to live healthy and successful lives in the community. In addition, the outcome metrics do not measure recovery, access to appropriate services or people's satisfaction with the services they receive.

The mental health community has been working diligently for years to build a robust continuum of mental health services and supports and to identify where gaps persist. As you continue this work, we urge you to look carefully at Minnesota's mental health system to see where we can build on promising and innovative strategies to achieve the goals of Olmstead. We know what works; it's time to make the investments necessary to meet the need.

Our more detailed comments are listed below:

Treatment, Services, and Supports

To ensure people living with mental illnesses can achieve success in the community, we need to ensure there is easy access to a broad array of treatment, supports, and services. Unfortunately, many of these services that have shown to be effective at helping people with mental illness manage their symptoms and achieve recovery are missing from the draft plan.

A great deal of our foundational mental health services are covered by Medical Assistance but we need to continue building the capacity of providers offering these services and to ensure that they are also

available to people who are still uninsured and underinsured as well as to people in every part of the state. These services include:

Adult Rehabilitative Mental Health Services (ARMHS): A fundamental service that seeks to reduce psychiatric impairment, restore functioning, improve community integration and increase self-sufficiency. Services can include independent living skills training, medication management, vocational rehabilitation, relapse prevention plans and management of medical conditions. The payment rate for these services is far too low and not all of the activities provided under this service are paid for. This has led many providers to reduce their service capacity or stop offering ARMHS altogether.

Assertive Community Treatment (ACT): A team of professionals who provide individualized and comprehensive treatment to people with serious mental illnesses. Services can include: supportive therapy, substance abuse treatment, symptom management, supported employment, family support, legal and advocacy services, time management and help with daily activities. ACT teams have been difficult to establish and sustain in rural areas.

Certified Peer Specialists: A service where people with mental illnesses provide non-clinical support as part of a treatment team. The draft plan suggests creating a peer-specialist program to support community engagement (p. 13) but makes no mention of Minnesota's current mental health certified peer specialist program. That program has been in place for seven years and has proven widely successful and the support these peers provide goes far beyond community engagement. Not enough mental health providers are employing certified peer specialists.

Community Support Programs: Assist people to live as comfortably, productively and independently as possible in the community. CSPs provide several related services, such as case management, housing assistance, meals and organized activities. More CSPs need to develop specialized programs targeted at young adults.

Crisis Response Services: Crisis services seek to intervene immediately, provide brief and intensive treatment, involve families in treatment, link people and families with other community support services and avert unnecessary hospital stays. Examples include crisis assessments, mobile crisis outreach teams, crisis intervention counseling and crisis stabilization. While mobile crisis teams received additional funding at the legislature during the 2013 session, we still do not have statewide coverage.

In addition to what we already have, we urge you to include the recommendation from the Olmstead Planning Commission to "develop comprehensive, early identification and intensive intervention services for children and adults who have a first episode of serious mental illness." We would recommend going further by developing a new state plan service under 1915(i) to meet the needs of people first experiencing the symptoms of a serious mental illness. We also support moving eligibility criteria for services away from specific diagnoses and categories such as Serious Persistent Mental Illness (SPMI) and move towards criteria that look at how the symptoms of a person's illness are impacting their ability to be successful in the community at that moment in time.

Employment

We strongly support the recommendation to increase the capacity of supported employment programs utilizing the evidenced-based practice Individual Placement and Support (IPS). IPS helps people find and maintain competitive employment in the general workforce, which is very different from integrated or shelter-based employment programs which are not appropriate for people with mental illnesses.

However, the plan completely overlooks the Extended Employment Program for People with Serious Mental Illnesses (EE-SMI), which funds the six IPS providers currently operating in Minnesota. Training and technical assistance (as currently recommended – see p. 13) will not be sufficient to expand the number of providers offering IPS supported employment or grow the capacity of current providers. Developing a true IPS program requires funding and infrastructure. We also need to ensure that programs are reviewed periodically to ensure they are meeting fidelity standards and are offering this service in the way the evidence shows is most effective. The Olmstead Planning Commission recommended developing a Medicaid employment service under 1915(i), which could include IPS programs, which is an approach worth considering.

Housing

We support the strategy to organize funding and services around the three main goals (p. 10) of: (1) helping people obtain housing; (2) helping people stay in their housing; and (3) helping people maintain housing during a crisis. However, here again, the activities to accomplish these goals should build on what is already working.

For goal number 1, there needs to be a specific recommendation to increase the capacity of the Bridges program. Bridges provides rental assistance to people living with mental illnesses who are awaiting a Federal Section 8 voucher or other housing assistance. This program directly supports the principles of Olmstead by focusing on people who are not living in the most integrated settings possible, including people experiencing homelessness, people residing in a Regional Treatment Center (RTC), people residing in community-based residential treatment facilities and persons living in substandard or rent burdened units.

Under goal number 2, we need to continue to increase our capacity of supportive housing for people living with mental illnesses. Grants for Supportive Housing services through DHS to pay for the wrap-around services that aren't offered through other services such as ARMHS – tenancy support, independent living skills, etc. – were part of 2007 Mental Health Initiative. These services were supposed to be sustained over time but funding has been scaled back in recent years due to budget cuts. In 2012, these grants funded about 39 programs and served 770 people, a small fraction of the need. Recommendations in support of this goal should also include services such as ACT teams that can come out to where someone lives.

We have concerns about the recommendation to separate housing from services. The need to ensure that one organization does not have 24 hour control over a person's life is far more relevant in the developmental disability community than to the mental health community. People need choices about where they want to live and for some people who live with a mental illness having services available in their apartment building can make all the difference. For people with mental illnesses, the focus should be on eliminating or minimizing rules or restrictions that would limit a person's rights and freedoms (e.g. curfews, timing of meals, etc.) more so than concentration of housing units or the connection between housing and services.

What we don't want is for people with mental illnesses to be stuck in corporate foster care, assisted living, board and lodges or other facilities that are not designed to meet their needs and where staff know very little, if anything, about mental illnesses. It would be far better for someone to have their own apartment in a building where support is available than to be placed in a four bedroom adult foster care home with people who have vastly different needs, where the opportunity for community

engagement is extremely limited, and where the level of control over the person's life does not reflect their needs or abilities. If a person with a mental illness is placed in an adult foster care setting we would like to see a requirement that the home either be operated by a mental health agency or have the mental health certification, and that it exclusively serve people with mental illnesses.

On goal number 3, we need to expand the Crisis Housing Fund. This is a state funded program available to adults with a serious mental illness who are in an in-patient setting for up to 90 days. It allows people to maintain their housing while receiving treatment so they can return to their community as soon as they are well again.

State Operated Services

Making recommendations related to the Minnesota Security Hospital (MSH) in St. Peter and the Anoka Metro Regional Treatment Center (AMRTC) is inherently difficult as the people being served at these facilities have been civilly committed for treatment by a court. There are indeed problems with the flow of people in and out of these settings that need attention but the recommendations as they stand do not address the major issues.

The recommendation to decrease the number of days between when an individual in an institutional setting requests their preferred services and when they receive those services (p. 8) does not make sense in the context of the Anoka Metro Regional Treatment Center or Minnesota Security Hospital. Again, people are in these settings because they have been civilly committed for treatment to help them recover from a psychiatric emergency. What we need is to make sure that people are receiving ample and appropriate treatment so that they can return to their community as soon as possible. The goal should be to decrease the number of psychiatric hospitalizations or reduce the number of bed days in these settings. Comprehensive discharge planning is crucial to ensure that people can stay healthy when they transition to less restrictive settings.

We have also heard numerous stories of people being stuck at hospitals around the state waiting for a bed to become available at AMRTC. We need to ensure that people who need the most intensive level of care have access to it in addition to making sure there are appropriate places for people to go when they no longer need such services. We need a continuum of community based care that can help people transition out of AMTRC and MSH as quickly and smoothly as possible – including a sufficient capacity of appropriate housing settings.

Criminal Justice

We agree with many of the recommendations in this area of the plan and appreciate that the Department of Correction's section is attentive to issues and needs specific to people with mental illnesses. We agree that there is an acute shortage of community-based programs that can meet the needs of people with criminal justice involvement contributes heavily to the criminalization of mental illnesses (see the "program match" section, p.39, and the related recommendations on p.42). Perhaps a specific funding stream is needed to help community mental health centers develop expertise in this area. These services should be integrated with our current community mental health system, not separate from regular mental health services or overly reliant on adult foster care and/or board and lodge. The recommendations to develop Forensic Assertive Community Treatment (FACT) services would be another way to support the development of this capacity.

Addressing the lack of adequate funding for appropriate housing is another area that needs attention. This shortage is a huge problem that contributes to people staying in prison longer simply because of their mental illness, as suggested in the discussion about the CADI waiver shortage on p.41.

We also have a few issues with this section of the plan:

- The list of key partners on p.45 is missing mental health advocates.
- The corrections plan addresses people with serious and persistent mental illnesses (SPMI) but mostly overlooks people with serious mental health needs who do not meet this standard.
- The plan should not rely exclusively on the counties for referrals and connections to mental health treatment and services (see top of p.41 -- that recommendation only mentions counties, not other available options.)
- There needs to be increased capacity to effectively treat co-occurring substance use and mental health disorders. Despite the widespread need, these treatment services are primarily located at only two facilities. Red Wing is among the facilities that lack adequate dual diagnosis treatment.
- The employment aspects of the corrections plan should incorporate Individual Placement and Supports (IPS), the evidence-based supportive employment model for people who live with serious mental illnesses.

Conclusion

This concludes our comments. If you have questions or would like more information, please contact us.

Sue Abderholden, MPH

Executive Director

Matt Burdick

Grassroots Advocacy Coordinator

Comment 77

From: Roberta Cich [mailto:roberta@accessnorth.net]

Sent: Sunday, August 18, 2013 12:59 PM

To: *DHS OPC Public

Subject: Comments on draft Olmstead Plan

August 19, 2013

Dear Olmstead Sub-Cabinet Members,

I would first like to thank the Sub-Cabinet for holding the listening sessions throughout the State and for the valuable work you are doing in developing an Olmstead Plan for Minnesota. I was present and spoke at the listening session in Duluth. I am writing this letter to offer some comments and suggestions to the Sub-Cabinet related to the draft Olmstead Plan.

I am the Executive Director of The Center for Independent Living of Northeastern Minnesota (CILNM). We provide a variety of Independent Living Services to people with disabilities living in Northeastern Minnesota. Last year, we provided direct services to over 1500 people with disabilities. We provided Information and referral services, technical support and education to many more. All of our services are community based, consumer controlled and self directed. Our mission is to assist people with disabilities to live independently and to have the same opportunities and choices as all people.

As you can see, our mission (along with that of all Centers for Independent Living in Minnesota) mirrors the intent of the Olmstead Decision. Our operational philosophy can be seen throughout the draft Plan. The services provided by CILNM are consistent many of those in the proposed goals in the draft Olmstead Plan.

- CILNM has provided nursing home relocation services for over 25 years. Last year alone, Centers for Independent Living statewide helped 241 people relocate from nursing homes.
- All Minnesota Centers for Independent Living are part of collaboration with Vocational Rehabilitation Services. This collaboration has been very successful with a 77.9% success rate in the metro area and a 66% success rate in greater Minnesota. This is significantly higher than the success rate when only VR services are provided.
- CILNM provides ramps, home modifications and assistive technology that assist a person with a disability to remain living as independently as possible in their own home.

Centers for Independent Living, along with many other community organizations, have been providing many of the services outlines in the draft plan. We have been doing so with very limited resources. I would like to encourage the sub-cabinet to review, support and strengthen the existing resources instead of developing new programs, services and organizations. I would also like to encourage the Sub-Cabinet to seek input and guidance from those of us who have been successfully doing this work for many years. Independent Living philosophy, consumer control, self-direction and choice are at the core of our organization and always have been. Over 50% of our staff and our Boards of Directors are people with disabilities.

I would like to request that the Sub-Cabinet use the Olmstead Plan to pursue an end to the Institutional Bias that makes it so much easier for an individual with a disability to go to a nursing home (or other institutional or restrictive setting) than to remain in their own home. It has been proven that home and community based services are much more cost effective.

I applaud the efforts of the Olmstead Sub-Cabinet and all the work that has been done so far. We have always looked at the Olmstead Decision as a deinstitutionalization decision. It is a reaffirmation of the ADA's integration (and inclusion) mandate. I again would like to thank you for coming to Duluth and I appreciate the opportunity to provide input.

Sincerely,
Roberta Cich
Executive Director
Access North: Center for Independent Living of Northeastern Minnesota
Duluth Office
118 East Superior Street
Duluth, MN 55802
218-625-1400
Hibbing Office
1309 East 40th Street
Hibbing, MN 55746
218-262-6675

Comment 78

From: *[Redacted text]*
Sent: Sunday, August 18, 2013 2:51 PM
To: *DHS_OPC Public
Subject: *[Redacted text]*

I Am Someone Who Has To Live In A Group Home, Against My Own Decision. I Am Upset ALSO, With The Way That The "SYSTEM" Works, When It Comes To Dealing With Human Rights, Privileges, Allowances, AND Freedoms, (LIKE MINE). I'll Back-Up Anyone's Decision, When It Comes To Not Making Decisions For People WHO:

- 1.) Do Have The Ability For A Successful Future.
- 2.) Do Have The Ability To Make Their Own Secure, Smart, & Practical Decisions.
- 3.) Do Know Right From Wrong.
- 4.) Do Want To Have Their Own Family & Specially Loved One, By Their Own Side.
- 5.) Do Want To Pursue Things Like Colleges & REAL Public Job Opportunities.
- 6.) Do Want To Pursue Things Like Musical Careers (Yes, With Rockstar Mentality).
- 7.) Do Want To Pursue Things Like Already Owned:
 - A.) Inventions
 - B.) T.V. Commercial Idea's
 - C.) T-Shirt Saying's
- 8.) AND Who Want To Do Nothing BUT SUCCEED

With No Ability To See Failure As A Deterrent, EVER!

Just To Let You Know,
These "8 THINGS"
ARE ME!!!!!!!!!!

I Live AT: *[Redacted text]*
FEEL FREE TO CONTACT ME WHENEVER!!!

Comment 79

-----Original Message-----
From: *DHS_Webmaster, DHS
Sent: Sunday, August 18, 2013 3:07 PM
Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/18/2013 AT 3:07:02 PM

NAME: *[Redacted text]*
EMAIL: *[Redacted text]*
DESCRIBE YOURSELF: I am a family member of someone with a disability
COUNTY: Anoka
COMMENTS:
Dear Olmstead Subcabinet:

The purpose of this message is to accept your offer to provide feedback on Minnesota's Draft Olmstead Plan.

Our son [Redacted text] is a [Redacted text] year old profoundly handicapped man. [Redacted text] is mentally retarded, has autistic-like symptoms, and has an uncontrollable seizure disorder (epileptic). For the past 15 years, [Redacted text] has received services during the day from [Redacted text]. He is thriving in this environment, and we are very pleased with the services.

We have read Minnesota's Draft Olmstead Plan and are aware of ideas expressed during the planning phase and from testimony held specifically around the Employment domain. We feel very compelled to express our grave concern around the notion that all people with disabilities can and should be employed in community settings ONLY.

We are concerned that eliminating services such as in-house production and non-work related programs, such as those offered by [Redacted text], will not serve all participants well. We are further concerned that elimination of these options would result in those unable to work in the community, such as our son [Redacted text], to remain at home - which then becomes the most restrictive environment for him, with no interaction with his peers.

Community employment and integration is important for people with disabilities, however, options and choice need to be provided. Please do not eliminate options for people, like our son [Redacted text], that are not able to work in the community and still require habilitative services during the day.

Respectfully submitted, [Redacted text]

Comment 80

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Monday, August 19, 2013 7:06 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/19/2013 AT 7:06:15 AM

NAME: [Redacted text]

EMAIL: [Redacted text]

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Rice

COMMENTS:

My sister is an adult with disabilities who receive services from [Redacted text]. I cannot begin to explain to you how important the services she receives are. without [Redacted text], [Redacted text] would not be as successful at her job as she is. the support she receives is crucial in her success. [Redacted text] works at a grocery store in [Redacted text] and if the grocery store were to have to pay [Redacted text] minimum wage [Redacted text] would not have her job she loves her job however she needs to support

that [Redacted text] provides if businesses were forced to pay a minimum wage people like Sarah would not be working.

Comment 81

From: [Redacted text]

Sent: Monday, August 19, 2013 7:25 AM

To: *DHS OPC Public

Subject: Olmstead Plan comments

I have a suggestion for the Olmstead Plan: you need to include the Department of Labor and Industry as an agency involved in the plan.

My husband, [Redacted text], was a [Redacted text]. He was injured by a blast in [Redacted text], and has a brain injury. I have been taking care of him for 8 1/2 years.

Because blast injuries were not well understood in the medical community in [Redacted text], we had extreme difficulty in getting appropriate medical care for [Redacted text]. He was not able to understand the extent of his injuries, and advocate properly for himself, but the system is not required to be understandable to him.

we had to wait more than a year to get brain injury treatment at the [Redacted text], because the city misunderstood the lack of medical understanding of brain injuries, and thought that [Redacted text] was malingering. We had to go to court to change doctors, because the city believed we were only seeking medical care as a legal strategy. This would have been an unbearably stressful fight even for someone who understands, but to play these kind of games with someone who has a brain injury is just cruel.

Later, [Redacted text] left him on the sidewalk, unattended, after he became very ill during a test. They had told me I didn't need to attend, but didn't make sure his ride was there before leaving him (he was not scheduled to return home for another hour.) He ended up laying on the sidewalk, surrounded by cigarette butts and who knows what. He recovered enough to call me on his cell phone, and I went to [Redacted text] and brought him home, but when I expressed my concern over the incident, the doctor said it was perfectly normal. I also told several city of [Redacted text] officials, but they didn't care enough to follow up, either.

A few months later, [Redacted text] attempted suicide. I found him collapsed in the yard, after he took an entire day's meds at once. He threatened to shoot himself if I called for help, so I had to sit with him and see if he went unconscious, so I could get help. He didn't, and I arranged an appointment with a psychologist at [Redacted text] and persuaded him that it was a routine appointment - I planned to ask the psychologist to intervene at the appointment and deal with the suicide attempt. The psychologist refused to allow me into the appointment, so I wasn't able to get help for [Redacted text]. I finally got him to [Redacted text], and they helped us. Again, I tried to talk to [Redacted text] officials about the lack of proper care for [Redacted text], and nobody cared - even during an administrative hearing with DOLI in [Redacted text].

We have a work comp attorney, but apparently everything they have done is legal. The city tried to keep [Redacted text] from changing doctors again - we were trying to get by with just our family physician, for several years, because it was too hard to fight for proper care. In early [Redacted text], we asked for approval to see a neurologist and a psychiatrist, and the city said no. It took until November before they finally approved the care - by then we had just gone to the doctor and paid for it ourselves, because we couldn't wait.

The city has refused to allow any respite care at all for [Redacted text], because they say I wasn't "ordered" to take care of him. At each new doctor, they would ask, "Who takes care of [Redacted text]?" and I would tell them I did. None of the doctors apparently felt that there was a need for an order - or that it was their job to do so. The city took away our QRC in [Redacted text], and we have not been allowed to have a case manager coordinate [Redacted text] care - it has all fallen on me, as [Redacted text] doesn't understand.

Finally, in [Redacted text], [Redacted text] neurologist officially requested that the city provide respite care. The city approved getting an evaluation at [Redacted text] in [Redacted text], and the evaluation came back that [Redacted text] needs 24 hour supervision, not to be left alone for more than 2 hours. The city refused to authorize any care, and we went to an administrative hearing in [Redacted text]. The judge found that the city must provide care, but didn't determine the number of hours. We have another hearing in October to determine the number of hours of care, because the city still believes that they should not have to pay for any care at all. There is a second hearing over payment of psychologist bills. [Redacted text] was suicidal 5 times in the space of a year, but the city won't pay his counselling bills, and won't tell us why they won't pay. They also have refused to pay for a neurologist visit in [Redacted text], and again, won't say why.

[Redacted text] injury was the result of an error in the computer program that was supposed to figure out whether the area near the blast would be safe or not. We tried to talk to the city about safety, but no one is allowed to talk to us about it. I asked for a copy of the city's safety investigation, but neither the city attorney, nor the police chief have any knowledge of any report or investigation. I asked OSHA to do an investigation, but they said that only [Redacted text] could request one - and since [Redacted text] had to retire due to his injury, he could not request a safety investigation.

If something were to happen to me, [Redacted text] would have to live in a group home, because he can't manage a household by himself. He doesn't want that, and would probably kill himself to avoid it - yet we have to fight literally for years, to get any help at all. The intentions of the Olmstead Plan are great - but why doesn't it apply to people who were injured in their jobs?

Thank you for your time.

[Redacted text]

Comment 82

From: [Redacted text]

Sent: Monday, August 19, 2013 7:36 AM

To: *DHS OPC Public; Plante, Judy (MMB)

Cc: sen.bruce.anderson@senate.mn

Subject: The Olmstead Plan - Commentary

Date: August 19, 2013

To: The Olmstead Plan Sub-cabinet

From: [Redacted text]

Re: Commentary on the Olmstead Plan Draft - Minnesota

Dear Members,

I have been carefully following the progress of the Olmstead compliance issues in Minnesota since 1999 and most certainly since Jensen v Settlement in 2011 and the current activity on the creation of the Minnesota Olmstead Plan. I have reviewed the Plan draft and the minutes of the sub-cabinet meetings and the first listening session as published. Along the way, over nearly a 40 year period, I have done my fair share of advocacy, receiving from the President's Commission on Developmental Disabilities the national JFK Jr. Award for cutting edge advocacy. I have engaged in the process of DHS appeals and conciliation meetings. I have continually bent the ears of elected officials locally and at the federal and state level, with the longest history and level of understanding being with Senator Bruce Anderson (formerly Representative Bruce Anderson), hence I am copying him on this e-mail.

I come to you now, with my comments, based upon that history and my professional study and experiences as an educator in the fields of Special Education, Developmental Disabilities, Parent Education, Family Life Education, and Corrections; based upon my experiences as a service provider of In-Home Family Therapy, of Licensed residential and care giving services to families and to people who have developmental disabilities; based upon my experiences as a court appointed guardian, and based upon my continued studies of the Olmstead Act and Civil Rights.

I am pleased to see the inter-agency activity created by Executive Order of Governor Dayton to develop this plan <http://mn.gov/governor/images/EO-13-01.pdf> . Additionally I am encouraged to see that the news media has helped to bring to the forefront those civil and human rights due to people who have disabilities and that have often been slighted; news media that will continue to cover this issue. Those two factors, along with the Executive Order and closer Federal oversight of the Courts help to build confidence in the potential success of the Plan.

My greatest concern is that this present effort, as has happened with other movements in the past, will be swept aside, and or prolonged to such an extent, that the necessary significant changes fall by the wayside.

That having been said, the draft proposal of the Minnesota Olmstead Plan misses the "Elephant in the Room"; The Plan needs to include, from the first day of implementation:

- a process of transparent meaningful oversight of the implementation of the Plan, with accountability to the consumer,
- a clear measurable demonstration of implementation of the philosophy behind the Plan by all government agents/agencies involved and by all providers accepting tax payer dollars for their services,

- a simplified and most direct means for the consumer to impact the administration, implementation and direct outcomes of the Plan without having to enter what has well been known as a circular bureaucratic run-around within the "system."
- a plan for training and enlightenment that includes county Human Services Boards, county Human Services Advisory Committees, county Commissioners, government employees, and legislators, as well as consumers and their advocates.

The Minnesota Olmstead Plan:

1. **Accountability to the consumer, "to the people we serve"** is expressly written into the DHS Mission Statement. It serves as the very foundation of the Olmstead Act in support of the civil rights of those who have disabilities. Ombudsman Roberta Opheim covers it well, including all nuances, in her video recording available at this link: <http://www.youtube.com/watch?v=VRAjAEuUJEE>

In the notes from the July 9, 2013 listening session,
http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_177874.pdf

[Redacted text], PCA expresses the sentiment when he urges the subcabinet to look at "the experiences on the ground".

[Redacted text] asks the subcabinet to be bold and to take this opportunity to create a legacy.

[Redacted text] comments that the system must be turned upside down and that true integration means being able to make decisions, to get information without jumping through hoops.

[Redacted text] gave an example of how services can change with input from the individuals.

Currently there is no ready and effective means for the consumer, or the consumer's representative, to evaluate the government agents/agencies that they work with. There is no provision for it in the Plan. In other words, there is no effective measure for the consumer to evaluate the county case manager who holds so many of the "strings" to services, even under this Plan, and/or to evaluate the case manager's supervisor and local human services agency. There is no effective measure to hold those case managers and that local agency accountable.

Now, the naysayers may argue that consumer safeguards do exist, (see attachment to this e-mail as provided to me by Alex Bartolic, DHS DD Division) however, those safeguards have proven to be less that effective and meaningful to the consumer and are weighted heavily in favor of the agency. a) Statutes exist that grant deference to the administrative agency in any given appeal situation. b) the agency, whether at the state or county level, benefits from the full legal representation of the County Attorney's office and/or the Attorney General's Office while the consumer is left to fend for themselves, often with minimal financial, emotional, and knowledge-based resources. c) deadlines and timelines appear to be only for the consumer while there is no adverse action toward the human services agents or agencies if they fail to adhere to a deadline or statute; in fact, if they fail to adhere, the consumer may certainly appeal, and that circles the situation right back through the fingers of the agency whose actions are initially being appealed. d) the listed Surveillance and Integrity Review Section, Office of Health Facility Complaints, Public assistance fraud hotlines, and Vulnerable Adult Reporting do not necessarily address the issues a consumer has with the Human Services agency administration of

support programs, and e) the Ombudsman's Office and the Disability Law Center have their own limitations based upon the high case loads and statutory authority.

In a February 19, 2013 e-mail exchange with Alex Bartolic of the DHS DD Division, I was provided with a one page document of standard Consumer Safeguards previously mentioned as an attachment. and the following, "Aside from the consumer protections, providers have certain rights as outlined in their contracts with counties, or as a DHS enrolled and/or licensed providers. County Commissioners often are resources for their constituents with concerns about county services or staff." Ms. Bartolic continues to offer, regarding the County Commissioners, (We) "have been working with representatives of the Association of Minnesota Counties which is comprised of county Commissioners. They are helping to shape what we do, and are providing information to them on our services and their role as counties."

With all due respect, the county commissioners, who serve as the head of the local human services agency, under Chapters 393 and 402.02, and who directly appoint and supervise case managers for services provided to persons who have disabilities under Chapter 245B.02, subd 3, and who are to provide direct oversight of the administration of services under Chapter 256B.092 as part of their duties as elected officials, generally minimize those those duties to that of rubber stamping the work of the agents. When approached by a constituent who has concerns, or observations, a common scenario is that the Commissioner may check with the county agent or supervisor who then assures the commissioner that they are merely doing what the state DHS tells them to do and/or that they cannot discuss the matter due to confidentiality, regardless of whether the consumer has granted releases to the commissioner. In some cases, the agent or supervisor may attempt to paint the consumer as "just trouble" or a "complainer." Beyond that, some county commissioners are known to admit that they know a lot about their roads, ditches, and zoning departments, however, when it comes to the Human Services agency, "it is just so big we have to just believe that the agency knows what they are doing." Interestingly, I have met with that same scenario and philosophy when I approach elected officials at the state level.

Minnesota Chapter 402.03 establishes local Human Services Advisory Committees

<https://www.revisor.mn.gov/statutes/?id=402.03>

The Advisory Committee membership can not include Human Services employees, and one-third of the membership shall be representatives of those persons receiving services. "The Advisory Committee shall appoint permanent task forces to assist in planning for corrections, social, mental health and public health services and each task force shall be chaired by a member of the Advisory Committee." By nature, an Advisory Committee membership brings to the elected officials the viewpoints of how services are affecting people at the ground level; being the eyes and ears for the Human Services Board out in the community. One would think that this Advisory Committee, statutorily mandated, would also provide some accountability to the consumer, however, the reality is that not all counties have Advisory Committees that operate as statutorily mandated. The agenda is prepared by county employees. The meetings are chaired by county employees. Task Forces, if they exist, are chaired by persons who have vested professional interests in that service area. And, not too surprisingly, I am advised by one new

member to a county advisory committee that the expectation from the agency is that Advisory Committee members community role is that of edifying the Human Services Agency.

2. Oversight - In 2004 the Office of the Legislative Auditor conducted an evaluation on the administration of the Federal Medicaid Home and Community Based Waiver in Minnesota. <http://www.auditor.leg.state.mn.us/ped/pedrep/0403all.pdf> The Auditor's office came up with many of the same concerns that attempted to be addressed by the draft Olmstead Plan. The Auditor recognized that the voice of the consumer was not really recognized, in fact, the Auditor noted that a fault in their own audit was a failure to solicit the views of the consumer. Still, the Auditor made recommendations that included the need for more close oversight by the legislature and also how the state level of DHS was to provide specific oversight of the county agencies. The Auditor was assured by DHS Commissioner Goodno that the agency would get right on with those plans. A year later, in a one page update to the Auditor's office, Commissioner Goodno explained that the Department had started to implement those recommendations, found them to be "too time consuming", and so the Department stopped. And here we are, going on a decade later, rehashing some of the same issues, and with no clear meaningful oversight for the meaningful implementation of the Plan.

Further, those who live with disabilities, readily recognize that some county case managers and supervisors seem to subscribe to a philosophy of control, intimidation and retaliation; not all county case managers and supervisors, but enough of them to create major havoc in the lives of people who have disabilities. Ombudsman Roberta Opheim recognized this phenomena in her written submission to the William Mitchell Law Review in 2005

<http://www.wmitchell.edu/lawreview/Volume32/Issue1/9Opheim.pdf> . Ombudsman Opheim is addressing a phenomena within the Child Protective system when government agents do not follow the law and or/when agents openly practice vendettas on those who oppose them. This is no different from those experienced by those who support people who have disabilities. This would include self-advocates, advocates, guardians, and often providers of services who have experienced retaliation or intimidation from the county agent or supervisor when the agency is opposed. Providers, who themselves should be advocating for the rights and well-being of consumers, are far too often in the position of tempering their advocacy under the realization that the county agency/supervisors have an inherent control over their livelihood through referrals and contracts.

Ombudsman Opheim, in her writing for the William Mitchell Law Review, is clear to state that:

When Government Does Not Follow The Law

In Minnesota, state agencies like the Department of Human Services believe that their role is to work collaboratively with the counties who are responsible for delivering services. While in theory this service system should work well, in practice it fails in many ways. What happens when a county chooses to ignore the law or refuses to take the time to adequately train its employees? History has shown that counties are not held accountable when they fail to follow the law. There are few, if any, administrative, legal, or financial sanctions which can be applied by the state against the counties

She adds:

The Ombudsman's Office acknowledges that there are many conscientious workers at all levels of the social service system working hard every day to improve the lives of children. The stories of families and the cases reviewed by the Office, however, reveal that the destructive practices and harmful decisions made by counties contained within this essay are not simply isolated cases.

And she ends with the following:

Children with mental and behavior disorders are growing and changing every day. These children suffer daily and can not wait for the system to slowly evolve. In the end, the emphasis should be on meeting the needs of children, rather than the county, the workers, the service providers, the judges, the attorneys, the therapists, or anyone else who is entrusted to serve children.

Alex Bartolic, of DHS, in her February 19, 2013 e-mail exchange with me offers, "We haven't found a specific statutory protection against retaliation or vindictive behavior by a county." and directs me to travel back through the labyrinth of the listed consumer protections that have proven less than effective against the well established bureaucracy.

Senator Bruce Anderson did attempt, as a Representative, to address some of this through the introduction Bill, House Bill HF 2180 His efforts were mirrored by Senator Amy Koch and Senator Steve Dille with SF 1888. An attachment is included with this e-mail. I am not certain on the present status of the Bill. I do know that we met with the woman who was the legislative head of the Health and Human Services Committee at the time and, while she nearly finished our sentences herself as to what our concerns were, indicating that she knew them all well, offered what had become the standard excuse of "It is just such a bit department and this is just how it is."

3. Implementation of the Philosophy: Anything that I would write here would be reflective of the writing that I have already offered. The philosophy of what is supposed to be happening for people who have disabilities has been spelled out in the ADA, the State Application for 1914 HCBS Waiver (offered as an attachment) , The Olmstead Act, and now the order to establish the Olmstead Plan. That the philosophy has eluded many who are in positions of administrative authority, some who may actively turn a blind eye to the philosophy, is disturbing to me and has proven harmful to so very many. In the listening session held on 7/9/13, Joan Willshire of the Minnesota State Council on Disabilities offered that "The Options Too report in 2006 covered many of these same concernsunfortunately many of these same issues are discussed in the plan today. There should be ongoing monitoring of the plan so that it is implemented and so we're not looking at these same issues again years later."

Dan Stewart of the Disability Law Center adds that "Yearly goals in the plan are not high enough." There are those who might counter that you can't "turn a ship on a dime", yet Chris Bell of DHS, in the same listening session, states it should be "turned upside down". "Turning upside down" can happen quite quickly, most especially in a multi-disciplinary action when all are committed to share the same philosophy...and when those who choose not to go with that philosophy are somehow eliminated. Documented history assures us that it is very likely this present effort will also go by the wayside if it is not transparent, is not given effective oversight, and does not include the consumer as the real focus and who has meaningful choice and authority.

4. Direct means for consumer to impact: The consumer and/or their guardian, under Chapter 256B.092 subdivision 7, <https://www.revisor.mn.gov/statutes/?id=256B.092> (among other statutes, laws, and the State Application for the Waiver) are to have significant authority to direct the services. As mentioned before, when that authority is usurped by the government agency, there exist little effective and efficient means to remedy that situation. Further, while the county agency/agents are in the position of conducting assessments on the consumer, there is not an existing meaningful source for the consumer to provide assessment on the actions of the agent. I don't know what more I can say about that other than the draft Olmstead Plan does not address it either.

5. A plan for training: As mentioned by several in the 7/9/13 listening session, the consumer and their advocates may well be so ingrained in the "what good will it do anyway" philosophy, that they will need training on the notion that true choice in matters such as "living independently is the new norm." I am personally aware of consumers and their guardians who are scared to take a stand for meaningful choice as they have seen what has happened to people who have stood to advocate or they have been targeted themselves for having done so. They are scared when they know the agents can literally hold their loved one's life and well-being in the balance.

And county agents need the training and need to know that the consumer has had the training. The consumer and the county agents need to know that their county commissioners who are supposed to be providing oversight have the training.....and that the Human Services Advisory Committees are active and have the training.....and that their elected officials on the state level have the training.

The training need not, and should not, come from Human Services. The efforts should be coordinated. The trainers could come from sources such as the Ombudsman's Office, from the Council on Disabilities, and/or from the state Management Analysis and Development agency that has provided facilitator Judy Plante to the development of this Plan. The training needs to be ongoing, comprehensive.

Thank you for the opportunity to provide this commentary. I look forward to monitoring the developing plan. Should you desire further information from me, do not hesitate to contact me through the information that I provided at the onset.

Respectfully,
Sue Mattson

[included 4 DHS and legislative docs as attachments]

Comment 83

From: Trish Stark [*Redacted text*]

Sent: Monday, August 19, 2013 8:59 AM

To: *DHS OPC Public

Subject: Public Comments

Olmstead Committee:

Please accept these comments concerning the Olmstead proposal.

Trisha Stark, Ph.D., LP, MPA
Legislative Chair
Minnesota Psychological Association
[Redacted text]

[Full text of attachment]

To: Olmstead Planning Committee
From: Minnesota Psychological Association

Re: Comments on Olmstead Recommendations

August 19, 2013

Dear Committee Members:

The members of the Minnesota Psychological Association are most appreciative of your efforts to develop a plan to allow individuals with disabilities to be equal participants in their community. The plan has many positive features, but seems to neglect an important distinction concerning types of disabilities and their related needs. From a mental health perspective, goals and plans need to reflect a recovery oriented philosophy, and practices, such that the goal is not simply to achieve some integration, but to continually work with individuals to maximize their independence. This concern is most evident in the area of housing. While individuals with some disabilities may have the goal of achieving a particular long term housing solution, an individual with mental illness, through the recovery process, would have goals to move to increasingly independent settings. For individuals with mental illness, symptoms may wax and wane, with the goal of recovery. Housing, employment, transportation, and employment for individuals with mental illness must contain the active provision of services to extend and enhance recovery in all aspects of an individual's functioning.

Because of this difference in populations, we would strongly recommend that a separate section of the Olmstead Plan specify the unique needs of individuals with mental illness including the mechanisms necessary to promote recovery and progression, rather than to achieve static outcomes.

Thank you for consideration of this input, and we would be happy to provide additional information or support to strengthen the Olmstead Plan to reflect the best interests of individuals with mental illness. Feel free to contact us at *[Redacted text]*.

Best regards,
Trisha A. Stark, Ph.D., LP, MPA
Legislative Chair
Minnesota Psychological Association

Comment 84

From: *[Redacted text]*
Sent: Monday, August 19, 2013 10:16 AM
To: *DHS_OPC Public
Subject: Olmstead Plan

Attached is a letter in response to the Olmstead Plan Draft.

[Redacted text]

[Full text of attachment]

August 19th 2013

I am a concerned employee, sister, friend and citizen after reading the Overview of Minnesota's Draft Olmstead Plan. As a program coordinator for a Day Training and Habilitation (*[Redacted text]*), I am concerned about the individuals who currently receive employment as well as life enrichment services through *[Redacted text]*. Services offered to individuals with disabilities through *[Redacted text]* would greatly be impacted by the proposed changes in this plan in a negative way. As a sister, I am worried that my brother will no longer have meaningful employment if this plan, as written, moves forward without changes. My brother works as part of a 3 person work crew with a job coach at an apartment complex in *[Redacted text]*. My brother requires intensive support from a job coach and earns subminimum wage. Does earning sub minimum wage mean that my brother is less valuable than someone earning minimum wage, does it mean that he is a pariah, does it mean that he is shunned by society or less of a person. Absolutely not. My brother loves his job, takes pride in his work, looks forward to going to work each day, and would be devastated if that was taken away from him or if he no longer worked with the people he does. The other workers on his work crew, his job coach, the residence of the apartment complex, and the employees at the complex are all a part of his integrated community of employment.

Every person, those with and without disabilities are individual. Their lives, dreams and wishes should also be individualized. Saying that every individual with a disability should be in a community based service rather than a facility based service, earning minimum wage or more and employed in an integrated setting; is like saying that everyone individual without a disability should attend a 4 year college after high school and graduate, make at least \$100,000 a year and work for a fortune 500 company. These expectations are unrealistic and so is saying that every individual with a disability should fit this one mold. Do changes need to be made in services to individuals with disabilities, yes. However, the key word to any plan is Individual. Every person is different and should be treated as an individual.

Thank you for your time and consideration in making the Olmstead Plan individualized.

[Redacted text]

Comment 85

From: Rebecca Melang [mailto:Rebecca.Schultz@csh.org]
Sent: Monday, August 19, 2013 10:51 AM
To: *DHS_OPC Public
Subject: Olmstead Draft Plans Coffee

Rebecca Melang
Program Manager CSH
2801 21st Ave. South, Suite 230
Minneapolis, MN 55407
T 612.721.3700 ext. 103

[full text of attachment]

August 19, 2013

CSH
2801 21st Avenue South, Suite 230
Minneapolis, MN 55407
612-721-3700

Olmstead Sub-Cabinet
C/o Lt. Governor Yvonne Prettner Solon
Office of the Governor
130 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

RE: Minnesota Draft Olmstead Plan

To Whom It May Concern:

We are submitting these comments on behalf of CSH in regards to Minnesota's Draft Olmstead Plan. CSH is a nonpartisan, nonprofit organization and Community Development Financial Institution (CDFI) that has been working in Minnesota for over 20 years. CSH assists communities throughout the state to change systems and leverage resources in order to create supportive housing. Supportive housing, as we define it is permanent housing that is affordable and offers voluntary support services. Supportive housing is an evidence based practice that can assist communities nationwide as they advance needed solutions to help people in institutional care and those at-risk of institutionalization, live successfully in the community.

In developing our response to the draft plan, CSH established a working group of supportive housing stakeholders to discuss housing and Olmstead. Feedback from this group informed these comments; however, the comments are made exclusively on behalf of CSH. It is CSH's intent that these comments

will help the Olmstead leadership committee to better understand what supportive housing is, and what it is not, as well as the role of supportive housing in meeting the integration mandates of Olmstead.

Plan Overview

The draft plan is a starting point for further conversation, but would benefit from several key elements necessary to guide it to an end result of a successful Olmstead Plan. This success would be defined as a reduction of unnecessary institutionalization in the state of Minnesota. Chief among these considerations is the draft plan's omission of identifying the population it is designed to serve. The plan does not adequately explain the process for determining the definition of institutionalized people in Minnesota, and further fails to designate where these people are currently living, their disabilities, their incomes, and the barriers that exist to their housing.

The State of Minnesota may want to address several populations with the Olmstead plan; however, effective implementation requires prioritizing the populations served. The State may first look to assist two distinct groups: 1) Those people immediately choosing to move out of institutions and who need minimal supports from the community; and 2) Residents in the two most restrictive settings: Minnesota Extended Treatment Options (METO) and St. Peter's, Minnesota's state security hospital. Those at risk of institutionalization who are cycling through other costly systems such as jails and homeless shelters, and not receiving appropriate medical care for their disabilities should also be prioritized. After having successful integration of the groups chosen to start with, the plan would then move forward and address those in other institutional settings. After such time as the plan is amended to properly identify institutionalized people in Minnesota, it is likely that a clear vision of what the Olmstead plan is going to address will emerge.

With the target population identified, it will be easier to ascertain what services are needed for the plan. It follows that it will also become more apparent what funding is needed to fully implement the plan. Identifying the population will also create more evident goals with metrics to track the success of the plan. Currently, the goals are aspirational and look at the problem as a whole. The State will need to develop clearer details, identify resources, define actions, and create measurements needed for success. The goals should include current data points that have been collected and future data points that the plan expects to achieve.

Inclusion of at-risk population in Olmstead plan

As case law has evolved, the Department of Justice, courts, and the disability community agree that those at risk of institutionalization should be included in state Olmstead planning efforts. (For more information go to [National Disability Right's Website](#)). In recent presentations, the DOJ staff has explained that those at risk of being placed in institutions include those in jails and homeless shelters. Currently this population group is mentioned only a sporadically throughout the draft plan, specifically on pages 10 and 72. Without addressing the at risk population, moving people out of institutional care would simply lead to those openings being filled by those at risk of institutionalization as their needs worsen. This would be counter-productive and prevent the state from realizing the goals of the Olmstead plan.

Defining Integration

At several times throughout the Olmstead plan, the drafters use the term "Integration". Integration is employed as both a goal of the plan and as a way to measure the plan's success. Despite its prominence in the Olmstead plan, integration is left undefined. As such, one of the most crucial parts of the plan and its implementation depends on how integration is identified and measured in various

housing settings across the state. Determining the characteristics of integration is not easy; integration is dependent upon an individual's personal choice, how he or she is able to interact with the wider community, and his or her satisfaction with their individual housing unit. For this reason, it is important that the state create threshold criteria for integration that are flexible and allow individuals choice and a continuum of housing. On page 75 of the Olmstead Draft plan there is a proposed list of characteristics shared by most integrated settings. Consistent with the language from the Center for Medicaid and Medicare Services (CMS), CSH has created a list of characteristics that better defines integration. CSH's list of characteristics is as follows:

- Sign a lease (or sublease if master-leased) with landlord, have rights & responsibilities of tenancy under state & local law, are free to come & go or have guests;
- Have no restrictions on length of tenancy, can remain in apartment as long as complying with lease terms & desires to remain in apartment;
- May participate in accessible, usually comprehensive, flexible array of services tailored to needs of each tenant, with a case manager on call 24/7;
- Are not required to participate in services as a condition of tenancy, of admission into housing, or of receipt of rental subsidies;
- Clients request case management services and supports from staff and seek health care and specialty services from community providers. Separate property management staff engage to resolve issues to prevent eviction;
- Live in housing that meets federal, state, and local quality standards for safety & security;
- Usually occupy own bedroom, bathroom, and kitchen &, if sharing common areas, choose own roommates;
- Are protected by Fair Housing law;

Once the meaning of integration is determined, it must be used to help communities create a variety of housing options that ensure maximum housing choice across the state. This can be accomplished by using the characteristics of integration to analyze current housing options available in Minnesota. In addition the state should survey those currently living in institutional settings and seeking community based housing to determine gaps in Minnesota's housing stock. These gaps will then lead to the creation of a housing plan that creates the appropriate mix of housing types for Minnesota

Department of Human Services (DHS)

CSH is pleased with what the plan includes regarding the Department of Human Services and its responsibilities. However, there are a few additions necessary for the plan to succeed. Primarily, the plan would benefit from meaningful discussion of Adult Mental Health's role in Olmstead. A significant percentage of people who are currently in institutional settings are consumers of the adult mental health programs at DHS. Adult mental health needs to determine how they will move their consumers into more integrated settings, and what the funding structure will look like during that transition. As more people move out of high cost institutions there will be actual cost savings to adult mental health. We recommend that there is a dedicated plan to determine how the savings are used, which continues to support people with mental health issues residing in the community, and should not be allowed to enter back in to a general DHS budget. Adult mental health also plays a large role in many of the Medicaid programs that support people in the community. The role of Medicaid is discussed in greater depth below, but it lends to the importance of its role in the Olmstead plan.

Secondarily, the plan does not address discharge planning from settings, such as emergency rooms, hospitals, and others to avoid institutionalization. These are key times and places in which to intervene

and create a plan for appropriate housing or increased services supports for those at-risk of institutionalization and to prevent over-utilization of health services and other poor outcomes.

The Department of Human Services will be responsible for funding a large part of the Olmstead plan. It follows then that both existing uses and new approaches for Medicaid funding should be explored more deeply to further the mission of Olmstead. Though currently Medicaid is reimbursing many services in Minnesota that assist people to live in the community independently, the need to keep people in integrated housing is not being fully met. The current Medicaid benefits include: Targeted Case Management (TCM), Adult Rehabilitative Mental Health Services (ARMHS), Home and Community Based Services (HCBS) including Community Alternatives for Disabled Individuals (CADI), and Assertive Community Treatment (ACT). There are several issues with current Medicaid funding being used, including: Rate of reimbursement for ARMHS, restrictions on where HCBS services can be delivered, long waiting lists of waivers, and lack of services for those who do not have a diagnosed serious and persistent mental illness (SPMI).

The Affordable Care Act and other Medicaid mechanisms give Minnesota many opportunities to break out of these siloed reimbursement mechanisms and improve services financing for those in community based housing. Soon, a Money Follows the Person (MFP) program will be initiated which could give rise to creative ways to think about using these funds in conjunction with Olmstead. CMS has stated it is looking for imaginative and resourceful ways to use MFP funding; this is a perfect opportunity for Minnesota. Next, DHS has applied to CMS for future waiver opportunities, including an 1115 waiver, which includes a section on tenancy support. It is important that DHS continues to work on this opportunity to ensure it is implemented. Finally, the plan also fails to mention the possibility of the state working with managed care organizations. As we move forward, the state of Minnesota should actively engage managed care and encourage them to be innovative in the ways they help to fund the process of moving people out of institutions and into integrated housing.

Minnesota Housing Finance Agency

The section of the plan regarding the Minnesota Housing Finance Agency's (MHFA) does a commendable job of listing the programs that MHFA already funds to help those with disabilities finance housing across Minnesota. With this strong base, MHFA can now work to build on the current programs to create a new subsidy program for people who are moving out of institutions, which should be separate from funding for other vulnerable populations, including the long term homeless funds. Such dedicated funding has been extremely useful in the state of Illinois.

An extremely important role not mentioned in the plan is that MHFA should lead community-wide housing creation planning. This will help ensure that there is choice available, advise housing developers on what opportunities exist for housing creation, and inform service providers as they create models and build resources to deliver care. Such action would start with the MHFA helping communities look at the housing that already exists in their area, and then use that data to create a plan that increases choice.

The last role that MHFA can play is to strategically use its existing funding streams through its Qualified Application Plan (QAP) to help all housing built in Minnesota align with the goals of Olmstead.

Cross-agency Work: Housing

This section of the plan is among the most useful because it articulates how the State will work across agencies to create new housing and support existing housing in the community for those who

have disabilities. Without strong dedication to the role housing plays, the Olmstead plan will not be successful.

A crucial area not included in this section is the need to create dedicated housing funding streams for those exiting institutions. Currently MHFA and DHS both have various funding streams that pay for housing. Together, along with the other departments, these agencies need to determine a source of new funding or a more coordinated way to organize existing programs. However, this resource should not reduce investments made to finance housing for other vulnerable populations, including long-term homeless. This would be shortsighted and only lead to harming those at risk of institutionalization going against the vision of the Olmstead plan.

The cross-agency section should address policy changes surrounding meeting the needs of people served by multiple systems across Minnesota. MHFA should be involved in discharge planning and coordinated assessment to ensure continuity of care for someone as they move from an institutionalized setting into individual housing. There should also be continuity between the Department of Corrections and DHS as people move between these two systems, often substituting prison for institutions or homeless shelters and jails. Without stability between these systems many people will simply fall through the cracks and not succeed in independent housing.

Conclusion

In conclusion while the plan is a good starting point to identify the roles of each state agency and areas for collaboration, it is lacking several structural facets that will make the plan actionable. CSH is committed to helping the most vulnerable people in Minnesota succeed in independent housing and we are extraordinarily proud that our state is seeking to take proactive steps to ensure that no person is institutionalized that want to live in the community amongst family, friends and neighbors.

Comment 86

From: Thomas Weaver [mailto:tweaver@achieveservices.org]

Sent: Monday, August 19, 2013 12:42 PM

To: *DHS OPC Public

Cc: [Redacted Text]

Subject: Comments on Olmstead Plan

Olmstead Subcabinet,

Attached are comments on the Olmstead Plan, submitted on behalf of Achieve Services, Inc., and the people with disabilities we serve. Thank you for your consideration.

Best regards,

Thomas H. Weaver

CEO, Achieve Services Inc.

1201 89th Ave NE, #105

Blaine, MN 55434

tweaver@achieveservices.org

www.achieveservices.org

(763) 783-4910

[Full text of attached file]

COMMENTS ON MINNESOTA'S OLMSTEAD PLAN

Submitted by Tom Weaver, CEO, Achieve Services, Inc.

Thank you for the opportunity to comment on the development of Minnesota's Olmstead Plan. The following comments are respectfully submitted on behalf of the board of directors, staff, and clients at Achieve Services, Inc., a day training and habilitation (DTH) program located in Blaine, Minnesota. At Achieve Services, we recognize the abilities that every one of our clients brings to work every day. The range of talent and ability is deep and wide, and we're always looking for new and creative ways to unlock our clients' potential. Sometimes that happens quickly, and sometimes it takes a bit more time. And when it comes to employment, we need as many employment options as possible to match the skills and abilities of our wonderfully diverse client base.

We currently serve 180 adults with a range of developmental disabilities. Our first priority is to place our clients in community jobs. When that's not possible or "appropriate," we provide work in our center-based production area as well as non-vocational services. About 59% of our clients are working in the community, while 36% are working in our (center-based) facility. The remaining 5% receive a variety of job training, life skills, and therapy services, and engage in community integration activities – like volunteering at Feed My Starving Children and delivering Meals on Wheels.

We applaud and support the Dayton Administration's efforts to develop an Olmstead Plan, and we whole-heartedly agree with the principle, as stated in the Attorney General's Title II regulations, that states should "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." See 28 CFR sec. 35.130(d) (1998). As a state, there's no question we can do more to facilitate integration, and the Olmstead Plan should chart a course for doing so. However, the Plan must be about *expanding* choices, not *restricting* them.

As you develop the final Olmstead Plan, I would ask that you consider three important questions:

First, what programs and services will be available to clients for whom community-based employment may not be "*appropriate?*"

Second, what options will be available to those clients who do not *desire* community employment?

And finally, will funding be shifted from center-based programs and services – despite those programs being the choice or most appropriate option for many – to integrated community-based employment programs?

Integrated Community-Based Employment is Not Always "*Appropriate.*"

Most of the discussion around the Olmstead Plan is focused on those with disabilities for whom community-based employment is appropriate, and whether sufficient integration opportunities are available to them. That's fine, that's what the *Olmstead* case was about. See *Olmstead v. L.C.*, 527 U.S.

581 (1999). But for some, community-based employment is not appropriate, and it is imperative that those people not be forgotten or left behind.

Achieve, along with many other DTH facilities around the state, provides services to clients with a broad spectrum of abilities and challenges. Some are non-verbal and unable to communicate. Some are non-ambulatory. Some are unable to feed themselves or perform other basic daily functions without 1:1 assistance throughout the day. Some have anxiety disorders or behavioral issues that make community-based employment extremely stressful. While we provide those clients with integration opportunities through various community outings and volunteer activities, community-based employment, or employment in any form for that matter, may not be appropriate.

As you develop the Olmstead Plan, we ask that you keep our higher-needs population in mind. As we work to expand integration opportunities, as we should, please do not forget or sacrifice the center-based work programs and non-vocational services that are most appropriate for our clients with higher needs. And yes, those programs are often segregated. But let's be clear about what those programs *are*, and what they *are not*.

Center-based programs like Achieve's most certainly *are not* the first or only option. They *are not* boring or institutional. They *are not* places where anyone is taken advantage of, or meaningless tasks are performed.

They *are* safe environments where clients receive a variety of vocational and non-vocational services. They *are* places where clients have the opportunity to perform real work for real customers. They *are* places where clients get paid fairly, based on their productivity, and in accordance with standards strictly regulated by the U.S. Department of Labor. They *are* places where clients develop employment skills, life skills, and receive therapy. They *are* places where clients build self-esteem and a sense of self-worth. And our clients are there because they and/or their guardians have made *informed choices* to be there. They *are* lively, high-energy places with lots of activity where clients are generally happy for the opportunity to contribute and earn a paycheck. They *are* one option - an option that should be preserved.

In *Olmstead*, the Court cautioned against taking a whole-sale community-based approach: "We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings." See *Olmstead* at 601-602. While our center-based programs are a far cry from "institutional settings," the Court's point is nevertheless valid: for some individuals, center-based settings are preferable to community employment settings, and those center-based settings should therefore be preserved.

Some Clients Do Not Want Community-Based Employment.

The *Olmstead* decision has properly been characterized as requiring more integration opportunities for people with developmental disabilities. Despite what some advocates argue, however, *Olmstead does not* suggest that integrated employment should be the ONLY option.

In *Olmstead*, the court specifically recognized that for some, a more restrictive, segregated setting is the most appropriate: “[T]he State generally may rely on the reasonable assessments of its own professionals in determining whether an individual meets the essential eligibility requirements for habilitation in a community-based program. Absent such qualification, it would be inappropriate to remove a patient from the more restrictive setting....Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it.” *Olmstead* at 602. The Court further recognized that “Persons with disabilities must be provided the option of declining to accept a particular accommodation,” citing 28 CFR pt. 35, App. A, p. 450 (1998).

Among those who serve the disability community, there has been a welcomed focus placed on “person-centered” programming. In other words, we should be listening to what our clients want, and honoring their choices whenever possible. The concept of respecting client choice is also embodied in the *Olmstead* decision.

In recognizing that persons with disabilities must have the option of declining community-based employment, the Court implies that other options – like center-based work programs and non-vocational services - should continue to be available. At Achieve, we have some clients who have been given opportunities to work in community jobs, but have chosen to work in our center-based shop instead. Some have gone so far as to self-sabotage their community jobs so they could return to our center. Obviously, that’s not in the client’s best interest. Moreover, these incidents can jeopardize the employer’s willingness to hire other workers with disabilities.

When we work with employers, we work hard to provide employees whose skills and abilities are a good fit for the demands of the particular job. We send job coaches out to learn the job first, so they can help ensure that the work gets done right. And often times it is completely appropriate to nudge a client out of his or her comfort zone, and to gradually increase the difficulty of assignments. However, pushing a client too hard, too fast, can result in failures that are bad for the client and the employer. And if community-based employment is the only option available, we fear that more clients will be forced into jobs for which they are ill-suited or unprepared, and the rate of failure will rise – again to the detriment of clients and employers alike.

Accordingly, we feel strongly that center-based work programs and non-vocational services will always be “appropriate” for some segment of our client base, and that those programs should continue to be available and adequately funded.

Community-Based Services Should Not Be Funded At The Expense Of Center-Based Services.

Obviously, we rely heavily on government funding to operate our programs and services, including our center-based programs. If funding were diverted from center-based services to community-based services, we could no longer serve our higher-needs population, and we worry about what would become of them.

What would happen to our high-needs clients if our center-based programs were closed? In a perfect world, all those workers with disabilities would then find jobs in the community. But we don’t live in a perfect world. The reality is, jobs for people with disabilities are hard to find. In fact, the unemployment

rate among workers with disabilities is roughly double what it is for non-disabled workers, and only 21% of those with disabilities are participating in the labor force at all. So most of the people who are now happy and productive working in center-based programs would suddenly be unemployed, and for most - perhaps spending their days in residential settings with more limited opportunities for community engagement and integration, and no opportunity to earn a paycheck. What would that do to their self-esteem and sense of self-worth? Would that enhance their quality of life? Of course not!

Some have argued that a lack of resources is not an acceptable excuse for providing integrated community options, and have encouraged the shifting of funds from center-based programs to community-based employment programs. Unfortunately, this would directly translate to robbing from the higher-needs populations for whom community-based employment is not appropriate, to better serve those higher-functioning populations for whom employment in the community is appropriate.

Moreover, the Court in *Olmstead* recognized that the availability of resources should, in fact, be considered, suggesting that states are not required to fund community-based programs at the expense of other programs. The Court concluded that states must provide community-based treatment when “such placement is appropriate, the affected persons do not oppose such treatment, and *the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.*” *Olmstead* at 607 (emphasis added.)

It has been estimated that there are over 3,000 Minnesotans on waiting lists for waived services. Clearly, to properly address the needs of persons with disabilities, new resources are needed – not a shifting of resources. Again, we are adamantly opposed to eliminating options, or funding, for our higher-needs clients, and ask the *Olmstead* Subcabinet to ensure that their services are not sacrificed or compromised in the *Olmstead* Plan.

To summarize, we respectfully request that the *Olmstead* Plan expressly acknowledge that (1) community-based employment is not appropriate for all persons with disabilities; (2) that persons may choose to reject community-based employment, and (3) that programs and funding for other “appropriate” or “chosen” options should be maintained. Again, the *Olmstead* Plan should be about expanding options, not restricting them, and it should not advance its goals at the expense of those with higher needs.

One final suggestion: Please get out and visit some of our programs, and observe what’s really going on. Visit with our staff and our clients. We sincerely believe that unless you see these programs yourselves, you cannot fully appreciate the impacts they have, and the impacts your decisions could have, on the people we serve. Thank you again for your work on the *Olmstead* Plan, and for considering our comments.

Respectfully Submitted, Tom Weaver, CEO, Achieve Services Inc.

Comment 87

-----Original Message-----

From: [Redacted Text]

Sent: Monday, August 19, 2013 12:56 PM

To: *DHS OPC Public

Subject: Housing

Last week I attended a listening session here in Duluth. Unfortunately, I was unable to speak as I had to leave for work before it was my turn. I was notified of the meeting by Chris Dahlberg, my county commissioner as our neighborhood had communicated some concerns regarding adult foster care homes in our neighborhood. Otherwise, I do not think I would have known about them; neither did the rest of the population of Duluth. The attendance at the meeting was primarily stakeholders who maintain businesses derived from all the needs for the handicapped and disabled. Consequently, the vast majority of what you heard was all positive about what is being done; the only negative things were that there was not enough of what is being provided.

The handicapped speakers at the listening session are not representative of who lives in my neighborhood. We have an array of homes: one for autistic boys, Traumatic Brain Injury homes, some with MS and CP, some profoundly retarded or brain damaged. There are a FEW that work, but I do not think many. We now have 10 homes in this area of 100-110 homes, and there are multiple ones within a 1 mile radius bordering the neighborhood. I do not have any issue with some homes in my neighborhood, but the sheer number is troubling. We have a near constant stream of vans, buses and shuttles all day. While we do not have daily issues other than traffic, there have been instances of behavior that are unsettling: a wandering resident coming into someone's home looking for cigarettes, a young boy running nude in the neighbor's yard, screaming coming from 2 of the houses, workers smoking outside, speeding.

Duluth has a very high percentage of adult foster care in the state. Many of the residents do not come from here. They are far from home, family and friends. The mission statement of Olmstead speaks to choice of where to live and whom they live with. This is an abysmal failure for many of those in adult foster care. I have spoken with a number of former caregivers from adult foster care, and they report many residents who detest their housemates due to inappropriate behaviors, but are powerless to change their living situation. Someone needs to address appropriate placement.

I have several acquaintances who report substandard training and lack of resources to handle difficult residents and subsequently had injuries or scares during their course of employment. We had so many police calls in Duluth last year that the Police Department sent communications to the county and to the homes that they cannot be considered part of the staff; they needed to come up with a different plan. My concern is that homes have simply instructed staff not to call the police and now events go unreported. I have spoken to two staff who were injured and quit. No reports filed. Most workers are young, inexperienced, paid \$9.50 hour, have a high turnover rate providing little continuity for residents. I was friends with one couple who had several homes and neither one had any special training nor did

they employ anyone with special training. They simply applied for a license from the state, paid a fee, and opened their doors. There is not near enough oversight.

I have concerns for the residents themselves. We live in a neighborhood that winds and turns, many curves that make visibility difficult. Our speed limit is 30. One young man in his motorized wheelchair is on these streets on a daily basis. We have had several instances of residents wandering away unnoticed. We had two deaths last year because of inattention when the residents were ill. In at least one case, they should have called for an ambulance, but the resident died in the car with staff on the way to the hospital. Lack of training and experience played a large part in this.

Lastly, I have become aware of how very lucrative housing is for adult foster care. I am aware of at least two people who made enough money in a few short years to retire, or in one instance to buy for cash a very expensive resort. Another of my friends took in two residents for 6 years and paid for his 4 boys to go to expensive colleges. None of this includes the money spent for programming, transportation and medical. I was told that the houses for TBI patients is especially lucrative with some getting \$100,000/year per resident. I am a liberal Democrat, but even I have to balk at the mind boggling amount of money being spent.

Comment 88

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Monday, August 19, 2013 1:03 PM

To: Vollmar, Rosalie (DHS)

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/19/2013 AT 1:03:20 PM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I am an interested citizen

COUNTY: St. Louis

COMMENTS:

I am a homeowner in the *[Redacted Text]* neighborhood in *[Redacted Text]*. I first want to make it known that I have family members with disabilities and value the services that are provided to her. I do have concerns over the concentrated number of homes that have been allowed to establish in this neighborhood, it is my understanding that we have 10 in our 3 blocks. Here are my concerns:

1. Increased traffic from the staff of the homes, with little regard to speed and the safety of children playing.
2. The owner of the residential home pays the same property tax as I do. This is clearly a business opportunity, no different then houses that rent to college students.

3. Most important concern - I would like to know of all the group homes in the *[Redacted Text]* area, how many of the residents that live there are actually St. Louis County residents of financial responsibility? I am aware from working in the mental health field that St. Louis County has many co-county concurrencies, where the resident from another county is placed here and their county of responsibility is not SLC. Resources are then not available for our own tax paying residents when available, for instance in-patient mental health beds.

Comment 89

From: *[Redacted Text]*
Sent: Monday, August 19, 2013 1:34 PM
To: *DHS_OPC Public
Subject: Public Comments

Aug 19, 2013

Honorable Yvonne Prettner Solon
Office of Lieutenant Governor
State Capitol
75 Rev. Dr. Martin Luther King, Jr. Drive
St. Paul, Minnesota. 55114

Dear Lieutenant Governor:

I have recently read the "Minnesota's Olmstead Plan Draft – June 2013". Frankly, my immediate impression is that for the most part it is taking current practices and regurgitating them. It has few measurable goals directly addressing the problems currently prohibiting people with disabilities from full integration and inclusion within society. The place in which I work has been assisting people from institutional settings to integrated community based setting since the mid-eighties and currently are assisted two persons in following their Olmstead Complaints which are pending. Following are a few real life problems we have documented it is based on a file analysis of over 50 people we assisted from nursing home care. I see few goals that would change any of these real world problems.

Vulnerable Adult Acts cause some county social service providers to worry that if they assist in discharge planning and something happens where a person is seriously hurt there may be repercussions. Clear delineations need to be made on when a person who falls under the definition of "vulnerable" can make a choice, and that choice is theirs alone. We look at competency, i.e., is the person his or her own guardian? Most recently we have seen this also extending into other professions it is our belief that some recent problems stem from Doctors fearing being sued if they OK a person's discharge. Evaluate Vulnerable Adult Act judge if it is written in such a manner that it infers one of incompetence and educate professionals on its real use.

Centers for Independent Living staff come from a perspective not medical model based. We believe that persons should be given the opportunity to succeed but with that opportunity may come failure. It is hoped that the failure would not cause serious harm or death, but it may. Options has worked with

people who are paralyzed from the neck down, knowing full well that after their PCA has assisted them to bed for the night and a fire should break out, they may die, but given the choice of living in a nursing home, they take that risk. It is difficult for county social service staff and nursing home staff where their job is protecting people with disabilities to understand that people have the right to make choices even ones that are perceived by other to be bad and which may cause harm. We cannot protect a person to such an extent they have no personal freedoms. What is real "consumer control" instead of here is the two choices I see you have you pick one.

Nursing home staff are in the business to provide care in an institutional setting. Few staff know what services are available on the outside. Trainings should be provided to potential nursing home discharge staff on community-based services, related community based professionals, and the nursing home's responsibility in the discharge planning process. We hit various roadblocks by nursing home staff who do not see discharge planning as a valid function for them. The reality of the business is to keep the beds full. Education of Nursing home staff on their part of a process not always leading to the funeral home but now rehabilitation also.

County social service staff with small populations also have limited experience on how to use the various programs to the best advantage for the people they serve. Required continuing education and case review by oversight agency.

We have had problems finding out if a person is their own guardian from the nursing home staff. It is a catch 22; the nursing home can't tell us anything unless the guardian approves so we don't know if they have one. Some nursing home staff mix-up power of attorney and other various guardianship mechanisms with full guardianship awarded by the courts. Some persons have guardians that do not want them back in the community one person was we assisted was placed 17 years prior due to alcohol abuse and the medical problems it created in another the guardian was living in the wards condo on a lake. Periodic review of all guardianships should be done by an outside entity.

Independent Living Centers are consumer controlled when the rules were developed regulating our program "consumer" was defined as the "person with a disability" not a parent or guardian. This was due to many good intentioned parents placing their children in institutions and the parent's objections when their children were being assisted out. This is what we see now but in reverse, children who live hundreds if not thousands of miles away not wanting their parents at home and the Ombudsmen, nursing home staff, doctors and county workers being scared to rock the boat. One of the reasons is alluded in the first bulleted example; it is very easy for the family to say if anything happens we will sue you for taking this "vulnerable" person out of this setting. Staff need to be reassured that they are not responsible for choices made by competent adults.

We have assisted a couple people who were unable to go back to their home. One case the wife said that the husband abused her, but yet there were no police records. Another wife had a boyfriend and she did not want the husband at home. Both women had large retirement policies they were benefiting from as long as the husband was institutionalized, the traditional service providers were unwilling to

rock the boat. You work for the person with a disability first and foremost the family only if supportive of the individuals wishes.

Since the beginning of DRGs and Acute Care Hospitals initiating Rehabilitation Wings to extend patients stays so that they have to seek even further acute care or Rehab in swing bed settings we have seen various problems. Some people we have assisted don't even reach level of care for any services once out. Periodic level of care should be completed from outside staff every six months to insure people are not stuck.

It is very hard to assess walking when the nursing home does not want the person to walk because CMS has them on report for too many slip and fall injuries. This is also tough when the very reason they are there is to gain strength so they can go home and they cannot walk. Talk with CMS and Nursing homes to remedy this problem that would give people the right to ambulate while accepting the likely consequence will be falls. What is being safe and restricting a person to such a degree they will atrophy become increasing more involved due to lack of use phenomena.

Sincerely, *[Redacted Text]*

Comment 90

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Monday, August 19, 2013 1:42 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/19/2013 AT 1:42:21 PM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

DESCRIBE YOURSELF: I am a service provider

COUNTY: Dakota

COMMENTS:

August 19, 2013

I would like to submit public comments in response to the June, 2013 release of Minnesota's Draft Olmstead Plan. I work for a provider of day services in rural Minnesota. We provide a variety of services including Day Training and Habilitation, Supported Employment and VR Job Placement. In several service areas, we have worked with people to find customized employment opportunities.

I commend the state for moving forward with efforts to strengthen opportunities for people with disabilities and for them to be more fully engaged in their communities. However, I have several comments regarding this document.

1. I believe that you have not identified a significant barrier to achieving the most integrated settings. Excessive concern for the health and safety of people with disabilities is a significant barrier. Our system is built around it. Eligibility is determined based on health and safety. Quality is measured by how we've kept people safe. The system regularly reinforces a person's vulnerabilities and unintentionally discourages consideration of risk. Family's foremost concern is the safety of their family member with a disability. Providers have potential concerns with licensing, insurance and lawsuits if someone's safety is threatened. All of these very legitimate concerns reduce the possibility that people with disabilities will be involved in more integrated settings. Natural supports are riskier than those supports provided by a licensed service. As a provider who is aware of safety concerns but also wanting to expand more integrated employment, we regularly hear from families and case managers that they want the close supervision of a job coach for all who are working in community businesses.

2. The standards of measurement that you have identified for employment are missing some valuable components. You identify the value of employment (specifically competitive employment), earning minimum wage and working with non-disabled peers. Missing from these standards are number of hours worked, total earnings and length of employment (which can be a measure of job satisfaction). In addition, I question how you define segregated and integrated work. Here's an example.

A man is working in a grocery store. While he bags groceries and stocks shelves, he regularly connects with customers and other store employees. He's working 25 hours a week. I would identify that this is integrated employment. However, what I didn't describe is that he has a job coach on site and two others with disabilities who also work at the grocery store. He is paid \$5.50 an hour, less than minimum wage but providing him with earnings of \$550 per month. Because of these factors, some would define this as segregated work.

Another man is working in a hotel. He is paid minimum wage for the work that he does. He spends most of his time working alone in the rooms that he's cleaning but he does pass by people in the hall and checks in with the manager at least once a day. On average, he works 8 hours per week. When he's not working, he enjoys watching TV at home. Some would define this as integrated employment. He's working competitively, earning minimum wage and working with non-disabled peers.

When comparing the two word-pictures above, I think the first is a more integrated job. He's working more hours, having more interactions with non-disabled people and earning more dollars per month. The first person has also enjoyed his job for three years and has been given new responsibilities as part of that job. The second person has been working at this hotel for 3 months. He found this job after being without employment for 6 months. He quit his last job because he didn't enjoy the work. Job satisfaction and longevity is important for true integration.

3. The definition of integrated employment and the measurement of success matters. If the Olmstead Plan redirects dollars away from institutions and institutional-like settings to the most integrated settings, they may direct what I think is a very integrated grocery store worker to be the very segregated hotel employee.

In Summary

- A. Consider the challenge of providing for the health and safety of Minnesotan's with disabilities while encouraging broader community connections.
 - B. Consider the complexity of defining segregation and integration. Resist the temptation to define them by a particular service type.
 - C. Do not eliminate the opportunity for people to earn sub-minimum wage. Many Minnesotans enjoy hours of community connections while working in settings where they earn less than minimum wage. Eliminating sub-minimum wage will not necessarily expand integrated employment.
 - D. If the state is truly committed to integration, the plan must include consideration of the funding necessary to achieve this goal.
- Respectfully, *[Redacted Text]*

Comment 91

From: *[Redacted Text]*
Sent: Monday, August 19, 2013 2:05 PM
To: *DHS_OPC Public
Subject: Olmstead Plan

Dear Olmstead Sub-Cabinet,

As a parent of a daughter who has developmental disabilities, we encourage the Olmstead Sub-Committee to provide choices to individuals with disabilities that will meet their individual physical, emotional and social needs. The State of Minnesota has developed an array of options that we believe sufficiently provide choices to meet the many unique needs of this population.

I believe the rights of individuals to receive care in a group home setting, or apartments for individuals that receive SILS services, provide wonderful choices for individuals with developmental disabilities. These settings provide these individuals with the level of care that they need, and also provide social connections that every person craves, and for which, it is difficult for many individuals to attain.

I am very concerned that the state may be moving away from this type of housing and some disability advocates want to force everyone with a disability to live in individual housing. This is certainly not safe or the best option for many individuals. As aging parents ourselves, we understand how many parents are concerned about the long-range health, safety, and socialization of their children with developmental disabilities. They are depending upon the availability of group homes or apartments with SILS services to provide for the care their children need and desire. Please continue to give many choices to parents.

Thank you, *[Redacted Text]*

"Don't worry about anything. Instead, pray about everything. Tell God your needs and don't forget to thank him for his answers. If you do these things, you will experience God's peace, which is far more wonderful than the human mind can understand. His peace will keep your hearts and minds quiet, as you trust in Christ Jesus." Philippians 4:5-7

Comment 92

From: Hoopes, Pamela [mailto:phoopes@mylegalaid.org]
Sent: Monday, August 19, 2013 2:40 PM
To: *DHS OPC Public
Cc: [Redacted Text]
Subject: Minnesota Disability Law Center/Mid-Minnesota Legal Aid Comments on Olmstead Subcabinet June 2013 Draft Olmstead Plan

Dear Olmstead Subcabinet,

On behalf of the Minnesota Disability Law Center of Mid-Minnesota Legal Aid, attached please find the Minnesota Disability Law Center/Mid-Minnesota Legal Aid's comments on the Olmstead Subcabinet June 2013 Draft Olmstead Plan. Please contact me with any questions at 612-746-3711 or phoopes@mylegalaid.org

Thanks,
Pamela Hoopes
Legal Director
Mid-Minnesota Legal Aid
Minnesota Disability Law Center
430 First Avenue North, Suite 300
Minneapolis, MN 55401-1780

612-746-3711 (direct dial)
612-334-5755 (FAX)
phoopes@mylegalaid.org

[full text of attachment]

TO: Olmstead Subcabinet (opc.public@state.mn.us)
FROM: Pamela Hoopes, Minnesota Disability Law Center/Mid-Minnesota Legal Aid (MDLC)
RE: MDLC Comments on Olmstead Subcabinet June 2013 Draft Olmstead Plan
DATE: August 19, 2013

Mid-Minnesota Legal Aid (MMLA) is designated by the Governor as the federally mandated Protection and Advocacy entity for Minnesota, and it carries out this function through its statewide program, the Minnesota Disability Law Center (MDLC). MDLC Legal Director Pamela Hoopes served on the Olmstead Planning Committee. On December 21, 2012, MDLC submitted comments on that Committee's Recommendations.

Following the publication of the Olmstead Subcabinet's June 2013 first draft of Minnesota's Olmstead Plan ("first draft Plan"), MDLC attended and testified at a number of the Olmstead Subcabinet's Listening Sessions around the state. We will not fully repeat those comments here. Because the Subcabinet characterizes the first draft Plan as "a very preliminary draft," our comments in this memo are correspondingly brief and summary in nature, and structured by areThrough general concern. We

hope that there will be an opportunity to review and comment on a subsequent draft Plan before the final Plan is released.

1. The first draft Plan lacks specific measurable goals, timetables and mechanisms to measure progress.

An adequate Olmstead Plan must include specific, measurable goals and outcomes, with timetables for reaching them and mechanisms to measure progress toward these specific goals. These are commonly understood as fundamental to an acceptable Olmstead Plan, consistent with the Department of Justice guidance. Moreover, the State agreed in the Jensen settlement to include them. We are concerned that the first draft Plan contains almost none. By section:

- Department of Human Services (DHS)—none (see first draft Plan at 6-15);
- Minnesota Housing Finance Agency (MHFA)—none; placeholder with no number (see first draft Plan at 19);
- Department of Employment and Economic Development (DEED)—some excellent statements of specific goals and activities with some very broad timelines, but lacks any specific measurable goals (see first draft Plan at 24-27);
- Department of Corrections (DOC)—no specific numerical goals or timelines (see first draft Plan at 44-46);
- Minnesota Department of Health (MDH)—none (see first draft Plan at 50-51);
- Minnesota Department of Human Rights (MDHR)—no measurable goals or outcomes. We commend the MDHR for dividing the “activity areas” into broad time sequences (see first draft Plan at 56-59). We also commend the MDHR for discussing how it can assess progress toward goals (see first draft Plan at 59);
- Minnesota Department of Education (MDE)—contains a few measurable goals and timelines (see first draft Plan at 65), but as we noted in testimony at the Subcabinet Listening Session, the goals are unacceptably low and limited to older students (i.e., aimed at improving work opportunities and training for an additional 4.8 % of students ages 18-21 yearly for the next 5 years.) Moreover, the goals are limited to work opportunities, and do not include plans to increase integration of students now being educated in segregated settings;
- Cross-agency work: housing—none (see first draft Plan at 71-76);
- Cross-agency work: transportation—none (see first draft Plan at 77-79);
- Cross-agency work: integrating service systems for students with disabilities—contains some specific measurable goals and timelines regarding increasing integrated employment outcomes for students (see first draft Plan at 81). But as noted above, we are concerned that the goals are set too low and cover too narrow a range of students. In addition, the proposed timelines are too attenuated.

2) An adequate Olmstead Plan must be based on sound data, but the first draft Plan lacks reference to sufficient data to form the basis for a solid Plan.

The first draft Plan refers in a general way to data that may be presently available; but too little is included in the document to provide the basis for a focused Olmstead Plan. Without data to establish a starting point, it is not possible to set measurable goals and outcomes with timetables, or for reviewers to assess the plans. We note instances where relevant data was included in the first draft Plan. By section:

- Department of Human Services (DHS)—no data (see first draft Plan at 6-15);
 - Minnesota Housing Finance Agency (MHFA)—contains useful data in chart regarding current programs (see first draft Plan at 17-18);
 - Department of Employment and Economic Development (DEED)—contains some relevant data and program descriptions, but only refers to lists of data that are not summarized in the draft (see first draft Plan at 21, 28);
 - Department of Transportation (DOT)—no data on the use of various systems by people with disabilities, or on the cost of serving people with disabilities, leaving the link to Olmstead planning unclear (see first draft Plan at 34-35);
 - Department of Corrections (DOC)—contains some good relevant data (see first draft Plan at 36-37), but no data on numbers of people with disabilities served by specialized programs or in discussion of barriers (see first draft Plan at 38-41);
 - Minnesota Department of Human Rights (MDHR)—contains data on disability-related cases (see first draft Plan at 54, 56);
 - Minnesota Department of Education (MDE)—contains some limited data on students with disabilities aged 18-21(see first draft Plan at 62-64) but none for younger students;
 - Minnesota Department of Health (MDH)—provides some data on numbers served (see first draft Plan at 52);
 - Cross-agency work—close to no data in any section, with the exception of Hennepin County data cited regarding integrated employment (see first draft Plan at 69).
- 3) The first draft Plan lacks a centralized mechanism to track and ensure progress toward measurable goals and outcomes.

Once the State has a solid Plan that contains measurable goals and outcomes, with timelines, the Plan must be implemented. A key to successful implementation over the long haul is a centralized, cross-agency mechanism to track progress to the goals. We suggest that a cross-departmental group similar to the Subcabinet in authority, but with operational expertise and ;the addition of disability community representation, be formed to meet quarterly for the purpose of reviewing and ensuring progress toward each goal and benchmark.

Conclusion

We recognize the hard work that has gone into creating the first draft Plan, and we appreciate the opportunity to review and comment on it. Please feel free to contact me with any questions regarding these comments at 612-746-3711 or phoopes@mylegalaid.org

Comment 93

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Monday, August 19, 2013 2:51 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/19/2013 AT 2:50:53 PM
[duplicate at 2:56:24 PM]

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I work for state or local government

COUNTY: Swift County

COMMENTS:

In reading this document, my impression is that it substantially covers a portion of the people with disabilities. There appears to have been a lot of thought completed for persons with physical disabilities and persons with developmental disabilities. I did not see much effort for persons with mental health/substance abuse disabilities. To say the least, I am disappointed.

There are so many issues that arise for persons with mental health and/or substance abuse disabilities. The number one issue is that for persons that exhibit any type of difficult behavior we have nowhere for them to go in our local region - other than jails; DHS has determined that persons with mental health/substance abuse disabilities that exhibit difficult behavior should all go to Anoka-that's not very local. Prior to the regional treatment centers closing there was at least a local TREATMENT facility available for them; jails do not provide treatment.

Not only do jails not provide treatment, but some jail and law enforcement personnel do not have a clue how to de-escalate a person. I know there is Crisis Intervention Training available for law enforcement personnel - that should be a requirement for all law enforcement personnel and correction personnel. The CIT was provided in our area about five years ago. It was extremely beneficial to our consumers with mental health/substance abuse disabilities. Unfortunately rural law enforcement does not have good personnel retention - therefore, many current officers have not received the training.

From reading the draft, it doesn't appear to me that persons who provided input have a very clear idea of rural Minnesota. It would be awesome if consumer choice could be a reality. When the reimbursement rates are so low that without large numbers of consumers, there are very few providers. We in Swift County feel very fortunate, we have a Community mental health satellite (not available daily) and a local mental health agency. please read that as CHOICE between two agencies. if the consumer's schedule works with the one agency that they may choose. There is a workforce shortage - our providers have an extremely difficult time recruiting qualified mental health professionals - especially psychiatrists and psychologists. Our closest child psychiatrist is 90 miles away. Because of the shortage of professionals, it is imperative that Certified Peer Specialist training be made available to assist with relieving some of the burden of the professionals/practioners.

Additionally, in rural MN we do not have regularly scheduled Public Transportation. We have public transportation when we have enough volunteer drivers - and then only Monday through Friday and before 6 p.m.

There are many other untouched areas for persons with mental health and/or substance abuse disabilities. It is my hope that the Olmstead Subcabinet expand the definition of persons with disabilities and include persons with mental health and/or substance abuse disabilities. I also hope there becomes an awareness of rural issues for our consumers with disabilities.

Comment 94

From: Stemper, Colin (MSCOD)
Sent: Monday, August 19, 2013 2:52 PM
To: *DHS_OPC Public
Subject: Public Comments

To whom it may concern,

Please consider the attached document to be the Minnesota State Council on Disability's response to the Olmstead draft plan.

Sincerely,

Colin Stemper, MPP
Minnesota State Council on Disability (MSCOD)
121 East 7th Place, Suite 107, St. Paul, Minnesota 55101
(651) 361-7809
www.disability.state.mn.us | Colin.Stemper@state.mn.us
Celebrating 40 years of service

[full text of attached document below]

August 19, 2013

To whom it may concern,

Established in 1973 by the state legislature, the Minnesota State Council on Disability (MSCOD) was created to advise the governor, state agencies, state legislature, and the public on disability policy. MSCOD advocates for policies and programs that advance the rights of Minnesotans with disabilities. Detailed below are our comments for the draft Olmstead plan for Minnesota. Hard work has gone into the plan and we thank the subcabinet for this work.

Unfortunately, when it comes to the draft Olmstead plan, many of the issues that are addressed, relating to housing, human services, and transportation, have been problems for many years. The Council is concerned that the departments specified in the draft Olmstead plan do not go far enough in assessing what can be done to address the questions at issue. Too often it seems as if departments detail their current services without asking what could be changed or improved to be more inclusive to

people with disabilities. Without changes this plan may preserve the status quo for Minnesotans with disabilities who desire to live independently.

The draft plan has outlined what each agency will do. One of the most necessary components of an Olmstead plan is collaboration between state agencies. For example, in order for people with disabilities to obtain and retain competitive employment with a competitive wage, they need adequate housing with nearby transportation options. To this end the database of Housing Link must be adequately funded if people need to know where to find accessible housing in their communities. This example is a small illustration of how agencies must coordinate action to support community living priorities. State entities must produce a detailed plan on how they will work together to achieve the goals identified within the draft Olmstead plan.

Ensuring access to competitive employment is also critical to the success of Minnesotans under the draft plan. We ask that Governor Dayton sign an executive order aimed at increasing the employment rate of people with disabilities in Minnesota by collaborating with the private sector and increasing pressure on state agencies to do the same. Many reports show that Minnesota's disability rates are increasing statewide, making disability the new norm for many residents. There are a number of actions that can increase access to work for people with disabilities. The State must start a serious conversation on the work that can be done with transition-age students. Hiring goals for people with disabilities must be established. A person-centered approach must be taken with individuals currently working at day-training and habilitation locations who desire competitive employment. All Minnesotans must now consider performing some sort of work during their life. All stakeholders have to ask themselves what work looks like when Olmstead is involved.

Reaching out to communities of color is a missing component of this plan. Minnesotans with disabilities are not a homogenous community, and the state would be best served to develop unique and innovative ways in communicating information and options to these communities. In 2011, four communities of color in Minnesota had a higher rate of disability than non-Hispanic white Minnesotans, showing the importance of reaching these groups. MSCOD encourages members of the sub-cabinet to contact the state's councils of color to what see can be done to improve outreach efforts.

Additionally, state/county employees must be trained on being receptive to the ideThrough people with disabilities who contact them. Olmstead is not just about removing people with disabilities from nursing homes. They are in homes because their need was not available to them in the community. The essence of Olmstead is fostering a person-centered approach, empowering people with disabilities to make choices, and ensuring a high quality of life when they become a member of a community. Many of the effected individuals have never had to make critical choices before, and may require training on making good, important choices. Department employees must learn that this must now be standard procedure. Practices that arise from Olmstead should not be separate components of state agencies. They should be integrated into every program and interaction that occurs. Hopefully, when the plan is complete it will work seamlessly when it comes to the integration of people with disabilities. Right now the plans from agencies are separate and disjointed. Importantly, the subcabinet must develop a metric to measure the level of choice presented to Minnesotans with disabilities.

Finally, state agencies must be accountable for potential inaction on following applicable elements of the Olmstead plan. As stated above, the success of the plan will be reliant on all agencies coordinating with each other. If one component fails, the success of the entire plan comes into question. Therefore, MSCOD advocates for the creation of an "Olmstead Ombudsman" that could receive and resolve all public complaints related to Olmstead. Such a step, along with the creation of an advisory committee, increases government accountability and sends a signal to the disability community that Minnesota wants to right past wrongs. MSCOD is ready to help the state fulfill its obligation. The changes that will occur because of this plan must be communicated to the community. Also, we recommend that an advisory committee be created after the sub-cabinet concludes its work to ensure the agencies do not become complacent in their task.

It is still unclear as to how change will happen if funds are not dedicated to this effort. The plan should drive to meet gaps in current services. We hope that you will contact our agency, the Centers for Independent Living, all disability agencies and commissions as resources to accomplish these items and other needs that arise from this process.

Joan Willshire
Executive Director
Minnesota State Council on Disability

Comment 95

From: *[Redacted Text]*
Sent: Monday, August 19, 2013 2:54 PM
To: *DHS OPC Public
Cc: *[Redacted Text]*
Subject: Comments on Minnesota's Olmstead Draft
Importance: High

Please see attached PDF.

Sincerely, *[Redacted Text]*

[full text of attachment below]

Comments on Minnesota's Olmstead Plan 8.19.2013

Dear Gov. Dayton, Lt. Governor Prettner Solon, Commissioner Jesson, and members of the Olmstead Sub-Cabinet Committee,

As a parent of a young adult with Autism Spectrum/Mental Health who's generation has been served under the Individuals with Disabilities Education Act (IDEA) that ensures educational services and supports in the least restrictive environment, Olmstead would seem like a given. We persevered and created individualized educational plans, which in turn created appropriate services and settings. We assumed we would be met with systems and supports that held the same beliefs as we did.

Unfortunately as we went from the child system to the adult system we quickly realized we were to encounter system barriers at every turn: healthcare, employment, transportation, Home and Community-Based supports and services (all those listed on pg.7 of the draft). Our perspective seemed to be foreign to those we encountered in the system(s) and we were met with percussatory words and actions that were not only alarming but also incongruous to the philosophies, services and supports we had known. Thankfully, the only way we have known how to live, work and play has been “in the most integrated setting” and it has taken tremendous dedication and work to get there.

It is with that foundation of inclusion and self-determination, we are able to endure challenging daily circumstances to create person-centered programs and services for individuals with disabilities. We have been doing it since our children were born and are continuing to do it as they are young adults, but cannot go on without individualized supports from the system. It has been 14 years since the passage of Olmstead and 4 years since we have left the school system. In the year 2013 we are seeing some movement toward what our generation is accustomed to and what we expect from our systems. However, as Thomas Nerney states, “we need to have a better sense of urgency because people’s lives are being lost.” I would also add to that “the family unit has been torn apart” without *preventative*, cost-effective supports and services at the *time they are needed* to enable the primary care-givers to continue to remain employed, stay healthy and strong. I believe this statement speaks to the essence of why timelines, compliance and monitoring are so crucial and urge you to create a system for doing so. While I agree with much that is written in the draft, and many other parents advocating for individual CHOICE, it is the implementation of the plan I am concerned about as a parent of a young adult caught in the middle of a “war” between the state, counties and providers.

I respectfully submit some initial thoughts on what my son needs and what I need as a parent/guardian working with a Home and Community Based Waiver Team to implement a person-centered program to “empower us to make choices and manage risk” and keep him in the most integrated setting:

From pages 8-9 “Description of overall plans to reduce or eliminate these barriers: Pg.8 - “People will select the type of service right for them and direct the provider of those services.” AND “Bolster and maintain effectiveness of family and other natural supports.”

- **Create a “Universal Individualized Service Plan”** As MN-Choices moves forward to provide a more assessment in a more equitable manner to all eligible persons with disabilities, the state needs to consider providing a tool to implement the outcomes: a Universal Individual Service Plan. Currently the state of MN does not have one Individual Service plan for all disabilities. The current plans contain vague language and are inconsistent across waiver types. Other states have developed, or are in the process of developing, a plan that is person-driven that can identify individualized supports, activities and resources required for a person to achieve life goals. I as well as other parents of children with disabilities coming out of the education system am familiar with a process and a plan (Individualized Education Plan) that has required components by law based on data, present levels of performance of the individual as well as goals and objectives to reach within a year’s time. In addition, services are indicated that state type, amount, frequency and duration of services. I cannot understand why my son’s plan (traditional CADI waiver) is different from the Consumer Directed Community Supports

(CDCS) Plan. Many other parents do not understand their son/daughter's current plan, menu of services or funding stream and the budget for their son/daughter and as a result are left out of the process. I believe it is going to be difficult to implement the outcomes to create a "comprehensive, effectively working plan" if Minnesota does not agree on a universal service plan.

• **Pg. 9 - "Expand the number of individuals with disabilities *who have the option to develop Person-centered plans.*"**

• Person Centered Planning to create an individualized community support plan that should drive the goals, objectives and the services and ultimately the budget.

• Please clarify "*those who have the option*". Person-Centered planners nationally and even internationally have the networks, appropriate training and tools to work with those individuals with more significant behavioral, and communication needs. My experience has been that there is a perception that these individuals are "too difficult to work with" and they get written off.

• While the initial training of advocates, case managers and providers is encouraging, we will need trainers with more specialized experience to consult to these individuals. In addition, there is no funding stream across waivers (I am aware of) to support this service. Since this service is integral to the foundation of a person's Individual Service Plan, what is the plan for its implementation?

Pg. 9- "Redesign the quality management system to one that is more person centered in how it evaluates and continually improves quality of life, outcomes, and the experience of people, from the moment of a person's first contact with the system, through assessment and the delivery of services."

As a former employee in the corporate business world for 20+ years, two words have come to mind in our journey to secure HCBS supports and services: "lack of business ethics and false advertising". If providers claim to provide a service they cannot, *or will not*, that leads serious consequences putting a person with a disability at risk of institutionalization. What is the consequence? I, and other parents/guardians, have taken on the "risk" to implement and manage our son/daughter's programs and proudly do so, but when we spend our valuable time interviewing providers that claim to provide the services they cannot provide they not only waste my time that impacts my quality of life, but my son's budget once services are secured. Specifically I am speaking about criteria and quality assurance standards that need to be met for providers/agencies who advertise that they serve individuals with Autism to provide the core training, ongoing supports, strategies and assistive technology/communication devices to implement an individuals services plan. In the corporate business world they would not likely be in business for long. Providers need to follow up with initial communication by a parent/selfadvocate in a timely way, have an respectful, honest discussion about what they can and cannot do and communicate if they are willing to partner with parents to problem solve and work through tough issues we all know exist. This is the only way we can create new models of services and supports.

Pg. 5 – "Integrate primary care, behavioral health and long-term care in ways that provide smart care that keeps people healthy and in their homes and communities."

As was discussed by the MN Department of Health, at the Olmstead Forum in June, without access to adequate healthcare none of the other issues really matter.

From the birth, our generation (late 80's) has had to piece together supports and services ourselves: Primary Care, Psychological/Psychiatric Care, Dietary, Functional medicine, Occupational Therapy, Speech/Language Therapy, Learning Disability supports, etc., we at a minimum, had supports in the child system to do so with primary private insurance and secondary state insurance. Transitioning to the adult system without any resources from our former providers, insurance company, or county to navigate the adult system almost cost my son his life and my ability to stay employed and stay afloat financially was put at serious risk.

During this crucial time he was deteriorating, we were shuffled between all the major hospitals, not understanding why we couldn't receive services from medical providers at the clinics and hospitals we previously had received services from. Why couldn't we receive the same quality services and level of support we had in the child system? We didn't seem to "fit in anywhere". I was actually told by one major hospital that "they did not serve person's with Autism" and by one nurse "Haven't you heard of group homes?" Friends and family were shocked at what we were going through and "No, there wasn't anywhere to put him".

This lack of resources and integrated care put our entire HCBS program that we had previously successfully implemented, at great risk not to mention the trauma of multiple hospitalizations for my son and my entire family. That trauma is not easily forgotten. We lost staff, critical relationships and services coming in and out of the hospital. Specialized behavior supports for my son and his team were not available but increased medication was. My son lost his employment in the community he had worked so hard to attain during his school Transition years. His plan to become more independent, move out of the family home and live with supports in the community was derailed. He was put at risk for unnecessary long-term institutionalization.

While "living at the hospital" during this time I had the chance to talk to many an administrator, doctor, social worker, direct care staff. These individuals strive to do their best under very tough conditions and circumstances. I do believe many of them may not know how to partner with parents. These issues and "gaps" are not insurmountable. Simple tasks we can do to connect people to resources at critical times are available and do not cost more money. The healthcare community needs to work together with parents of young adults to gather the important knowledge and experience to create these services within our medical community now. We have worked a lifetime to create and implement programs and services together for our son's/daughters, please do not let them drop off the cliff.

Pg. 14 – "Partners necessary to ensure success. "The most important partners that DHS needs to work with to ensure success are the individuals receiving services and their families..."

"Service delivery partners, key stakeholders groups, the Home and Community-Based Services Partners Panel, providers....etc." In all the years my son has received services (starting with PCA in elementary school) we have never been contacted directly to provide feedback from the state. We have taken it upon ourselves to contact our advocacy organizations, legislators and take the time to seek out forums to speak when we are able. We greatly appreciate what the advocacy organizations have provided recently to host forums but we also hope the state can look at other ways of communication (online sessions, survey's) to reach parents, families, individuals who do want to learn and give their feedback.

In addition, many stakeholders groups, forums are held at times parents cannot access due to employment or direct care responsibilities and notice is not given in a timely way to adjust scheduling.

In closing, I go back to Thomas Nerney again who states that self-determination is really about the “restoration of citizenship for individuals with disabilities”. This is what Minnesota’s Olmstead Plan can begin to do for us. Please authentically engage parents/families and self-advocates so we can learn from each other, build on our experiences to move these systems forward.

Sincerely, *[Redacted Text]*

Parent/Guardian of a *[Redacted Text]* year old with Autism Spectrum/Mental Health

Comment 96

From: *[Redacted Text]*

Sent: Monday, August 19, 2013 3:12 PM

To: *DHS OPC Public; Bibus, Beth (MMB); Kuhl, Luke (GOV)

Cc: *[Redacted Text]*

Subject: Comments on the Draft Olmstead Plan

Importance: High

SENT ON BEHALF OF NANCY HYLDEN

On Behalf of the Coalition for Choice in Housing

Please find attached a Letter from myself and a Statement from the Coalition for Choice in Housing for the Olmstead Sub-Cabinet’s consideration. If you have any questions, please feel free to contact me.

Thank you very much for your consideration!

Nancy Hylden

Partner

nancy.hylden@FaegreBD.com

Direct: +1 612 766 6923

FaegreBD.com [Download vCard](#)

FAEGRE BAKER DANIELS LLP

2200 Wells Fargo Center

90 South Seventh Street

Minneapolis, MN 55402-3901, USA

[Full text of Coalition attachment]

Coalition for Choice in Housing

Who We Are:

We are a diverse and growing coalition of tenants, advocates, individuals, and providers who share the fundamental belief that all people, including people with disabilities should have meaningful choice in housing. New coalition members are always welcome.

What We Believe:

Bound by our foundational belief in choice, we believe no one should be forced to “choose” between deciding “where they live, with whom, and in what type of housing” and receiving the government funded services they are both entitled to and require to be successful. See Draft Olmstead Plan, pg. 4 of 83.

Likewise, consistent with Minnesota’s venerable Human Rights Act, we believe no one should be effectively denied the housing of their choice because of their race, color, creed, religion, national origin, sex, marital status, familial status, public assistance, sexual orientation, or disability.

Accordingly, as a coalition, we are opposed to not just the present no more than four or 25% statutory limitation, which denies people with disabilities the government funded home and community based services they are entitled to and require to be successful, but any other arbitrary cap on how many or a set percentage of people with disabilities can choose to live in a given setting. See Minnesota Statutes 256B.492.

Our goal, however, is not to replace the present no more than four or 25% limitation with nothing. Rather, we are actively working with the State and other stakeholders to arrive at a new paradigm, which looks to the totality of the individual’s experience rather than requiring that a rigid battery of factors must be met in their entirety for every individual at all times.

Given our shared belief that individuals with disabilities must have meaningful choice in housing and our sensitivity to the particular concern for people who choose to live with other people with disabilities above the current four or 25% limitation, we welcome enforceable standards to ensure that such persons are truly living in the housing of their choice, so long as these standards are based on the totality of the individual’s experience and not on arbitrary limitations.

What Our Objective Is:

By working collaboratively with the State and other stakeholders, we seek policies which ensure meaningful individual choice in housing, avoid a “one size fits all solution,” allow for a full spectrum of housing options which are as diverse as the individual desires and needs of the Minnesotans who choose to live in them, and are consistent with the promise of Olmstead.

Comment 97

From: Hammergren, Rick [mailto:rhammergren@opportunities.org]

Sent: Monday, August 19, 2013 3:15 PM

To: *DHS OPC Public

Subject: MOHR Member Comments and Observations on the State of Minnesota Olmstead Plan (draft)

TO: Lieutenant Governor Yvonne Prettner Solon and the Olmstead Plan Subcabinet

FROM: MOHR – Minnesota Organization for Habilitation and Rehabilitation

Attached please find comments and observations regarding the current draft of the State of Minnesota Olmstead Plan. Many MOHR members have attended the public listening sessions; we appreciate your openness and genuine interest in our programs and the people we serve. Please continue to call on any

MOHR member organization for specific questions. You may also reach me or any MOHR Executive Team member for additional testimony or dialogue.

Sincerely,

Rick Hammergren, President MOHR

Rick Hammergren | Vice President, Public Policy, Vocational and Habilitation Services

phone: 952-351-5400 | fax: 952-930-4279 | cell: 651-587-3587

5500 Opportunity Court | Minnetonka, MN 55343 | <http://opportunities.org>

[full text of attachment]

August 16, 2013

Lieutenant Governor Prettner Solon and the Olmstead Plan Subcabinet:

On behalf of the Minnesota Organization for Habilitation and Rehabilitation (MOHR), we are submitting public comments in response to the June, 2013 release of Minnesota's Draft Olmstead Plan. MOHR represents over 50 organizations providing employment supports to thousands of Minnesotans with disabilities, through Day Training and Habilitation programs (funded largely through Medical Assistance waived services), Vocational Rehabilitation Services, and Extended Employment (funded largely through the Department of Employment and Economic Development). We understand that the Draft Olmstead Plan will lead to a Final Olmstead Plan that will include specific goals and action plans aimed at resolving current service delivery barriers that limit the integration of Minnesotans with disabilities into our communities. As a coalition of organizations, we are committed to representing the broad spectrum of person centered services, community integration and inclusion, common access to all public transportation and other typical services, and individualized employment support services. We commend the state for moving forward with efforts to strengthen the opportunities available to Minnesotans with disabilities for full participation in their communities.

However, if the state is truly committed to this goal of increasing the ability of Minnesotans with disabilities to receive supports in the most integrated setting appropriate and of their choosing, there must be clearly defined outcomes and a specific plan for the funding necessary to achieve this goal. MOHR's member organizations are extremely proud of the work we do; supporting a wide range of options for people who have disabilities to exercise their choices, engage in self-advocacy, and integrate into typical community education and other learning experiences, as well as the outcomes we have achieved in supporting Minnesotans with disabilities in their community employment goals. But there is a basic level of funding necessary to provide these supports, and a decade of deep cuts and stagnant funding for Minnesota's disability services system has made it increasingly difficult to provide high quality support services. Putting forth a plan calling for increased service and support options with little or no discussion of the waiting list that currently exists for services or the funds necessary to support this increase is of questionable value. We support commitment to valuing the choices that people who have disabilities and their families make! They are in the best position to select their service providers and direct specific individualized outcomes for integrated services. Decisions are best informed and honored when people have a wide variety of services to choose from, a rich service menu, with predictable, sustainable funding to meet the needs of people served.

Furthermore, the Olmstead Subcabinet's Vision Statement includes the specific outcome of creating "the opportunity and freedom for meaningful choice, self-determination, and increased quality of life". Implied in "meaningful choice" is the notion that, if they desire, individuals have the ability to experience a wide spectrum of support services before making a decision about which option best fits their preferences. To this end we strongly encourage Minnesota's Olmstead Subcabinet to avoid structuring the Final Olmstead Plan in such a way that any specific disability employment support model is eliminated or discouraged.

If we are ultimately successful in our shared goal of creating a disability service system where individuals have meaningful choice and self-determination, then it will be Minnesotans with disabilities who will decide which supports and services are needed into the future.

We strongly request that the Final Olmstead Plan, currently estimated to be released in November of 2013, specifically address these issues. We believe that failure to do so could result in diminished long term value of the report in moving Minnesota's disability service system forward.

We would be happy to answer any questions or further discuss these issues.

Sincerely,

The MOHR Executive Committee
Rick Hammergren, President
952-351-5400

Comment 98

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Monday, August 19, 2013 3:35 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/19/2013 AT 3:34:41 PM

NAME: [Redacted Text]

EMAIL: [Redacted Text]

DESCRIBE YOURSELF: I am a family member of someone with a disability

COUNTY: Swift

COMMENTS:

The Olmstead discussion fuels many emotional thoughts. I am very concerned that the presumption seems to be that no one could ever want to be associated with a program that has some institutional qualities and that by making these assumptions is only doing the opposite of what is trying to be done. It is saying that someones choice to work in a sheltered setting for a sub-minimum wage is wrong and they need to make a different choice. Why can't working in a sheltered environment for a commensurate wage be an acceptable option for someone? Many DT&H providers' missions are to

provide people with a wide variety of work options, not all competitive, not all in an integrated community job, but no less important. By pushing everyone into the stream toward competitive wages sends a message that if that is not what they want, they are not right in the eyes of society. My aunt loves the environment she works in, loves the work she does, feels productive, feels like she is part of a team and does not always make a competitive wage and does not always work in the community, even though she has the opportunity, she chooses not to most of the time and that should be okay. She should not be considered "less than" by choosing not to be competitively employed in a setting made up of mostly non-disabled individuals.

Comment 99

-----Original Message-----

From: [Redacted Text]

Sent: Monday, August 19, 2013 3:41 PM

To: *DHS_OPC Public

Subject: Olmstead plan

Hello,

My son is [Redacted Text] and has autism. He works at [Redacted Text] and loves it! He works on sight and is very productive. Change, sensory overload is hard on him. I believe he is so productive at [Redacted Text] because he is comfortable in his environment .

Please do not eliminate options for people that are not able to work in the community! Everyone should be treated fairly and with dignity. You don't do that law with typical/normal employees.

My son loves his job, please don't take that away from him.

Thank you, [Redacted Text]

Comment 100

From: Cami Groll [mailto:cgroll@accessiblespace.org]

Sent: Monday, August 19, 2013 4:06 PM

To: *DHS_OPC Public

Subject: Public Comments

Attached are public comments for the Olmstead Plan draft submitted on behalf of Accessible Space, Inc. (ASI).

Thank you,
Camille Groll
Contract Manager
Accessible Space, Inc. (ASI)

2550 University Avenue West, Suite 330N
St. Paul, MN 55114
1-800-466-7722, ext. 213
651-645-7271, ext. 213
Fax: 651-645-0541
cgroll@accessiblespace.org
www.accessiblespace.org
"Housing with Care"

[full text of document]

August 19, 2013

Dear Lt. Governor Prettner Solon, Members of the Olmstead Planning Committee and Subcabinet:

Thank you for allowing the public the opportunity to submit comments regarding Minnesota's Olmstead Plan draft. The following comments are being submitted to you on behalf of Accessible Space, Inc. (ASI), a nonprofit organization which has been mission driven for the past 35 years to provide accessible, affordable "Housing with Care®" to very low-income adults with physical disabilities.

The Department of Human Services (DHS) webpage for Minnesota's Olmstead Plan states, "Having a disability does not mean a person has less desire to make choices about how to live, where to live and who to live with. It doesn't lessen the basic human desire to exert control over one's life."

DHS states that these are some of the human values that are part of public laws, programs and policies and indicates that the intent of the Olmstead Plan is to "address how well current public policies and practices in Minnesota match these values and how well public programs match what people with disabilities and their families want and need in real life". Additionally, as stated in the background information section of the Olmstead Plan, "The Minnesota Human Rights Act and the American with Disabilities Act both require government entities to ensure that people with disabilities can access services and programs".

If Minnesota is to deliver a plan that promises to value people's choices then we must not only look to the future but look at our current law as well. Currently, Minnesota statute limits the number of individuals with disabilities who are able to use certain Medicaid Home and Community Based Service (HCBS) Waiver funding for services to 25% of the units in a multifamily setting. This restriction is contrary to the Minnesota Human Rights Act and the Americans with Disability Act's requirements of "ensuring that individuals can access services and programs" and does not match the values expressed by DHS as part of the Olmstead Plan, which promises as part of their overall goal that "People with disabilities will choose where they live, with whom, and in what type of housing". If the intent of the Olmstead Plan is to address how well current public policies, practices and programs in Minnesota match these values and goals, as well as address what people with disabilities and their families "want and need in real life", then this issue of a maximum unit cap for waiver funding must be addressed and modified to allow real choice, without imposing restrictions. The 25% cap for waiver services in multifamily settings could in reality force a person to choose between their housing preference *or* their

services. **We should not impose limits on housing choice by restricting the availability of funding for services.**

Additionally, the same statute excluded U.S. Department of Housing and Urban Development (HUD) Section 811 housing for very-low income adults with disabilities from the definition of a Community Living Setting, making residents of HUD Section 811 housing ineligible for certain HCBS Medicaid Waiver funding. Again, this statute limits choice by imposing restrictions. Minnesota's Olmstead Plan is a promise to ensure not only integration but also choice and that includes the choice to live with other people with disabilities, if that is the individual's preference. Imposing HCBS Waiver restrictions or exclusions does not allow real meaningful choice but rather **forces or directs choice** by removing options.

Restricting HCBS Medicaid Waiver funds based on housing choice is especially harmful to individuals who use Medicaid Community Alternatives for Disabled Individuals (CADI) or Brain Injury (BI) waiver funding as these individuals must require the level of care provided in a nursing home to be eligible for such a waiver and are at high risk of institutionalization without a variety of housing and service options to meet their individual needs and preferences.

The Olmstead Sub-cabinet Vision Statement expresses that Minnesotans with disabilities, both now and in the future, will have the opportunity and freedom for meaningful choice, self-determination and increased quality in life including choices of living location and situation and having supports needed to allow for these choices.

ASI supports the Sub-cabinets' vision statement and urges the Olmstead Planning Committee to support the widest possible array of housing and service options for people with disabilities, recognizing that individuals have different preferences and needs and that individuals should be allowed to make meaningful choices without arbitrary restrictions. **The choice should remain with the individual.**

We thank the Olmstead Planning Committee and Sub-Cabinet for their hard work in developing the Minnesota Olmstead Plan draft and appreciate the opportunity to submit comments.

Sincerely,

Camille Groll,
Contract Manager
Accessible Space, Inc. (ASI)
2550 University Avenue West, Suite 330N
St. Paul, MN 55114
1-800-466-7722
cgroll@accessiblespace.org
www.accessiblespace.org

Comment 101

From: *[Redacted Text]*

Sent: Monday, August 19, 2013 4:25 PM
To: *DHS_OPC Public
Subject: Comments on draft Olmstead Plan

Dear Olmstead Sub-Cabinet,

Attached please find comments on the draft Olmstead Plan from Catholic Charities of St. Paul and Minneapolis. You are welcome to contact me with any questions or follow-up.

Marie Ellis
Marie Ellis, Attorney
Public Policy Manager
Catholic Charities of St. Paul and Minneapolis
Office for Social Justice
60 Plato Blvd. E. Ste. 230
Saint Paul, MN 55107
Direct Dial: 651-647-2582
marie.ellis@cctwincities.org

[full text of attachment]

To: Minnesota's Olmstead Planning Committee
From: Catholic Charities of St. Paul and Minneapolis
Date: August 19, 2013
RE: Comments on Minnesota's draft Olmstead Plan

Catholic Charities of St. Paul and Minneapolis appreciates the opportunity to provide comments on Minnesota's draft Olmstead Plan.

The broad goals articulated by the Olmstead Subcabinet are appropriate. However, we are concerned that implementation will be impossible because of the barriers to affordable housing and mental health treatment that exist, and that implementation may increase homelessness in Minnesota.

This is of specific concern to Catholic Charities because our clients face enormous challenges finding affordable housing and treating mental health issues. These challenges exist for people both with and without disabilities.

We urge you to take into consideration the lack of support for people wanting to live independently who need assistance. For example, currently there is not enough funding for all people who would be eligible to receive Community Alternatives for Disabled Individuals (CADI) or Brain Injury (BI) waivers services, which would allow people to stay in their home if they choose to do so. If funds for those waivers were available, these clients could "choose where they live, with whom, and in what type of housing." Without the availability of these waivers, people who want to live independently cannot. The goal of the plan therefore is unachievable for people who want to live independently, without the availability of funding for waivers and services.

In addition, there is a serious lack of affordable housing in Minnesota. As vacancy rates for all rental housing in the seven county metro area approaches 2.3%, the vacancy rate for affordable housing in the seven county metro and in the whole state approaches 0%. “People with disabilities will choose where they live, with whom, and in what type of housing” is a great goal, but unattainable if few or zero types of affordable housing are available.

Compounding this problem is increasing poverty. One in ten residents of Minneapolis and St. Paul live in deep poverty, an income so meager that a family of four would be living on less than \$12,000 per year. Since 2007, the city of St. Paul has experienced almost 30% growth of residents living in poverty.

The Great Recession contributed to a continued growth in homelessness in Minnesota, growth of 6% between 2009 and 2011, following a 25% increase between 2006 and 2009. (Wilder Research statewide count 2012 and 2009)

According to Wilder Research’s 2012 Minnesota Homeless study, 41 percent of homeless adults across Minnesota are on waiting lists for affordable housing, with an average wait time of almost a year. An additional 15% of homeless adults were unable to get on such a list because they no longer taking names.

We know from internal data that 16 percent of clients who stayed overnight at the Dorothy Day Center shelter in St. Paul in March 2013 had physical illnesses that required specific accommodations (such as being situated near an electric outlet so that the client’s oxygen tank could continue to run through the night).

In addition, many of our clients deal with mental health issues. In some programs, this makes up over 80 percent of our clients. According to Minnesota’s Department of Human Services, 71 percent of clients in the Special Needs Basic Care program have mental health issues. The numbers are similar in Ramsey and Dakota counties. Lack of appropriate housing and mental health services also often contributes to longer prison stays because there is no alternative housing and health services in the community. And often when people are discharged from jails or prisons they are left to the vagaries of the streets, losing a roof over their heads and any kind of health services.

There are two issues related to mental health we see as particularly underdeveloped or underfunded. These include: Bridges, which provides rental assistance to people living with mental illness who are waiting for a Section 8 voucher or other housing assistance, and increased capacity to effect co-occurring substance abuse and mental illness. A large number of our clients deal with both, and appropriate treatment is very difficult to obtain.

We echo NAMI Minnesota’s call for a separate plan for those with mental illness to be developed with advice from the mental health community.

We disagree with the recommendation to separate housing from services. In order for a person to truly “choose where they live, with whom, and in what type of housing,” as many options for

housing as possible should be available. For some people, services available where they live is a exactly the option they are seeking.

We recommend that the key measurements, which will be included in the overview of the final Plan (as stated on page 1 of the draft) include an ongoing measure of people with disabilities, including mental illness, who are homeless in Minnesota. This will allow the State to assess whether implementation of the Olmstead Plan is unintentionally leading to more homelessness in our great state.

We look forward to the final Olmstead Plan and appreciate your review of our comments.

Sincerely,
Kathleen Tomlin
Vice President of Social Justice Advocacy
Catholic Charities of St. Paul and Minneapolis

Comment 102

Letter from AARP, received by Lt. Gov.'s office on 8/15/13

[full text of document]

August 14, 2013

Dear Lt. Governor:

AARP is writing to express its appreciation to you and other Sub-Cabinet members for the opportunity to comment on the state's draft Olmstead plan. Serving Minnesotans aged 50+ and their families, AARP is a non-profit, non-partisan organization dedicated to enhancing the quality of life for all generations through positive social change; Minnesota is home to nearly 700,000 AARP members. AARP provides information and resources, engages in legislative, regulatory and legal advocacy, assists members in serving their communities, and offers a wide range of unique benefits to our members.

AARP believes all seniors aged 50 and older-- whether or not they have disabilities-- must be allowed to age in place, meaning they must have access to services that would support their ability to live in the communities of their choice. While we applaud Minnesota's status as a national leader in providing long-term services and supports, we believe the proposed Olmstead plan would benefit from increased specificity and examination of existing service delivery problems faced by seniors with disabilities. As AARP Public Policy Institute's State Long Term Services and Supports Scorecard recently highlighted, 14.5 percent of nursing home residents in Minnesota had low care needs compared to the U.S. average of 12.8 percent, a ranking of 32nd in the nation. Therefore, we respectfully request the final version of the Olmstead plan include the following issues and recommendations:

Reform 2020. A centerpiece of the Department of Human Services' (DHS) section of the Olmstead plan involves implementation of the Reform 2020 initiatives. As we articulated in a letter to DHS dated July 17, 2012, "AARP is supportive of the Department's efforts to reform the system to be more person-centered in order to achieve better outcomes and efficiencies, improve health, and reduce reliance on institutional care." However, we remain concerned about the ongoing effects of recent changes to in-home assistance services such as Personal Care Assistance (PCA) and the loss of Elderly Waiver services for thousands of seniors due to changes in the Nursing Home Level of Care Criteria (NOLC) beginning in 2014.

As we noted in our prior correspondence, the heightened eligibility criteria for in-home PCA is more stringent than the nursing facility level of care. For example, the PCA policy now requires an individual to need "constant" supervision and cueing if they do not require hands-on assistance to complete an Activity of Daily Living (ADL). Minn. Stat. § 256B.0659 (4)(b)(1)(i). The provision of services to facilitate the transition of people out of nursing facilities is an essential component of making the right to community integration meaningful. Also, while the Department's "Essential Community Supports" program purports to meet the needs of individuals who do not meet the new NOLC criteria, we continue to have concerns that it may not be adequate to assist many seniors due to its low funding limits. The draft Olmstead plan correctly recognizes that "[t]here is a bias towards provider controlled supports" and "[i]nstitutional services are more accessible than 'most integrated' services." AARP remains concerned that some of the existing policies contained within the Reform 2020 initiatives may instead reinforce these biases.

Income and Asset Inequities. AARP strongly recommends the final version of the Olmstead plan should address the inequities in the income and asset standards for people with disabilities and seniors eligible for Medical Assistance (MA) compared to newly eligible individuals for MA under the Affordable Care Act (ACA). Under current eligibility rules, the income standard for seniors and persons with disabilities is 100% of the Federal Poverty Level (FPL) and 75% of the FPL for those with high medical needs whose income is even just one dollar higher than the poverty level. Additionally, seniors and persons with disabilities can only retain \$3,000 per person in assets. By contrast, newly eligible individuals for MA under the Affordable Care Act (ACA) can retain up to 138% of federal poverty with no asset test. These inequities leave many seniors unable to pay for other basic necessities, such as food, utilities, and other medical care.

In-Reach and Options Counseling to Institutionalized Persons. The draft Olmstead plan focuses on the commendable goal of averting institutionalization. However, it contains few references to bringing presently-institutionalized individuals back into the community. The provision of services to facilitate the transition of people out of nursing facilities is an essential component of making the right to community integration meaningful. As the U.S. Department of Justice recently noted in its Olmstead guidance to states, "[t]o be effective, the [Olmstead] plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan."

According to a recent study commissioned by the Minnesota legislature, nursing facility utilization rates among seniors age 65+ has steadily declined by over 50% over the past thirty years. AARP commends

the state's existing efforts to de-institutionalize its citizens from nursing homes. The draft Olmstead plan contains a reference to "expanding" the existing Return to Community program, which provides outreach and options counseling to current residents of nursing facilities about possible community-based services. However, there appears to be little data on the utilization of facilities that, while institutional in character, do not meet the criteria for skilled nursing facilities under state and federal regulations.

AARP recommends the Department (1) obtain more data on the institutionalization of individuals in facilities other than skilled nursing facilities and (2) expand the reach of the Return to Community program to residents of all institutions, not just residents of skilled nursing facilities.

Support for Family and Other Unpaid Caregivers. The continued success of an individual with a disability in the community often requires the watchful care and support of unpaid caregivers. According to a recent report commissioned by the Minnesota legislature, the vast majority of older Minnesotans residing at home depended on the assistance of caregivers such as a spouse, friends, or other members of the family. These caregivers are called on a daily basis to assist individuals with disabilities in performing basic activities of life-such as eating, dressing, or assisting with mobility-and to assist with more intensive tasks-such as administering daily injections or other medication. In addition, caregivers often fulfill a necessary role of coordinating the various services involved in an individual's care. Individual support to caregivers, such as regular training and respite, ensures that caregivers have the necessary skills and energy to provide safe and enduring care. Despite the value of unpaid supports to seniors, the Olmstead plan makes little mention of the role caregivers will play in averting institutionalization. Further, the plan does not identify the numerous supports that exist today for caregivers or other supports needed that would enable them to continue providing care to individuals with disabilities. Future versions of this plan must address this issue.

Specific Performance Benchmarks. AARP applauds this plan's comprehensive approach to Olmstead implementation that requires the involvement of multiple agencies, departments, and programs. We appreciate that the plan outlines concrete goals for each department, but feel the final version of the plan should identify short-term goals for each department, as well as an approximate timeline for completion of these goals. Such internal measurable goals will allow for greater transparency and accountability by both governmental entities and the community.

Again, thank you for the opportunity to comment on this plan. AARP hopes these comments serve as the start of an ongoing dialogue which will ultimately promote quality, cost-efficient care for all Minnesotans. Please feel free to contact AARP's Associate Director of Advocacy, Mary Jo George, at mgeorge@aarp.org or 651-271-6586 with any questions.

Sincerely,

Michele Kimball
State Director
Cc: [Redacted Text] Strickland, Attorney-Litigation
AARP Foundation Litigation

Comment 103

Copy of document from 8/19 Rochester listening session from *[Redacted Text]*

[full text of attached document]

The cages are back, but they are gilded now. Providers are investing in lovely high end homes so residents have nice bedrooms where they spend most of their free time.

The identified list of barriers in the Olmsted Plan are all important. The last barrier, The assumption that individuals with disabilities lack the capacity to make day to day decisions affecting the quality of their lives deserves deep consideration.

At every annual meeting, a copy of the rights of the self advocate are handed out. Each and every one of those rights can be and are taken away with no consideration for the wishes of the self advocate. The right to associate is most often abused.

My two sons with disabilities own their own home. I am their guardian. Their in home provider would not allow former staff to visit their home. I called licensing thinking they would address this issue. Staff made it clear licensing was not interested in rights of individuals. I could have called in a VA report but when my son was struck by a staff some years ago, the result was a three week suspension with pay for the staff. He then came back to work with other people with disabilities. The Olmsted Plan needs to find a system that works.

A former house mate of my son continues to live in a four bed waiver home. He develops close attachments to staff who care about him. It's very upsetting to him when staff leave. The people who control his life developed a program where this self advocate has a chance to say his final good bye. Then staff and he are instructed that no further contact can be made. This does not work well in a small community when former staff work for other agencies and this self advocate and former staff attend many of the same activities. In fact, this self advocate makes every effort to say hello and even sit at the same table. He no longer is allowed to attend functions with his peers, so he sends greetings to former staff through his housemate.

These are two examples out of many. Too many providers are denying access to former staff. It has been my experience that when an organization provides good service, they welcome anyone because they are proud of their success. Currently, many providers have their attorney on speed dial and their residents closeted in their rooms. The advice given by an attorney never seems to contribute to any kind of quality lifestyle.

[Redacted text] developed a Quality Assurance program that addressed these very issues. It was focused on the self advocate and good things resulted from a VOICE review. Funding to that program has been cut in the past few years. Quality Assurance is a system that works, it needs to become a statewide program.

The Housing Access program also provides opportunities for self advocates to have choices. When you are living in a home of your own, staff become more supportive and less controlling. Many of the barriers created by corporate adult foster care liability issues are eliminated. Transportation is a liability issue for many providers. As a result, ride sharing is not allowed. If your friend is not served by your agency, he or she cannot share a ride in your vehicle. Your neighbor can not pick you up for church unless you have provided a background check and proof of insurance. A home of your own allows you to make your own transportation arrangements, just like others do who do not have disabilities. Quality of life improves in your own home.

Arc Southwest offers many opportunities for self advocates to network together about what is important in their lives. Currently, we hear about people who want to come to activities or attend family events but they are short staffed. If family do not or can expand the extra effort to provide transportation, self advocates miss graduations, family picnics, weddings, etc. A few days ago, I was talking with a family who are very upset that their son is very seldom allowed out in the community. He needs a one on one staff and that position is being funded but it is not being filled. This family and their son want options. So do the rest of the families and self advocates.

Minnesota knows how to provide a quality lifestyle for people with disabilities. It is our hope that Olmsted will eliminate unproductive paperwork and put efforts into productive support services for people with disabilities.

[Redacted text]

Comment 104

Copy of document from 8/19 Rochester listening session

[full text of document]

Good afternoon:

My name is [Redacted text]. I know many of you in this room. We have worked on related topics for many years.

Many of you are aware of the current employment project underway with Mayo. We all see this as a major breakthrough that will take time and talent focusing on specific two way learning and actions by both Mayo, the employer, and the potential employees and support organizations.

For those of you who don't know me, I had a [Redacted text] year career with [Redacted text]. For most of my career I was assigned to leadership and senior management positions both in the U.S. and international operations.

[Redacted text] years ago I retired from [Redacted text] and started my consulting company dedicated to helping organizations improve their quality and productivity.

Most organizations need help in establishing strategic plans with specific strategic direction and measureable results.

I have read and studied the 60 plus pages of the current Olmstead document; in my opinion, we should net it down to the overall statement plus the strategic directions listed in the main goals. We should focus on the critical few actions that will lead to measurable outcomes or results. We should dispense with the long list of activities and stick to the specific outcome based actions.

To determine what actions to take-check to see if the actions have led to measurable results. Remove activities that say, hire a staff member. Place your attention on what you will do to meet customer/consumer needs, requirements and expectations.

In the private sector, reorganization around strategic directions is a reality; in government you may not be able to reorganize but you can do a better job of interagency integration, collaboration, etc. In the end test your entire plan against the SMART criteria:
Is it strategic? Is it measurable? Is it achievable? Tell us who is responsible? Add in timelines.

Just as we are doing in the Mayo project, let's focus on critical actions by both the employers and the employees with their support organizations.

Thank you for listening; I am willing to help in any way possible.

Comment 105

Copy of document from 8/19 Rochester listening session from *[Redacted text]*

[Full text of document]

I Have the Right

1. I have the right to hang out with my friends
I have the right to speak up for myself
I have the right to have the job I want
Fight every day. Fight for your rights.

2. I have the right to make my own decisions
I have the right to be with family
I have the right to have my opinions heard
Fight every day. Fight for your rights.

Words: © 2011 Self-Advocates Minnesota Workshop Participants: *[Redacted Text]* Tune: I Walk the Line (Johnny Cash)

Comment 106

Copy of document from 8/19 Rochester listening session from Sandra Gerdes

[full text of document]

LAURA BAKER SERVICES ASSOCIATION

Bringing the Power of Possibility to People with Special Needs

Governor Dayton, Lieutenant Governor Prettner-Solon, Commissioner Jesson, and members of the Olmstead Sub-Cabinet,

As Executive Director of a private, not-for-profit service organization, I have spent a great deal of time studying your preliminary reports and Olmstead plan recommendations. I, and my organization, are committed to helping people live integrated lives, where they can easily access the services and supports they need to lead the lives they choose.

I have watched the Olmstead journey on the Federal level since 1999, while also studying the individuals we support and reflecting on stories that I regularly hear from families. I have studied the DOJ's Statement on Enforcement.

In the early 90s, you would have heard me talking to members of our board and the community about moving everyone *out*, and not having any congregate settings. My view has changed, because of the people we support, and the needs I hear from families.

Here's what I have learned:

- 1) Some people need more structure and support than others. They need to have a setting where they get enough structure and the right support to engage with the world. Often, it is not possible for that to happen in the family home, because the individual's needs overwhelm the family. We need to acknowledge and plan for this.
- 2) Having a stranger come into your home to provide support doesn't work for every family. Families are afraid of being judged. There may be unrelated issues that the family isn't comfortable sharing with the social service system. We must have ways to provide services that respect families' privacy, dignity and trust.
- 3) Families need easily identifiable, accessible, and friendly places to talk about their needs for support.
- 4) Current State policy makes it difficult for some individuals to get services in the community while their family is at home: Providers of certain services can't bill unless the person is at home, or is considered to be in an integrated community setting. Some individuals need more steps in making transitions from home to the general community. An individual with sensory issues may not be successful in an integrated gym, or at the public library. These individuals do better with new experiences when the setting is not overwhelming. Disallowing payment for adapted transition services severely limits the options for families and providers.
- 5) Families have told me that they think it's normal for people to outgrow their families, and move out on their own. Finding ways to allow gradual transitions for their loved *ones*, such as regular out-of-home respite with trusted providers, is something that families want.

Families *can't* carry the burden of finding and training support staff or respite providers. *Often*, their lives are consumed with caring for their loved one(s). It becomes easier to do it all themselves, to just make do until the family is broken, than to expend the considerable effort required to find and train people they can trust.

6) It isn't always more cost-effective for people to live in the community. I think we need to be very clear about this, to avoid the firestorm that will come if community members believe our decisions are made primarily for financial reasons. Sometimes, it costs less - and helps more - to serve people with disabilities in a congregate setting.

7) Living in an integrated setting does not mean an individual is integrated in the community, or has friends. A house in a neighborhood does not guarantee that I will be a part of the community, whether or not I have a disability. *Housing is not an end; it is a means to an end.* We must keep sight of this.

Individuals who live in a smaller town without accessible transportation, and without a community of support, may be more isolated than those who live in a city that provides transportation and community access.

8) Isolation in a community setting can be more damaging than an "institutional" setting. If social services places me in a house way out in the country so there are no neighbors to be disturbed by my schizophrenic episodes and running naked in my *yard*, that is not community integration. We need to acknowledge that these kinds of situations *exist*, and give those individuals the best options *for them*.

9) The issue is choice, not setting. The setting- in-community, or institutional - does not define how people are treated, or what opportunities they have. We need to focus on providing opportunity and choice, rather than setting.

10) We need to identify the scope and nature of the problem *in Minnesota*:

- a. Who is *inappropriately* living in segregated settings, and why?
- b. What have we identified as the unmet need, and how will we meet that first?
- c. How do we engage our communities: what do they understand about the unmet needs, and what will the community allow, or not allow, in their backyards?
- d. What is the community willing to spend on meeting the unmet needs, and what do we need to do move the community along in accepting differences in their own backyards?

Here's what I think you need to include in your Olmstead plan:

1) People need to have access to resources that give them the appropriate level of support and services for their needs and desires. Part of the government's job is to create a system that allows that, to whatever extent resources are available. We need to use those resources in ways that are cost-effective, least restrictive, and *most appropriate to the individual*.

2) The community must buy into the plan. The State has a responsibility to ensure that *all* citizens understand the broad range of needs, and the ways those needs are being supported.

3) As you seek to unbundle housing and services, you must address the associated issue of sufficient resources: We must have adequate access to affordable food and housing for individuals with disabilities. Under the new plan, people need to feel that they have access to similar or better housing options they have now. This is not currently possible in Northfield: Simply, housing is too expensive, no Section 8 vouchers are available, and Section 8 housing has limited availability for people under 55. Handicapped accessible transportation is only available during the day and its scope is limited. We must recognize that by unbundling services and housing, we put people with disabilities into competition with others who need the same supports. We need more benefits available, enough for all those in need, so we don't force the most vulnerable people to compete for basic living resources.

I share two stories, to illustrate the challenge of ensuring the Olmstead Plan serves all Minnesotans.

[Redacted Text] had lived in our ICF-DD for many years. Over 18 months, her behavior became increasingly dangerous to herself and others living here. Her team tried many solutions, including a stay at a state-operated crisis home, and adjustments to her medication. The situation didn't improve. Her team developed an independent-living plan. *[Redacted Text]* rents an apartment in the community; our organization co-signs the lease. *[Redacted Text]* has 24-hour staffing, and likely will need that long-term. Her behavior has stabilized. She does best living alone.

[Redacted Text] needs intensive support: Someone to cook and clean for her, someone to help her manage her activities, someone to tend the household and pay the bills. *[Redacted Text]* services cost \$342 a day. Her living expenses cost another \$929 a month- not including the cost of bus fare to work, or laundry, a new pair of shoes, or toothpaste and shampoo, or ever renting a movie or going out to eat. Her rent is \$610 a month.

[Redacted Text] gets social security benefits of \$710 a month, and SNAP benefits of \$128 a month. She is eligible for Section 8 housing, and is on a waiting list to access it. Her expenses exceed her income, but this is the right living arrangement for her.

[Redacted Text] lived in the locked basement of a suburban house before she moved to our ICF-DD in *[Redacted Text]*. *[Redacted Text]* can't handle a lot of external stimuli, so her living space had been kept barren. She had no contact with neighbors or friends, despite living in what's considered a community setting.

Now in the ICF-DD, *[Redacted Text]* lives with others who eat together, play together, share activities and conversation. With proper support, Linda interacts with *her* community- housemates, staff, neighbors - on her terms.

It's extremely stressful for *[Redacted Text]* to go to unfamiliar places, so community activities must be well planned, with significant support, and for short periods of time, until she is comfortable with the outing. *[Redacted Text]* is now able to regularly visit a few places in town to get a meal. It has taken six years for her to be able to go to the dentist's office. This year, she begins the process of going to the doctor's office- growing beyond the need for house calls.

Minnesota's Olmstead Plan must serve both *[Redacted Text]*, and *[Redacted Text]*- and the thousands of individuals on the spectrum of disabilities.

I recognize that the challenges are many. Certainly a primary challenge is ensuring that we are not creating "one size fits all" solutions-that's how we got to this point. People have a full spectrum of needs; we must have a full spectrum of solutions. Please create solutions that meet this full spectrum. In your process, please engage those of us who work with the highest-need individuals, and hear from families what they need, so that together, we can create long-term, sustainable solutions for all Minnesotans.

Sincerely,

Sandra Gerdes
Executive Director

Comment 107

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-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Monday, August 19, 2013 7:39 PM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/19/2013 AT 7:38:53 PM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I have a disability

COUNTY: Olmsted

COMMENTS:

Pg 4 - sub goal of family supports should specifically mention the spouse.

Pg 11 - Transportation - Rides for ElectroConvulsive Treatments.

Pg12 - If you are disabled and want to work that you do not lose your benefits.

Pg 13 - Case worker for every mental Health disabled person. With emphasis on helping navigate medical billing nightmare including clear and concise medical bills.

Included copy of document from 8/19 Rochester listening session from *[Redacted Text]*

[Full text of document]

[Redacted Text] would like a BETTER Minnesota for people with disabilities.

Hello, my name is *[Redacted Text]*. I am a Mom of 7 children and grandmother of 5. *[Redacted Text]* years ago my son *[Redacted Text]* was born with developmental disabilities. *[Redacted Text]* has a great

smile and award winning personality. *[Redacted Text]* is a big part of our family. Here are just a few of *[Redacted Text]*'s dreams.

SCHOOL

- When *[Redacted Text]* was 5 *[Redacted Text]*'s dream was to go to Kindergarten with his peers, at the same school as his big sister. After planning and working very hard we made it happen. His kindergarten teacher was impressed with what *[Redacted Text]* and his peers were learning together.
- *[Redacted Text]* was in regular education classrooms in his 12 years of education because that is where he wanted to be and where he learned best. It took team work and 3 conciliation hearings and one great lawyer to make this dream happen.
- When *[Redacted Text]* was 18 years old *[Redacted Text]*'s dream was to graduate with his peers. On graduation day *[Redacted Text]* rolled across the stage in his wheelchair to get his diploma. *[Redacted Text]* was all smiles that day.
- TODAY: There are kids with disabilities that want to be in regular education classrooms FULL time. They have been told they can't because they are "too retarded" or there isn't enough room or time to be in a regular education classroom.
- Minnesota goal: The purpose of education is to prepare and educate every student for the real world based on what the person needs to make that happen.

WORK

- When *[Redacted Text]* was in 9th grade *[Redacted Text]*'s dream was to work in the community. We worked on a transition school to work plan. We had several transition planning meetings. *[Redacted Text]* worked at a radio station and at a city hall. He had so much fun.
- Once *[Redacted Text]* graduated from school: he went to a DTH with a goal to get a job in the community. After 2 years working at the DTH doing shredding I asked when *[Redacted Text]* can start a job in the community. The staff at the DTH said that *[Redacted Text]* would never be able to work in the community.
- Minnesota's goal should be that everyone should be able to work where they are happy.

LIVING IN THE COMMUNITY

- When *[Redacted Text]* was in school he had a dream of living in his own place. We are still working on that dream.

[Redacted Text] meets, greets and interviews all of his prospective staff. *[Redacted Text]*'s dream would be to have all blondes working with him and they should be paid a million dollars an hour because that is what they are worth.

- Minnesota goal: Everyone should be able to live where they are happy. All direct care staff be paid a salary that is worthy of the work they do.

SUGGESTIONS ON A BETTER INTEGRATED FUTURE FOR MINNESOTA

- ALWAYS Start with the person ... Everyone has a VOICE. Everyone has abilities.
- Base QUALITY on what the PERSON says QUALITY is.
- When making changes to services in Minnesota ask everyone: including people with disabilities what is working and not working.
- NEVER ASSUME
- One story: When *[Redacted Text]* was 13 years old a teacher told us that *[Redacted Text]* had a mentality of a 9 month old. I told the teacher this story. Our family was at the Rochester Mayo Civic Center attending a Wrestling tournament. At the time *[Redacted Text]* had very poor head, neck and trunk control and had a hard time holding his head up. When I looked over at *[Redacted Text]* he had his head up and he was looking to the left. I thought what are you looking at .. I looked over and saw cheerleaders in makeup, mini skirts, and pony tails walking toward *[Redacted Text]*. The closer they got, the bigger *[Redacted Text]*'s smile got. *[Redacted Text]* kept eye contact with the cheerleaders as they walked behind him. I told the teacher that a 9 month old doesn't understand boy /girl relationships, attracting the opposite sex or how to flirt and *[Redacted Text]* understands all of it.
- NEVER ASSUME anything.
 - o Just because someone is in a wheelchair doesn't mean that they don't hear, see, understand and comprehend you.
 - o Just because someone doesn't make eye contact with you doesn't mean they don't see you.
 - o Just because someone doesn't shake your hand doesn't mean that that they are not happy to meet you.
- Remember, we are all people with abilities.

The care of human life and happiness and not their destruction is the first and only legitimate object of good government." Thomas Jefferson

Thank you, *[Redacted Text]*

Comment 108

Copy of document from 8/19 Rochester listening session [22 individual letters using a form letter, some added their personal stories and are included below]

[Full text of document submitted by multiple individuals]

August 19, 2013

Dear Gov. Dayton, Lt. Gov. Prettner Solon, Commissioner Jesson, and members of the Olmstead SubCabinet Committee,

As you create the Olmstead Plan that will affect the lives of Minnesotans with disabilities, we wish to add the voice of families and individuals whose future lies in the balance. We are parents, guardians, friends and advocates of people with developmental disabilities. We speak on their behalf. Our loved ones will be profoundly affected by your decisions. We have three messages for you, and three requests for action.

First: One Size Doesn't Fit All.

It takes a range of services to meet the varied needs of *all* individuals on the full spectrum of disabilities. Developmental disability is different from physical disabilities. DHS has already combined licensing standards for Minnesotans with physical disabilities, developmental disabilities, and the elderly. When DHS combines governance of services for these three groups, it puts them all in the same box. That does all individuals disservice, because each population has strikingly different needs.

Even within developmental disabilities, there is a broad spectrum. Some people need modest support; others need intensive supervision and a carefully modulated living environment to thrive. The spirit of an Olmstead Plan is to provide community integration and community access for all individuals. To achieve this, the state must provide a spectrum of options.

You recognize that not everyone fits in the same box. You have heard from many people with disabilities who want more independence. The issue is *choice* for each individual, and appropriate *levels* of care. Many of our loved ones need- and choose -a structured setting that feels safe and lets them interact with other people at a level that's comfortable to them.

You have mostly heard from people who want *less* intervention and *more* independence. We urge you: Don't forget those people who cannot live independently. These are our loved ones. Do not restrict their choices in your effort to provide more independence for others. Do *not* shift from one generalization to another.

Second: "Community" is in the eye of the individual.

Not everyone is equipped to live "in-community" in an apartment or private home. Some high-need individuals can be better served through community-based congregate settings: group homes, or campus cottages.

"Linda" lived in the locked basement of a suburban house before she moved to Northfield to live on the campus of Laura Baker Services Association. Linda can't handle a lot of external stimuli, so her living space was kept barren. She had no contact with neighbors or friends. This is what is considered "a community setting."

Now in Northfield, Linda lives with others who eat together, play together, share activities and conversation. With proper support, Linda interacts with *her* community- housemates, staff, neighbors – on her terms. Is she ready to live next door to you? No. Does she deserve a home that is warm and inviting? Yes. In her current home, she is treated warmly.

This is the "institutional setting" that the Olmstead Plan might eliminate. We ask you: Which home gives Linda a true community?

Congregate housing can be the most appropriate level of community for high-need individuals. It is important to have a range of options available.

Third: Minnesota's Olmstead Plan should focus not on a single path for community integration, but on a true understanding of "community."

At Laura Baker Services Association in Northfield, people who live on-campus and in group homes are in community. These are the most appropriate settings for our loved ones with high needs, individuals whose capacity to engage with others is very different from the mainstream. Congregate settings fit the spirit of the Olmstead Plan because they allow each individual to have the scale and depth of community that is best for them.

We urge you to evaluate your policies in the context and spirit of these Olmstead Plan principles:

• **Community integrated**

We invite you to visit Northfield, a town of about 20,000 people, and home to St. Olaf and Carleton Colleges, to see for yourself how individuals with disabilities engage with the Northfield community on~ and off-campus. Laura Baker's campus is six blocks from downtown Northfield, close to the Northfield Public Library and Carleton College. On~campus homes are set in an established residential neighborhood that has grown up around them. Six group homes are in neighborhoods across Northfield. Laura Baker's congregare settings are *Integrated in the Northfield community*. We urge you not to assume automatically that an Intermediate Care Facility for the Developmentally Disabled- an IFC-DO- is, by default, not in the community. or that corporate group homes are not in community

• **Provides a typical setting**

Cottages on Laura Baker's campus provide individual bedrooms and bathrooms for each person, and common spaces typical of a family home: living room, kitchen, dining area. Group homes are single-family homes in neighborhoods all around town. Both provide a warm, caring, well-supervised home. It's the kind of home that we wish for our own son, when we can no longer care for him.

• **Meets the individuals' choice**

Some individuals with disabilities prefer- and thrive in- a home with clear structure and the choice of moderate interaction with the others. Individuals need different levels of structure. Those living on Laura Baker's campus prefer the strong structure there: A place of retreat, to feel safe, so they can handle their travels into the wider community. Over two-thirds of the people that Laura Baker supports are dually diagnosed with a developmental disability and mental health issues that range from depression and anxiety to schizophrenia and borderline personality disorder. We celebrate every time our loved ones make a step beyond the safety and security of their home into the wider community.

In the meantime, we want them to be safe, and feel secure.

- **Cost-effective**

Right now, DHS is considering the case of 12 individuals who live in Northfield, in an 86-year-old dormitory building. They receive services that cost, on average, about \$230 per person per day paid by the state. Plans have been made to replace the dormitory with two cottages, and provide the same level of care at the same cost, in a more traditional home environment.

Instead, DHS is pressing to move these 12 people into housing in the community- apartments, or private homes. To provide the services these individuals need, it would cost over \$400 per person per day- nearly double the current rate.

This would cost the state of Minnesota nearly \$770,000 *more* per year ... for just 12 people. We're not asking for more money. We are asking for a full range of options.

Congregate-care settings -on-campus and in group homes -fit the principles of an Olmstead Plan.

As you seek to establish an appropriate range of options to serve all Minnesotans with disabilities, we request that you take these three actions.

1. **Maintain funding for congregate care settings to serve the highest-need individuals.**

2. **As you consider future options, in the meantime, lift the moratorium on group homes.**

The 2009 moratorium took money out of Minnesota's social-service system that ensured places for people with disabilities. The moratorium has put people with developmental disabilities in competition with other Minnesotans receiving social services: Mothers and children, the elderly, people with physical disabilities, and those with mental health issues. The moratorium on group homes eliminated an option without creating other options appropriate to some individuals' needs. There isn't enough capacity now for those who need this level of care. There isn't enough room for our loved ones. You must allow more group homes to be established and licensed. The state needs to ensure adequate housing- enough options, and access to it -whatever form the housing takes.

To act immediately, please include "corporate group homes that provide foster care for adults with disabilities" in the list of exemptions from the current moratorium.

3. **Give parents the tools to help you create capacity.**

Parents who consider starting a group home find themselves faced with cumbersome regulations and the knowledge that, under current law, after the parents die, the group home *is* shut down. We ask you to amend current liability laws to provide greater protections for parents who establish a private group home. Amend current regulations to allow parent-established private group homes to continue after the death of the parents.

In conclusion, we urge you to consider, and serve, the full spectrum of Minnesotans with disabilities. Don't make policy based on the lowest-need individuals, or the loudest voices. You are facing a patchwork of individual needs that requires a vibrant patchwork of solutions. Embrace it.

Thank you for your time, and for your work on behalf of our family.

Comment 108A [Personal letter added to letter from Comment 108]

To: Minnesota Olmstead Commission

From: *[Redacted Text]*

Date: August 19, 2013

I have been testifying before state legislators and commissioners on the care of developmentally disabled citizens since the de-institutionalization years of the 1970s. What we won in that decade led to the creation of a system in this state that astonishes parents with whom I have talked from other states. We should be very careful how we set out to change it.

The Olmstead decision itself is a restatement of the case made in Minnesota forty years ago aimed at ending the "confinement" of developmentally disabled people in inappropriate settings. The Department of Justice memorandum moves beyond that judgment to assert that states should not support "congregate settings" for housing developmentally disabled people. However, DOJ does not go so far as to argue against a state system that provides a variety of service options for this population. Their principal concern seems to be that states not compel citizens to accept inappropriate settings in order to receive services. The state's responsibility is to insure that families and individuals have a real choice.

The Minnesota Olmstead vision sets forth that principle, and the Department of Human Services identifies individual and family choice as central to the system of service provision in this state. However, the DHS promises at the same time to initiate a policy of restricting that choice. Although nothing in the Supreme Court decision or even in the DOJ memo would require it, they have laid out a campaign against what they call "institution-like" settings. In Minnesota that means de-funding ICF-DDs, without any apparent intention to judge the quality of service or the satisfaction of the families using those services. The "institution-like" setting applies, in their vision, to a lovely campus in Northfield, where 30 people live in five newly-built or remodeled cottages, each one with his/her private room and bath. I have walked the halls of the Faribault State Hospital. It is not only unjust and insulting, but intellectually absurd to maintain that these two places are comparable.

That Northfield campus, where my son lives, is operated by Laura Baker Services. It is not isolated from the community. He goes downtown, to the library, out to dinner, to movies, etc., all the time. Because of his multiple disabilities, the campus is a location that reassures his parents that he is not at risk from traffic or other dangers. He enjoys rewarding relationships both with his housemates and a great variety of people who do not live on campus. I cannot imagine that life for him in a four-person home elsewhere in Northfield would be in any way "less restrictive" than life on campus is." The ICF is the "most-integrated" setting in which he can thrive. I know many other parents feel as I do, that any system that denies us this choice is compelling us to accept someone else's judgment as to what is good for us. Except for the scandal of limitations on access, the Minnesota system works. There is no need for the kind of radical change DHS has in mind.

Comment 108B [Personal note added to letter from Comment 108]

I am the co-guardian/conservator for an individual with developmental disabilities living in a group home setting and she is thriving in that environment.

Comment 108C [Additional note added to letter from Comment 108]

END OF THE Spectrum RESIDENTIAL OPTIONS FOR AUTISM

Dear Gov. Dayton, Lt. Governor Prettner Solon, Commissioner Jesson, and members of the Olmstead Sub-Cabinet Committee,

It is with great concern that I continue to monitor the progress Minnesota is making in appropriately housing people with developmental disabilities, especially autism. We continue to desperately need housing that does not isolate people with developmental disabilities as do many of the current models, especially group homes. For individuals with conditions such as classic autism, who cannot be out in the community due to noise and sensory challenges, life in a typical home or group home is tantamount to segregation. It is reminiscent of the institutions we closed decades back. We need to be proactive in developing models that support the needs of divergent populations and particularly cognizant of the needs of populations that cannot take advantage of mainstream community resources.

Let me highlight with the story of my son *[Redacted Text]*, who is *[Redacted Text]* and has just moved into his 6th placement.

1. He started in a group home in Roseville that "couldn't meet his needs." He was left unsupervised, fell off something high and dislocated his ankle. He often came to school in a filthy diaper and was not provided adequate food. The school reported the group home for neglect and *[Redacted Text]* was sent home.
2. Fifteen months later he went to an out-of-state treatment center where he made tremendous progress. He started talking, sleeping through the night, and was completely toilet trained. It was a campus model with therapeutic interventions and a strong sense of community. He happily lived there for 2 years.
3. Funding ran out and he was moved to a group home in *[Redacted Text]*. Here he lost all his gains, was put back in diapers and stopped talking. He was mistreated, *[Redacted Text]* and contacted MRSA. He was ill for 4 months and after he recovered was moved to a different group home. The *[Redacted Text]* in particular happened because there were not enough people around in the small group home setting to keep the children safe from *[Redacted Text]*.
4. *[Redacted Text]* then moved to a group home in Brooklyn Park, the only opening at the time. Here he was kept in his room for weeks on end and fed marginally. Parents were not allowed in the home and on the rare occasion I was able to obtain access found his room filthy, smeared in feces with his mattress

soaked in urine. All the children in the home lost substantial amounts of weight because staff, an almost entirely non- English speaking immigrant population, was stealing the children's food, clothes and possessions. The home was repeatedly reported for child neglect by parents, schools and other professionals, but nothing happened. Also with so few placement options the providers can hold the parents hostage to very low levels of care, but it was unacceptable to me.

5. [Redacted Text] was moved from this setting to the only opening in the state at that time, 4 hours north of the Twin Cities on the Iron Range in Chisholm, Minnesota. Here he was finally in a relatively safe and caring home; however there was no appropriate school placement and he was four hours from his family! The only school was half an hour away in Virginia and he was forced to ride a noisy bus, amongst adolescent boys dealing with drug and behavior issues. By the time he reached school each day he completely dis-integrated and essentially incapable of learning. Other than school he did not leave the group home for over four months after he was placed. With his autism there is nowhere he can go in the community. He was in Chisholm for almost 2 years.

6. In June, he finally moved to a more appropriate setting. He now resides at the Laura Baker School in Northfield, Mn only 45 minutes from his family in Minneapolis. This small campus model, with a school on-site, is by far the best setting [Redacted Text] has been in. He now has a large community of people around him; people who engage with him, know his name and care about him. He has things to do on the small campus and is engaged and living a much more vibrant life. He still goes out into "our community" as much as possible, because [Redacted Text] loves to "GO." But he cannot handle the stimulation of most stores or establishments, so he is limited when on an outing. Laura Baker however provides him with his own community. I cannot say enough good about the small campus setting for [Redacted Text] and for autism. [Redacted Text] lived in utter isolation in a group home, confined to a room with nowhere to go and nothing to do but watch hours of TV. Now there are people and activities on the campus on a daily basis and although his world is still small, it is far more expanded than it was at home or in a group home.

When you are considering how best to look at the Olmstead Act as it relates to disabilities in Minnesota, please keep in mind the need to accommodate different disabilities differently. For severe autism, the community at large is barely accessible; please consider options for community that these populations can take advantage of.

One Size Does Not Fit All. We need choice and appropriate placements for our loved ones. Thank You.

[Redacted Text]

Comment 108D [Personal notes added into the letter from Comment 108]

1) One size does not fit all

I am very aware of the truth of this statement since I have two sons in the autism spectrum. My oldest son has Asperger's syndrome and has just graduated from high school. He is making plans for his future including getting a job, getting his driver's license, and eventually going to college and getting his own

apartment. He wants to be "integrated in the community", and I believe with the supports available to him he will be successful.

My other son, *[Redacted Text]*, has more severe, classic autism. He is mostly non-verbal, has sensory processing dysfunction, and is prone to aggressive and self-injurious behavior when he's frustrated. He has little sense of danger, and has eloped several times making it necessary to call the police to help find him. He does not have the same desires or needs as his brother, and I don't believe that "integrating into the community" in the traditional way is on the top of his list of things he wants and needs to be happy.

2) Community is in the eye of the individual

[Redacted Text] will soon be turning *[Redacted Text]* and currently lives in a group home in *[Redacted Text]* with two other housemates. According to the letter of the law of the Olmstead Act, besides living at home with Mom and Dad, this is the best setting for him. He lives in a home in the "community", is enrolled in the autism class at a public high school, and has access to the programs and services he needs. On paper, it seems like all the "best practices" are being followed and that he is living in a "least restrictive environment".

Real life often looks different than it does on paper, and that is certainly the case here. *[Redacted Text]* lives in a nice neighborhood in town, but he doesn't know or interact with his neighbors. He doesn't want to and he doesn't know how. He may want to interact with their dogs, but not with them. *[Redacted Text]* has a nice although not very big yard outside his house. He doesn't get to play in it because staff is afraid he will dart off into a neighbor's house or yard or into the street.

[Redacted Text] has two housemates, but he doesn't interact with them. Their disabilities are different than his, they don't understand him, and frankly they are afraid of being the target of one if his angry and aggressive outbursts.

[Redacted Text] is enrolled in the autism class at a local public school, but he doesn't get to go to school. He has homebound instruction where a teacher or paraprofessional comes and does work boxes with him. There have been times when the instructor left early because *[Redacted Text]* sped through the prepared material and they didn't have anything else ready to fill the forty five minute block. They haven't invited him to participate with the other students because they are afraid of him having an angry outburst at school.

The staff at his home take him on "community outings". These usually consist of van rides in the country, visiting county or state parks, and driving to see horses. They will sometimes take him to a fast food restaurant, but not to movies or malls or libraries or swimming pools as these settings have a lot of people and can be over stimulating to *[Redacted Text]*. He does have a "quad" bike that he likes to ride with staff, but unfortunately when he recently became overwhelmed and had a behavior on a bike ride, his fellow community members reacted by driving by and angrily shouting at the staff and then walking up too closely to *[Redacted Text]* in the middle of his meltdown, all while staff was trying to calm *[Redacted Text]* and take care of the matter with his supervisor on the phone.

Consequently, a large part of *[Redacted Text]* life consists of sitting alone in his room watching videos. Probably the most control he has in his life involves which movie he wants to watch next. Is he in his "least restrictive environment"? Is he an "integrated" member of the "community"? On paper he is, but

is this the vision the crafters of the Americans with Disabilities Act and the Olmstead Act had in mind when considering what kind of life people like my son should have? I hope not!

It is obvious from [Redacted Text] experience that residential proximity does not equal "integration" or "community". It is also obvious to me that because of the nature of his autism, my son will never be able to "integrate" comfortably into society, no matter where he lives. Also because of his autism, I don't believe that he even cares to "integrate" with the rest of us. But I do believe that he has desires of how, where, and with whom he wants to live that should be honored.

3) Minnesota's Olmstead Plan should focus not on a single path for community integration but on a true understanding of "community".

Community means different things to different people, and just because someone has a disability "does not mean a person has less desire to make choices about how to live, where to live and who to live with. It doesn't lessen the basic human desire to exert control over one's life. It doesn't lessen the desire to be seen as a person first; a person with strengths and hopes", as the Minnesota's Olmstead Plan homepage states.

So as the Olmstead Planning Committee and the Olmstead Sub-Cabinet strive to answer the question "How well do public programs match what people with disabilities and their families want and need in real life?", please remember that when it comes to community, one size does not fit all. People with disabilities and their families need a complete range of residential options available, from being integrated in our neighborhoods and communities, to congregate settings like campuses and group homes, to rural agricultural communities. Everyone should have the right to choose the scale and depth of community that is comfortable for them.

And please remember my son, [Redacted Text]. [Redacted Text] wants to live on a farm! Even when he was a little boy, he preferred being in the country. Maybe because when he is in the country he has a sense of freedom and independence that he doesn't get when he's in town. Maybe because in the country he has room to roam and doesn't have to be within arm's reach of someone like when he's in town. Maybe he likes the calmer, quieter environment. Maybe he likes the cows. Whatever the reason, it is where he is happiest and where he likes to be the most.

Across the country, there are dozens of "agricultural communities for adults with autism". A few examples are Bittersweet Farms in Ohio, Safe Haven Farms in Pennsylvania, and our own [Redacted Text]. We need to develop more of these communities in Minnesota! [Redacted Text] deserves the choice to live and work in one of these communities!

On the home page of Agricultural Communities for Adults with Autism, a consortium of existing and information organizations focused on sharing best practices and advocating for holistic, agricultural based employment and housing models for adults with autism, the ACAA states that they are striving to ***"dispel the incorrect notion that agricultural communities are institutional, segregated congregate care models when, in fact, our members, residents, and day program participants are strongly woven into the fabric of their respective communities. We are nonurban, low density community based integrated models. Agricultural communities are a terrific option for adults with autism in our community who prefer the choice of a non-urban, community based, active lifestyle that typically combines a variety of rewarding employment opportunities with quality, affordable housing and a wealth of activities in their local communities."*** (<http://ac-aa.org/>) .

Please also see the letter ACAA co-founders Gene Bensinger and Vicki Obee-Hilty sent to HUD Secretary Donovan regarding the true nature of agricultural communities countering the incorrect and unsolicited advice HUD received from the National Council on Disability (NCD) (<http://ac-aa.org/wp-content/uploads/2013/06/ACAA-HUD-Final.pdf>).

The environment offered in an agricultural community is what my son needs to live a happy and purposeful life. He needs the calmer, quieter atmosphere. He needs the space to run and play and be in the sunshine. He needs a buffer from the commotion of urban communities. He needs meaningful and interesting work activities and the physical and mental stimulation that natural farm activities such as planting, harvesting, and working with animals provide. He needs this calmer, least restrictive atmosphere where he can relax, learn skills that are meaningful to him, and develop more independence and self-esteem. He had the right to choose a more joyful life.

One of the requirements of the Olmstead Act is for "public entities to administer programs in the most integrated setting *appropriate to the needs* of qualified individuals with disabilities." It also states that public entities are to "*avoid discrimination on the basis of disability*". By denying individuals and families choices of where an individual may live that is *most appropriate to them, legislators and policy makers are in fact showing discrimination on the basis of disability* by making the assumption that because someone is disabled neither he nor his family knows what is best for that person.

If we are to honor the spirit and the letter of the concepts of "self-determination", "personal choice", and "person-centered planning", we must support each individual's rights to choose to live where and with whom they wish. We must actually listen to the person, and when that person needs support in verbalizing and making decisions, we need to listen to and trust the family members and loved ones who know him best to act as spokespersons of his wants and needs.

Respectfully, *[Redacted Text]*

Comment 108E [Personal note added to the letter from Comment 108]

August 14, 2013 Re: Olmstead Plan

I am writing today with my "parent hat" on, as the mother of a *[Redacted Text]* year son, *[Redacted Text]*, with autism. I would also like to mention that I am a licensed social worker in Minnesota, have 30+ years in the social work field, most recently 8 years as County case manager for adults with developmental disabilities, and the last 2 years providing guardianship services.

I have seen, facilitated moves, and worked with residential providers all over the state in my attempts to meet the needs of people with disabilities who are not able to live at home or need some kind of different setting for their health and safety. I implore you to see that this vulnerable population needs a spectrum of options while you are considering and defining "community integration and community access" in the Olmstead Plan. One of the options has to be community based congregate settings such as Mount Olivet Rolling Acres and Laura Baker Services.

Strictly speaking from a health and safety viewpoint, some people with difficult behaviors can be cared for, managed, and live a better quality of life in a congregate setting simply due to the number of staff immediately available to deal with any rising potentially explosive incident.

My son was just about *[Redacted Text]*, when due to his size and aggressive behaviors, I was unable to care for him while ensuring his, my, my daughter's or the community's safety. We placed him at Laura Baker for residential services, where he had attended school program for years when our school district was unable to manage him and meet his needs. At times, many staff were needed to keep him and others safe. While his behavior now, 6 years later, is more easily managed, he continues at times to need a larger number of staff involved, than he would have available in say a 4 person group home setting.

Mt. Olivet Rolling Acres was the only place (congregate setting) in the state that would do respite services when he was younger. I knew and appreciated that he was safe there too because of the high supervision and staffing level.

Both of these settings are beloved and part of the surrounding communities they live in. Sometimes, when there are more beds, more opportunities are available for recreation, enrichment, leisure, and community activities. Just living in a 4 person group home setting "in the community" does not insure people have access to these things or staff available to take them outside their residence to participate. I also appreciate the physical setting, including his bedroom with his own bathroom.

Please learn about and keep the congregate setting as an option for those who need it. I want my son, and others that I know, to have the best quality of life possible while keeping them and others safe. They deserve that option. Thanks for your time and consideration.

Sincerely, *[Redacted Text]*

Comment 108F [Personal note added to the letter from Comment 108]

Aug. 14, 2013
Re: Olmstead Plan

Dear Governor Dayton, Lt. Governor Solon, Commissioner and members of the Olmstead Sub-Cabinet Committee,

We are parents of a *[Redacted Text]* year old son with developmental disabilities and autism. We write to you to request action as you create the Olmstead Plan affecting Minnesotans with disabilities.

First the one size fits all plan doesn't work. It takes a range of services to meet varied needs of people, especially those with disabilities. We want as much independence for our son as he can handle but he needs supervision, care to protect him, and a structured setting that is safe and lets him interact in the least restrictive manner. He cannot live alone but he doesn't need to be put in an institution either.

Second, the term community isn't the same for everyone. Not everyone can live in a house, some need a cottage setting that is "set" in a neighborhood. I live in *[Redacted Text]* where we have a wonderful facility, the *[Redacted Text]* which provides for those who need more care. It is in the community and it also has group homes in town. Whatever meets the needs of each person is important. Do not generalize all categories of people and leave them with no choice. And consider the cost of putting all people into apartments or private homes.

Third, the moratorium on group homes needs to be lifted. There isn't enough capacity for those who need homes. My son will someday not live with us and he needs options. Also please amend current law to allow parent-established private group homes to continue after a parents death. We'd like to establish a group home but the regulation and knowledge that it will be shut down after we die keeps us from further considering it.

Thanks for your time and work, *[Redacted Text]*

Comment 108G [Personal note inserted into letter from Comment 108]

Dear Governor Dayton, Lt. Governor Prettner Solon, Commissioner Jesson, and members of the Olmstead Sub-Cabinet Committee,

Laura Baker Services Association (LBSA) is an amazing organization that is able to serve people with developmental disabilities in a dignified, respectful manner that supports and honors each person's goals and dreams. I have served on the LBSA Board of Trustees for almost nine years and have seen the exceptional life quality experienced by our clients, have observed an incredible staff consistently go above and beyond to serve our clients, have listened to stories of families who search for the best care for their loved ones and have worked unceasingly as a board to realize that each person is unique and deserves to have their dreams and life choices respected and fulfilled to the best of our ability.

Warm regards, *[Redacted Text]*

Comment 108H [Personal note added to the letter from Comment 108]

We have taken care of *[Redacted Text]* in our home for his entire life. This has been very challenging and now that we feel he may be ready to move into a more independent setting out of our home, we have no options. Please consider this very carefully, there are many parents and care givers who have given up so much to get their child to this point and to gain back some normalcy into their lives knowing that their child is in a setting that will meet the needs of the now adult child and build on the community relationships that have been built throughout that child's life.

Thank you.

[Redacted Text], mother of *[Redacted Text]*, an *[Redacted Text]* year old developmentally disabled individual

[Redacted Text], sister of *[Redacted Text]*

Through August 26, 2013 (Comments 109–110)

Comment 109

From: [Redacted Text]

Sent: Wednesday, August 21, 2013 1:23 PM

To: *DHS OPC Public

Subject: Public Comments

Thank you

[Redacted Text]

[Full text of document]

My name is [Redacted Text] and I currently reside in [Redacted Text] County. My husband and I have three beautiful children, [Redacted Text], [Redacted Text] and [Redacted Text] was born with Down Syndrome.

We didn't know [Redacted Text] had Down Syndrome until he was 5 days old. The Dr. noticed a little bend in his pinky finger. After blood tests were run, we went home and the last words we heard from the Dr was, "don't worry, I really don't think he has DS". The next day we got the call. The dr quietly said, "the test came back positive....your child has Down Syndrome". It threw us into a tailspin! It's at that point when we realized our life plan has forever changed. The fear of the unknown hit us hard. We didn't know anything about this disability; but we moved forward and can't even imagine life without him. We are very blessed to have [Redacted Text] in our lives.

After 11 years, we finally decided [Redacted Text] needed some additional resources, resources that we couldn't give him. This is the reason our family finally made the decision, to contact the county and look into options to help [Redacted Text] become more comfortable with others and to learn to trust others. We always thought we could do it on our own but now realize that we can't, and having [Redacted Text] feel this way is not healthy for him or us.

After filling out what felt like hundreds of papers, [Redacted Text] was finally granted Medical Assistance 5 months later. When I received my first invoice from the county, it took my breath away. The bill was nearly \$8000.00. This is double what our private insurance deductibles are. And I would like to add that the county requires parents to carry their private insurance in addition to MA. So we have the fees for that along with the Parental fee. It just didn't make sense.

After seeing the high fees charged for mandated services that my vulnerable child requires to live safely in our community, it made my heart sink for our family because we are just trying to see [Redacted Text] succeed in life along with helping my other children feel more like a family and not see their parents have these worries. Now we worry about how we are going to pay that bill on top of all the other monthly bills just to survive. It went from elation that we finally took this step in [Redacted Text]'s life to total deflation and thoughts of "what have I done" started going through my head!! Here I thought I was doing something great for our entire family, not just [Redacted Text]. When in reality it has caused more

stress on my family. It's just one vicious circle. Having to pay high fees just because [Redacted Text] was born with a disability is devastating.

The response from the county to my concerns over the high parental was....If there is not any ability to reduce the fees; we can certainly have a conversation about the pros and cons of staying on Medical Assistance. In my eyes the answer is not to quit but to find a solution that works for everyone!!! Unfortunately that has not happened so we may be forced to drop MA due to the stress of the high fee leaving us back to square one. All the hard work we have done up to this point is great but any outlook for additional care in the future is looking bleak. Why should [Redacted Text] pay the price for this? He is the one who will suffer the most if we are forced to drop MA.

I don't know many people who can afford an additional bill like this on top of all their other daily living expenses. Add in the additional cost a family endures with a child that has special needs and it completely stops you in your tracks. The economy is not doing well; people are struggling to make it day by day. People shouldn't have to choose between getting the much needed services for their child and buying groceries or fixing their car so they can get to work.

My husband and I have worked very hard in life to get where we are today and feel we are in some way being punished for that success. We don't make a lot of money but we were getting by. I now understand why many families are force to go down to one income families in order for their son or daughter to receive the care they need. However, parental providers are paying the price too. Some find the only way to survive life caring for a child with special needs is to be the primary caretaker for that child. They quit their professional jobs to become a caretaker making just over \$13 an hour however half of that goes back to the state to cover the parental fee. [Redacted Text] wants to work and go to college. He has many many dreams. He doesn't want to sit around and see life pass by.

This is why this program was designed. To help those who need it. Obviously there are more expenses to raising a child with special needs, so these services would be beneficial to families and help them acquire the tools needed to ensure their child succeeds.

If we give them the tools to be successful, they will become much more independent.

Comment 110

From: Margaret.Holm@co.hennepin.mn.us [mailto:Margaret.Holm@co.hennepin.mn.us] **On Behalf Of** Todd.Monson@co.hennepin.mn.us

Sent: Thursday, August 22, 2013 12:20 PM

To: *DHS OPC Public

Subject: Hennepin County Reactions to the initial draft of the Minnesota Olmstead Plan

Thanks to Loren and Alex for giving us a couple extra days to get this done. Let me know if you have questions or need more information. Thank you.

Todd Monson
Area Director
Human Services and Public Health Department
A-1500 Government Center; MC 150
612-348-4464
612-348-2856 (fax)

[Full text of document]

Hennepin County feedback to the initial draft of the Minnesota Olmstead Plan

Thank you for the opportunity for input into this important work. As partners in helping persons with disabilities lead full, satisfying lives we look forward to helping develop and implement a more robust set of life choices and promoting integration and independence as key guideposts of our work.

We recognize that this is just the initial effort and draft and has, given the timeframes and leadership, focused primarily on state agency leadership and obligations. We see the system, though, as evolved from a state controlled state hospital based care system for those with serious disabilities to a community based continuum of options through a lot of local leadership, creativity, and hard work. We hope that the refinement of the plan and the implementation options will welcome and include that local partnership and leadership. It is based on our experiences in our county that we offer these reactions to the initial draft plan.

We have organized our feedback into four areas: overall approach, employment, housing, and health.

Reaction to overall approach:

1. Move forward with a recognition that resources will be needed

Change can happen faster than the plan assumes if there are adequate resources, both technical and financial, and a strong, firm commitment to different outcomes tied to outcomes accountability. To “go slow” is to risk a court directed approach via an Olmstead Decision based lawsuit. That could limit the ability of Minnesota and its partners to develop a more flexible implementation system.

But a fast implementation will require the involvement of local partners in overseeing and guiding system change and service development while maintaining oversight so that individual needs and desires don’t get ignored in the implementation but instead guide it. Just like state resources, our human and financial resources are not unlimited and we would hope that all involved in implementation will have sufficient resources to guide the many transitions and needs for service development that the Olmstead Plan envisions.

2. Presenting alternatives and enabling “choice” requires ongoing decision support

“Choice and implementation support” needs to be a funded service in all aspects of life, especially in the move towards integrated and greater independence in housing and employment. Informed choices only

result after learning about, exploring and serious considerations of options. They cannot evolve solely from a comprehensive assessment of assets and challenges.

Our experience:

Hennepin County struggled to meet the needs of new clients once the state moratorium on new corporate foster beds was imposed. So it initiated a project with a team of creative, talented staff to identify and move individuals who seem capable of living independently with supports to apartments or preferably, home ownership. That would help many achieve greater independence and assist others needing the more intensive supervision of corporate foster care.

What was encountered was significant hesitancy to support change by family members and guardians who found comfort in the predictability of the current situation and who had fears about the safety of the person in a more independent situation. The individuals themselves had never contemplated such a change either but many were interested. They needed to see examples of what that would look like and hear of stories of how others make it work in their lives. So even broaching the issue meant lots of discussion, exploring options, and introducing success stories.

Finding affordable housing options is an ongoing challenge. The wait lists for Section 8 rental subsidies is formidable – often years long and the vacancy rate for affordable rental units is extremely low in Hennepin County. Affordable buying or renting options tend to be in more urban communities, and some parts of our suburban communities that offer the advantage of transit and walkable options to stores and recreational opportunities. But even there, there are few limited equity co-ops and other affordable ownership models that offer both ownership and manage maintenance obligations. So decision support involved not just choices re: moving to a more independent situation but also the need to explore different housing options and communities.

Based on this experience, we believe that helping people transition to more consumer directed lives in integrated settings will require the funding of extensive “transition supports” to assist in options exploration before decision making and implementation support afterwards. Also, there needs to be support to “go back” so that a person can try a greater level of independence without the fear of never being able to return to the previous level of supports. The fear of “failure” and not being able to return to higher level of support was a major obstacle to trying greater independence.

3. Integration needs to be emphasized and promoted as the path to greater independence and choice

To prepare people to be comfortable in integrated work and living, persons now in sheltered or congregate settings should have maximum exposure and participation in integrated activities, and this should be a major program component of preparation. Those able and interested in greater independence will be comfortable forming relationships in integrated settings and those for whom segregated living or working is the best option do not find themselves isolated with little contact with others without disability, other than those paid to be with them. Turnover in paid staff often works against ongoing, trusted relationships.

Overall, there seems in the plan to have more emphasis on “freedom of choice” with less emphasis on the integration requirements of Olmstead to ,as much as possible, have people meet their needs and achieve life goals in an integrated setting. “Choice” without exposure to the real options will result in the natural fear of change of individuals and/or families/guardians leading to more “choices” of the status quo. Who will be the trusted agent to present these “choices” without a conflict of interest, give individuals a chance to see and experience the range of choices available, and provide needed transitional support?

4. Results Based Accountability

One wit observed that “whatever is measured improves”. An approach DHS could take is the Results Based Accountability (RBA) method of developing population based measures as described by Mark Friedman in the RBA training provided in 2013 to state staff. Using the RBA process, DHS could establish a simple dashboard of population outcomes for people with disabilities in some of the area articulated in this Olmstead Plan in order to measure meaningful progress with the plan.

Employment

- 1. Employment goals should focus on “competitive employment first” and have expectations that more, perhaps most, persons with disabilities will have typical work lives and earn mainstream incomes.**

Others have shown this is possible. For example, in the state of Washington, a policy directive to give all individuals, regardless of their disability, an opportunity to pursue competitive employment was adopted in 2004 with a deadline of 2006 for full implementation. There were learnings and revisions as this evolved. But the result was that between 2007 and 2009 the number of clients in integrated employment increased by 54%.

Washington State requires a full nine months of pursuing and testing competitive employment options before other alternatives are considered.

Competitive employment should be the priority because it is more satisfying and allows persons with disabilities to develop and nurture new skills not only on the work done but in forging and maintaining meaningful relationships with a broad range of people. It also has the advantage of increased compensation which may have a benefit in reducing publicly funded costs and improved lifestyle.

- 2. Expectations of work week should be based on an individual’s abilities and most should be expected to be able to work the normal schedule for their occupation.**

This will increase a person’s independence and greatly increase the job possibilities available for consideration. While some may have limitations that prevent full-time work, that should be an individual exception, not the norm.

- 3. Obstacles that result from improved earnings need to be removed**

A common fear among our clients is loss of needed benefits if earnings become significant. While some provisions now make exceptions for those that work, they are tied to specific programs and are generally not well understood. As the draft plan notes, clear guidance and broad education in the field is needed in this area.

Increasingly support benefits need to be defined as services that “wrap around” the gaps in the individual’s ability to be independent and self-sufficient. Just as MA now accommodates “cost effective” contributions to private employer based health insurance costs, new models need to emerge that blend resources to enable adequacy, rather than being “eligible” or “not eligible” for a fully paid package being the only option.

Likewise, incentives to maintain employment must be established. There should be financial benefits to employment that allow the working person to retain additional cash for desired goals. Like their co-workers, they should be able to save for vacations or desired new possessions or experiences.

4. Career awareness and planning must begin early

Just as their mainstream peers without disabilities start career exploration before high school, so should students with disabilities. Waiting until age 18 is too late for many and will reduce their options. It was discouraging to see almost no mention of post-secondary education as an appropriate option. Yet many with disabilities are able to successfully enter advanced programs, with and without supportive services.

5. New employment service roles need to evolve

Outreach to and promotion of hiring of persons with disabilities to the business community and understanding their job profiles will help those who help persons with disabilities find jobs have a broader range of possibilities. Those persons also need to be able to do pre-vocational work to help the individual assess their interests and abilities and help them explore the options in the local job market. Development of summer job and after school employment possibilities, volunteering opportunities, internships and job shadowing opportunities will also help persons increase their work skills and understanding of common work expectations. Periodic “check ins” with persons placed in employment can help the individual identify whether this is a long term good fit or, like most, opportunities for advancement and change are desired after a while.

6. Service models that support non-day hour employment need to evolve

Many competitive jobs, such as service work and shelf restocking, health care facility work, and others require evening, night, and weekend workers. Employment supports, such as transportation and supervision, need to evolve to support our clients in these career options. When competitive employment isn’t a fulltime option, “fill the gap” strategies need to broaden as well.

7. Employment measures should reflect high expectations

The measures suggested don’t reflect the diversity of persons with disabilities and the desire for more of them to have competitive, full time employment. Instead of the suggested measure focused on the

percent earning over \$250 per month (8 hours of work per week at the federal minimum wage), the measures should be based on hours worked per week (under 10, 10-20, 21-31, 32-40, over 40). There should be parallel measures of earnings along a continuum. The measures should also reflect the degree of segregation/integration in job placements and the percent who advanced to a higher level of employment each year.

Housing Services

1. Separate housing obligations from service provision

We support the separation of housing from services as much as possible so that people can retain their housing and the relationships connected with it even as their service needs change significantly.

2. Make more rental and ownership options available

MHFA's current support programs for persons with disabilities focus significantly on accessibility to units occupied by persons with physical disabilities— a key issue to address, increase options, and do better match making on. The majority of persons with disabilities hoping to leave congregate settings are not challenged as much by physical as financial accessibility. In response to that a variety of additional options should be considered:

- Setting aside a portion of Section 8 scattered site vouchers for persons with disabilities. Prioritizing low income persons with disabilities and providing a preference for this population when new Section 8 becomes available.
- Setting standards for a certain percent of publicly subsidized units be set aside for people with disabilities who are mobile, just as there is currently a set aside for persons with mobility issues. As much as possible, these units should be in mixed income buildings and support integration with non-disabled and non-subsidized neighbors.
- Promoting models of homeownership that will provide long term for their availability to lower income buyers and that keep maintenance responsibilities manageable and affordable. This could include limited equity co-ops, land trust housing, and affordable condominium construction or conversions. Limited equity models have the advantage of remaining affordable to succeeding generations of owners.
- Promoting affordable options for on-going maintenance to handle those responsibilities for a wide range of homeowners. Incent models of fixed price basic maintenance services such as are used in the condominium and townhouse association models.
- Providing financing for existing private sector affordable market rate rental housing to make needed improvements in energy efficiency, accessibility and other “reasonable accommodations”, and needed maintenance so neighborhood based, older affordable housing is also an option.

3. Promote more accessible and integrated communities

- Independence can also be enhanced by requiring preference for housing for persons with disabilities as part of “transit oriented design developments” and MnDOT’s Transportation Economic Development grant projects.
- Facilitate community integration by requiring or incenting “universal visiting design” or other access standards in all housing developed using public funds so increasingly persons with mobility disabilities are able to visit friends and family in their homes. This will also allow more mainstream populations to age in place and avoid costly access renovations.

4. Promote integration in all housing models

While concentrating persons with the same disability or diagnosis in a housing setting should not be the norm, people need a range of choices, including the option of living with many similar people. For example, not all senior citizens want to live in Sun City, but some do. It would be great if our lower income Minnesotans with disabilities had the freedom to choose housing like those middle class elderly Sun City residents.

5. Support housing transitions

- To encourage persons in corporate foster care or other institutional care to try more independent living, it would be good to be able to fund two “transitional” months so that if it didn’t work out the person could return to their original situation. Just as mainstream young adults bounce back home as various experiments in independence run into problems, some “fall back” options would give more persons the courage to try greater independence and integration.
- Before and during the time of transition they will need additional support as they plan and implement change and those professional services need to be financed.

6. Create housing for complex populations

Complex populations require more intensive supports to place in the community safely and to cover the necessary supports. There is a significant gap today for those who are currently “stuck” in acute care venues, in that community support options do not meet their needs and hence they either stay in acute care venues or cycle inappropriately through failed placements and back to acute care, which is a disservice to those we serve in both instances. We need to create a community housing model for those individuals who are in need of 24/7 behavioral health supports when at baseline functioning. There are several community models which are successfully working with these populations (example: Aeons partnership at 1822 Park) - where housing, behavioral health supports, community living, and wellness supports all come together to support individuals in the community. Moratoriums have reduced our ability to create such venues and have resulted in crisis cycles for many of our most vulnerable residents. State and county partnerships to create these support systems would go far in reaching the Olmstead intent.

7. Funding programs must reflect housing costs in different parts of the state

It is well documented that housing costs vary across the state and even within large, complex counties like Hennepin. Property taxes alone are almost twice as high in the metro area vs. most parts of

Greater MN. Budgets for housing must be able to reflect the local market if we are to have integrated neighborhoods and communities.

8. Housing measures should reflect Olmstead values

- Percent of persons moving to more independent and integrated housing situations.
- Percent of persons receiving services in a home they own
- Percent of persons living in integrated multi-family buildings with non-disabled or non-senior persons in other units.
- Percent of persons who report they know and feel free to call non-disabled neighbors who live near them for assistance when needed.
- Increase in the number of housing units in a given community that are “visitable” and/or offer easy opportunities to age in place or otherwise accommodate persons with mobility constraints.
- Percent of “self-evaluation” of persons with disabilities wanting to and having the opportunity to interact with non-disabled persons.

Healthcare and Healthy Living

While this goal is not yet developed, we strongly encourage a robust effort in this area that measures progress. There are significant health disparities experienced by people with disabilities. Although access to primary health care and specialty care are of critical importance, a focus on primary prevention in community settings is also essential. While Americans of all ages and abilities struggle with inactive lives and unbalanced diets, being overweight or obese occurs much more frequently in many populations of persons with physical, mental or developmental disabilities. Smoking rates are very high among individuals with mental illnesses. Given the major role that government funded supports play in the life of many, this reflects too much inattention to these aspects of life by those paid to organize and oversee their care. Life planning for these individuals must extend beyond housing and employment to also encompass health promoting lifestyles and environments throughout life.

1. Health Promotion

Hennepin County has been working to improve the health and wellbeing of people with intellectual and developmental disabilities (IDD) through an initiative called *Wellness for Every Body* (WFEB). The WFEB initiative seeks to reduce health disparities in this population by providing technical assistance and competency-based staff training on nutrition and physical activity to IDD care providers. The goal is to create work and home environments where healthy behaviors and lifestyles are the norm for individuals with IDD. The pilot project demonstrated improvement in the amount of time individuals with IDD were physical active, a slight improvement in BMI, as well as consumption of a more healthful diet. In addition, care providers reported a significant percentage of individuals with IDD had an improvement in at least one of the following measures: lab values, challenging behaviors, functionality, mobility, mood, or a decrease in the number or dosage of medications. DHS could disseminate the findings from their program as well as other similar successful efforts to the myriad of MA providers that DHS enrolls in its provider system.

2. Nutrition standards in group settings

Congregate living options for individuals with mental illnesses for whom no more independent option is feasible are not always “small homelike settings” or “supportive small group residential care.” Under any circumstances, though, government regulations should require that current federal dietary guidelines should be met, including special diets for individuals with comorbid physical illnesses. These group residential settings should also include requirements that staff are trained in strategies to promote healthy eating, physical activity and tobacco-free living.

3. Health status monitoring

Lack of attention to preventative and maintenance health care, especially in adult populations, is also a concern. For example, mental health visits and medications may be monitored but not whether the person uses tobacco products, is physically active, has a healthy diet, or has had appropriate dental or physical health needs met. Interactions between therapeutic medications and major weight gain and other physical health issues need to be weighed to enable the person served to make an informed choice of treatment and to arrange for the appropriate health monitoring and lifestyle interventions. Through the federal Community Transformation Grant, Hennepin County has been working with a number of medical clinics to enhance their ability to improve the healthy behavior of their patients. DHS could use the findings of this grant and others to enhance the effectiveness of medical care systems in addressing unhealthy behaviors among people with disabilities.

4. Health and social service connections

There is a criticality in health and welfare working together to improve the overall wellness of this population; however, the system does not often know who is engaged in service provision and clients are often unable to connect the two worlds - creating a mechanism to complete “big data” hits across these two venues in order to identify where case management and/or care coordination is overlapping would go far in allowing “virtual teams” to work in unison (vs. duplication or fragmentation) to better meet the needs of this population. Our residents are often dismayed that we are not coordinating across system in order to improve their care but are also often unable to link us to other providers proactively. Creating a venue where service providers could team together to provide supports would produce beneficial outcomes.

5. Fee for Service technical changes

A simple thing such as allowing for physical health/mental health/dental care visits on the same day to each be covered services, would improve the outcomes for this population who often have transportation challenges and same day visits could improve adherence to service recommendations.

In conclusion, we support your continued work to move the life options for persons with disabilities in a direction that provides for a more “mainstream” and integrated life with many options and the opportunity to make changes throughout one’s adult life. We will be glad to further offer our experience and insights as the planning moves into more detailed phases.

Through September 2, 2013 (Comments 111-112)

Comment 111

-----Original Message-----

From: *DHS_Webmaster, DHS

Sent: Tuesday, August 27, 2013 11:15 AM

Subject: FEEDBACK FROM OLMSTEAD PLANNING COMMITTEE SITE

THE FOLLOWING RESPONSE WAS RECEIVED ON 8/27/2013 AT 11:14:33 AM

NAME: *[Redacted Text]*

EMAIL: *[Redacted Text]*

REASON:

DESCRIBE YOURSELF: I am a service provider

COUNTY: *[Redacted Text]*

COMMENTS:

As a provider I am interested in how our residential homes for individuals with disabilities can respond to our neighborhoods with concerns about their neighbors with disabilities. I was not available for the Listening Sessions and would appreciate a link (if there is one) that would help us understand the issues some of our neighbors have. Our focus is on integration but communities and neighborhoods need to support integration, we want to understand and respond to feedback.

Comment 112

From: *[Redacted Text]*

Sent: Thursday, August 29, 2013 2:23 PM

To: *DHS_OPC Public

Subject: Public Comments

I would like to comment on the lack of information in the Olmstead Plan document regarding Minnesota's funding under Extended Employment for sheltered work which is segregated employment service under Center Based Employment. The State of Minnesota continues to fund these services even though 14 of the 29 Extended Employment Providers only provide Community Based Integrated Employment. This is one of the first Olmstead liabilities that should be resolved and transfer the funding of \$2,341,177 per year into community based services. The State of Minnesota needs to stop funding segregated employment services with state dollars. This is a serious liability as the rule for Extended Employment is in state law.

Please correct this liability as soon as possible and fund ONLY EMPLOYMENT SERVICES IN THE COMMUNITY

[Redacted Text]