

## 2017 Biennial Report on Long-Term Services and Supports for People with Disabilities

### Disability Services Division

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January 2017

**For more information contact:**

Minnesota Department of Human Services  
Disability Services Division  
P.O. Box 64967  
St. Paul, MN 55164-0967

651-431-4300

## 2017 Biennial Report on Long Term Services and Supports for People with Disabilities

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is \$10,000.

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## I. Executive summary

The Minnesota Department of Human Services (DHS) prepared this report in response to legislation passed in 2012. The legislature requires DHS to report every two years on our goals and priorities for people with disabilities and how programs administered by DHS support those goals. DHS structured this report based on the [Centers for Medicare & Medicaid Services \(CMS\) Home and Community-Based Services \(HCBS\) Quality Framework \(PDF\)](#) as well as the Minnesota-specific indicators for the national framework, as identified by the State Quality Council.

Minnesota is on a continuing journey to transform services for people with disabilities. We once had large, state-operated regional treatment centers. As they have closed, Minnesotans with disabilities have moved into communities across the state. However, living in the community may not be the same as being part of the community. Some Minnesotans with disabilities remain isolated from meaningful relationships with people who are not family or paid staff.

In all of our work, we use CHOICE outcomes for all people with disabilities as a guide:

- Community membership
- Health, wellness, and long-term supports
- Own place to live
- Important long-term relationships
- Control over supports
- Employment earnings and stable income.

**As you read this report, it is important to remember: Most people with disabilities live independently in their communities without publicly funded services.**

However, for people who do need additional support to live and work as independently as possible, informal supports and social networks are crucial. DHS is committed to create and implement policies that provide needed services at the right time.

People with disabilities should be able to participate in all aspects of community life if they choose. DHS historically has been a national leader in supporting people with disabilities to live at home or with family members. Yet, there is so much more to accomplish.

To promote quality of life, we must use the resources we have well. DHS honors that balance and responsibly manages the many programs and policies that make up the state's disability services strategy. This report is a summary of those efforts.

You will see that we have created a robust network of formal and informal supports. We are creative about problem solving. As an example, Minnesota invests in a variety of services that do not use federal funding. We will continue to build services in Minnesota with that well-rounded approach.

**Together with our partners, DHS strives to help people have the right support at the right time in the community of their choice.**

In recent years, there have been broad legislative and operational changes to the long-term services and support system. DHS is at the center of implementing those changes. For providers and lead agencies (counties, tribal agencies and managed care organizations), the comprehensive nature and pace of the changes often has been confusing and difficult to implement. To support the transition, DHS is working with our partners and stakeholders to provide the most current information, technical assistance and resources.

As implementation continues, DHS will address common misunderstandings while we continuously work to expand awareness of systems change. Ultimately, the result of the many reforms will be a more person-centered and integrated system. That puts quality of life for people with disabilities at the center of our work.

## II. Legislation

The 2012 Minnesota Legislature required the Department of Human Services (DHS) to submit a biennial report, beginning Jan. 1, 2013. The report must address DHS' goals and priorities for people with disabilities. This includes how programs administered by the commissioner support those goals and priorities. Specifically, [Minn. Stat. §252.34](#) states:

### 252.34 REPORT BY COMMISSIONER OF HUMAN SERVICES.

Beginning January 1, 2013, the commissioner of human services shall provide a biennial report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and funding. The report must provide a summary of overarching goals and priorities for persons with disabilities, including the status of how each of the following programs administered by the commissioner is supporting the overarching goals and priorities:

- (1) home and community-based services waivers for persons with disabilities under sections [Minn. Stat. §256B.092](#) and [Minn. Stat. §256B.49](#);
- (2) home care services under section [Minn. Stat. §256B.0652](#); and
- (3) other relevant programs and services as determined by the commissioner.



### III. Introduction

The Minnesota Department of Human Services (DHS) submits this report to the Minnesota Legislature pursuant to [Minnesota Statutes, Chapter 252.34](#). It is a biennial report that summarizes goals and priorities for people with disabilities. It also details how DHS supports them.

We believe that every person, with or without a disability, deserves to have CHOICE:

- Community membership
- Health, wellness and safety
- Own place to live
- Important long-term relationships
- Control over supports
- Employment earnings and stable income.

Most people with disabilities live and work in their communities without publicly funded supports. They typically do not need formal or paid support services. Just like for people without disabilities, informal supports and social networks are crucial. For those who need additional support to live and work as independently as possible, informal supports may not be enough.

#### A. Our work

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DHS plays an important role in our work with partners to help people with disabilities to live with dignity and fulfill their dreams for the future. We are committed to help people with disabilities live, learn, work and enjoy life in the most integrated setting in all aspects of life.

The [Minnesota's Olmstead Plan](#) guides our work. It documents the 13 goal areas and the steps Minnesota is taking to increase opportunities for people with disabilities to:

- Build or maintain relationships with their families and friends
- Live as independently as possible
- Engage in productive activities, such as employment
- Participate in community life.

#### B. Person-centered practices

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A key part of our approach to support people has been the focus on using person-centered practices in everything we do. Person-centered practices are a way to approach services with the focus on what is important to and for the person. It does not focus on what is better for the system, state or provider.

Using person-centered practices is a fundamental part to overcoming system bias. It allows us to support people so that they can engage fully in community activities. To achieve that, we strive to align policy, regulations, funding and practices to reach better outcomes for people.

## C. System-level changes

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As we work, we address change with the following three levels in mind:

- Level 1: Change that results in a positive difference in the lives of people who use services or in the work life of the person who provides support
- Level 2: Change an organization makes to its practices, structure or rules that result in positive differences in the lives of people
- Level 3: Change to practice, structure and rules at the system level, which have an effect on many organizations and people.

DHS has been building our capacity so we can offer more training, technical assistance and coaching at each level. As we assist providers, counties, advocacy and regional organizations in these areas, we create better outcomes. We are encouraged by what we have seen so far. More organizations are seeing the positive results of the changes they have implemented (e.g., such as reductions in staff turnover and worker's comp claims). All of this allows more people with disabilities be able to live their dreams.

As more lead agencies (counties, tribal agencies and managed care organizations) and providers do and use person centered plans, we build our knowledge of how to implement person-centered practices system wide.

## D. Regulation and oversight

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A recent rule issued by the Centers for Medicare & Medicaid Services (CMS) regarding home and community-based services (HCBS) (which are funded through Medicaid) highlights the importance of person-centered practices. Often called the HCBS Rule, it outlines expectations for person-centered practices. It describes the characteristics for the settings where home and community-based services are provided. Settings must meet those requirements in order for states to receive federal HCBS funding.

The rule provides assurances that people using home and community-based services:

- Receive those supports in the most integrated setting
- Have full access to the benefits of community living (including employment) and engaged with people who do not have disabilities.

DHS recently submitted our [transition plan to comply with the HCBS Rule](#) to the federal government for its comment and approval. Before we submitted the plan, we actively sought input from people who use services, their families, providers, advocates, counties and other stakeholders.

We also continue to progress with earlier reforms authorized by the legislature, including:

- MnCHOICES, which is a person centered assessment and support-planning process
- Provider standards, with 245D licensing
- Positive supports rule
- Disability Waiver Rate System, which is midway through the implementation period.

We describe each of these in more detail in this report. As we implement these changes, we will continue to evaluate and respond to what we learn from the people and organizations who are doing the work.

## E. Challenges

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One thing that we cannot overlook is the looming workforce shortage. As baby boomers age, there are fewer working-age adults. To address this, DHS worked with community partners to hold a workforce summit in July. It identified common themes and action steps to address the issue.

Following the summit, we asked direct care/support workers and the people they support to take a survey. We received surveys from nearly 1,100 workers and 181 people who receive services. Details of the results are in the [provider capacity section](#) of this report. Stakeholders identified action steps they will take together to address the workforce shortage.

## F. Accomplishments

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We have more to do, but much to celebrate, as well. In this report you will find accomplishments, such as:

- The elimination of the waiting list for the CADI waiver
- An interagency collaboration to develop a consistent approach across state and local agencies to explain employment options for people with disabilities and provide work experiences to increase opportunities for employment
- A new early intervention benefit for children who have autism spectrum disorder or related conditions.
- Success stories that share what is happening with people.

## G. What is next?

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Many people have said recent reforms are the single greatest amount of change since home and community-based services began. With the number of large initiatives that have significant impact on everyone, it is critical that we continue to work with our partners and stakeholders to analyze data about what is happening and to monitor our progress.

We value and very much appreciate the time and dedication that so many people (including those who receive services, their families, providers, counties and tribes, advocates, and others) invest into workgroups and advisory groups on these initiatives. As we work through implementation, this helps us adapt where necessary to make recommendations to the legislature for further refinements.

## H. Data in this report

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You will find a number of facts and figures in this report. We provided the most current information available at the time of the report. The sources were selected to help answer three questions:

- How much do we do?
- How well do we do it?
- Is anyone better off?

Below is information about each data source referenced throughout the report.

### Medicaid Management Information System (MMIS)

MMIS is the largest health care payment system in Minnesota, and one of the largest payment systems in the nation. Health care providers — as well as DHS and county staff — use MMIS to pay the medical bills and managed care payments for more than 525,000 Minnesotans enrolled in the following programs:

- MinnesotaCare
- Medical Assistance (MA)
- General Assistance Medical Care (GAMC)
- Alternative Care Grants Program (ACG).

These public programs (collectively referred to as the Minnesota Health Care Programs, or MHCP) provide health care services to:

- Families and children who have low income
- People who are older and have low income
- People who have physical and/or developmental disabilities
- People who have mental illness
- People who are chronically ill.

Some MHCP enrollees receive care through a fee-for-service arrangement where they find their own doctor. Others receive care through one of the state-contracted managed care health plans. The information available and how it is extracted differs between fee-for-service and managed care. Most of the people who are under age 65 and who receive long-term services and supports use fee-for-service arrangements for their long-term services.

### The DHS forecast

DHS prepares a forecast of expenditures in its major programs twice each year. These are used in state forecasts released in November and February during each fiscal year. Minnesota Management and Budget reviews these forecasts and uses them to update the fund balance for forecasted programs. The February forecast, as adjusted for changes made during the legislative session, becomes the basis for end-of-session forecasts and planning estimates.

The DHS forecast is a "current law" forecast. It aims to forecast caseloads and expenditures given the current state and federal law at the time the forecast is published.

### The National Core Indicators Program

The National Core Indicators Program was originally developed as a means for states to measure and track their performance in serving people with intellectual and developmental disabilities. The program has expanded to include people with other disabilities as well as seniors receiving services.

The core indicators include approximately 100 consumer, family, systemic, cost and health and safety outcomes. These outcomes are important to understanding the overall health of public disabilities agencies. The program collects data via standardized surveys, including consumer, family and provider surveys. The consumer survey, which is the heart of NCI, requires an in-person interview. The survey recently was revised to include more information about health and wellness, employment status and ability to self-direct among people with disabilities.

Program participants are randomly selected for participation in the surveys. Collecting 400 completed surveys in each state allows valid comparisons to be made across states with a 95 percent confidence level and a +/- 5 percent margin of error. Both the confidence level and margin of error used are widely accepted for reviewing results, regardless of population size.

The table below describes Minnesota’s participation in the National Core Indicators Surveys to date.

**Table 1: Minnesota's participation in the National Core Indicators Surveys (2014-2016)**

Year	Population	Completed surveys	Notes
2014	Adults with I/DD	406	
	Older adults and people with disabilities other than I/DD	357	Survey pilot test
2015	Adults with I/DD	410	
	Families of adults with I/DD living at home	593	
	Families of children with I/DD living at home	450	
2016	Adults with I/DD	429	Data analysis pending
	Families/guardians of adults with I/DD who do live in the family home	467	
	Adults with physical disabilities	1,962	Will allow for regional analysis
	Staff stability survey of I/DD providers	270	Does not include all provider types.

NOTE: I/DD means “intellectual and developmental disabilities.”

### HCBS lead agency reviews

The HCBS lead agency review uses multiple data collection methods to assess the administration of the waiver programs throughout lead agencies in Minnesota. In particular, the reviews are an effective mechanism to:

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- Support lead agencies in their work
- Promote collaboration across lead agencies
- Share best practices.

The team reviews each lead agency once every three years. Over the past three years, we:

- Reviewed 6,446 cases
- Interviewed 223 supervisors
- Talked to 894 focus-group participants.

## IV. Background

### A. Long-term services and supports for people with disabilities

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Of Minnesota’s approximately 5.3 million residents, census data show an estimated 10 percent (or approximately 530,000) identify as having a disability. DSD oversees long-term services and supports for about 75,000 people with disabilities each year. Our goal is to provide the right services at the right time for the people we serve.

In Minnesota, lead agencies (counties, tribal agencies and managed care organizations) assess eligibility for long-term services and supports. Long-term services and supports programs have eligibility requirements that are specific to each program. It is important to note there are two types of eligibility:

- Financial (i.e., income and assets)
- Program (i.e., state plan or waivers) and services (e.g., PCA, case management, supported employment, etc.).

The vast majority of funding for long-term services and supports has moved toward home and community-based services. In 1995, there was a 51 to 49 percent split in funding between institutions and home and community-based services. DHS now spends more than 90 percent of long-term services and supports funding for people with disabilities on home and community-based services.

Services provided at home and in the community promote independence. They give more choice and control to the person. Informal support opens doors to the same resources that people without disabilities use. People who have choice and flexibility in supports and services are more likely to report a higher quality of life. Home and community-based services also are less expensive than institutional services on average.

### B. Resources that support home and community-based services

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To deliver long-term services and supports that build upon a person’s informal supports, Minnesota uses a combination of:

- Medical Assistance state plan services
- Medical Assistance home and community-based service waivers
- State and local funded supports and services.

#### Medical Assistance state plan

Medical Assistance is a publicly funded insurance program for people who have low income and people who are “medically needy.” It provides health-related coverage for children, seniors and/or people who are blind or have other disabilities.

The federal government jointly funds the program with each state and the District of Columbia. Medical Assistance requires states to offer some benefits (such as inpatient hospital care) and allows states to offer others (such as personal care and home care nursing). Minnesota offers a comprehensive Medical Assistance benefit set that includes both federally mandated and optional benefits. States can limit the amount and duration of optional state plan services a person can receive. The state must assure, however, that anyone who qualifies for the service receives the service.

In addition to home care services (such as personal care assistance, home-based nursing and home health aide), one example of an optional benefit is the Early Intensive Developmental and Behavioral Intervention (EIDBI). It is a service that offers medically necessary treatment to people under 21 years old who are on Medical Assistance and who have autism spectrum disorder (ASD) or related conditions. The results of a comprehensive multi-disciplinary evaluation lead to recommendations for the type of intervention, which is the basis for service authorizations. Therapeutic interventions are designed to improve functioning and decrease behavioral challenges. This is a new benefit. We expect it will grow as more providers enroll and the legislature considers proposed legislation that will help build statewide capacity.

Receiving services in institutions (such as nursing facilities, hospitals and intermediate care facilities for persons with developmental disabilities) is costly. State plan services also offer a continuum of medical care and support services provided in the person’s home and community for people who have nursing facility or hospital level of care needs. Services range from a level of care similar to that provided in a hospital to simple assistance in activities of daily living. There often is some type of prior authorization process through Minnesota’s lead agencies (counties, tribal and managed care organizations), who administer programs as delegated or contracted agents of DHS. As an example, all home-care services require prior authorization through DHS or a lead agency. The state Medical Assistance plan pays for home care services.

People who need long-term services and supports beyond what the medical assistance state plan covers may be able to access those services through home and community-based waiver services. We include more information on waiver services in the [home and community-based services section](#).

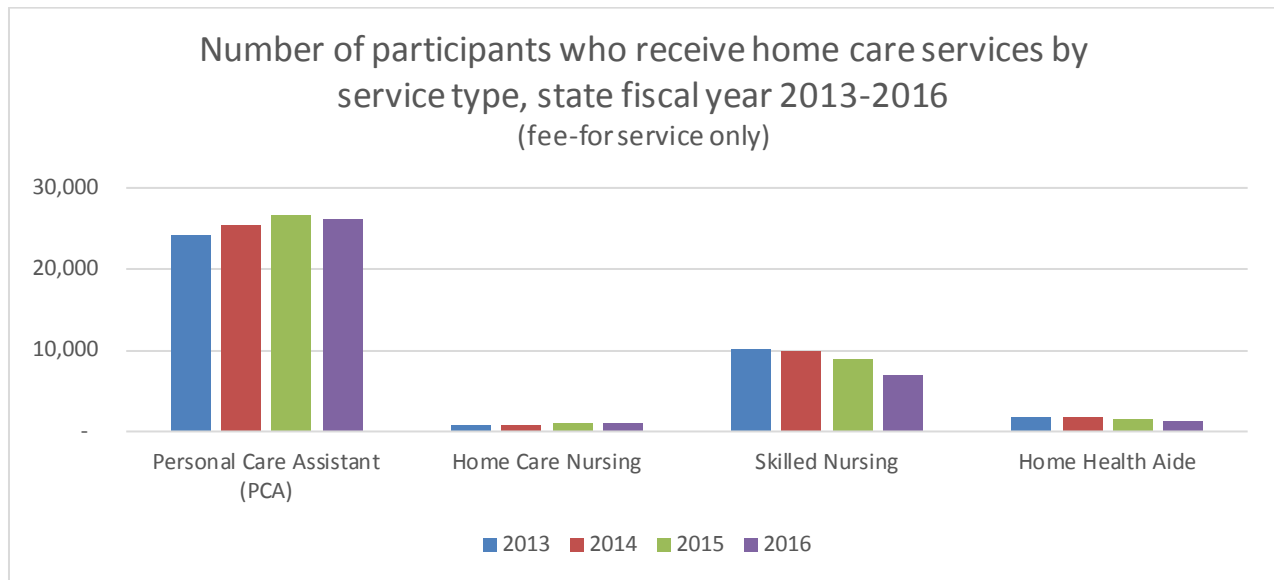
**Table 2: People who receive various types of long-term services and supports by age group among the fee-for service recipients (2013-2015)**

SFY	2013	2014	2015	2013	2014	2015	2013	2014	2015
Age group	0 to 22	0 to 22	0 to 22	23 to 64	23 to 64	23 to 64	65+	65+	65+
Personal care assistance	8,402	8,444	8,415	14,133	15,134	15,993	1,761	1,843	2,238
Home care nursing	445	491	514	333	355	384	62	59	51
Skilled nurse	2,423	2,231	2,077	5,508	5,447	4,730	2,292	2,186	2,234
Home health aide	10	9	8	711	662	548	1,179	1,088	1,034

SOURCE: MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) SERVICE AGREEMENT AND PAID CLAIM DATA



**Figure 1: Number of participants who receive home care services by service type (SFY 2013-2016)**



SOURCE: MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) SERVICE AGREEMENT AND PAID CLAIM DATA

As shown in Figure 1, of the state plan services for people with disabilities, personal care assistance is the mostly widely used. Disability services covered through Medical Assistance are not managed through health plans; instead, DHS pays on a fee-for-service basis.

### Home and community-based service (HCBS) waivers

One of the ways Minnesota provides services outside of an institution is through home and community-based services (HCBS) waiver programs. Waivers, or HCBS waivers, provide services to people who otherwise would be eligible to receive institutional care. DHS administers waiver programs in collaboration with public health or social services through counties and tribal agencies.

Waiver programs are not an entitlement. Waivers allow states to “waive” certain Medicaid rules to provide long-term services and supports in the home or in the community to specific people or populations. This prevents the need to provide those services only in institutional settings.

DHS manages the waiver programs under the authority of Minnesota statute. The federal government gives DHS permission to offer these services through agreements between the state and the federal government. Home and community-based services waivers offer various services in a person’s home and in the community, at an average cost that is less or equal to the cost of serving people in institutions.

The home and community-based services waivers provide additional services that support a person when state plan services do not meet a person’s assessed needs. The [Centers for Medicare & Medicaid Services \(CMS\)](#) bases eligibility for waiver programs on certain levels of need (also called level of care).

### *Funding sources*

A combination of state and federal dollars fund waivers. Minnesota receives federal financial participation (FFP) to match state dollars spent on waiver programs. The current federal financial participation for waiver services in Minnesota is 50 percent. To obtain this federal match, Minnesota submits waiver plans that describe the services, standards and assurances the state agrees to meet to CMS for approval. Changes to waiver plans require review and approval by CMS.

Each of the home and community-based services waiver programs meets federal guidelines. That includes the obligation to meet federal guarantees in six areas:

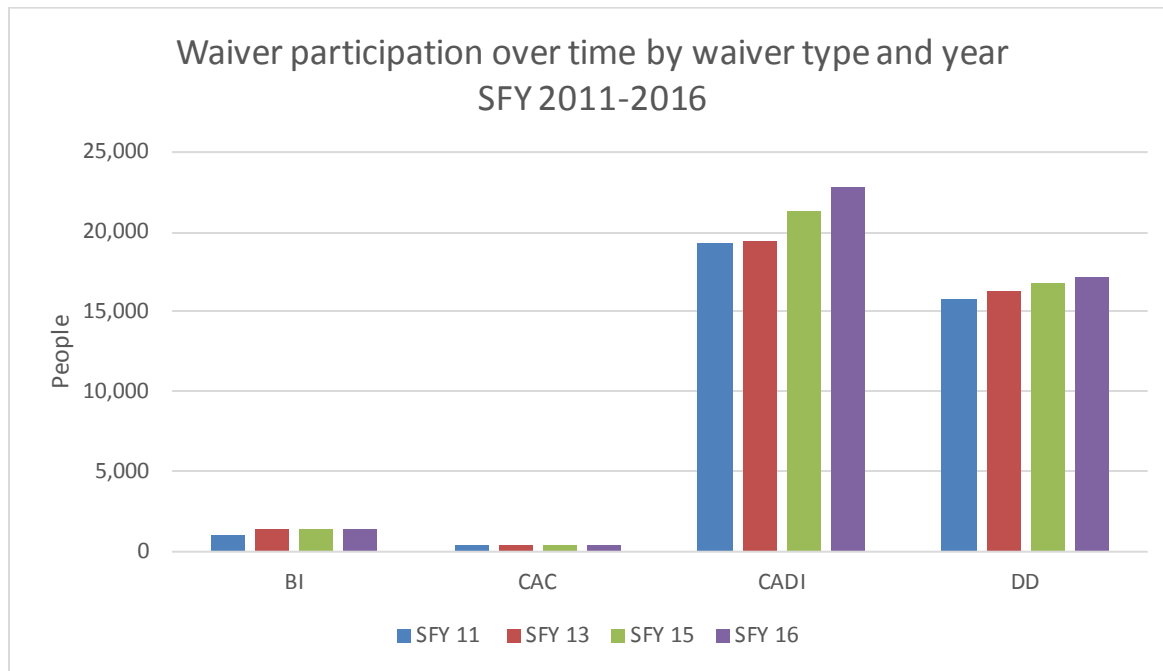
- Level of care
- Service plan
- Qualified providers
- Health and welfare
- Administrative authority
- Financial accountability.

### *Waiver types*

The four waivers specific to disability services in Minnesota are:

- **Brain Injury (BI) Waiver:** For people with a traumatic or acquired brain injury who need the level of care provided in a nursing facility or neurobehavioral hospital.
- **Community Alternative Care (CAC) Waiver:** For people who are chronically ill or medically fragile and need the level of care provided at a hospital
- **Community Access for Disability Inclusion (CADI) Waiver:** For people who need the level of care provided in a nursing facility
- **Developmental Disabilities (DD) Waiver:** For people with developmental disabilities or a related condition who need the level of care provided at an intermediate care facility for people with developmental disabilities (ICF/DD)

**Figure 2: Waiver participation in Minnesota over time by waiver type and year (SFY 2011-2016)**



SOURCE: MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) SERVICE AGREEMENT AND PAID CLAIM DATA

Figure 2 lists the number of people on each waiver in SFY 2011, 2013, 2015, 2016.

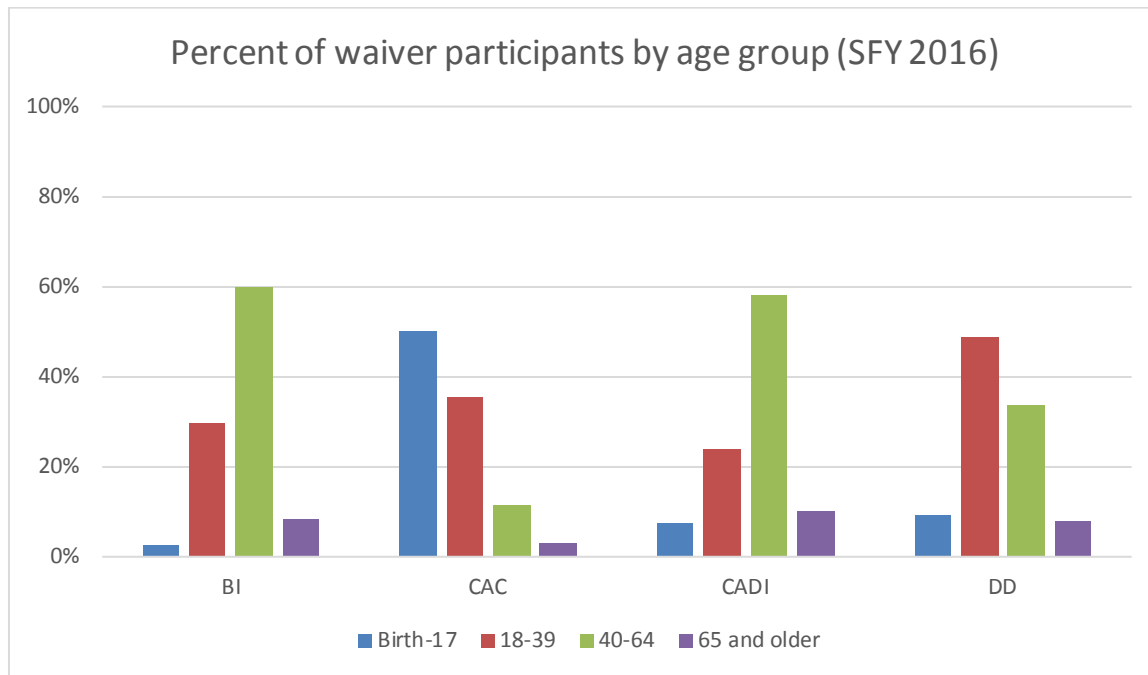
- BI participation went from 1,104 in 2011 to 1,417 in 2016.
- CAC participation increased from 403 participants in 2011 to 469 in 2016.
- CADI participation increased from 19,336 in 2011 to 22,826 in 2016. The span between 2013 and 2015 showed an increase of nearly 2,000 participants.
- DD participation went from 15,846 to 17,155. It shows steady growth over time.

**Table 3: Number of waiver participants by waiver type (SFY 2016)**

Waiver type	Total number (all ages)
BI	1,417
CAC	469
CADI	22,826
DD	17,155

SOURCE: MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) SERVICE AGREEMENT AND PAID CLAIM DATA

**Figure 3: Percent of waiver participant by age group (SFY 2016)**



SOURCE: MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) SERVICE AGREEMENT AND PAID CLAIM DATA

**Table 4: Expenditures and projected expenditures by waiver type (in millions)**

Waiver type	FY 2015 actual	FY 2019 projected
BI	101.9	120.3
CAC	30.1	42.6
CADI	663.2	1,123.0
DD	1,190.0	1,480.0

SOURCE: MINNESOTA BUDGET FORECAST

Services authorized under all home and community-based services waiver federal plans must:

- Be necessary to assure health, safety and welfare of the person
- Have a cost that is reasonable
- Have no other funding source for the services
- Help a person avoid institutionalization and be an appropriate alternative to institutionalization
- Help a person function with greater independence in the community
- Meet the unique needs and preferences of the person.

Waivers allow states to provide various service options not available or allowed under regular Medical Assistance. They are a crucial piece of our goal to improve quality of life for people who have disabilities and older Minnesotans who have low incomes. With waiver services and supports, people can live as independently as possible in the community of their choice.

## Waitlists

Sometimes people are not able to receive waiver services when they request them. While it is important to note that Minnesota offers many other, non-waiver services for people with disabilities, there have, at times, been limits on the amount of growth that is allowable in the waiver programs. Limits on the dollars available for growth in certain waivers can mean that there are wait lists for the services. Most recently, there were waitlists for the Developmental Disabilities (DD) and Community Access for Disability Inclusion (CADI) waivers. (The two other disability waivers, the Brain Injury (BI) and Community Alternative Care (CAC) waivers, do not have waitlists.)

Wait lists include people eligible for waiver services, but do not yet receive them. Lead agencies manage waiting lists for waiver coverage giving priority to people with the most urgent need as defined in statute.

For more information on waiting lists, see our recent legislative report on [Disability Waiver Financial Management and Waiting Lists, December 2016 \(PDF\)](#).

### *CADI*

Minnesota eliminated the CADI wait list on Oct. 1, 2016. It happened, in large part, thanks to 2015 legislation that gave DHS the authority to manage the resources differently. Specifically the eliminated financial limit on the amount of growth allowed each year.

On May 30, 2015, the statewide CADI waitlist included 1,420 people. Beginning July 1, 2015, DHS instructed lead agencies to no longer place people on the waitlist.

DHS also told lead agencies to begin delivery of CADI services for people on a CADI waitlist who needed waiver services. DHS set a goal in Minnesota's Olmstead Plan of eliminating the CADI waitlist by Oct. 1, 2016. Lead agencies and DHS met this goal by increasing enrollment of eligible people and managing available dollars on a statewide basis to shift dollars where most needed.

### *DD*

Beginning Dec. 1, 2015, DHS began a new process to assess the urgency and timing of need for waiver services to address the DD Waiver waitlist. As of April 2015, it included 3,586 people.

To this point, the DD waitlist included people who were eligible for the DD Waiver, but not receiving the waiver. For example, people would be on the DD waitlist in anticipation of a future need for DD services but have no current need for the waiver.

Through reform efforts outlined in Minnesota's Olmstead Plan, DHS directed lead agencies to assess each person's urgency of need for DD Waiver services. Now, the following people are included in the DD waitlist, based on the four urgency categories:

1. **Institutional exit:** This category includes people who currently reside in an institutional setting who indicate they are not opposed to leaving that setting. People in this category also would like to receive home and community-based services.

2. **Immediate need:** This category includes people who meet prioritization criteria established in [Minn. Stat. §256B.092, subd. 12](#). The applicable criteria include people who:
  - a. Have an unstable living situation due to the age, incapacity or sudden loss of the primary caregivers
  - b. Experience a sudden closure of their current residence
  - c. Require protection from confirmed abuse, neglect or exploitation
  - d. Experience a sudden change in need that no longer can be met through state plan services or other funding resources alone.
3. **Defined need:** This category includes people who have an assessed need for waiver services within one year of the date of assessment.
4. **Future need:** This category includes people who do not have a current need for waiver services or who do not currently wish to use waiver services within the next year.

The DD Waiver wait list includes people in the institutional exit, immediate need and defined need categories. We do not consider people in the future need category to be on a wait list, as they do not have a current need for, or desire to use, waiver services.

If a person's need for waiver services changes following an assessment, he or she has the right to request a new assessment anytime during the year. This allows the lead agency to update his/her urgency category to reflect this change in need.

Because of these efforts, DHS anticipates there will be a significant reduction in the number of people on the DD waitlist. DHS will submit a report to the Olmstead Sub-cabinet in March 2017 with the final waitlist numbers.

## State and local funds

The Minnesota Legislature appropriates disability services funds for specific purposes. Depending upon their resources, counties also may fund long-term services and supports for people when state and/or federal funds are not immediately available to serve the person.

Primarily, Minnesota uses state funds for innovative programs that serve a small number of people where federal financial participation funding is not available. The following are examples of such programs.

### *Family Support Grant*

The Family Support Grant is a state-funded program that:

- Helps families access disability services and supports
- Prevents out-of-home placement of children with disabilities
- Promotes family health and social well-being.

The Family Support Grant program provides cash grants to eligible families with children who have certified disabilities. These grants offset the high expenses directly related to a child's disability. These grants cannot

exceed \$3,113.99 per calendar year for each eligible child. Minnesota spent approximately \$3.2 million on Family Support Grants in state fiscal year 2016.

### *Consumer Support Grant*

State grants provide flexibility and freedom of choice to participants. The Consumer Support Grant program is an alternative to Medical Assistance home-care services. It allows for greater freedom of choice in service selection and service delivery. With the Consumer Support Grants, people only use the state share of what otherwise would have been provided through home care.

People can use Consumer Support Grants to purchase a variety of goods, supports and services beyond what is available through Medical Assistance. It is an alternative to using traditional home-care services. Minnesota spent approximately \$24.4 million on Consumer Support Grants in state fiscal year 2016.

### *Semi-independent living services*

The semi-independent living services (often referred to as SILS) program helps adults with developmental disabilities live successfully in the community. The goal of semi-independent living services is to support a person in a way that enable him/her to achieve personally desired outcomes and lead a self-directed life.

To be eligible for services, the person must be 18 years of age or older and not at risk of placement in an intermediate care facility for people with developmental disabilities. There is a 30 percent county match to state funds for semi-independent living services. Minnesota spent approximately \$9.1 million on semi-independent living services in state fiscal year 2016 (\$6.4 million state, \$2.7 million county match).

### *HCBS innovation grants*

DHS actively works with our partners to increase positive outcomes for people with disabilities. Recently, we developed three requests for proposals (RFPs) to increase integrated competitive employment, living in the most integrated setting and increased community integration for people with disabilities. These are the three types of grants that we will award:

- Ten contracts to agencies for multi-year proposals to achieve outcomes.
- A contract to one grantee to establish and maintain a micro-grant program for people with disabilities to identify and achieve solutions to their personal goals.
- The third set of contracts in spring 2017 DHS will select for innovative approaches from people and organizations that have not typically participated in RFPs.

Other existing state grants that foster innovation for people with disabilities include: assistive technology, housing access, local planning for alternatives to corporate foster care, autism respite, and autism residential services. These initiatives are described in more detail later in the report.

## V. Access

### WHAT'S IMPORTANT

- DHS provides information in a way that allows people to have access to it and so it is easy to understand.
- Informed choice is crucial to the process.

The key element in all of our services is informed choice. Informed choice means choosing from a range of options and opportunities to make the best personal decision about services. We want people to base their choices on relevant, factual and experiential information. Minnesotans with disabilities must have the right type of information and experiences with options to understand what choices are available. Then, they can make a decision that is right for them.

We also know that people's needs and preferences change over time. That means both services and what people want to do with their lives will change over time. Our services must reflect those changing needs.

### A. Information and referral

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It is important for people who need services to understand their options. We want them to be as engaged as they can be when they make decisions about their lives. We support a number of initiatives that promote informed choice.

#### MinnesotaHelp.info®

[MinnesotaHelp.info](http://MinnesotaHelp.info)® is an online resource database for people with disabilities and older Minnesotans. It offers information on a wide range of community services. DHS and the Minnesota Board on Aging worked together to build it. We included and identified licensed, registered, certified and/or approved providers. This allows people to easily search for service providers. Having information like this supports informed choice.

Each service type contains a service description staff reviewed to meet plain language requirements. It includes eligibility, contact information, application information and maps. People can contact providers directly. Staff keeps each service type on a regular schedule for updates (monthly, quarterly, etc.) to make sure the information is current.

DHS wants to make it possible for people who use waiver services and those who support them to make informed decisions about which service(s) to choose. To address that, DHS is developing the home and community-based services (HCBS) report card through [MinnesotaHelp.info](http://MinnesotaHelp.info)®. It will give consumers the ability to compare providers within a specific service type and learn about others' experiences.

In addition to information about a provider, [MinnesotaHelp.info](http://MinnesotaHelp.info)® customers will be linked to quality information such as consumer satisfaction survey results, home care complaints and quality improvement goals. A pilot test of a customer review component currently is underway.



## Disability Linkage Line®

In 2005, DHS launched the Disability Linkage Line® to make it easier for people with disabilities to:

- Get the information they need to understand their options
- Connect to community services.

This statewide service provides access to timely, consistent and accurate information that supports self-determination, informed choices and quality of life.

The Disability Linkage Line® is a free statewide resource network that makes it easier for people with disabilities to solve problems, navigate the system and plan for their future. People can discover options and tools they can use to manage their health, money, work, home and every aspect of living in the community. Staff knows the ins and outs of community resources and government programs. They have years of experience helping people fit them all together.

The Disability Linkage Line® is a MinnesotaHelp.info Network partner along with the Senior LinkAge Line® and Veterans Linkage Line™. The Disability Linkage Line® can be accessed via email, a toll-free number or through online chat through Disability Benefits 101 ([www.db101.org](http://www.db101.org)) or Minnesota Help ([www.MnHelp.info](http://www.MnHelp.info)). Disability Linkage Line® staff is located in seven sites throughout the state.

Disability Linkage Line® usage continues to expand every year. In 2013, it received 44,308 inquiries. In the first half of 2016, it already has received 45,681 inquiries from 21,105 people.

**Table 5: Number of inquiries through DLL by calendar year (2013-2016)**

Calendar year	Inquiries
2013	44,308
2014	65,297
2015	78,386
<b>2016 (first 6 months)</b>	<b>45,681</b>

According to customer satisfaction surveys, 99 percent of people who called reported that the Disability Linkage Line® was helpful and 98 percent would recommend the service to someone they know. When asked how we can improve the service, customers wrote:

“Disability Linkage Line has been very helpful. All of the staff were very knowledgeable and took the time to help me understand the system and my options.”

“I am new to this whole disability process, and when I connected with [the options counselor], I was thrilled!!! She was able to answer all of my questions & give me helpful, useful, easy-to-understand information that no one had before! And she was so kind to me — I was touched by her kindness!”

“All I have to say is I would be lost without Disability Linkage Line.”

Customer satisfaction surveys also indicate the DLL provides an array of help.

**Table 6: Disability Linkage Line 2015 Customer Satisfaction Survey Results**

DLL helped me ...	Frequency
Understand my benefits and options	72%
Resolve a problem	52%
Make decisions	51%
Connect to a provider	48%
Explore work and school/training	10%

## INSIDE THE DLL: A STORY



Jane had just returned home from a nursing home rehab stay, so DLL staff reached out to her to see how she was doing. Jane told us she returned with more needs than when she went into the hospital. She went on to say that since her stay, she was feeling depressed and disconnected from life.

In the initial conversation, the Disability Linkage Line discovered that Jane had some immediate needs and some long-term goals. She needed a ramp, in-home service and was just starting on the CADI Waiver. She also had other goals for her life, like going back to work and getting a service dog. DLL explored resources and strategies with Jane, set up next steps and then began check in with her weekly to see how things were going.

DLL staff noted, “Jane has many strengths including determination and the ability to advocate for herself. The greatest service DLL provided was to listen, support and call her back when promised so that she is motivated to move forward.”

After working together for two months, Jane was able to get a service dog, a job, a ramp, and a CADI case manager. DLL staff continues to check with Jane to see if her needs change. We encourage her progress and help her to understand how to work with her new case manager.

Jane told the DLL: “Having someone check-in with me on a regular basis helped me stay on track and working to do what I need to do. You all provide not only a connection to resources, but also a personal connection that helped me with my depression.”

### Disability Benefits 101

Disability Benefits 101 ([mn.db101.org](http://mn.db101.org)) helps people with disabilities learn how income from work may affect benefits in order to make informed choices, reduce fears and ensure work is part of the plan.

Disability Benefits 101 provides:

- Centralized information that is easy to understand
- Customized estimators that tailor results to a person’s situation
- Experts that can talk to you live via chat, phone or email.

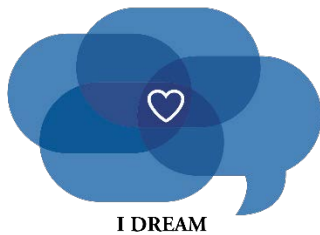
As seen in Table 7, usage of Disability Benefits 101 and its tools continues to grow.

**Table 7: Number of DB101 Visitors by Calendar Year 2013-2016**

Calendar year	Number of visitors
2013	107,540
2014	168,832
2015	177,296
<b>2016 (first 6 months)</b>	<b>111,031</b>

In 2016, Disability Benefits 101 launched a new feature called The Vault. The Vault allows a person to securely request, store, and share information. For more information, see [The Vault section](#) of this report.

## INSIDE THE DB101: A STORY



Jim contacted the Disability Linkage Line® through DB101’s Talk to an Expert option. He wanted to see if he should quit his job as a taxi driver to take a job with a transit company. He wanted help crunching the numbers to see if he was better off in the new job.

After talking with Jim, and meeting with him at a local VRS site, staff learned he had a former Navy career. He took great pride in his work. He wanted to work for the U.S. Postal Service, but was holding off because he thought he would be worse off financially and lose his medical benefit.

Together, DLL staff and Jim completed DB101 estimator sessions for the transit job and the postal job to compare each and its impact on his bottom line and his benefits. Jim discovered that the lower paying transit job might not make economic sense for him, but earnings from the postal service job would more than replace the loss of his financial benefits. In addition, he learned he could still keep all the medical benefits he has now. He realized he was unnecessarily holding himself back, and decided to apply for the postal position.

### Minnesota Autism Resource portal

DHS works in collaboration with the Minnesota departments of Health, Education and Employment and Economic Development to create and maintain a comprehensive website to connect people with other

people, resources and information related to autism. We are collecting information on the local, state and national level.

The state is committed to improve services and outcomes for children and adults with autism and related conditions. This website is a key strategy to foster increased connections to people, resources and information related to autism.

Currently, the Minnesota Autism Resource website is in the initial design and development phase. Once the website launches, we will continue to add new information, resources and ways for people to connect with each other. One of the main strategies to make the website relevant and meaningful is to involve the community. We are partners with other non-government organizations.

## **B. Intake and eligibility**

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### **MnCHOICES**

In the past, people with disabilities and their families could go through several assessments before they found the right service to meet their needs. Having multiple assessments to learn what services they may be able to receive can be a burden. It was not an efficient way to determine eligibility and plan for supports. That is what led Minnesota to develop MnCHOICES. Rather than multiple assessments, MnCHOICES is one assessment that determines eligibility for a variety of services. It helps a person plan for the future.

MnCHOICES is a tool to plan long-term services and supports. DHS designed MnCHOICES to incorporate principles of person-centered planning. It shifts the conversation from “What programs do you qualify for?” to “What do you need to meet your goals?”

It is for people of all ages and disability types in Minnesota. The MnCHOICES tool is a web-based application that certified assessors can use on- or off-line in any setting. It embraces a person-centered approach to help providers tailor services to the person’s:

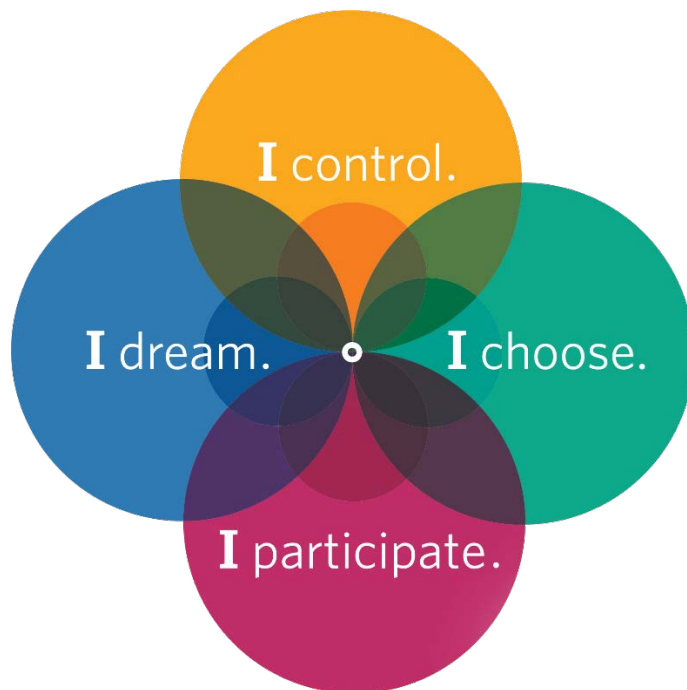
- Assessed needs
- Goals
- Preferences
- Strengths.

DHS launched MnCHOICES on Nov. 4, 2013. As of Jan. 1, 2015, all of Minnesota’s counties and two tribal agencies use MnCHOICES to determine eligibility for people who receive publically funded long-term services and supports for the first time. Also in 2015, counties and tribal agencies began using MnCHOICES for people who currently receive publically funded long-term services and supports and are due for a reassessment. The full rollout of all Minnesota’s lead agencies, including managed care organizations, should be complete by the end of calendar year 2017.

Our goal is to meet a person with disabilities’ needs in a timely way. In the FY 2013-15 round of reviews, 64 percent of lead agencies have met our goals for prompt assessments for program eligibility.

## VI. Person-centered practices

Figure 4: What person-centered practices mean to a person with disabilities



### WHAT'S IMPORTANT

- Minnesota is moving toward person-centered practices in all areas of service delivery
- There are service options that allow a person to self-direct his/her services
- DHS is committed to implementing person-centered practices so that people with disabilities can live in the most integrated setting possible
- DHS is reforming programs and policies to reflect person-centered practices.

Treating the people we serve with dignity and respect, listening to their wants and wishes and encouraging them to explore their dreams for the future are among the basic tenets of person-centered practice.

Minnesota is moving toward person-centered practices in all areas of service delivery. As a state, Minnesota strives to make sure everyone who receives long-term services and supports and mental health services can live, learn, work and enjoy life in the most integrated setting. The goal is for people to lead lives that are meaningful to them. To do this, we must have a person-centered support system that helps people:

- Build or maintain relationships with their families and friends
- Live as independently as possible
- Engage in productive activities, such as employment
- Participate in community life.

Together with the person, lead agencies plan, coordinate and implement services and supports that fit the person's unique needs, expressed preferences and decisions concerning his/her life in the community.

## A. Person-centered service planning

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Person-centered planning focuses on the person and his or her hopes and dreams for a fulfilling life. There are excellent examples across the state of good person-centered planning and action on those plans, but we have a lot to do before this is a reality for everyone. The term person-centered planning refers to a family of approaches, but all value similar goals for a person's life.

The essential components of a person-centered plan and planning process include:

- A plan that provides necessary information and support to the person to ensure that the person directs the process to the maximum extent possible
- A plan that reflects cultural considerations and uses plain language
- A process driven by the person
- A process that offers choices to the person regarding services and supports the person receives and from whom.

Currently, DHS collaborates with the University of Minnesota to offer and promote person-centered thinking/planning training. The training is designed to change the culture of service planning and delivery of those services. It helps providers and lead agencies learn how to listen to the person and take steps that help the person with what is most important to him/her. The person is the primary focus when using person-centered planning, not the disability, service or some other issue.

Training in person-centered thinking serves as a foundation for everyone who supports the person with disabilities. It offers specific ways to discover:

- What is important **TO** a person (e.g., it is something he or she believes adds to his/her quality of life)
- What is important **FOR** a person (e.g., it meets the need to stay healthy, safe and well).

The Centers for Medicare & Medicaid Services' new HCBS Rule requires the service recipient to lead the person-centered planning process where possible. For additional guidance, see the new [DHS webpage on person-centered practices](#).

MnCHOICES helps us meet person-centered goals. Regardless of program eligibility, every person assessed through MnCHOICES will have a plan that maps needed services, supports, goals and outcomes. The support plan is the one document that all participants receive. It should include personalized and detailed information about their strengths, needs and planned services.

The goals in the support plan should be meaningful and unique to the participant. It should include his or her preferences. The support plan should not only outline the participant's health, safety and needs, but also explain how planned services will address these needs. DHS created the [Person-Centered, Informed Choice and Transition Protocol \(PDF\)](#) as a guide lead agencies (counties, tribal organizations and managed

care organizations) must use to implement person-centered practices. The protocol explains DHS expectations for lead agencies and others who do support planning for people who receive long-term supports and services

### **Perspective of the person**

Recently, the Disability Linkage Line® asked focus groups, comprised of people with disabilities, what person-centered meant to them. For more on their feedback, see the [Appendix](#).

We learned it is important that people have choices in their service planning. That includes:

- Choosing which services and providers they would like
- Where they would like to live
- Participating in their support planning process.

Planning is a significant first step. How the plan is implemented is even more important.

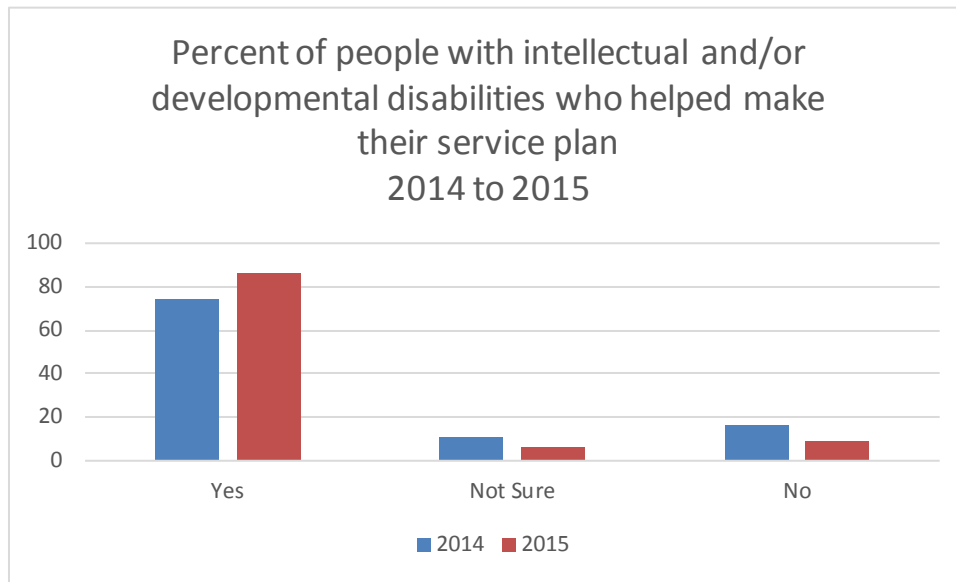
### **How are we doing?**

Over the course of this report, we include survey information from the National Core Indicators (NCI) survey. It is compelling information. DHS contracts with Vital Research to conduct NCI survey interviews in Minnesota. We recently completed a survey of adults with developmental disabilities in Minnesota and a different survey for people with physical disabilities. Our counterparts in the DHS Aging and Adult Services Division also are conducting a survey for older adults.

Through this data, we will be able to compare the experiences of people with disabilities in Minnesota with others from across the nation. We also will be able to see if we are doing better from year to year. That will help us understand if the changes described in this report are making a difference in the lives of the people we serve.

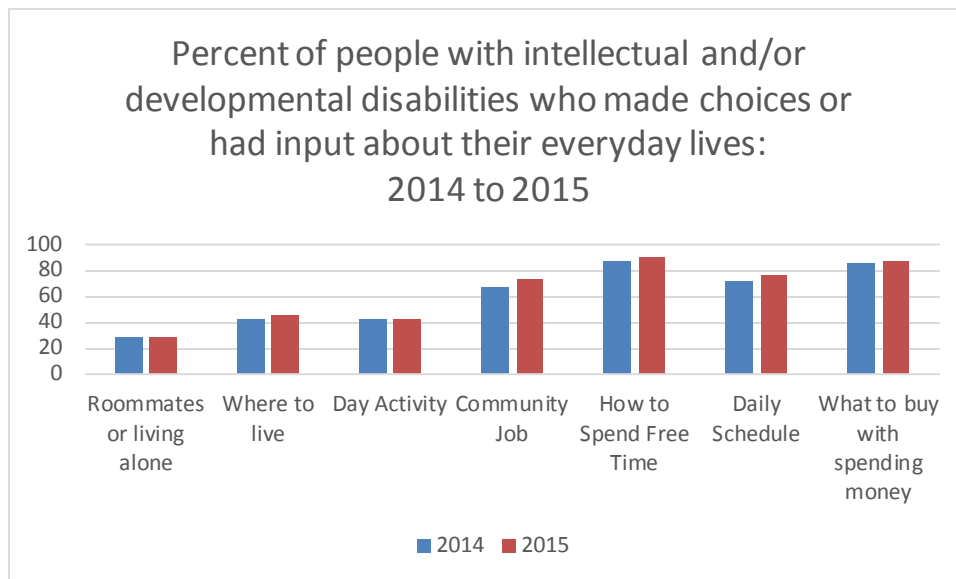
Figure 5, on the next page, indicates people's experience on various dimensions of person-centered planning and choice.

**Figure 5: Percent of people with intellectual and/or developmental disabilities who helped make their service plan (2014-15)**



SOURCE: NCI SURVEY

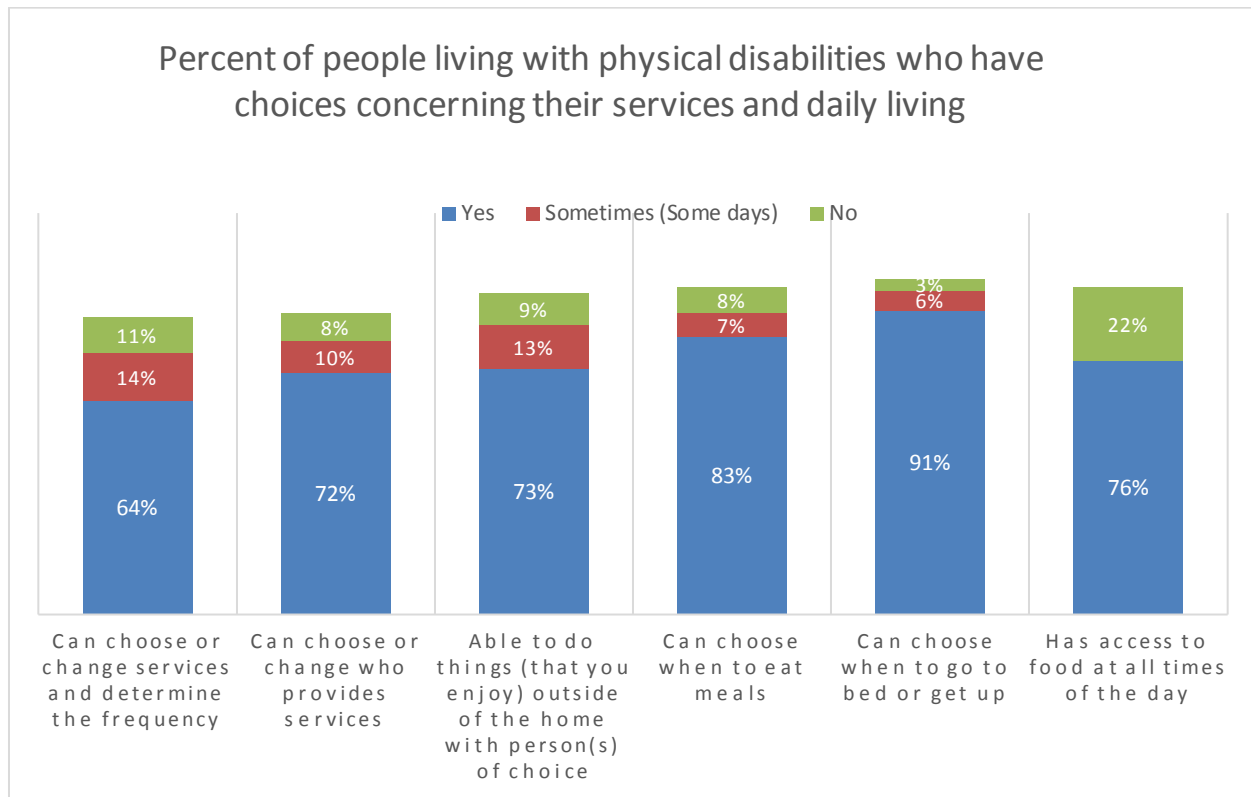
**Figure 6: Percent of people with intellectual and/or developmental disabilities who made choices or had input about their everyday lives (2014-15)**



SOURCE: NCI SURVEY



Figure 7: Percent of people living with physical disabilities who have choices concerning their services and daily living



SOURCE: NCI SURVEY

NOTE: There were a low number of responses to the “has access to food at all times of the day” question.

## B. Self-direction

Many of our services have an element of self-direction. However, we specifically identify several of our currently available services as “self-directed,” because the primary function of the service is for a person to design and manage their own services. That includes hiring, firing and supervising his/her staff.

### Consumer-directed community supports (CDCS)

Consumer-directed community supports is a unique service option available through the waivers. It can give people greater control, flexibility and responsibility to manage and direct services and supports. Many people choose consumer-directed community supports so they can customize their services, hire and fire staff, etc. Participants are willing to assume greater responsibility for the implementation of their plan because of this increased flexibility.

Consumer-directed community supports may include services, supports and items currently available through the waivers, such as assistance with personal care or environmental modifications for accessibility. The additional flexibility built into the service expands a person’s choice to purchase support from people

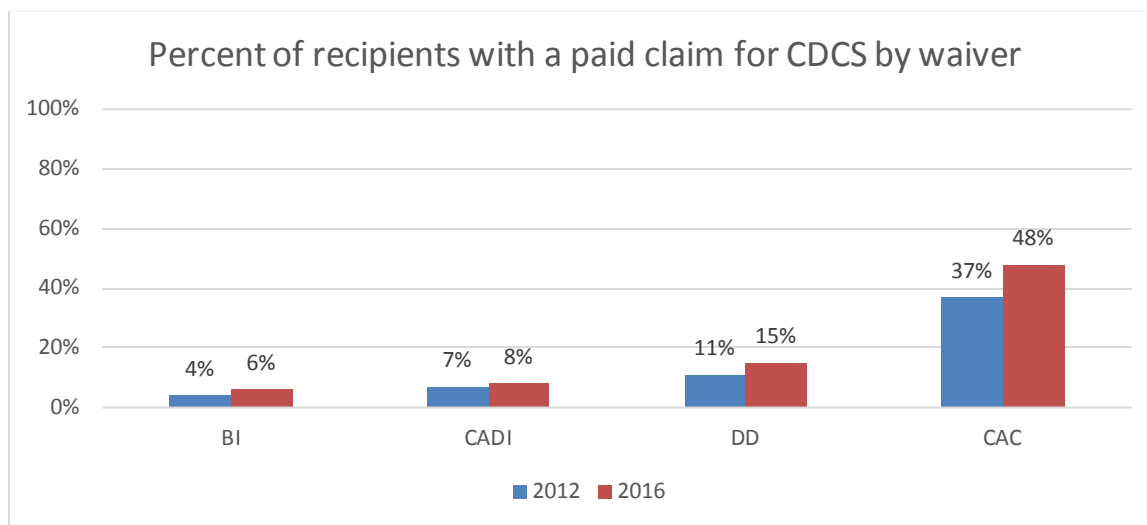
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such as parents or spouses. CDCS is especially appealing to families with a child served through the Community Alternative Care (CAC) Waiver.

People who participate in this option have a yearly budget. They can decide how much to pay the people they hire to provide their services. In addition, a person may purchase other allowable supports and goods to support their ability to live in and participate in the community. DHS determines individual budget limits for participants.

Legislation passed in 2014 and amended in 2016 allows a 20 percent budget increase, if necessary, for people who use CDCS and meet specific criteria. It is a time-limited demonstration to learn how the additional money will help graduates with employment. One hundred eighty-five (185) people have used this 20 percent adjustment. This legislation will expire when CMS approves 2015 legislation that expands the budget-exception eligibility.

**Figure 8: Percent of recipients with a paid claim for CDCS by waiver**



SOURCE: MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) SERVICE AGREEMENT AND PAID CLAIM DATA

### PCA Choice

PCA Choice is an option of the personal care assistance service. It allows people who receive PCA services more control. People are able to choose, hire, train and supervise their personal care assistants (PCAs). By choosing this option, the participant acts as the employer of their direct-support workers.

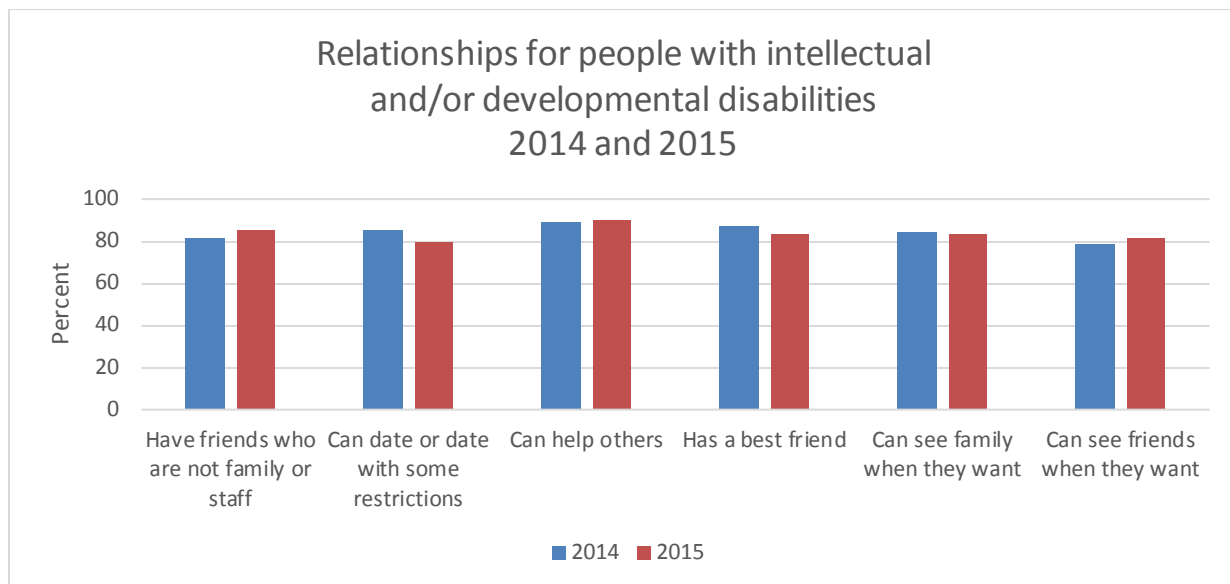
In the future, a new program, Community First Services and Supports (CFSS) will replace personal care assistance and Consumer Support Grants. CFSS is similar to PCA in many ways, but it can offer people more control, flexibility, responsibility and choice in how they use the service if they choose. It is a service that, once finalized, will be available under the Medical Assistance state plan and waiver programs. Instead of waiting for access to a waiver for one particular service, people may be able to meet their needs through CFSS alone.

### C. Progress toward community inclusion

The Americans with Disabilities Act and Minnesota’s Olmstead Plan require full and meaningful integration in the community for people with disabilities. This aligns with many public policy decisions by the legislature during the past three decades. DHS is committed to making it happen, as we know it benefits everyone. Inclusion establishes more informal/natural supports for people with disabilities and enriches relationships for people with and without disabilities.

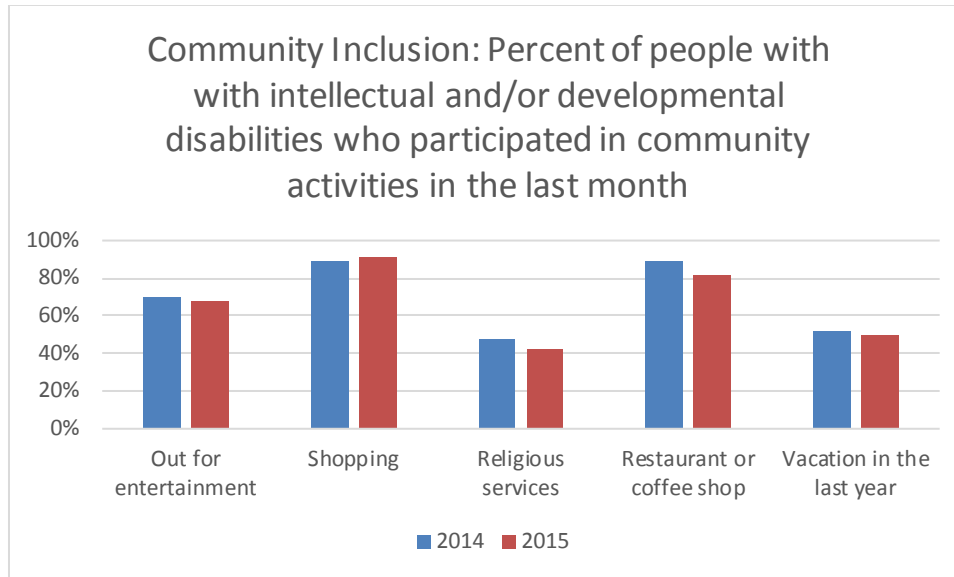
As in indicator of progress in that area, the National Core Indicators survey again provides insight on how we are doing. We will be able to track our progress over time and see how we compare to other states. There are a couple of ways to look at inclusion: In Minnesota, we include relationships with others and engagement in the community. While small changes from year to year may not indicate a significant difference, trending the data over time will help us evaluate how we are doing.

**Figure 9: Relationships for people with intellectual and/or developmental disabilities**



SOURCE: NCI SURVEY

**Figure 10: Community Inclusion: Percent of people with intellectual or developmental disabilities who participated in community activities in the last month**



SOURCE: NCI SURVEY

### Transition plan for home and community-based settings

The Centers for Medicare & Medicaid Services (CMS) published regulations, effective March 17, 2014, which, among other things, created a definition of home and community-based services settings for the 1915(c) Medicaid HCBS waivers, 1915(i) and 1915(k) programs. The new definition considers a person’s experience and outcomes in addition to a setting’s location, geography and physical characteristics.

CMS has issued guidelines that provide questions for states to consider when deciding whether settings are home and community-based. CMS has determined certain settings are “presumed not to be home and community-based.” CMS issued specific guidelines for residential settings and non-residential settings.

In Minnesota, the rule affects all home and community-based services waivers (BI, CAC, CADI, DD, and Elderly waiver). The rule allows for a five-year transition plan for existing programs to comply with requirements by March 17, 2019. (For more information, see the [DHS Transition plan for home and community-based settings webpage](#))

DHS has and will continue to work with stakeholders to refine standards and expectations. There may be areas where regulatory changes are needed. We know, however, that providers need clarification to strengthen practice to meet the intent of the rule. Practice changes may include training and clarifying existing policy manuals, tools and protocols.

## D. Responding to changing needs: Case managers are essential

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Case management is a service that provides a person with access to planning, referral, connection, assessment, monitoring, coordination and advocacy. This is done in partnership with a person and his or her family. A case manager assists with access to and navigation of social, health, education, vocational and other supports and services based on the person’s values, strengths, goals and needs.

### INSIDE STORY: A COMMENT FROM THE 2016 NCI FAMILY GUARDIAN SURVEY



I CONTROL

“We have a great case manager who works very hard to give my son the services he needs and wants. All services should be 'Person Centered.' To us this means finding out what makes the person happy & finding a way to make their dreams come true. Find a safe way to do the things they want to do. Even though I'm my son's guardian, he has also made his own decisions. I'm here to help him and explain things. I want him to have the best and most fulfilling life he can have. He is a person - his disability doesn't change that. We don't live thinking about the disability we just live & enjoy life. The disability is there but it doesn't affect how we live our lives. We just do things differently.”

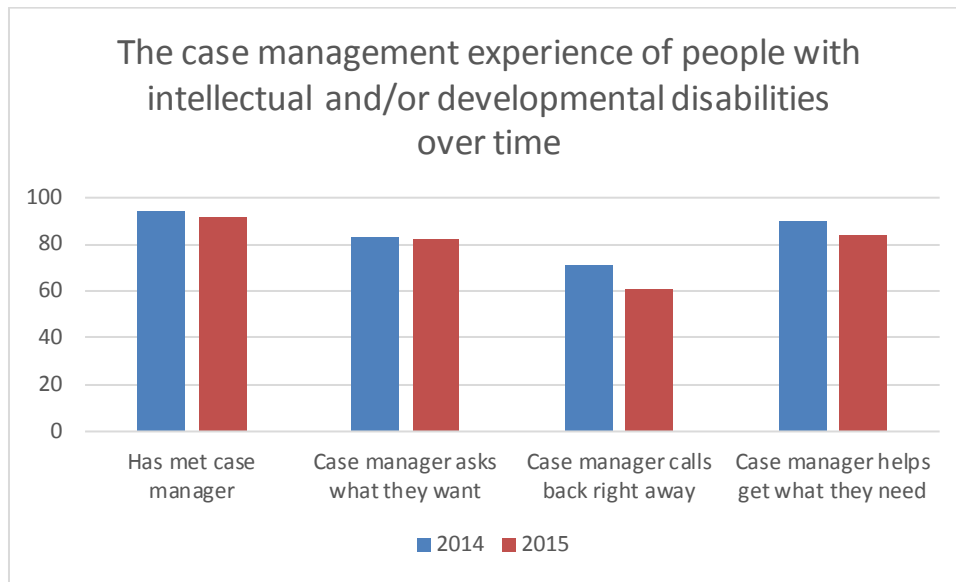
Through lead agency reviews, DHS determined that case managers visit with waiver recipients 4.03 times over an 18-month period on average — or about once every 100 days. Waiver policy requires three visits over an 18-month period.

**Table 8: Average number of case manager visits in past 18 months (January 2015-June 2016)**

Waiver program	Average number of visits in past 18 months
BI	4.2
CAC	3.6
CADI	4.0
DD	4.4

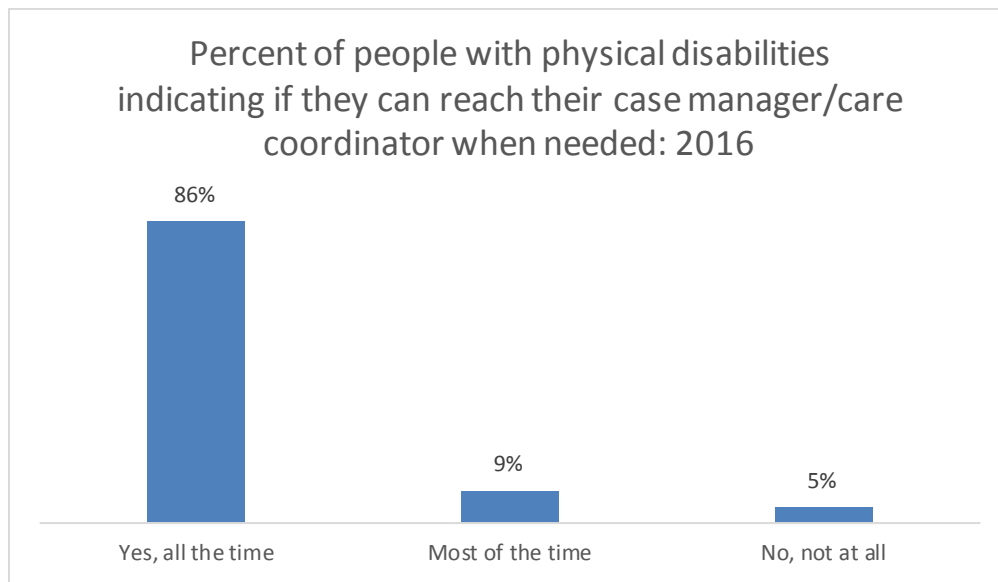
SOURCE: LEAD AGENCY REVIEWS

**Figure 11: Case management experience of people with intellectual and/or developmental disabilities**



SOURCE: NCI SURVEY

**Figure 12: Case management experience of people with physical disabilities**



SOURCE: NCI SURVEY

### Case management redesign

In 2013, the legislature asked DHS to propose legislation to redesign the home and community-based services case management system ([Minnesota Laws 2013, Chapter 63 Sect. 19](#)). The advisory workgroup

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met regularly and published its recommendations in a June 2014 joint report on [Minnesota Case Management Reform \(PDF\)](#).

In the report, DHS recommended a new process for its mental health and disability services divisions to administer case management. The new process standardizes the definition and service activities. The report also provided guidance on standards, outcome measures, increased choice of service provider, caseload size and payment methodologies and rates.

In an effort to provide consistent and quality case management services, DHS is working actively with partners and stakeholders to redesign the case management system. In that effort, DHS recently asked county/tribal partners and stakeholders to engage in the process, review documents and participate in a survey. Here are the two announcements we shared:

- [Oct. 7, 2016, case management redesign memo](#)
- [Nov. 3, 2016, case management redesign follow-up memo](#).

In addition, we are working with tribal organizations to create a parallel tribal process. We believe stakeholder engagement is a crucial element in reform, so we will continue to work with our partners to create a unified vision for case management. For more information, see the DHS public webpage on [case management redesign](#).

## VII. Person-centered outcomes

### WHAT'S IMPORTANT

- Priorities vary from person to person
- Individualized planning and customized supports help people achieve the outcomes that are important to them.

The services and supports DHS oversees are meant to improve the quality of life for people with disabilities in Minnesota. We have learned that the best way to find out the impact on people's lives is to ask them. We posted examples of [success stories](#) on the DHS public website.

One of the most effective ways to gather input is the National Core Indicators project. Specifically, the NCI Family Guardian Survey, which is given to families and guardians where the adult with intellectual and/or developmental disabilities does not live with the family. Here is a sample of comments from participants in the 2016 survey:

### INSIDE STORY: COMMENTS FROM THE 2016 NCI FAMILY GUARDIAN SURVEY



"I think it is critical that parents and providers work together. His outings were to large group functions in the community. He would get overwhelmed. Now he goes on a one out to supper for his community outings. He hasn't been this healthy in a long time. Keeping him out of the hospital saves so much emotionally, physically and financially. I'm so thankful for meeting his needs where is at. He is happy and calm now."

"Overall we are very pleased with DHS support. The major challenges for my sister is staff turn-over with care takers and also lack of transportation & staff to get out into community, to church etc. The other challenge is the confusion about the various agencies and people in the system she uses."

"Our family member has a productive fulfilling life because of the services she receives. They're essential to her livelihood."

### A. Individual satisfaction

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What people say about their services is the best way for us to create policies and programs that work. One way we hear from people is through surveys. We participate in the National Core Indicators (NCI) Survey of

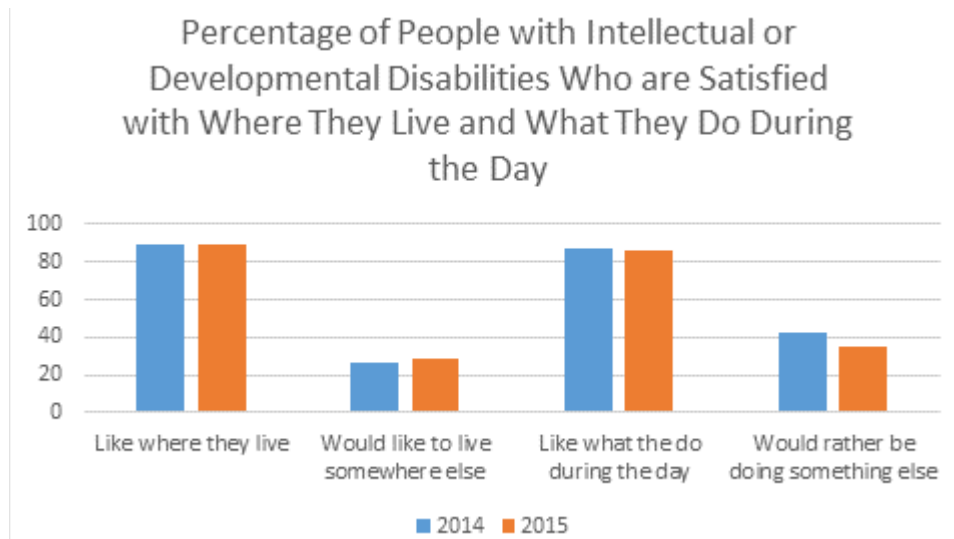


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people with intellectual disabilities and another for people with physical disabilities. We also survey families of children and adults with intellectual or developmental disabilities how they think we are doing. This will help us more fully understand their experience.

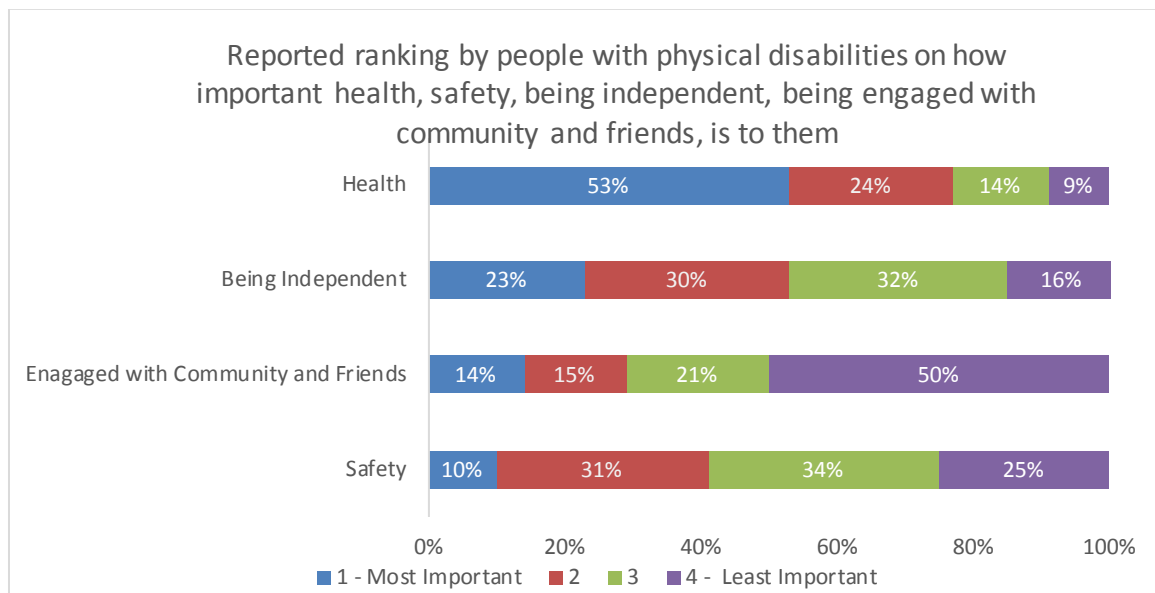
Mostly people are satisfied with the services they receive through programs funded by DHS. However, there is room for improvement. When asked, most people like where they live, yet if given a choice, they would rather live somewhere else. The same can be said for their activities during the day.

Figure 13: Percentage of people who are satisfied with where they live and what they do during the day



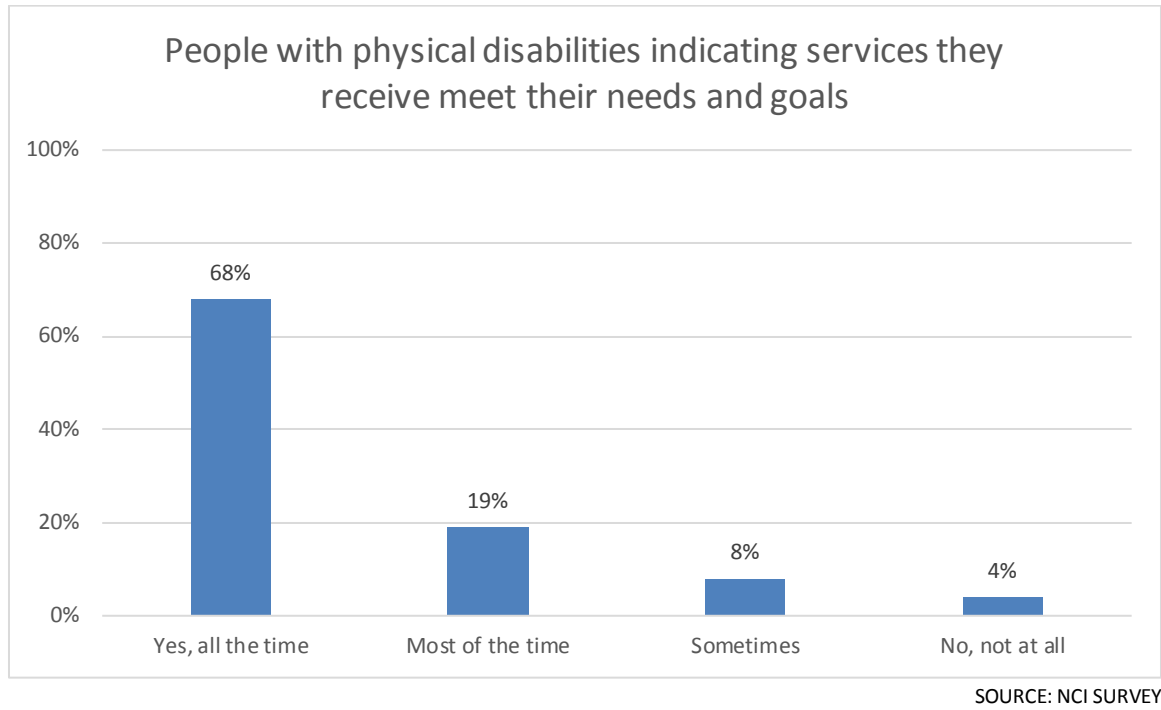
SOURCE: NCI SURVEY

Figure 14: Ranking of priorities by people with physical disabilities



SOURCE: NCI SURVEY

Figure 15: People with physical disabilities who indicate services they receive meet their needs and goals



## B. Employment

### Employment First policy

[Minnesota's Employment First policy](#) asserts that people with disabilities can work, want to work and do work. Minnesota's Employment First policy maintains that people with disabilities must have an informed choice about the range of employment options and opportunities open to them. It includes the idea that competitive, community-integrated employment is the preferred outcome.

During 2016, DHS and the Minnesota departments of Employment and Economic Development (DEED) and Education (MDE) developed, piloted and implemented a statewide interagency informed-choice framework and resource toolkit. Service planners and teams who support people with disabilities use the informed-choice framework and resource toolkit.

Going forward, DHS will continue to work on competitive, community-integrated employment outcomes for people with disabilities by:

- Developing new service options and rates to better align with competitive, community-integrated employment outcomes
- Integrating discussion about work into person centered planning (e.g., MnCHOICES, Moving Home Minnesota, etc.)
- Providing technical assistance to county and tribal lead agencies about the benefits of making competitive community employment a part of the person's plan.

## DHS employment initiatives

During 2015 and 2016, DHS engaged in five key areas that support the state's Olmstead employment goals and strategies for providing a pathway to achieve competitive, community-integrated employment. The five areas are:

- New disability waiver employment services
- Earned-income database and employment dashboards
- "The Vault:" A disability employment tool
- Supported employment policy guidance
- Day services redesign.

### *New disability waiver employment services*

DHS is developing three new disability waiver-employment services to advance competitive, community-integrated employment for people with disabilities. The proposed services are:

- **Employment exploration services:** Community-based orientation services that introduce a person to competitive employment opportunities in their community. The service does this through individualized educational activities, learning opportunities, work experiences and support services. This results in the person making an informed decision about working in competitively paying jobs at community businesses.
- **Employment development services:** Individualized services that actively support a person to achieve paid employment in his/her community. This service helps people find paid employment, become self-employed or establish small businesses in their communities.
- **Employment support services:** Individualized support services that help people maintain paid employment at community businesses.

People who use these services will explore employment options that address their goals. It will give them the opportunity to interact meaningfully with local businesses and with people without disabilities. These services ultimately will help people obtain and maintain employment in the community.

### *Earned-income database and employment dashboards*

DHS developed an earned-income database to provide information on the employment, program participation and earnings of people with disabilities who are between 18 and 64 years old and use one or more of the following:

- Medical Assistance for Employed Persons with Disabilities (MA-EPD)
- Home and community-based service disability waivers
- Adult Rehabilitative Mental Health Services (ARMHS).
- Mental Health Targeted Case Management (MH-TCM)

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The database includes information about employers, types of employment and the amounts of earned income per month. The dashboards allow users to estimate the numbers of program participants who are competitively employed and working at jobs in community businesses.

DHS has provided the earned-income database to all county and tribal lead agencies. DHS will provide an updated earned-income database to lead agencies on an annual basis. The employment dashboards will be updated annually.

### *“The Vault” – An employment tool*

As mentioned in [Disability Benefits 101 section](#), DHS developed a secure online resource tool known as [The Vault](#). The Vault is a Disability Benefits 101 option that helps people with disabilities make informed decisions about competitive, community-integrated employment.

The Vault allows people to set-up secure accounts to access their public benefits information. That information can be used to populate estimation calculators to see how earned wages from employment may affect their benefits and income. The Vault gives complete control to the person. It allows people to share public benefits information, if they wish, so they can coordinate information between all the people who help them across agencies and organizations.

This functionality means that, for the first time, a person can directly access his/her public benefit information without contacting a case manager, financial worker or other telephone-based support. Going forward, DHS will develop additional tools within The Vault to support the economic advancement and financial goals of people with disabilities.

### *Supported employment policy guidance*

DHS is part of an interagency group focused on the use of waiver-funded supported employment services (SES) for secondary school-age (“school-to-work”) transition youth and adults with disabilities.

The group developed a new policy that addresses “best practice” use of waiver-funded supported employment services to obtain and maintain competitive, community-integrated employment when public education funds and vocational rehabilitation funds are not available. The guidance describes how different agencies can effectively work together to fund and support competitive, community-integrated employment for [transition youth \(PDF\)](#) and [adults with disabilities \(PDF\)](#).

### *Day services redesign*

DHS is meeting with stakeholders to explore innovative ways to transform day training and habilitation (DT&H) services and prevocational day services to better align with the federal [HCBS Rule](#). Our goal is to better support people with disabilities who seek or are involved in employment or other life-enriching activities in their community. Redesigned DT&H and prevocational day services would evolve into person-centered, community-based support services. The hope is that the new experience would help develop and

maintain essential and personally enriching life skills. That way, people with disabilities could fully participate in their preferred activities in their community.

DHS will continue to work with various stakeholder groups on redesigning DT&H and prevocational day services to better support people with disabilities.

## C. Housing

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Having a sense of control and ownership over your living space is important to all people, including people with disabilities. Supporting people to live independent lives to the extent possible is a priority for DHS. It is important from a human perspective, but also makes fiscal sense as well.

### Housing access services

Since fall 2009, more than 1,700 people have used housing access services to move from licensed or unlicensed settings to homes of their own that are not owned, leased or controlled by disability-services providers. Instead, many people with disabilities are living in safe, affordable homes of their own because of a state grant funded program.

Housing access coordination has been available through the DD Waiver, but the Housing Access Services grant allowed us to focus on developing this service to serve more people. We were able to create a prototype for future inclusion in all the disability waivers as a Medical Assistance-funded service.

A new housing access coordination waiver service launched July 1, 2016. DHS developed the service based on our experience with the grant-funded work. The service helps people plan for, find and move to homes of their own. It is a pay-for-performance, person-centered service that pays staff to assist the person in the process. For eligible people who do not receive waiver services, housing access services grant funds will still be available.

To see program participants, families and county staff tell their stories about housing access services, check out [our YouTube video](#).

### Moving Home Minnesota

[Moving Home Minnesota](#) is a person-centered approach to help people transition from nursing homes, intermediate care facilities for persons with developmental disabilities and other institutional settings to a community-based living setting that meet their needs and wants.

Moving Home Minnesota provides services to help during the transition. Those services are available to eligible Minnesota residents for up to one year after their move from institutional care. The initiative is funded through a federal grant called Money Follows the Person.

Under the Moving Home Minnesota initiative, Minnesota has helped 45 people get housing using rental assistance vouchers for Section 811 housing for people with disabilities under the age of 62. That is more than any other state, including several states that received a larger numbers of vouchers.

### Return to Community

[Return to Community](#) is a comprehensive initiative to help nursing home residents who want to return to a home of their own in the community. The initiative has two general approaches:

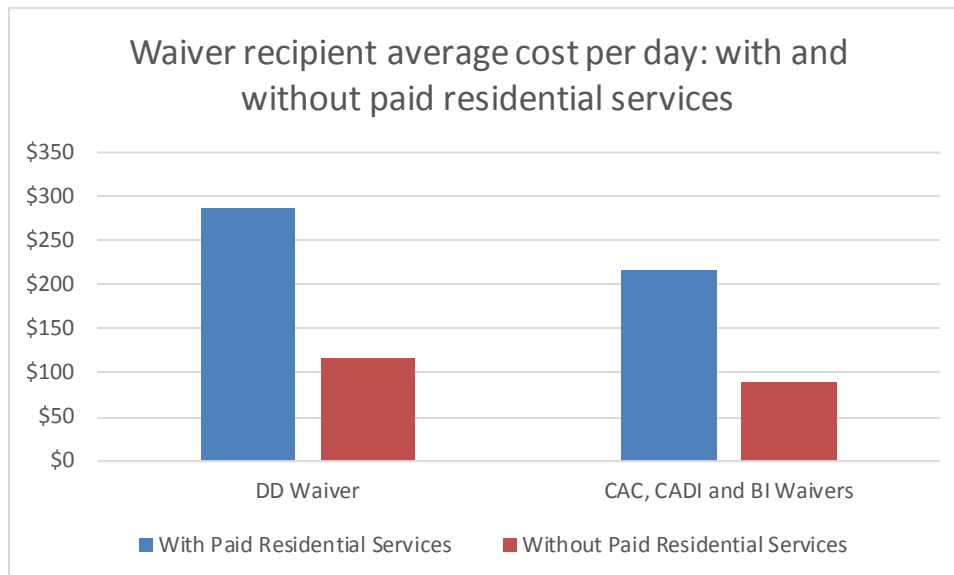
- A formal transition program for people who live in nursing homes and want to return to the community
- Interventions to motivate and support nursing home providers to facilitate moves to the community.

### Single point of entry

When someone who receives services is at risk of losing their placement in a residential program or their ability to remain in their home, the situation becomes a crisis. We all must act quickly and efficiently to best serve that person. To help streamline the process, DHS is implementing an intake system called the “single point of entry.” It acts as a central system to accept and triage requests for crisis services for people with developmental or intellectual disabilities who have lost or are at immediate risk of losing their residential placement.

Currently, we are working to expand this service to enable **any** person with a disability who has lost residential services so that he/she can have access to the single point of entry system.

**Figure 16: Waiver recipient average cost per day: with and without paid residential services**



SOURCE: MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) SERVICE AGREEMENT AND PAID CLAIM DATA

## VIII. Provider capacity

### WHAT'S IMPORTANT

- It is crucial for Minnesota to have a strong network of quality service providers and top-notch services.

We want to retain and build provider capacity. To do that, we need to work to educate and help others as they learn about what these changes mean and how they can be used to support people in need of services in a more person-centered and cost-effective manner.

### A. Provider networks and availability

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#### Analyzing service gaps

The [gaps analysis](#) study gathers local information about the perceived capacity and gaps of the Minnesota home and community-based services system across populations. DHS conducts the Gaps Analysis study every two years. We gather input from lead agencies (counties, tribes and managed care organizations), and local community members. That includes people who receive services, caregivers, advocates and providers. We ask about their perceptions regarding:

- Barriers to getting services
- Services that are needed but either difficult or unable to get
- Use of services.

In the [2015 gaps analysis](#), lead agencies most frequently identified the following as gap areas for people with disabilities:

- Respite care provided out of the person's home
- Foster care
- Respite care for crises.

Statewide, only 11 percent of counties said the availability of out-of-home respite care met or exceeded current demand. Thirteen percent said the availability of crisis respite met or exceeded demand. Thirty percent said the availability of foster care met or exceeded demand.

The 2017 gaps analysis will take a different approach from previous years. We will hold regional meetings to engage all of our partners in solutions-oriented, person-centered conversations to address identified top service gaps in their region.

Along with the above noted gaps, lead agencies have seen the availability of other services decrease (namely, personal care assistance, chore services and medical transportation – for both older adults and

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for people with disabilities). Shortages of trained providers and the inability to recruit or retain staff appear to be the primary reasons for the gaps.

### Staff stability

In the fall of 2015, with the support of trade associations that represent residential and day-service providers, DHS agreed to implement a staff-stability survey related to direct-support professionals for people with intellectual and developmental disabilities. We heard from 256 residential, in-home and day-service providers who employ more than 22,000 direct support professionals. The following are the results of our preliminary analysis:

- Nearly 70 percent of the provider organizations who responded have fewer than 50 direct-support employees
- Nearly 10,000 direct-support professionals left positions in 2015
  - There were 3,000 vacancies on Dec. 31, 2015
  - The percentage of part-time vacancies is twice that of full-time vacancies
- The median starting wage across service types is \$10.93/hour. The median wage for current workers is \$11.87/hour
- Employee benefits are not readily available, particularly for part-time direct-support professionals

### Addressing issues

“Building relationships between the providers and the residents is most important and the most difficult with low wages. Staff turnover hurts everyone.” (Comment from 2016 NCI Family Guardian Survey)

To better understand and address these workforce issues, DHS sponsored a workforce summit in the summer of 2016. The 181 participants included:

- 145 organization representatives (about 70 different organizations and 11 state agencies were represented)
- Twenty direct-care/support workers
- Sixteen people who receive direct-care/support services.

The goal of this event was to identify solutions with actionable strategies. DHS also surveyed direct-support professionals as well as people receiving services and shared the findings of both the summit and the surveys.

Eight small groups identified more than 300 solutions through discussion. Five major themes appear most often in notes:

- Increase workers’ wages and/or benefits
- Expand the worker pool



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- Enhance direct care/support worker training
- Increase job satisfaction and elevate profession
- Conduct a public awareness campaign.

In October 2016, the DHS Community Supports and Continuing Care for Older Adults administrations hosted a follow-up discussion to the direct-care/support workforce summit held in July. Stakeholders at the meeting were asked to identify action steps to take together to address the workforce shortage, and identify leads and those willing to work on the issues. For more information, see the [direct care/support workforce summit summary report and next steps, DHS-7271A \(PDF\)](#).

### Addressing service gaps

DHS is taking steps to address issues with provider availability. We:

- Awarded grants to develop specific services such as respite services for people with autism
- Promote self-directed services to allow people to have more flexibility in service design and hiring
- Are exploring shared living/host home approaches in which people with disabilities and a person/family choose to live together with program and administrative support provided by a 245D-licensed waiver provider.
- Are studying the impact, if any, that changes in rates and moving from a county-based to a statewide system of determining provider qualifications might have on provider availability.

### Corporate foster care needs determination

The 2009 Minnesota Legislature authorized a moratorium, or freeze, on growth of corporate foster care or community residential settings for adults and children. Corporate foster care is a setting in which the home is licensed as foster care and the license holder does not live in that home.

The goal of the moratorium was to:

- Reduce growth in the programs during difficult economic times
- Promote practices that provide more options for those using services.

This allowed for growth in the waivers, while decreasing the average cost per day for services.

The moratorium was intended to reserve the use of foster care to those who need it most, and help more people be supported in settings in their communities that are more inclusive and tailored to their needs. As part of the moratorium ([MN Stat. §245A.03, subd. 7e](#)), DHS submits an annual needs determination report to the legislature each year. (The most recent [Needs Determination report \(PDF\)](#) published in August 2016.) Each report includes:

- Actions taken to manage statewide long-term care services and supports resources
- Information and data on the overall capacity of licensed long-term care services.

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Currently, DHS contracts with nine counties who use local planning grants to develop alternatives to corporate foster care in their areas. A new request for proposals was out in December 2016 for state fiscal years 2017-2019 to build on the successes these counties have achieved both independently and collaboratively.

By working with lead agencies and providers, DHS also explores strategies, some of which may require legislation. We seek to help people live in their own homes with less intensive services (that can vary in intensity as needed), live near or with their families, and honor their choice in communities. Options being considered include:

- To clarify the commissioner's authority to manage capacity to address the needs determination findings
- To consider additional limited exceptions to the moratorium.

### **Respite service development**

Services to meet the needs of people with autism and related conditions have been a high priority for DHS and the Minnesota Legislature. In order to address the need for more respite capacity and well-trained providers, DHS asked interested counties and tribes to respond to an application to improve respite options in the state. A one-time legislative grant appropriation of \$2.5 million funded this effort.

All grant-funded respite has a goal to:

- Build respite services capacity
- Train respite workers and providers
- Provide classes and training to families
- Assist the person to maintain his or her quality of life and community living.

In order to increase capacity for serving people in need of short-term crisis services, DHS issued a [crisis respite Request for Proposal \(RFP\) and a Request for Information \(RFI\) in April 2016](#). It sought qualified providers to provide crisis respite for people with disabilities.

The RFI sought information on people providing in-home crisis respite to settings where the person resides (This is a current waived service that is underused). The RFP awarded new community residential setting license capacity for people in out-of-home crisis respite. DHS has awarded capacity to several providers for people to receive out-of-home crisis respite (e.g., a place for the person to reside until the need for crisis services ends). To date, DHS has awarded capacity to develop up to 41 crisis respite beds.

### **Foster care services for children with severe autism**

DHS developed a pilot project to address the need to serve children with severe autism who already are in out-of-home placement. We requested proposals from current and qualified corporate foster care

providers to use up to twelve new corporate foster care beds as an exception to the moratorium. This pilot allowed one child, who was living out-of-state in an institution, to move back to Minnesota closer to family.

We continue to investigate and encourage alternative models for supporting children with autism and their families, including services that will support families who care for their children at home.

## B. Provider qualifications

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### Provider training

A core component to ensuring providers are well equipped to meet the needs of people with disabilities is to have high quality, sustainable training available. DHS is committed to implement positive supports and person-centered practices, and as such, has sponsored several trainings dedicated to promoting these practices. These include:

- **Person-centered thinking training:** This two-day, interactive training focuses on the balance between what is important TO and what is important FOR a person. Approximately 4,000 people have gone through this training.
- **Person-centered planning training:** This two-day, interactive training builds on applying person-centered thinking, as well as learning and using planning tools that help people envision the life they want in their community. More than 500 people have taken this training. DHS expects this number to continue to increase in 2017.
- **Person-centered “train-the-trainer” sessions:** In order to develop true provider capacity and ensure the sustainability of the person-centered trainings, DHS has invested in training people to facilitate person-centered trainings themselves. More than 50 people have been trained and certified as person-centered thinking trainers. Ten people have been trained and certified as person-centered planning trainers.
- **Person-centered organizations training:** This one-day training focuses on evaluating person-centered practices at an organizational level. (For more information, see the [organizational change training section](#) later in this report). In 2015, 540 people from 280 organizations completed this training.
- **Person centered organizational change initiative:** This is a multi-year, facilitated process where organizations increase their capacity to support their employees and those served using person centered principles and practices. Four agencies are in their second year of the training and eight others are in their first year. The results are encouraging, with improvements in outcomes for people, staff retention, satisfaction and decreased worker’s compensation.
- **Positive behavior support training:** A yearlong, intensive training in which participants demonstrate competency in multiple practices and tools related to positive behavior supports functional assessments and data-based decision-making. Eight people are participating in the current cohort. DSD has recently begun an online training series on positive behavior supports for

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people that want to learn more but may not need an intensive training. There are currently 35 participants in this training series statewide.

### College of Direct Support

To help providers and lead agencies navigate training requirements of 245D licensing and the positive supports rule, DHS expanded the availability of the College of Direct Support to all of Minnesota's disability service providers. The College of Direct Support is a competency-based, online training resource dedicated for those in the human service profession or for those directly affected by the human service system. It includes a performance management system for supervisors and managers to observe and verify the demonstration of competence of those who have gone through training.

The curriculum of the College of Direct Support helps meet 245D-licensing requirements and the staff-training requirements of the positive supports rule. The curriculum includes information about how to:

- Help people with disabilities lead more self-directed lives
- Promote the quality of services
- Support person-centered practices
- Have more knowledge of Minnesota requirements.

As of Sept. 1, 2016, there were 24,782 people in Minnesota actively using the College of Direct Support. We expect this number to increase as new content dedicated to person-centered practices is added. For more information on the new positive supports rule, see the [positive supports section](#) of this report.

### Licensing

To address the need for statewide consistency in services, the 2013 legislature passed home and community-based services standards under [Minnesota Statutes, Chapter 245D](#). They became effective Jan. 1, 2014. Twelve home and community-based services that previously did not require a license now require a 245D license.

Many providers have said they like the ability to serve people across the different disability waivers. They say it allows them to provide a variety of services. It has eliminated the need to contract with individual counties and to hold individual county-specific service licenses. It also has allowed providers to expand services and options to people they serve.

As of Jan. 1, 2016, there were 1,289 245D-licensed providers in Minnesota. To assure licensing standards, DHS schedules regular site visits for programs. DHS also visits outside of scheduled site reviews when necessary, such as in response to maltreatment investigations.

DHS continues to work with lead agencies to better define state and county roles to monitor:

- How services are provided across the state
- How providers develop practices that ensure quality services are available to people with disabilities.

## IX. Individual safeguards

### WHAT'S IMPORTANT

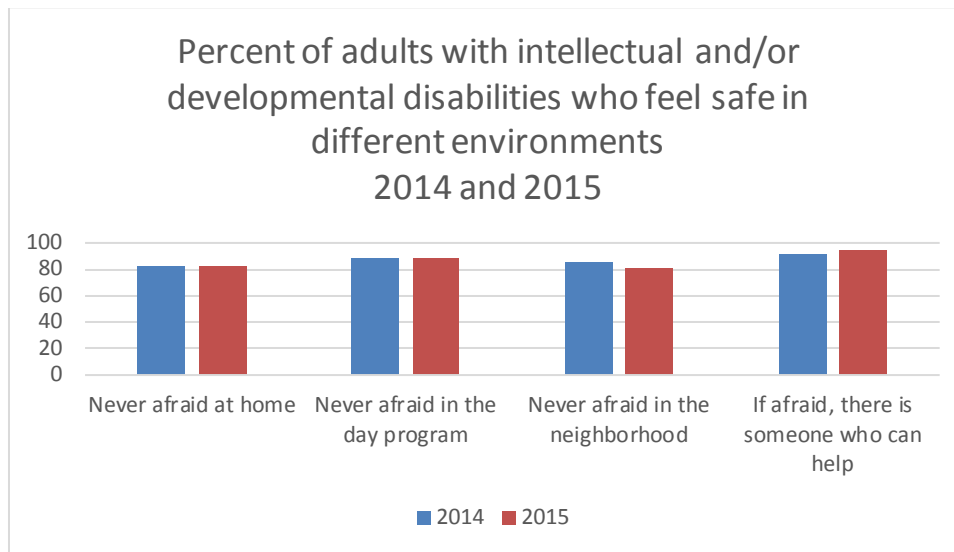
- People are safe and secure in their homes and communities
- DHS, lead agencies and providers take into account the person's informed and expressed choices.
- We balance risk with the importance of a person's civil rights.

Currently in human services, there is a shift away from “risk management” and toward “risk mitigation.” This is especially true when addressing potential adverse outcomes for people who participate in long-term services and supports. Up until recently, our “risk management” relied on provider supervision and action to prevent or avoid adverse outcomes. It put the focus on what is important **FOR** a person in order to keep them safe.

Risk mitigation changes the focus to include what is important **TO** the person. It allows the person to make decisions about the type and level of risk he/she is willing to take. This supports informed choice by the person. It allows him/her to have the quality of life he/she desire based on personal preferences.

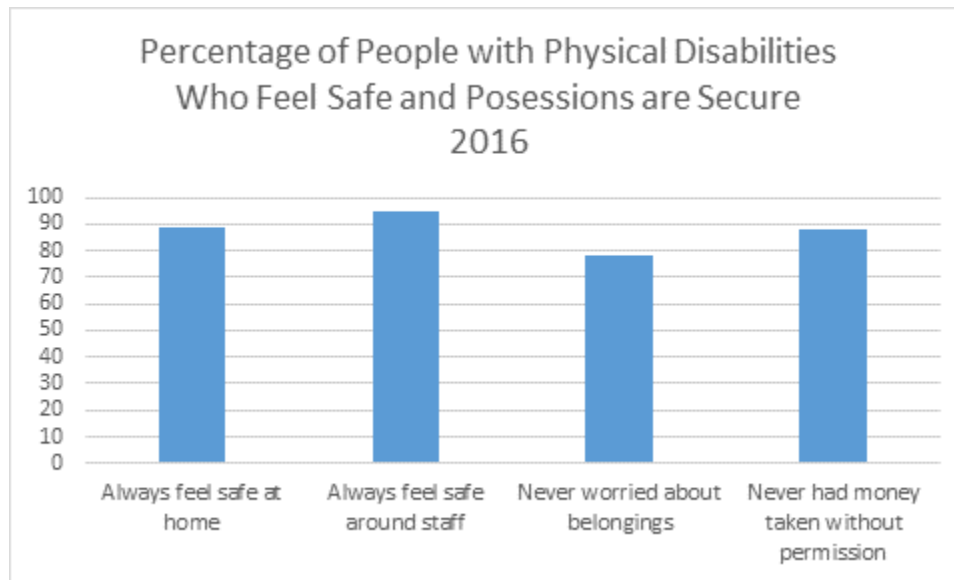
The standards of 245D licensing require an integrated and normalized environment. This provides the opportunity for self-sufficiency while also ensuring the person receives the required supervision and protection. This level of supervision and protection balances risk.

Figure 17: Percent of adults with intellectual and/or developmental disabilities who feel safe in different environments



SOURCE: NCI SURVEY

Figure 18: Percentage of people with physical disabilities who feel safe and possessions are secure (2016)



SOURCE: NCI SURVEY

## A. Risk and safety planning

State law requires immediate reporting of suspected maltreatment by mandated reporters (e.g. providers and staff). The law encourages reporting of suspected maltreatment by any person.

DHS created [Minnesota Adult Abuse Reporting Center \(MAARC\)](#) as a central system for reporting suspected maltreatment of vulnerable adults. This system streamlines reporting suspected maltreatment. People can report through a phone call or the online system. This is a significant change as this common entry point replaces a previously fragmented system.

Depending on the nature of the allegations and the type of program, the lead investigative team may be DHS, the Minnesota Department of Health or law enforcement. Based on the finding, the lead investigative agency makes a determination of whether maltreatment occurred. When a provider is found responsible for maltreatment, DHS licensing may suspend or revoke the provider’s license.

Table 9: County-substantiated maltreatment of disability waiver participants (all ages)

Waiver	2015	2016
BI	<10	<10
CAC	<10	<10
CADI	79	93
DD	51	35

NOTE: Table 9 information is based on completed adult maltreatment investigations as of Oct. 10, 2015, for SFY2015 and Oct. 10, 2016, for SFY2016 and completed child maltreatment investigations as of Sept. 6, 2016.

Trends indicate that repeat maltreatment is rare among waiver participants. Less than one-half of one percent of all participants served under the disability waivers has a county-substantiation of maltreatment each year.

The most frequently verified types of maltreatment are neglect and physical abuse. For adults, financial exploitation also is proven through county investigations.

### Maltreatment in licensed programs

The majority of licensed home-and-community based services provided to Minnesotans with disabilities require a 245D HCBS license. DHS investigates allegations of maltreatment in 245D licensed programs.

**Table 10: State-investigated allegations substantiated as maltreatment in 245D programs licensed to serve people with disabilities –state fiscal year 2015-2016**

Responsibility	SFY 2015	SFY 2016
Facility/provider agency	37	35
Facility/provider staff	175	202
Inconclusive	12	7
<b>TOTAL</b>	<b>224</b>	<b>244</b>

In state fiscal year 2016, all verified findings of maltreatment that were the responsibility of facility/provider agencies resulted in negative actions for the provider agency. Approximately 40 percent of the findings that were the responsibility of facility/provider staff resulted in disqualification of those staff due to serious or recurring maltreatment.

## B. Positive supports

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Positive supports are practices used to improve a person’s quality of life by using a variety of evidence-based strategies. It does not include punishment, seclusion or restraints. Positive-support strategies reinforce desirable behavior while removing the source for challenging behavior. Person-centered planning is key to learning more about a person and their life circumstances. This may help us better understand why certain behaviors and reactions occur, and it will help us develop better plans for positive ways to support the person.

However, the concept of positive supports is much more than that. Positive supports is about respecting the dignity and rights of every person and supporting people in the life they want to live. Whether a person receives mental health services, housing services, disability services, educational services or any service/support meant to improve the person’s life, positive supports:

- Focus on the person and their unique strengths, talents, interests, expectations, cultures and goals
- Respect the rights and individuality of each person
- Offer tools and supports that are effective.

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Previously mentioned 245D-licensing standards prohibit the use of many restrictive interventions including:

- Restraint
- Seclusion
- Aversive practices.

On Aug. 31, 2015, [Minnesota Rule, Chapter 9544](#) went into effect. It governs the service delivery of all DHS licensed providers when they serve a person with developmental disabilities or related conditions. Rule 9544 requires the use of positive support strategies and person-centered planning with people who receive services. It also applies to the service delivery of all providers under 245D. It extends the prohibitions from 245D to all DHS licensed providers.

Rule 9544 tasks DHS to oversee the process to assure that positive supports become standard practice across the state. Providers governed by Rule 9544 must submit reports to DHS and the Office of the Ombudsman for Mental Health and Developmental Disabilities when they use restrictive interventions. These reports allow DHS to:

- Track the use of restraint, seclusion and aversive practices
- Respond to incidents of mistreatment.

Providers must submit their plans for positive support, known as [Positive Support Transition Plans](#), to DHS anytime they phase out the use of a restrictive intervention. This allows DHS to track the progress of teams as they fade the use of restrictive practices and implement positive support strategies.

Minnesota surpassed the 2016 Olmstead goal to reduce the number of people who experienced a restrictive procedure by 5 percent from the previous year (51 people). The actual number of people who experienced a restrictive procedure in 2016 decreased to 761, a reduction of 106 people. This represents an actual reduction of 12 percent in the second year.

It is important to note that the overall Olmstead goal was to reduce the number of people by 200 by June 30, 2018. As of this reporting period, the state already surpassed the overall goal.

Minnesota surpassed the 2016 Olmstead goal to reduce the number of behavior intervention reporting form (BIRF) accounts of restrictive procedures by 409 reports. In 2016, the number of reports decreased by 1,116. (It is important to note that the overall goal is to reduce the number of reports by 1,596 by June 30, 2018. As of this reporting period, the state already surpassed the overall goal.)

### **Positive supports website**

A new website, [Positive Support Minnesota](#), now offers information about positive supports. The site, developed by a team of community partners, the Institute on Committee Integration at the University of Minnesota and DHS, provides information for everyone.



Positive Supports Minnesota also serves as the home of the Positive Support Manual, a resource manual that provides guidelines for positive supports in DHS-licensed settings.

## **C. Crisis management**

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Minnesota requires processes to be in place to handle difficult or dangerous situations. Home and community-based services providers licensed under 245D must have plans in place for each person when he or she has a crisis.

This requirement stems from our federally approved waiver plans and applies to all waiver participants—regardless of waiver program. One specific requirement is the person has a back-up plan that contains:

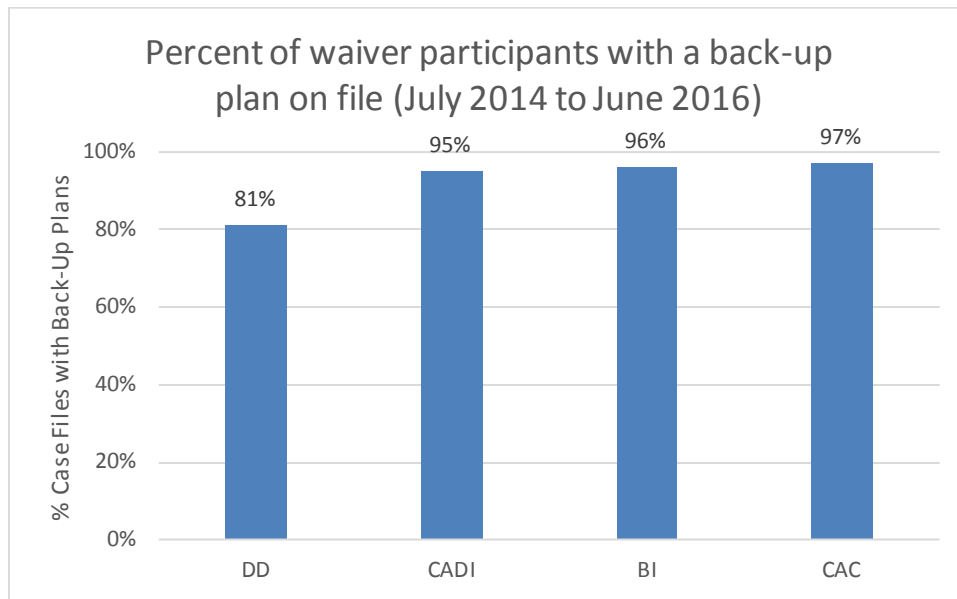
- The participant’s preferred admitting hospital or medical care provider.
- Emergency contact in event that primary caregiver cannot be reached.
- Back-up staffing plans in event that primary staff are unable to provide needed services.

### **Natural disasters and other public emergencies**

We know that when procedures are in place ahead of time, providers are prepared for the unexpected. Providers who had a plan in place when an emergency happened report that they were able to continue operations quickly while maintaining health and safety. Advanced planning requirements by the programs is crucial to support recovery and maintain essential services in such disasters.

All 245D licensed providers of home and community-based services must be prepared to respond to disasters and emergencies. There are DHS supports in place to assist providers when disaster strikes. If they have a good plan in place ahead of time, we can help fund the recovery process.

Figure 19: Percent of people who have a back-up plan on file by waiver type (July 2014-June 2016)



SOURCE: LEAD AGENCY REVIEW

## D. Housing and environment

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There are times when a person needs adaptations to his or her home to make it accessible. Because living in one's own home can increase quality of life, DHS supports home and community-based services and supports that make that possible. Often, just a few adaptations can keep someone in their home as opposed to living in a facility.

### Home modifications under the waivers

All four disability waivers (BI, CAC, CADI, and DD) cover environmental accessibility adaptations for the purchase, installation, maintenance and repairs of environmental modifications and equipment. In order for the waiver to cover repairs of an environmental modification or equipment, the repairs must be cost-efficient compared to replacement of the item.

### Technology for Home

[Technology for Home](#) is a state-funded initiative available through a contract between DHS and Live Life Therapy Solutions. It offers at-home in-person assistive technology consultation and technical assistance to help people with disabilities live more independently. Programs like this often can keep someone in their home longer or help them move to a home of their own in the first place.

With Technology for Home, people who want to stay or move home direct the outcome. Technology for Home helps with the assistive technology resources. Expert consultants provide possible, cost-effective

solutions. They communicate with the lead agency to develop a plan for people who receive home care or home and community-based waiver services.

Technology for Home staff consults with eligible people in their own homes, workplaces or public locations. They help people find tools that will help them live in their own homes. The team will:

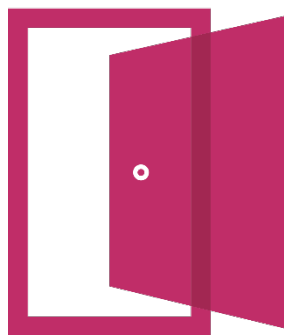
- Consult with eligible people in their own homes, workplaces, or public locations
- Connect people to resources that will help them live in their own homes
- Follow up to ensure effective training, set up and installation
- Serve on the person's team to develop a plan to assure assistive technology goals have been met.

As of June 30, 2016, Technology for Home consultants had served 972 people with disabilities whose goals for assistive technology had not been met through other services. Approximately half of the people served were children.

For more information on the program, see the recent [Technology for Home video](#) they created. It shares what the program and its participants can achieve together.

## **INSIDE TECH FOR HOME: PARTICIPATION SUCCESS**

This is a story of a 20-year-old young man with developmental disabilities and autism. He did not have a communication system for many years since his augmentative and alternative communication device had been stolen. Recently he had become more agitated as his communication needs had increased but he had no way to make them known.



**I PARTICIPATE**

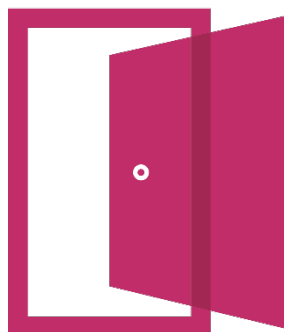
“A Technology for Home speech pathologist consultant worked with a young man who had recently become frustrated with his ability to communicate effectively.

He demonstrated both interest and trainability to use a tablet device camera right away. He was also able to use an app called Talking Cards, which allows a person to either use one word drawings or photos from his own library to create a simple communication system.

A tablet device was recommended along with the Talking Cards app. A follow-up visit trained his mother on how to use it for the best functional outcome. A phone conversation a few weeks after that revealed that the person was effectively using the app. It was simple, yet flexible enough to add more vocabulary, because it allowed for use of actual photos from the client's environment. A heavy-duty case protects the device to ensure many years of continued use. He can make his needs, and wants known.”

## **INSIDE TECH FOR HOME: COMMUNICATION SUCCESS**

The following story was written by a Technology for Home occupational therapist who worked with a 21-year old man who sustained a spinal cord injury in a car accident. He had been living in a senior assisted-living center while he completed outpatient rehabilitation. His outpatient team referred him to Technology for Home. The goal was for him to move to an apartment. The outpatient team sought out the Technology for Home team to assess his abilities and needs for technology and modifications when he moved to an apartment.



**I PARTICIPATE**

“This young man was assessed by TFH at a rehabilitation facility when he was still living in an assisted living center. It was determined that he would need adaptations to be able to cook simple meals, access his door and phone, and to start to explore school or job options. He also identified the desire to use a computer and explore options for him to work so he could earn money to buy land and build an accessible home in the future.

The young man did move to his own apartment three weeks after the assistive technology assessment. I completed an assessment once he was in his own home. The primary areas he identified to work on for his independence were use of the phone, the door to his apartment and his wheelchair fit/stander. During the follow-up, an application for a phone from the Telephone Distribution Program was completed, so that he will have a phone he can access and use when he is in his wheelchair or from his bed. I assisted him in getting the application submitted for a door modification so he would be able to lock/unlock and open/close his front door independently.

He is doing things with his friends again. Recently he went on a hunting trip. This young man went from a flat affect when he first came to the rehabilitation setting to smiling and interacting about his future thru his work with Technology for Home. His long-term goal is to buy land and build an accessible home near his parents. To explore going to school or career options, he will apply to Vocational Rehabilitation Services. He will continue to receive assistive technology services now to focus on his physical therapy equipment.”

## **X. Individual rights and responsibilities**

### **WHAT'S IMPORTANT**

- People with disabilities receive support to exercise their rights and in accepting personal responsibilities.
- People are informed of and supported to exercise their rights freely, decision-making authority and ability to register grievances and complaints.

DHS works with our partners to support people with disabilities to both exercise their rights and accept personal responsibilities. People are informed of their rights and receive training and support to use their own decision-making authority.

### **A. Civic and human rights**

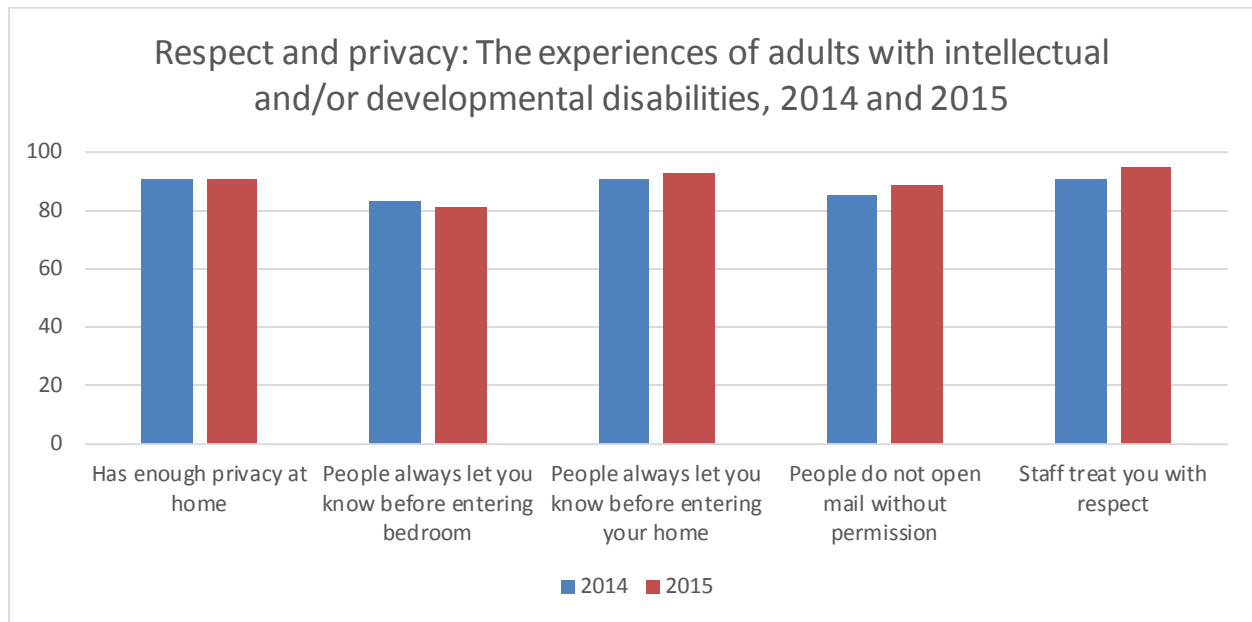
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Federal courts and Minnesota law agree: People with disabilities have the same human and civil rights as everyone else. Minnesota's 245D standards codify their rights as service recipients.

Providers are responsible for the use and protection of those rights. They also must inform people of their rights within five days of when they first receive services (and every year after that). These rights may only be restricted to ensure the health, safety and well-being of a person. However, the law requires that restrictions of that kind must be documented in the person's community support plan. Essentially, the provider must document and implement any restriction. Providers cannot restrict rights as a way to control a person's behavior or as a default method to keep a person "safe."

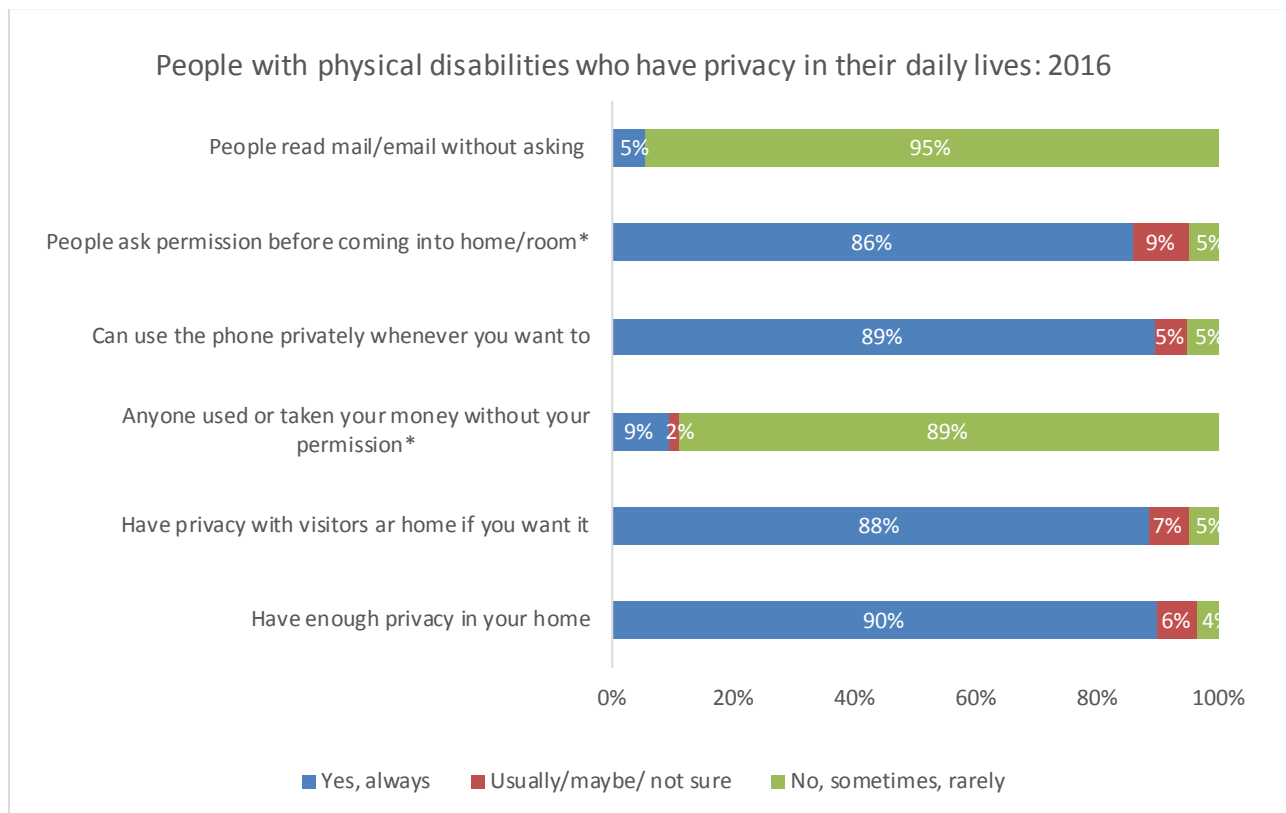
The National Core Indicators Survey gives us insight as to how people with intellectual and/or developmental disabilities perceive their basic rights are being respected.

Figure 20: The experiences of adults with intellectual and/or developmental disabilities



SOURCE: NCI SURVEY

Figure 21: Percent of people with physical disabilities who have privacy in their daily lives (2016)



SOURCE: NCI SURVEY

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NOTE: The majority of the questions in Figure 21 were targeted to people who live in group homes, foster homes or assisted living situations specifically, except the two questions “people ask permission before coming into my home/room” and “anyone used or taken your money without your permission.” Those were also asked of everyone else.

### Guardianship

The courts may decide that a person with disabilities needs someone to act in his or her best interest and assist in the supported decision-making process. The DHS commissioner acts as court-appointed public guardian for approximately 2,000 adults with developmental disabilities. These are people who the court determined are in need of a guardian and they do not have another private party who is willing or able to act as guardian.

DHS and county staff work on behalf of the commissioner to act as a delegated guardian for these people. The county staff carries out most of the guardianship duties. This includes completion of annual well-being reports, which they submit to DHS for review.

DHS provides ongoing technical assistance and consultation to the county staff in the performance of their duties. However, certain functions and decisions are not delegated. This includes reviewing requests for the commissioner’s consent for health care decisions related to:

- Do not intubate orders
- Do not resuscitate orders
- Limited medical treatment orders.

### B. Individual decision-making authority

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DHS makes resources available so that people have the information they need to make decisions. These resources support planning and service delivery that is truly person-centered.

An appropriation from the 2013 Minnesota Legislature funded an agreement for unlimited statewide access to College of Direct Support (CDS) for people with disabilities and their families. For this group, CDS provides a [free, online training curriculum](#) that focuses on:

- Helping people with disabilities make decisions about their own lives
- Improving knowledge
- Helping people know what to look for in quality services.

### Advocating Change Together

DHS has a grant contract with Advocating Change Together. It is a non-profit disability rights organization run by and for people with developmental and other disabilities. Their programs build self-advocacy in three ways:

- Personal empowerment

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- Disability awareness
- Systems change.

Advocating Change Together uses the money to develop learning modules and to support leadership development among people with intellectual and/or developmental disabilities.

### **The Arc of Minnesota Southwest**

DHS has a contract with The Arc of Minnesota Southwest. It is a non-profit, voluntary organization that promotes and protects the human rights of people with intellectual and developmental disabilities. It actively supports full inclusion and participation in the community throughout a lifetime. Services include information and referral, education and public policy development.

DHS sponsors a self-advocate from Minnesota to participate on a national board for people with intellectual and/or developmental disabilities who advocate for themselves.

## **C. Due process**

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People who receive home and community-based services governed by 245D have the right to file complaints on their service providers. Providers must develop and implement policies and procedures that direct how they act on complaints.

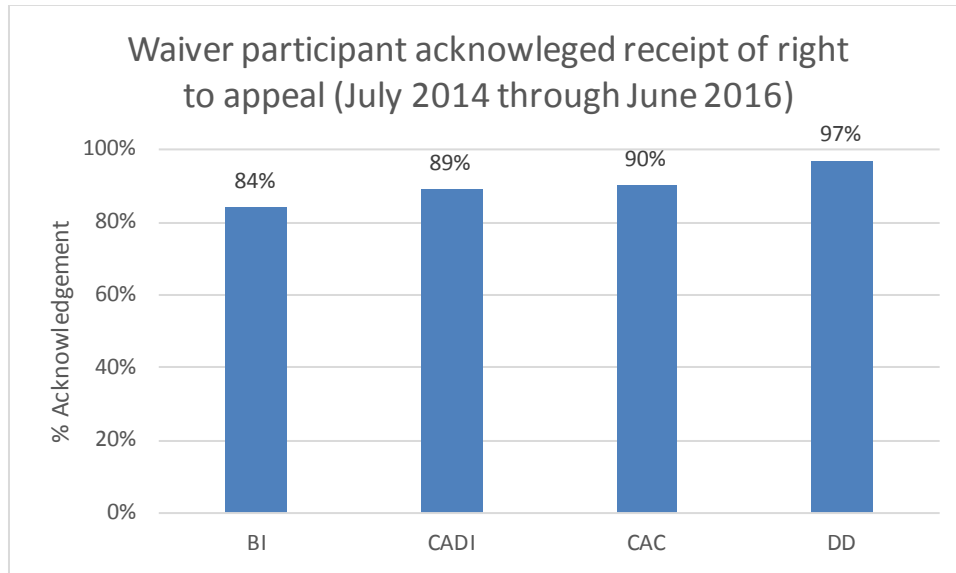
When a provider suspends or terminates services, they must give the participants written notice. That notice must address the person's right to seek a temporary order that pauses the termination of service.

### **Waiver appeals**

When there is a reduction or termination of waiver services, participants have a right to appeal if they disagree with the decision. Waiver participants must receive information about their appeal rights during the initial assessment and subsequent support planning. To comply with appeals law, lead agencies must document their practices in participant's case files.



**Figure 22: Percent of individual files reviewed where the waiver participant acknowledged receipt of their right to appeal information within the past year (July 2014 - June 2016)**



SOURCE: LEAD AGENCY REVIEW

## XI. System performance

### WHAT IS IMPORTANT

- DHS oversees a system that supports people efficiently and effectively and strives to improve quality.

Our services and systems must be flexible to respond as the needs and expectations of the people we serve change. We measure the performance of our systems to assure they align with our strategic goals and are working effectively to monitor, communicate and drive performance.

### A. Disability Waiver Rate System

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In 2014, DHS implemented the Disability Waiver Rate System (DWRS). It determines statewide prices for services paid by the disability waivers in a consistent and transparent way. The Centers for Medicare & Medicaid Services require uniform rate-determination methods and standards across a state.

DHS conducted extensive research on the cost to provide disability waiver services in Minnesota. After stakeholder input and legislative negotiations, the 2013 legislature finalized implementation of the DWRS.

On Jan. 1, 2014, the DWRS transferred the responsibility of setting service rates from counties and tribal agencies to a statewide system. The system promotes quality and participant choice. It recognizes a person's assessed need for particular components within each service. Counties and tribal agencies assign waiver funds according to a person's assessed needs.

DHS is in the middle of evaluating the DWRS for efficiency and accuracy. Between 2014 and 2020, DHS will conduct a comprehensive evaluation of the DWRS. It is assessing the following:

- Impact to program outcomes, such as access to services
- Fiscal impacts of DWRS statewide, by lead agency or service
- Specific component values that may need to be modified
- Specific policy areas where end users do not accurately implement the application of the system.

DHS has submitted two annual reports to the legislature (the first in [January 2015](#) and the second in [January 2016](#)). We will submit a third report to the legislature in January 2017. The legislative report in January 2015 addressed first-year implementation of the statewide rate system.

Research from 2016 indicates an increase in total projected spending upon full system implementation. The impact of DWRS does vary: some providers, services and lead agencies show increases while others indicate decreases. As an example, we project spending for residential services to increase 2.4 percent, while spending for day services likely will decrease 4.8 percent.

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DHS has heard concerns from stakeholders about DWRS. The two primary concerns from service providers have been:

- The projected decrease in day training and habilitation (DT&H) service rates
- The increased administrative effort required to implement the new system.

Lead agencies also have expressed concern about system complexity and the staff time required to complete associated administrative work.

During DWRS implementation, DHS will continue to employ a comprehensive research plan to ensure:

- The DWRS system accurately reflects the cost to provide services
- Recipients continue to have access to the services they need
- The DWRS system is implemented fairly and consistently throughout the state.

For additional information about DWRS, please see the most recent [2016 DWRS Legislative Report \(PDF\)](#) and the 2017 DWRS legislative report, which we expect to post in mid-January 2017.

## B. Measuring effectiveness

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Our ability to measure performance gives policy makers, stakeholders and ourselves a way to reach desired outcomes through:

- Identifying changes connected to an intervention
- Measuring achievement
- Recognizing and replicating what works.

DHS maintains performance measures and other program reports through the [long-term services and supports public planning and performance reporting](#) webpage.

### Lead agency reviews

The HCBS lead agency review has been successful in using multiple data collection methods to assess the administration of the waiver programs throughout lead agencies in Minnesota. In particular, the reviews serve as an effective mechanism to:

- Support lead agencies in their work
- Promote collaboration across lead agencies
- Share best practices to advance managing by performance.

The review team works with every lead agency and reviews a sample of cases and documents on a regular schedule to assess compliance.

DHS developed and maintains the [home and community-based services \(HCBS\) lead agency review website](#). It is a resource where local agencies can access tools, resources and information on best practices to use while administering HCBS programs.

The lead agency reviews promote person-centered plans and implementation of those plans. Part of the review involves reviewing samples of a lead agency's case files to determine whether a person's support plan is individualized and meaningful. Because of these reviews, lead agencies have a process to evaluate their person-centered practices. To increase compliance, DHS has changed and updated review protocols to assure consistent practices across all lead agencies.

Once the final analysis of a lead agency is complete, the team prepares a report for each lead agency and gives recommendations. The recommendations encourage lead agencies to set expectations for the quality and content of support plans as well as to seek out training for their staff about providing person-centered services. This may involve changes in agency practices as well as changes to how agencies work with their community partners.

### **DHS Equity Initiative**

DHS is working to use data across our programs to inform and influence Equity Initiative policy development and implementation. The Equity Initiative Research and Data Analysis Workgroup engages in the following activities to accomplish this goal:

- Gather data to develop a common understanding of services and outcomes for cultural and ethnic groups served by DHS and other state and local programs, using existing data
- Develop and refine data structures and access that integrate and merge DHS program data (and other available data sets) to evaluate the impacts on cultural and ethnic groups across programs
- Identify information and data gaps and suggest strategies to address them
- Work with communities to develop data and research approaches
- Communicate findings to other equity initiative workgroups and the larger DHS community
- Find the best ways to share findings with various cultural and ethnic communities.

### **National Core Indicators survey**

The National Core Indicators surveys described throughout this report allow us to compare the experiences of people with disabilities in Minnesota with others from across the nation. We also will be able to see if we are doing better from year to year. That will help us understand if the changes described in this report are making a difference in the lives of the people we serve.

## C. Improving quality

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### Quality Improvement across the Continuum Conference

DHS held the first biennial [quality improvement conference](#) in June 2016. It focused on long-term services and supports. More than 450 people from HCBS providers and nursing homes across the state attended the one-day event. The goals of the conference were to:

- Promote innovative best practices in quality improvement efforts that impact older adults and people with disabilities
- Provide an opportunity for people to learn about quality improvement efforts in nursing facilities and home and community-based services
- Offer opportunities to network.

### Minnesota Age and Disabilities Odyssey Conference

DHS organizes the two-day [Minnesota Age and Disabilities Odyssey Conference](#) held every other year. The first conference was in 1998. The conference:

- Promotes best practices
- Provides training and technical assistance about DHS programs and services
- Recognizes and honors excellence at the individual, organization and programmatic level
- Offers many opportunities to network.

This two-day conference generally attracts more than 1,400 attendees. Attendees are interested in long-term services and supports. They include advocates, consumers, policy makers, providers and those from Area Agencies on Aging, counties, tribes, managed care organizations and state government.

### HCBS improvement initiatives

#### *Quality improvement add-on rate increase*

On July 1, 2015, a one-percent quality add-on rate increase went into effect for most home and community-based service providers that included a quality improvement requirement.

To keep the increase, providers had to implement quality improvement projects by June 30, 2016, and address one of the following goals:

- Improve the quality of life of home and community-based service recipients in a meaningful way
- Improve the quality of services in a measurable way
- Deliver good quality services more efficiently while using the savings to enhance services for the participants served.

*HCBS Performance-Based Incentive Payment Program (PIPP)*

In 2013, the legislature provided funding to DHS to help providers implement time-limited quality improvement projects ([Minn. Stat. §256B.439, subd. 5](#)). DHS awarded \$3.5 million in performance-improvement funding to 27 projects in 39 Minnesota counties. The resulting HCBS Performance-Based Incentive Payment Program Grants (PIPP), required grantees to put strategies into place to:

- Improve the quality of life of older adults and people with disabilities in a measureable way
- Improve the quality of services in a measurable way
- Deliver good quality services more efficiently.

In fiscal year 2015, DHS created a series of webinar trainings based on topics identified by grantees. The purpose of these webinars was to be a resource to HCBS providers who implemented or were interested in implementing quality improvement projects. These webinars and a growing list of best practice ideas and quality improvement resources are available on the [Minnesota home and community-based services quality improvement](#) website

DHS used the findings from both of these initiatives to develop the [HCBSimprovement.info](#) website.

**Person-centered and positive supports organizational change training**

In 2015, in partnership with the University of Minnesota, DHS began the Person-Centered Organizational Change training cohorts. This training:

- Supports organization-wide implementation of person-centered practices
- Promotes person-centered culture throughout the organization
- Works toward systems changes envisioned most notably in the state’s Olmstead Plan.

Four organizations participate in the initial cohort and twelve organizations are in the second cohort (which began in 2016).

The organizations that participate in the cohorts consist of provider agencies and lead agencies. They come from three areas of Minnesota:

- The Twin Cities metro area
- St. Louis County and the Iron Range
- The west central area of the state.

The concentration of regions is intentional. We want to develop relationships among providers and lead agencies. We hope to build self-sustaining pockets of expertise that will continue after the training is complete. Furthermore, the participating organizations will be equipped to provide continued training and technical assistance to others in their regions. That will move the burden off DHS and the University of Minnesota as being the primary source of expertise.

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What makes organizational training unique is how the approach provides structured methods for the organizational and systems changes that are required for agencies to provide person-centered support. Each organization that participates in the cohort identifies people to serve as leaders and others to serve as coaches in order to support the implementation of person-centered practices at all levels of service delivery. This allows for ideas and changes to permeate all levels of each organization, including:

- Management practices
- Supervision practices
- Staff relationships with one another.

However, perhaps most importantly, the knowledge affects the way they serve people with disabilities at every level.

While participants work together within their own organizations, they also collaborate and problem-solve with the other participating service-delivery organizations. Having various perspectives from each organization is crucial. It allows the groups to focus on all aspects of life and to be truly person-centered. DSD staff also participates in the cohort. That allows for open dialogue and problem solving, with an eye on sustainable systems change. Some common results of the training are:

- Increased staff retention
- Restructured human resources processes to accommodate and support staff
- Consistent worktime dedicated to furthering person-centered practices
- Brainstorming and increased communication with direct-support staff and management for problem-solving during difficult situations
- Enhanced relationships as it intentionally matches staff with people served
- Multiple people exercising choice and direction in their lives.

DHS is exploring ways to expand the availability of this training across the state.

## D. Partnerships

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Meaningful engagement with our partners in disability services is critical. We are committed to their involvement in the design, implementation and evaluation of long-term services and supports. Each partner brings a perspective to the table that contributes to making good decisions. Our partners include:

- People with disabilities
- Their families
- Lead agencies (counties, tribal agencies and managed care organizations)
- Service providers
- Advocates.

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People who access services are experts on how our system functions. Their knowledge gives us a necessary perspective. As experts based on their experiences with the system, they deserve to be a part of high-level decision-making. Those conversations and decisions could affect their lives and their families' lives. It is essential to helping all of us make good decisions.

### **Home and Community-Based Services Partners Panel**

In 2008, DHS initiated the [Home and Community-Based Services Partners Panel](#), which we continues to support. The panel is a group that meets regularly and serves as a communication link among the system's stakeholders and as a means to support specific initiatives.

Panel members are people with expert knowledge and experience of long-term services and supports. The panel includes representatives of:

- Participants and family advocates
- Mental health and disability-specific advocates
- County groups
- Existing advisory and policy groups
- State agencies
- Other related groups.

Members represent organizations that are engaged in statewide activities to support home and community-based services.

### **HCBS county-state work group**

DHS formed the HCBS county-state work group in 2010 as a forum to manage legislatively mandated home and community-based service reform initiatives. We work with counties who are DHS's delegated local administrative agents to act on behalf of the commissioner. Membership includes:

- Lead agency and state staff that oversee the administration of home and community-based services
- County representatives appointed by the Minnesota Association of County Social Service Administrators, the Local Public Health Association and the Association of Minnesota Counties
- Additional county members with particular expertise, as needed.

DHS' Disability Services and Aging and Adult Services divisions are members of the home and community-based county-state work group as well.

### **State Quality Council**

Early in 2012, DSD organized the [State Quality Council](#) as directed by the legislature ([Minn. Stat. §256B.097](#)). The council consists of a diverse group of stakeholders including people with disabilities and



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their family members. It monitors quality assurance and improvement practices. It recommends state quality-improvement priorities. The council's quality indicators workgroup identified the indicators used throughout this report.

The legislature appropriated grant funding to support the State Quality Council starting in state fiscal year 2015. DSD has applied those funds to support three regional quality councils and a single council coordinator.

### **Other collaborations**

At any one time, The DHS Disability Services Division, often in collaboration with the Aging and Adult Services and/or other DHS divisions, may have one or more temporary work groups with external stakeholders running to advise us on specific projects. Current and recent work groups for reform initiatives include:

- Assistive technology
- Autism and related conditions
- Case management reform
- Community First Services and Supports implementation
- Crisis
- DHS/MDH leadership
- Disability Waiver Rate System
- [Employment Learning Community](#)
- [Home and Community-based Services \(HCBS\) Rule](#)
- [MnCHOICES](#)
- [Rule 40 Advisory Group](#)
- Self-directed workforce labor management
- [Traumatic Brain Injury Advisory Committee](#)
- Other ad hoc workgroups created as needed for topic/policy areas
- Public meetings, forums, comment periods for formal and high profile changes.

## XII. Summary

Minnesota is on a continuing journey to transform services for people with disabilities. We once had large, state-operated regional treatment centers. As they have closed, Minnesotans with disabilities have moved into communities across the state. However, living in the community may not be the same as being part of the community. Some Minnesotans with disabilities remain isolated from meaningful relationships with people who are not family or paid staff.

In all of our work, we use CHOICE outcomes for all people with disabilities as a guide:

- **Community membership**
- **Health, wellness, and long-term supports**
- **Own place to live**
- **Important long-term relationships**
- **Control over supports**
- **Employment earnings and stable income.**

Most people with disabilities live independently in their communities without publicly funded services. However, for people who do need additional support to live and work as independently as possible, informal supports and social networks are crucial. DHS is committed to create and implement policies that provide needed services at the right time.

People with disabilities should be able to participate in all aspects of community life if they choose. DHS has been a national leader in supporting people with disabilities to live at home or with family members. Yet, there is so much more to accomplish. Together with our partners, DHS strives to help people have the right support at the right time in the community of their choice.

In recent years, there have been broad legislative and operational changes to the long-term services and support system. DHS is at the center of implementing those changes. For providers and lead agencies (counties, tribal agencies and managed care organizations), the comprehensive nature and pace of the changes often has been confusing and difficult to implement. To support the transition, DHS is working with our partners and stakeholders to provide the most current information, technical assistance and resources.

As implementation continues, DHS will address common misunderstandings while we continuously work to expand awareness of systems change. Ultimately, the result of the many reforms will be a more person-centered and integrated system. That puts quality of life for people with disabilities at the center of our work.

## XIII. Appendix



I CONTROL



I DREAM



I CHOOSE



I PARTICIPATE



I CREATE

What are those icons, anyway?

You may have noticed that we used the above images throughout this report. Recently, with the help of focus groups, members of the Disability Linkage Line<sup>®</sup> staff published a helpful document about what person-centered mean to a person with disabilities. It is available online at [What does person-centered mean for me? An introduction, DHS-6803, \(PDF\)](#).

We talk a lot about what person-centered means on a systemic or programmatic level, but it also is important to remember what it means practically for the person.

We want to encourage people with disabilities to talk with the people who support them about what they want. The following images from that document include ideas about how to do that.

**Talk about what you  
want with the people  
who support you.**

**If you need help, call us.  
866-333-2466**



Disability Linkage Line is here to help. We make it easier for you to seek solutions and build a plan. The service is free for all Minnesotans. There are no wrong questions. **866-333-2466**